

**Investigation into the circumstances surrounding the
death of a man at HMP Wandsworth
in August 2007**

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

July 2008

This is the report of an investigation into the circumstances of the death of a man on Monday 20 August 2007. At 7.35am that morning, the man was discovered hanging in his cell at HMP Wandsworth. Cardio pulmonary resuscitation was carried out, but at 8.31am he was pronounced dead. The man was 46 years old and had been in Wandsworth for five days.

I would like to offer my sincere condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man had nominated an elderly friend, whom he described as his "adopted" mother, as his next of kin. Both her family, and the man's relatives, were contacted by my family liaison officer. I hope this report offers answers to their questions.

The investigation was led by my colleague who was assisted by another investigator. A clinical review was conducted by Joint Medical Director, Wandsworth Primary Care Trust, and I am grateful for his assistance. I would like to thank the Governors and staff at HMP Wandsworth and HMP Gartree for their co-operation with this investigation.

The man arrived at HMP Wandsworth from HMP Gartree on 15 August 2007 to receive visits from his family. He had spent 18 months applying for the visits and was said to be very excited about them. He was expected to remain in Wandsworth for at least four weeks. However, in the early hours of 18 August the man self-harmed and told staff that he felt threatened on the wing. He was placed on the Prison Service's self-harm monitoring and support procedures (ACCT), and moved to the Onslow Centre which houses vulnerable prisoners.

The man was placed in a double cell with another vulnerable prisoner who had mental health problems. Almost immediately, his behaviour began to deteriorate and he continually expressed fear of other prisoners. On the day before his death, the man said on more than one occasion that he intended to kill himself. Staff tried to reassure him but they did not carry out a review of his risk of self-harm or increase the frequency of observations.

It is clear from his records that the man had experienced great anxiety on two previous occasions when he moved from one prison to another. Why he apparently took his own life cannot be known. However, a number of failings, including poor communication between staff and a lack of adherence to monitoring procedures, may have increased his opportunity to do so.

I have made a number of recommendations, reflecting the seriousness of the matters revealed by this investigation. I apologise for the delay in issuing this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

July 2008

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SUMMARY

In September 2004, the man was sentenced to life imprisonment. He spent a year at HMP Wandsworth before being transferred to HMP Swaleside. The following day, the man self-harmed and said he was fearful of other prisoners. He was placed on self-harm monitoring and support measures and there were no further incidents of self-harm. On 14 October 2005, he was moved to HMP Gartree following his request for a transfer.

At Gartree, he was located onto H wing. Three days later, he barricaded himself in his cell and threatened to self-harm. Again he was placed on self-harm monitoring and a mental health assessment stated that he had an “abnormal fear of coming to harm”. It was decided to locate the man in Gartree’s healthcare unit, which is used predominantly for prisoners who find it difficult to cope in the environment of the main prison, rather than those with health needs. Neither the incident nor the mental health assessment was written up in the man’s medical records.

The man remained on the healthcare wing and progressed very well. He obtained certificates in basic literacy and secured a job within the wing. He had his own cell and by all accounts was comfortable and stable.

In January 2006, the man made his first application for accumulated visits. He wanted to go to a prison nearer London to receive visits from a close and elderly friend who was in failing health. Population pressures meant that transfers were not possible at that time. The man grew increasingly frustrated with the situation and frequently put in written complaints to the prison and the Independent Monitoring Board. He occasionally threatened to self-harm if his visits were not granted.

In July 2007, HMP Wandsworth agreed to take the man and he transferred there on 15 August. He was said to be delighted. However, after three days at Wandsworth, he self-harmed and was taken to the Care and Separation Unit. An Assessment, Care in Custody and Teamwork (ACCT) document was opened and he was moved to the Onslow Centre, the vulnerable prisoners’ unit. He was located in a cell with an extremely vulnerable prisoner who was awaiting transfer to an outside hospital for a mental health assessment. This information was not known by staff on the wing, although the man was known to be unable to care for himself and had received warnings about the poor state of his cell.

Within a few hours, the man pressed his cell bell, expressed fear of other prisoners, and asked to be moved off the wing. Staff told him this was not possible at the time. Over the afternoon and following day, the man did not come out of his cell, nor eat any meals, and on a number of occasions he said he would harm himself. Throughout this time, and despite concern from some staff, his ACCT observation level remained the same.

The man was last seen alive at 6.00am on 20 August 2007. He should have been checked at least once more before 7.30am. The man was discovered hanging at 7.40am. Cardio Pulmonary Resuscitation was carried out but he was declared dead at 8.35am.

