Investigation into the circumstances surrounding the death of a prisoner at HMP Wandsworth in January 2006

Report by the Prisons and Probation Ombudsman for England and Wales

February 2007

This is the report of an investigation into the death of man, who was found hanging in his cell at HMP Wandsworth. Staff attempted to resuscitate him but, sadly, without success. He was 49 years old.

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

The investigation was carried out by two of my investigators. I am grateful to the Governor of Wandsworth and to the governor who acted as liaison officer, for their assistance.

One of my Family Liaison Officers contacted the man's family to ascertain any concerns they had about the man's care. She will ensure that they receive a copy of the findings. This was a complex and time-consuming investigation dealing with a number of important issues. Consequently, the publication of the report has been delayed, for which I extend my apologies to all concerned.

The man was a life sentenced prisoner. At the time of his death, he had served ten years, three years more than his minimum tariff. He spent most of his time at HMP Wakefield, where his life was very settled and he had had a tight-knit group of friends who provided companionship and support. In spite of this, in October 2005, he tried to harm himself and spent three months being cared for in the healthcare centre. In November 2005, he was charged with a further serious offence. In early January 2006, he was moved to HMP Wandsworth to be close to the London court where his trial was to be held. The circumstances of the transfer were such that staff did not have access to his computerised records and, for a time, the man was given a new prison number.

The wing at Wandsworth on which he was located was being refurbished and the physical conditions were far from ideal. The man was away from his friends and their support. He was also facing a new charge that, if proven, would have meant many more years in prison. On the evening before his death, he was bullied by a group of prisoners who congregated outside his cell calling him names and threatening him.

The following afternoon, eight days after appearing at court and arriving at Wandsworth, the man was found hanging from a bed sheet attached to the window bars. Rigor mortis had set in and he had obviously been in that position for several hours when staff found him. If all the required checks had been carried out correctly, the man would have been found much sooner.

I make eight recommendations in this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2007**

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SUMMARY

The man was born in 1956 and was 49 years old when he died in HMP Wandsworth in January 2006. He was a life sentenced prisoner (lifer) who had been in prison for ten years, three years more than his recommended minimum tariff. He had been in Wandsworth for only eight days, after being transferred to London to be tried for a further serious offence.

In June 1995, the man had been arrested and charged with a number of serious, sexual offences. In October, he was convicted and remanded in custody while psychiatric reports were prepared. During this time, he spent a period of time being assessed at Ashworth Hospital. However, in June 1996, he was sentenced to life imprisonment with a judge's recommendation that he serve a minimum of 12 years before being considered for parole. In 2001, this tariff was reduced on appeal to seven years.

The man spent the first two years in London prisons before being transferred to HMP Wakefield in April 1998. It took him a considerable time to settle into prison life and begin courses to address his offending behaviour. However, he attended full-time education where he studied 'A' levels, before moving onto a degree course with the Open University. He eventually began a Sex Offender Treatment Programme (SOTP) in April 2002, but was removed after only two months. He had failed to face up to the circumstances of his offences and threatened another participant.

Staff reassessed him several times over the following years but they did not allow him to restart the course. They felt that his behaviour and attitude did not reach the standard necessary to undertake the course. The man was very aware that his failure to complete the course had a negative impact on his parole hearing in 2004. The board members noted that the man said he was willing to do the course. However, because he had not yet completed it, he could not show that his risk to the public had decreased during his imprisonment. The man's solicitors engaged in lengthy correspondence with prison staff in an effort to get him onto a course as soon as possible. However, as late as October 2005, he was told that he would be assessed again in January 2006.

Early in the morning of 26 October 2005, the man was found with a ligature and marks round his neck. He told Wakefield staff he had tried to strangle himself. He was immediately moved to the prison healthcare centre and put on an F2052SH plan. (The F2052SH form describes the problems facing a prisoner at risk of harming himself and implements a plan to help him through a period of crisis.) The man told staff that he had taken the action because he could not face more time in prison, and as a result of the uncertainty over starting the SOTP. Over the next four weeks, his depression gradually lifted and he began to interact with the people around him.

However, in November, the man was arrested and charged with an offence that pre-dated the offences for which he was already in prison. In the days afterwards, he told staff that he wished his suicide attempt had been successful. During the next few weeks, his mental health gradually improved and the F2052SH was closed on

22 December. In December, lawyers from the Crown Prosecution Service made a successful application to have the trial held in London.

The man appeared at Blackfriars Crown Court in January 2006 and was then taken to Wandsworth. On arrival, there were problems with the computer system and staff could not access his records from Wakefield. This caused a number of difficulties. Among others, it meant that staff did not know that the man had made a suicide attempt and, until only three weeks earlier, had been on an F2052SH. He was put in a shared cell on the Onslow Centre which houses vulnerable prisoners. At the time, the living conditions were uncomfortable due to building work which was in progress. Over the next few days, staff resolved the problems relating to his transfer and, as a lifer, he was given a single cell. However, on the night before he died, he was subjected to concerted bullying that went unnoticed by staff.

Early the following day, the man appeared to be fine when checked by officers on night duty. But several checks that should have been carried out during the rest of the morning were not completed. As a result, staff did not realise that he had not been seen at all that morning. Only at lunchtime was his absence noted and an officer investigated. She discovered the man hanging from the window bars in his cell. It was clear he had been there for some considerable time. In spite of a concerted and efficient effort to resuscitate the man, he was beyond help. Sadly, at 12:26pm, the prison doctor and paramedics confirmed his death.

THE INVESTIGATION PROCESS

1. The man died in January 2006. My investigators opened the investigation the following Monday when they visited the prison. They met the Governor and representatives of the Independent Monitoring Board and Prison Officers' Association. They saw the man's cell and walked round the Onslow Centre.

2. The investigators interviewed staff and prisoners at Wandsworth, staff at Wakefield and prisoners who had been in Wandsworth but had since moved to other locations.

3. One of my Family Liaison Officers spoke to the man's brother to ask if the family had any concerns that they wanted included in the investigation. They raised a number of issues including the man's earlier attempt to take his life, the care he received and the failure to return his possessions to the family. I hope this report goes some way to answering these questions.

4. A clinical review was commissioned from Wandsworth Primary Care Trust. One of their joint Medical Directors carried out the review and I thank him for undertaking this task. The conclusions and recommendations have been considered and are discussed in the section of the report on issues considered. The full report can be found at Annex 2.

HMP WAKEFIELD and HMP WANDSWORTH

5. HMP Wakefield is a high-security prison for men. The current building is of Victorian radial block design. The cells are single and have integral sanitation. It is now a main centre for lifer prisoners with the focus on serious sex offenders. The average prison roll is approximately 700, including a maximum of 100 Category A and 10 High Risk Category A prisoners.

6. The prison accepts prisoners serving over five years imprisonment, primarily for sexual offences or those who have previously committed sexual offences. Preference is given to those who are willing to participate in offence-focused treatment programmes.

7. HMP Wandsworth is a large prison in South West London, with a separate vulnerable prisoner unit. It is currently able to hold 1,416 prisoners and is the largest prison in London. Alongside Liverpool, which is of similar size, it is one of the largest prisons in Western Europe. It is a local prison and so accepts all suitable prisoners from courts in its catchment area.

8. The prison was built in 1851, and the residential areas remain in the original buildings. There has been extensive refurbishment and modernisation of the wings, including in-cell sanitation, privacy screens for cells occupied by more than one prisoner, and in-cell electricity.

9. There are two main parts to the prison. The Heathfield Centre is the main prison and has five wings, each with four landings. The Onslow Centre houses the vulnerable prisoners unit and has three wings holding approximately 330 prisoners. All wings have in-cell sanitation and in-cell electricity is currently being installed. At the time the man was there, building work was being carried out and scaffolding and tarpaulins prevented much natural light from entering the building.

KEY EVENTS

10. The man was remanded into custody at Wandsworth by West London magistrates in June 1995. He was convicted in October and further remanded for a psychiatric report to be prepared under Section 12 of the Mental Health Act (1983). In November, two further psychiatric reports were ordered. In February 1996, the court was satisfied that the man was suffering from a mental illness and an Interim Hospital Order was made, admitting the man to Ashworth Hospital. While waiting for a place at Ashworth, the man continued to be held at Wandsworth.

11. The psychiatrists who prepared the reports on the man did not agree in their recommendations to the court. InJune 1996, the judge decided against making a hospital order and sentenced the man to four terms of life imprisonment, with a recommendation that he serve a minimum of 12 years. This was later reduced on appeal to a minimum of seven years.

12. On sentence, all life sentenced prisoners (lifers) are advised by the trial judge of the minimum period of imprisonment that they must serve. No life sentence prisoner can expect to be released before they have served the minimum sentence period (tariff). Regular risk assessments are carried out in order to assess a lifer's progress and whether they are ready to progress to a lower category prison, including open conditions, or release. Once released, the licensee is supervised by the probation service. Although, the supervisory element of that licence may be cancelled when appropriate, the licensee remains liable to recall to prison for the rest of their natural life.

13. The man served the early part of his sentence in a number of London prisons but, in April 1998, he was transferred to HMP Wakefield. He remained there until a week before his death, when he was moved back to HMP Wandsworth pending court appearances for a further charge.

14. The man took many months to settle into prison life and routine and begin the work and courses identified in his sentence plan. However, in June 1999, he completed an Alcohol Education Course and two months later he began full-time education. Over the next two years, he studied a number of subjects at GCSE and AS level and in 2001 he began an Open University course. He also completed a stress management course. After a psychiatric assessment, the man was put on the waiting list for an Enhanced Thinking Skills (ETS) course and Sex Offender Treatment Programme (SOTP) to help him address his offending behaviour. He eventually completed an ETS course in March 2002.

15. The following month, he started the SOTP. However, the man was removed from the course after two months, due to failure to address issues surrounding his offence and his disruptive behaviour. This included threatening another prisoner who gave him negative feedback during a session. Staff informed the man that he would not be reassessed for the course until he had achieved "a period of stable and appropriate behaviour".

16. The man's suitability was re-assessed several times over the next three years, but each time he was judged not to be ready to resume the course. At his parole hearing in February 2004, the board members noted that his failure to complete the SOTP meant that his risk level had not reduced during his period of imprisonment. The board did note, however, his stated willingness to do the course. Parole was refused and the next review date was set for 2005. This was later postponed at the man's request. His solicitors kept in regular correspondence with prison staff about his need, as a matter of urgency, to complete an SOTP. In October 2005, he was told that he would be reassessed for the SOTP in January 2006.

17. Shortly after 8:00am on 26 October, the man was discovered in his Wakefield cell with a ligature fashioned from a bed sheet and marks on his neck. He told officers that he had tried to take his life by strangling himself. He was immediately moved to an in-patient ward in the healthcare centre and an F2052SH Self Harm at Risk form was opened. The man told staff that he felt unable to carry on due to the stress of his impending SOTP. However, he was not attending the SOTP, nor did he have a firm date when he would begin one. Two days later, he told a member of staff that the problem was the length of time that it was taking for him to start an SOTP, as he felt he should have completed one by then. He was also very aware of the fact that he was still in prison three years beyond his minimum tariff.

18. Over the next two weeks, the man remained in the healthcare centre as staff continued to be concerned about his low mood and failure to initiate contact with others. A chaplaincy visitor described him as, "closed down … the complete opposite to his usual outgoing self". The only comment the man would make about his self harm was that he could not face any more time in prison. He spent most of his day sleeping or watching television. By 13 November, he appeared to be a bit brighter and he began to play snooker and hold brief conversations with staff. He also attended education classes in the healthcare centre. A week later, staff noted that the man was beginning to laugh and joke with other prisoners.

19. However, on 22 November 2005, a teacher reported that during education the man had said that he "did not want to be here any more". She felt that he could be at increased risk of self harm, so staff began to monitor him closely once again. His mood gradually lifted over the next few days but he continued to spend most of his time watching television and sleeping.

20. In November, the man was arrested and questioned by detectives from the Metropolitan Police about events that had taken place in 1995. (This would have been a complete surprise to him.) The interviews were conducted at a police station in Wakefield. The police were made aware that the man was on an open F2052SH, and agreed to supervise him closely whilst he was in their custody. After being questioned, the man was charged with a further serious sexual offence and returned to Wakefield. When he returned to prison he told staff about the new charge and said that he felt a bit down. The following day, he appeared in court where he was remanded in custody. Over the next few

days, he appeared fairly relaxed and spent some time playing pool. However, he told a member of staff that the new charge had "knocked him for six".

21. In early December, the man appeared in court again, via a video link. During the proceedings, the Crown Prosecution Service (CPS) asked for the case to be transferred to a London court, because the alleged offence was being investigated by detectives from the Metropolitan Police. On his return to healthcare, the man said that his head was full of problems and that he wished his suicide attempt had worked. The following day he agreed to ask for his parole hearing to be postponed until after the new charge had been dealt with. His solicitor wrote three days later, informing him that the CPS application was likely to be granted.

22. Over the next two weeks, the man appeared gradually to become less depressed and on 22 December the F2052SH was closed. However, he remained in healthcare. He then received another letter from his solicitors informing him that his case had been transferred to Blackfriars Crown Court and that the next hearing would be early in the new year. They added that, before the hearing, the court should issue a production order to enable him to be transferred from Wakefield to a London prison. In a letter sent the following day, they informed the man that the court date had been set for early January 2006 and the hearing would agree a timetable for the case. On 30 December, the man met a member of staff for a review meeting following the closure of the F2052SH. He appeared to be coping and gave the officer no cause for concern.

23. The first notice that staff at Wakefield had about the man's court appearance in London was the day before he was due in court. Just after 2:00pm, one of the custody clerks received an email requiring them to send the man to Blackfriars Crown Court the following day. She spoke to a clerk at the court and asked if it was possible to have the man appear via a video link. When told this was not possible, she arranged that he would arrive at the court in time to appear at 2:00pm. The custody clerk contacted the local prisoner escort service to book the trip for the following day. She was told that the man would have to spend the night in a London prison, as the round trip could not be done in a day. However, they could not tell her at which prison he would be staying.

The man's time at Wandsworth

24. The following day, the man was taken from Wakefield to Blackfriars Crown Court in London. At the hearing he pleaded not guilty and the trial was set for late February. His lawyer told my investigator that the man understood the impact of the new charge and was resigned to the probable outcome. She said that he looked depressed, but he behaved rationally in light of the situation that he was facing.

25. After his court appearance, the man was taken to Wandsworth. On his arrival, he told officers that he was a lifer and gave them his prison number. When an officer entered the number on the computer, the front page of the

man's record appeared but it could not be accessed any further, nor could it be updated. The problem was that, because he was still on the computer system at Wakefield, staff at Wandsworth could neither see the whole record nor update it to reflect that the man was now at Wandsworth. As it was late, staff resolved the immediate problem of how to take the man onto Wandsworth's roll by giving him a new prison number.

26. The Wandsworth staff intended to revert to the man's original number once the problem had been rectified. They did not telephone Wakefield to try to resolve the problem immediately. (However, it should be noted that it was early evening and the discipline office at Wakefield would have been closed.)

27. The man asked to be put on Rule 45. (Rule 45 provides vulnerable prisoners with accommodation separate from the main prison.) At Wandsworth, vulnerable prisoners are housed in the Onslow Centre, which is where the man went after completing reception procedures.

28. The first part of the reception health check was completed by a nurse in reception. She observed the problems the uniformed staff had in entering the man's prison number into the computer. She noted that the screen indicated that, although he had been on an F2052SH plan, it had now ended. As the computer screen was locked, she did not know when the F2052SH booklet had been closed.

29. When the man left Wakefield, a Prisoner Escort Record form accompanied him, first to the court and then to Wandsworth. Section 3 of the form lists a number of risk categories that may apply to individuals, one of which is suicide or self-harm. This was not checked, nor was any reference made in the space for further information to the man's recent, lengthy stay in the healthcare centre. Had either part of the form been completed, it would have alerted staff at Wandsworth.

30. As he was transferring from another prison, the nurse looked through the man's accompanying medical records. They showed that he was receiving medication. She therefore appropriately referred the man to the doctor to get his medicine prescribed. The man saw the doctor who wrote out a prescription. The doctor added a note to the medical record that simply said, "medication done". My investigators were unable to speak to the doctor who saw the man on reception as, before an interview could be arranged, his contract was terminated. However, the nurse explained that the man's records showed that he was taking sleeping tablets, anti-depressants and antibiotics.

31. The man was allocated a shared cell on the Onslow Centre. The next day, he attended an induction session during which he asked a lot of questions. His main concerns appeared to be why he had been given a new prison number and whether his money had been transferred. He also said that, as he was a lifer, he wanted a single cell rather than the two-man cell he was currently in.

32. The induction officer spoke to the custody officer to try to resolve the issue of the two numbers. She then asked staff at Wakefield about his money, as it was not showing on the computer, and was told that it had been transferred to Wandsworth. Staff in Wandsworth's finance department explained that until the system was altered back to the original prison number it could not be accessed. The induction officer passed this information to the man and said that it would not be resolved until after the approaching weekend. The problem of two numbers also meant that the money on the man's telephone PIN card could not be transferred. As a result, he could not make telephone calls. However, staff allowed the man to use an office telephone to make a call. The induction officer also told him to put in an application for a single cell.

33. Over the weekend, the man did not attend the treatment room to take his medication as he should have done. The prescription charts record Did Not Attend (DNA) for Saturday, Sunday and Monday.

34. The man put in an application for a single cell first thing on Monday morning. It was approved and he moved into one the next day. It was on H wing on the 'threes' landing, which actually means on the first floor, and was very close to the centre. (The centre is the area where the three wings come together and where the wing office and senior officer's offices are located.) The man told another prisoner that the cell was cold. My investigators were told that there were problems with the heating system that meant the wing was unusually cold.

35. On Tuesday, the man again failed to go to the treatment room for his medication. The male nurse who was on duty that day, left a note in his cell, asking him to collect his medication but he did not do so. Again, staff recorded DNA against his name. The following day, the male nurse informed his colleague, a more experienced, female nurse about the man's failure to collect his medication. The female nurse went up to the man's cell and he said that he did not want his medication and that he was fine. When asked, he said he did not want to see a doctor either. The nurse entered "Refused" against his name in the prescription chart. The following day (Thursday) she asked the male nurse to try to persuade the man to take his medications, as she thought a man to man appeal might have more success. However, although the male nurse took the medication to the cell, the man said he was fine and refused to take it. Again, his refusal was recorded on the prescription sheet.

36. After this refusal, the two nurses decided to refer the man to the doctor, as the first step in ensuring that he was seen by a member of the psychiatric team. The female nurse explained to my investigators that it is possible for nurses to submit a psychiatric referral form. However, it is sometimes quicker to refer the prisoner to the doctor and for the doctor to make the referral to the psychiatric team. The list to see the doctor on Friday was already full, so they put his name on the Monday list.

37. Also on Thursday, the man thanked the induction officer for her help with the problems related to his prison number which had now been resolved. He had reverted to using his lifer number and his money and PIN phone card were again usable. The man was on his way to work at the time and the induction officer thought he seemed fine.

38. The man had been assigned to work in the laundry and had his induction that morning. When he was there, he told another prisoner that he was cold and his cell was cold. The man did not return to the laundry after lunch but spent the afternoon on the wing. After the workers returned to the wing at the end of the afternoon, the man went to the cell of another prisoner who worked in the laundry and asked if he could borrow a couple of items. The man stood in the doorway and the two men chatted for a few minutes.

39. After the evening meal, due to a shortage of staff, only the prisoners who worked as cleaners were given association and time out of their cells. During this period of association, a group of the cleaners gathered outside the man's cell and shouted abuse at him through the locked door. They also threatened that, unless he gave them canteen items such as tobacco and sweets, they would spread the story that he and another prisoner had been seen engaging in a sexual act.

40. My investigators spoke to the other prisoner alleged to have been involved in the sexual act and he totally denied the allegation. They also spoke to the prisoners who were supposed to have seen the activity happening. The prisoners denied that they had seen any such thing and named other prisoners as the source of the rumour. The other named prisoners also denied seeing anything and starting the rumour. I can only conclude that the rumour was manufactured in a malicious attempt to extort tobacco and other canteen items from the man. The very limited contact between the man and the laundry worker appears to have provided the idea for the rumour and subsequent bullying.

41. In spite of the fact that about 25 cleaners were on association, no prison officers appear to have been supervising the men on the landings. Had any officers been present, they could not have failed to hear the noise and seen the group of prisoners crowded around the man's door. According to prisoners, there was quite a lot of noise and it went on for some time during which the size of the group fluctuated as individuals came and went. For the man, it must have been a very unpleasant experience.

42. Staff did not become aware of these events until after the man's death when a prisoner informed an officer. The then governor of the Onslow Centre investigated the matter locally and her report and all information were passed to my investigators.

43. The night staff checked all prisoners in the Onslow Centre at about 5:45am on Friday morning, as they are required to do. At that check, the man was still in bed. After that, he was not seen again until the discovery of his body at

12:10pm. A number of checks on his location and his cell ought to have meant that he was discovered much earlier than he was.

44. The last person to see the man alive appears to have been one of the night shift officers. The two night officers did a roll check from approximately 5:30am to 5:45am, towards the end of their shift. One remembered counting the men on H3 landing, including the man who died. He told my investigator that, although he did not know the man, he was absolutely convinced that he was alive in his bed at the time of the morning roll check. He explained that it was his practice to stay at a cell until he was sure that the man or men inside were alive. He also recalled, after learning of the man's death, that on the side of H3 that included his cell, all the prisoners were still in their beds when he checked them.

45. At some point after the roll check, it seems the man secured one of his bed sheets to the window bars and hanged himself from it. At that time, each cell in the Onslow Centre had a privacy curtain that stretched almost fully across the width of the cell. It ensured that a prisoner using the toilet and washbasin, which are located under the window, could do so without being observed. The curtain was not floor length, which meant that feet were visible in the 18-inch gap from the floor to the hem of the curtain. The man pulled the curtain across his cell. It is not possible to say when exactly when he did this.

46. The first time an officer should have checked on the man was for the morning roll check. It is the policy at Wandsworth that the officers who relieve the night shift must carry out a roll check at the start of their shift, at approximately 7:30am. They then sign to confirm that the check was done. On Friday morning, the labour officer signed to say that he had conducted the morning check. However, when he spoke to my investigators, he admitted that he had not carried out the check although he had signed to say that he had. He explained that when he came on duty, he helped the two night shift officers do their check. When it was time for him to do the morning check, another call was made on his time and he did not do the count. Although he knew that a new count should have been done, he used the number from the night shift check as the morning roll. The officer has since reached retirement age and has now left the Prison Service.

47. At 7:45am, the cell doors are unlocked to allow the prisoners to get ready for the morning activities. The officers who unlock do not count the prisoners or stop to chat with them, although some greet the men as they open the doors. The then governor of the Onslow Centre said that she would expect that staff who unlock in the morning to check that the prisoner is in the cell and that he is alive. If a prisoner appeared to be behind the privacy curtain, the officer should verbally confirm that he was okay.

48. Once the prisoners are unlocked, they are able to use the showers and telephones, or collect hot water to make a cup of tea. They do not collect food for breakfast as 'breakfast packs' are issued. (This means that when they collect their evening meal, they are given a pack for breakfast the following morning containing cereal, milk and sachets of tea and coffee.

Many prisoners also take extra bread with their evening meal, in order to keep some for breakfast.) Accordingly, there is no reason for officers to notice whether or not a prisoner comes out of his cell after being unlocked in the morning.

49. At approximately 8:30am, the prisoners are called to work and those who work or attend education leave the landings. Some prisoners do not work - for example those on remand who chose not to, men of retirement age and those who are too ill. These men are left unlocked and are free to move about the wing until the workers return before lunch, when all prisoners are then locked up. During the morning, the wings are usually quite busy and noisy.

50. The next occasion when the man could have been discovered was during the cell fabric checks. Officers check each cell every day and then sign and record the time they complete the checks on each landing. They look for damage to the walls, floors, doors and window bars, to ensure that no attempt at escape is being made. They check the fittings and also have a cursory look around for any items in the cell which should not be there. All the officers who spoke to my investigators said that, if a curtain was pulled across the cell, they would pull it back as they have to go behind the curtain to check the toilet, sink and window. The staff who spoke to my investigators were all quite clear that, when doing any kind of check, unless a prisoner was behind the curtain, they would tell the prisoner to keep it pulled back.

51. On Friday morning, two officers carried out the cell fabric checks on the third landing and one of them signed to say they were completed at 8:45am. The fact that the man was not discovered during the checks has one of two explanations. It may be that the man was out of his cell during the fabric check and returned later. However, my investigators could find no-one who remembered seeing the man that morning. It would also mean that he left his cell for a time, then returned and moved behind the curtain almost immediately. We know that by approximately 9:00am the curtain was pulled across the cell.

52. Alternatively, the man could have been behind the curtain which would mean a proper check was not done on his cell. Officers explained to my investigators that it might be possible to miss out a cell during a check. If they were called away in the middle of a check, they might not recall accurately what cell they had reached. As a result, they might continue not where they left off but at a nearby cell. However, all the staff were all clear that each cell must be checked each day and what a check requires.

53. The next time a working prisoner's absence should be noted is at about 9:00am, after the labour officer has checked the workshops to note which men have not reported for work. They then cross reference this with the list of prisoners who have a valid reason for being absent, for example those having a visit or who are sick. Prisoners who are not at work without a valid reason are not paid for the time they miss. The labour officer then looks for absent

prisoners, beginning with their cell and then moving to a general search of the wing.

54. The labour officer that Friday recorded that the man was not at work in the laundry. He went to his cell and looked through the observation hatch but did not see him. He noted that the privacy curtain was pulled across the cell but did not go in and pull the curtain back. Had he taken a minute or two to do so, the man would have been found much earlier. However, the labour officer explained that he had a lot of tasks that morning and he decided to look for the man later. He did not inform a wing manager that he could not locate the man or ask another officer to look for him. For the remainder of the morning, no one took any action to find the man.

The discovery of the man

55. At 11:45 am, prisoners return from morning activities and are locked in their cells. At midday, they are unlocked a few at a time to collect their lunch from the hot plate on the ground floor. An orderly (a prisoner) has a list of prisoners and the meals they have ordered and checks off the names as the men collect their food. When the man did not collect his meal, the prisoner alerted an officer at the hot plate and an officer on the third landing went to his cell. She immediately noted that it was extremely cold in the cell as both windows were open. As it was too cold for somebody to be sitting there, she assumed that the man was not in the cell and that he must be at a visit or a religious service. As the privacy curtain was pulled across the cell, she pulled it back and discovered the man hanging.

56. The officer immediately ran to the door and shouted to another officer at the end of the landing to help. She then returned to the man and supported his weight. The other officer came in and went to the other side and they were able to raise him further. Further officers heard her shout and ran to assist. A third officer arrived very shortly afterwards and released the bedsheet from the window. They moved the man to the bed where they removed the bedsheet. As they did this, a nurse arrived and told them to lay the man on the floor so that she could begin treating him. Once the man was on the floor, an officer used the radio he was carrying to contact the control room and ask for the hospital response team to attend. (The responding nurse rightly asked for the man to be moved to the floor. The Governor may wish to remind all staff of the requirement in Annex C of PSO 2700 to place an unconscious prisoner on his / her back on a flat, solid surface.)

57. Two nurses were in the treatment room on the ground floor dispensing medication when an officer asked them to go to help the man. One went ahead while the other collected the emergency bag and oxygen cylinder before going upstairs. At the cell, officers told the second nurse that they had called for the duty nurse, the doctor and an ambulance.

58. The second nurse noted that the man's skin was cold, he had no pulse and was not breathing. She noted the presence of rigor mortis (the stiffening of the body after death). His jaw was shut tight and she could not open his

mouth to put in an airway. As a result, she put a face mask over his nose and mouth and administered oxygen through it. The nurses also performed the chest compressions necessary to carry out cardio-pulmonary resuscitation. After a short time, the duty prison doctor arrived as did the paramedics. They each examined the man and at 12:26pm agreed that there was nothing more that could be done for him and that he had died.

59. The governor of the Onslow Centre and another governor visited the man's next of kin to inform them of his death. Unfortunately, there was a delay of some hours while they checked the address and then travelled through rush hour traffic to reach the family home. There was a further delay while prison staff liaised with police officers from the local police station. To date, neither the man's property nor his money have been returned to his family.

ISSUES

The F2052SH plan and support for the man

60. When staff at Wakefield learned of the man's attempt to take his life, they acted quickly and put support in place. He was admitted to healthcare, where he was put on regular but intermittent observations and an F2052SH plan was opened at once. The first review meeting was held within the required timescale and was attended by staff from a range of departments. The man's mental health was monitored throughout his time in healthcare and whilst the F2052SH was open.

61. However, it appears that staff did not consider contacting the man's family to include them in his support plan. PSO 2700 Suicide and Self-harm Prevention states in paragraph 3.4.3, "After consultation with the prisoner, the nominated next of kin must be notified, unless:
    - There is a clinical reason not to, or
    - If aged 18 and over, the prisoner does not consent, or
    - The prisoner's support plan indicates otherwise."

    There is nothing on the record to show that staff considered encouraging the man to include his family in his support plan. Wakefield has now moved onto the new Assessment Care in Custody and Teamwork (ACCT) system for supporting prisoners who are at risk of self-harm. It also includes a requirement to involve the next of kin in support if the prisoner gives his consent.

    The Governor of Wakefield should remind staff of the requirement in PSO 2700 to involve the family in the support of a prisoner on an ACCT plan and introduce an audit of records to establish compliance.

Prison numbers and the computer system

62. It is not clear whether the man was expecting to return to Wakefield the day after appearing in court. His solicitor had written in December 2005, saying that he would be transferred to a London prison while his case was being heard. But staff at Wakefield fully expected the man to be returned to them as soon as possible. He was therefore sent to court and Wandsworth with only some of his documentation. His possessions remained at Wakefield. My investigators looked at the circumstances of the transfer, but were unable to find any documents relating to an arranged transfer or an indication of how long the man was to remain at Wandsworth.

63. When the man arrived at Wandsworth, he gave officers the prison number he had used for many years. However, when staff entered it into the Local Inmate Database System (LIDS), they could see only the front page and could not add or change any information. This caused problems both for the staff and, more importantly, for the man. The reception staff resolved the immediate issue by giving him a new number, meaning that the man could be put onto the roll at Wandsworth. However, it meant that for almost five days the man did not have access to his money or to his phone card. It obviously

concerned him as he spoke to officers about it for several days until the problems were resolved.

64. The difficulties arose because of the way LIDS is set up – each prison's database is stand-alone and is not fully accessible across the prison estate. When the man was taken to Blackfriars Crown Court staff at Wakefield did not know which prison he would be taken to for the night. Had they known, they would have entered the details onto LIDS and the man would have been removed from Wakefield's system and roll and added to the other prison's. The man had to be removed from the roll at Wakefield in order to keep their roll correct. Staff in the discipline office had to enter a destination for the man and the only destination they were sure of was the court. The man was then on the roll of the court and neither Wakefield nor Wandsworth could access his records beyond the first page. The problem was only resolved when the man was removed from the court roll and put onto Wandsworth's. That then allowed Wandsworth to take him on to their roll and revert to his original prison number. Only then did the man get access to his money and PIN phone card.

65. Another important ramification was that, although staff could see that the man had been on an F2052SH form, they could not access the screen that gave the date it had been closed. Had they been able to do so, they would have seen that it had been closed just over two weeks previously. However, I am surprised that staff in reception who saw the information about the F2052SH did not ask the man when it had been closed. The information would have been useful to add to the medical record, particularly as the man was on anti-depressant medication. It should also have informed the decision on the Cell Sharing Risk Assessment.

66. I have been pleased to learn that the problems experienced during the transfer of the man from Wakefield to Wandsworth via the London court will not occur when LIDS is replaced with the new C-NOMIS computer system. When it is fully in place, the new system will allow staff in all areas of the National Offender Management Service (NOMS) to access and update information on any person on the system.

Health checks

67. The medical notes show that, before the man left Wakefield, he was assessed as being 'fit for court and any overnight stay'. The record does not record whether the assessment looked at his recent mental health problems and the recently closed F2052SH. In his report, the clinical reviewer highlighted the importance of monitoring the man's mental health, especially as he was facing a new charge. It would have been helpful if the assessment had mentioned the F2052SH and the man's self-harm.

Wakefield West PCT in partnership with HMP Wakefield should ensure that all prisoners being transferred have recent self-harm attempts and F2052SH plans noted in the clinical record at the assessment prior to movement.

68. When the man arrived at Wandsworth, a nurse completed the health procedures in reception. She took his medical record which had travelled with him from Wakefield. She saw from the record that he was prescribed a number of medications and, as required, she referred the man to see the duty doctor before going to the wings. She also noted from the LIDS screen that he had been on an F2052SH but it was now closed. Because of the problems accessing the man's full record on the computer, the reception nurse could not find out when the plan had been closed. Unfortunately, she did not ask the man for this information. When asked why she had not done so, the nurse replied that she hoped the doctor would speak to the man about this. She said that the man looked fine and was happy that he was going to see a doctor. He did not mention that he was facing a new charge.

69. Although the closure of the F2052SH is mentioned in the medical record, there is no way of knowing whether the doctor read this or discussed the man's mental health with him. As already noted, the only record of the consultation was that medications were prescribed. The brevity of the entry leaves that part of the man's medical assessment blank.

70. As a prisoner who was transferred from another prison, the man did not undergo the full First Reception Health Check as a new prisoner would have done. Nor did he have a follow up health check at a later date. As part of the First Night procedures, the man would have been asked if he wanted to be referred for a well-man check up, but that check is voluntary. There is no formal health screen process for a transfer prisoner. As a result, it appears that no-one asked the man about the F2052SH, thus missing an opportunity to have learned about his recent mental health needs.

    The Wandsworth PCT in partnership with the prison should ensure that all prisoners, including those transferred from other prisons, receive a structured and well documented health review that includes mental health issues.

Living conditions on the Onslow Centre

71. During the week he spent in Wandsworth, the man passed the time playing pool and table football (my investigators were told that he was a very good player). He chatted with some other prisoners and his impending trial was obviously in his thoughts. He told one prisoner that he had already done a long time in prison and was looking at a potential life sentence. When talking to another prisoner, he said that he had destroyed his life. However, staff and prisoners generally commented that the man was very quiet and mainly kept to himself.

72. This was very different to his life in Wakefield where he was known to the staff and had a group of close friends. There, he was part of a tight-knit group of men from the same ethnic background who cooked their own food and ate together. They supported the man, and his personal officer said that they had

a calming influence on him. When he moved to the healthcare centre, they sent him cards that showed concern and support.

73. The building housing the Onslow Centre was very dark, due the building work that was going on at the time. The outside of the wing was covered in scaffolding and the skylights were covered over to prevent materials falling onto those below. A boiler was broken and there was no hot water available in the showers. A prisoner told my investigators that he had given the man his newspaper to read in his cell. He later discovered that the man had put the pages on his bed for warmth.

74. The man was not issued with a battery-powered television as there were none available at the time. According to his property cards, the man's radio/CD player had remained at Wakefield along with his other property as the staff there had expected him to return after an overnight stay in London. When my investigators saw the man's cell, they noted that, apart from two library books, it was quite bare. The living conditions in Wandsworth must have seemed very stark compared to the life he had had in Wakefield.

The Governor of Wandsworth should consider providing sufficient televisions to ensure that there is one per cell available.

The bullying on Thursday evening

75. Shortly after the start of the investigation, several prisoners informed my investigators that the man had been bullied and blackmailed for his canteen. In an effort to establish the truth of the allegations, my investigators spoke to six men who had been prisoners on the Onslow Centre when the man was there. Their accounts differed somewhat, but they all described a very similar scene that occurred during association on Thursday evening. One prisoner said that the prisoners had returned the following morning and that the man had spoken to the induction officer when she unlocked his cell. However, none of the other prisoners corroborated this information and I conclude that it was rumour and unreliable.

76. It is disturbing to learn that a group of approximately six to eight prisoners was confident enough openly and noisily to bully another prisoner. Even more disturbing is the apparent absence of officers from the landings supervising association. When asked where the officers were whilst the 'mob' was at the man's door, the prisoners replied that they were not on the landings. The cleaners are generally in positions of trust, but they are still prisoners who must be supervised. The lack of supervision on the last night of the man's life meant that others were able to subject him to serious verbal abuse and threats.

77. The local enquiry that was carried out by the the governor of the Onslow Centre of the unit did not find any evidence of the man being bullied. My investigators spoke to the prisoner who made the initial allegation and a number of the cleaners named as being involved in the spreading of the rumour and the bullying. They all confirmed that the disturbance had taken

place. I can only conclude that whilst the prisoners were willing to give information to my investigators, they were more reticent when being questioned by prison staff.

78. The apparent lack of supervision appears to be in keeping with the autonomy the cleaners seemed to have had up to the middle of January 2006. One prisoner told my investigators that he had arranged a job as a cleaner on his second day in the prison. He explained that all he did was have a word with one of the prisoners who was already a cleaner. During the early part of the investigation, my staff were told that cleaners held supplies of equipment such as mugs and blankets. They also held the application forms so that any prisoner who wanted to make an application, including a medical one, had to ask a cleaner for the correct form. The investigators were told that several cleaners abused this responsibility by not issuing equipment or forms when they were asked to. They discussed these issues with the unit manager and prompt action was taken and the responsibilities removed from the cleaners. Application forms are now readily available from a rack outside the wing office. At the same time, a number of cleaners, including those named as being involved in the bullying, were transferred to other prisons.

Missed checks on Friday morning

79. The man was not seen alive at any time after 5:45am when the officers on night duty did the roll check towards the end of their shift. During the morning, several other checks ought to have been carried out that should have resulted in staff finding the man significantly earlier than actually happened. Either the checks were not done, or they were not done to the required standard. The result was that the man was not found until lunchtime when there was no possibility that a successful resuscitation could be carried out. The list of failures makes unhappy reading. It is also worrying that, in effect, a prisoner disappeared from view for a whole morning without any action being taken to discover his whereabouts.

The Governor of Wandsworth should remind all wing staff that a morning roll check must physically be completed before being signed for in accordance with local policies and procedures.

The Governor of Wandsworth should remind officers who unlock prisoners in the morning to check that the prisoners are in the cell and are well.

80. The two most serious omissions lie at the door of the one officer who has now retired from the Prison Service. Had he not done so, I would have recommended that the Governor consider an investigation under the code of discipline. Whilst there is no excuse for his signing for a check that he did not carry out, there were mitigating factors in his failure to search for the man on Friday morning. As the labour officer, he had a long list of tasks to carry out during his shift. (The role of labour officer at the time does appear to have been far more heavily weighted than that of a landing officer, especially as it involved tracking down prisoners who had unexpectedly failed to attend work.)

The unit manager raised this issue during her interview with my investigators and indicated her intention of carrying out an assessment and reallocation of the duties of the officers on the Onslow Centre.

81. The other probable omission is the lack of a cell fabric check on the man's cell. An officer signed to say that the threes landings had been checked. If the timings that were recorded are accurate, he and the officer who assisted him did the cell checks for the threes landings between 8:15am and 8:45am. With 15 cells on each side of the wing, that means that the two officers checked 30 cells in 15 minutes. That would imply that each cell check took approximately a minute. It is impossible to say what happened about the man's cell fabric check, apart from noting the speed with which the whole landing was completed.

    The Governor should remind staff of the importance of ensuring that no cells are missed during the daily fabric checks.

Return of the man's possessions

82. When my Family Liaison Officer contacted the man's family in early November 2006, she was told they still had not received his property and money from the prison. The man's brother had tried several times to contact staff about this but without success. I have made the Governor aware of this lack of care for the family and, at the time of writing this report, he is resolving the matter. I am aware of occasions where the staff at Wandsworth have been very caring and considerate in their treatment of bereaved relatives. It is, therefore, all the more disappointing that this care was not given to the man's family.

    The Governor should investigate the cause of the unreasonable delay in returning the man's possessions and take action to prevent a recurrence.

RECOMMENDATIONS

The Governor of Wakefield should remind staff of the requirement in PSO 2700 to involve the family in the support of a prisoner on an ACCT plan and introduce an audit of records to establish compliance.

This recommendation has been accepted.

Wakefield West PCT in partnership with HMP Wakefield should ensure that all prisoners being transferred have recent self-harm attempts and 2052SH plans noted in the clinical record at the assessment prior to movement.

This recommendation has been accepted.

The Wandsworth PCT in partnership with the prison should ensure that all prisoners, including those transferred from other prisons receive a structured and well documented health review that includes mental health issues.

This recommendation has been partially accepted and the resource implications will be examined. In the meantime, the prison transferring the prisoner should ensure that the clinical record is up to date and complete and that it accompanies the prisoner. The Head of Health Services at Wandsworth will ensure that the system is reviewed with the intent that the clinical record of each prisoner being transferred is read and an entry made in the record to this effect. An action plan will be entered in the clinical record where necessary and brought to the attention of relevant staff.

The local PCT is currently re-assessing the requirements for healthcare provision in Wandsworth and have now included a section on physical and mental health reviews for all patients arriving at the prison. The computerised medical record system that all local GPs use will also be installed in the prison to improve the quality of information staff will have on their patients.

The Governor of Wandsworth should consider providing sufficient televisions to ensure that there is one per cell available.

In-cell electricity was being installed on the Onslow Unit at the time of the man's death. This has now been completed and each cell now has a television.

The Governor of Wandsworth should remind all wing staff that a morning roll check must physically be completed before being signed for in accordance with local policies and procedures.

The Governor of Wandsworth should remind officers who unlock prisoners in the morning to check that the prisoners are in the cell and are well.

The Governor of Wandsworth should remind staff of the importance of ensuring that no cells are missed during the daily fabric checks.

For the three recommendations above, Governor's Orders have been issued on these three subjects. The Local Security Strategy document also sets out in detail the correct procedures. This is published on the intranet and is available at all times to staff.

The Governor of Wandsworth should investigate the cause of the unreasonable delay in returning the man**'s possessions and take action to prevent a recurrence.**

One of members of the Senior Management Team has been in contact with the man's family to ask what their wishes were regarding his property. The family have not yet confirmed what property they want to have forwarded to them.

ANNEXES

1. Documents considered during the investigation

Core Record
Custody File
Security File
Medical Records
Parole dossier
Lifer file
Correspondence from the man's solicitors regarding his new court case
Emails and notes supplied by the Custody clerk at Wakefield relating to the man's movements on 5 January 2006