THE INVESTIGATION PROCESS

1. My investigator conducted a preliminary visit to HMP Wandsworth on 22 August 2007 to open the investigation. She visited the cell where the man died. My investigator also met the Governor of Wandsworth and his appointed liaison officer. Subsequently, all the relevant documents were reviewed and a chronology of events established. Feedback on the findings of the investigation were given to the Governor and the prison liaison officer on a regular basis. It is understood that Wandsworth is conducting an internal investigation regarding a number of issues raised in the feedback.
2. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my investigators. No one came forward as a result.
3. My investigators met representatives of the local branch of the Prison Officers' Association and the Independent Monitoring Board (IMB). No specific concerns were expressed. Numerous attempts were made to contact the officer in charge of the police investigation, without success, as telephone calls were not returned. My investigator informed one of the Coroner's officers about this as well as other aspects of the investigation.
4. Given that the man had been temporarily transferred from HMP Gartree, my investigators visited the healthcare unit where he had been located. Gartree was able to provide considerable additional documentation. Four staff members were interviewed and one prisoner. My investigators met a member of the IMB who had known the man as he had written to the Board a number of times regarding his request for accumulated visits. The Board was shocked to learn of his death but did not have any concerns regarding Gartree.
5. The Joint Medical Director at Wandsworth Primary Care Trust, undertook a clinical review of the healthcare provided for the man. The clinical reviewer conducted a number of joint interviews of medical staff with my investigator, my investigator. He was provided with transcripts of these interviews and, in addition, with copies of the man's medical record.
6. Twenty-four members of staff, both discipline and healthcare, were interviewed and a number of others were spoken to informally. Some staff members were interviewed twice to clarify certain matters. Two prisoners at Wandsworth were interviewed. However, the man's cellmate in C wing was deported prior to the start of the investigation, and consequently it was not possible to speak with him. His cellmate in the Onslow Centre was also no longer at the prison, and attempts to discover his whereabouts were unsuccessful. Recordings of three telephone calls made by the man whilst at Wandsworth were made available to my investigators.
7. One of my family liaison officers contacted the man's niece. She expressed an interest in the investigation and has appointed solicitors to represent her. The man's nominated next of kin was also informed of the investigation and given an opportunity to participate.

8. A draft copy of this report was sent to the prison service. A number of factual observations were made and four minor changes have been made. The Prison Service made one comment asking that recommendations five and eight be incorporated as one, which is repeated verbatim in the relevant section (on page 26). The comment has not been accepted and the recommendations remain unchanged as they refer to separate issues. No further comments have been received and an action plan has not yet been submitted.
9. Solicitors representing the man's niece were sent a copy of the draft version of this report. Their comments have been noted but no changes to the report were requested.

HMP WANDSWORTH AND HMP GARTREE

HMP Wandsworth

10. HMP Wandsworth is a large category B local and remand prison in South West London, built in 1851. With an operational capacity of 1,416 prisoners, it is the largest prison in the United Kingdom and one of the largest in Western Europe. Although the residential areas remain in the original buildings, there has been extensive refurbishment and modernisation of the wings.
11. HM Chief Inspector of Prisons, Ms Anne Owers, conducted a follow-up inspection of Wandsworth in 2006. She noted that it was an improving prison, but with a significant way to go. The man was a resident in the Onslow Centre, a unit of three wings that holds about 321 vulnerable prisoners. (Vulnerable prisoners are those identified as needing protection from mainstream prisoners. This is often due to the nature of their offence or their risk of being bullied.) During the inspection, the Centre was found to have good staff-prisoner relationships, with 75 per cent of prisoners in the unit saying that most staff treated them with respect. Wandsworth's healthcare services are provided by Secure Healthcare and commissioned by Wandsworth Primary Care Trust.
12. There were seven apparent self-inflicted deaths at Wandsworth between 2005 and the man's death. A death in January 2006, which has been to inquest, found that a number of checks had not been carried out by staff as they should have been. My investigators were told that Governor's Orders had been issued in response and we were provided with copies of these.

HMP Gartree

13. HMP Gartree is a category B prison. It holds life sentence prisoners in the first and second stages of their sentence. Gartree has an operational capacity of 577 prisoners. Two new units were added in November 2006.
14. HM Chief Inspector of Prisons last reported on Gartree in May 2005 when she found the prison wanting in its delivery of lifer services. She described Gartree as "showing all the signs of a prison that had been drifting..." In respect of healthcare provision, Ms Owers described the healthcare services as giving her cause for serious concern. She was particularly worried that staff shortages, coupled with inappropriate use of healthcare staff for discipline roles, was leading to poor service delivery. There were 14 beds within the healthcare centre, but only two of these beds had been allocated to clinical need. This meant that healthcare staff were used to supervise non-patient prisoners, thereby detracting from their clinical duties. This situation continues to date. Prior to his transfer to Wandsworth, the man had been located on the healthcare wing as a non-patient prisoner.

KEY FINDINGS

15. The man was remanded into custody on 17 September 2003. A year later, on 29 September 2004, he was sentenced to life imprisonment with a 14 year tariff. During this time, he spent 12 months in HMP Wandsworth.
16. On 14 September 2005, the man transferred from Wandsworth to HMP Swaleside. The following day (15 September), an Assessment, Care in Custody and Teamwork (ACCT) document (a system used by staff to manage the care of a prisoner considered to be at risk of harming themselves.) was opened at Swaleside after the man cut his arm using a razor blade. He was placed on constant observations in a gated cell in the healthcare wing. At the time, the man described having a sudden drop in mood upon his arrival at Swaleside and said the self-harm was impulsive. He mentioned being scared of other prisoners and requested a transfer. The ACCT was closed on 30 September. On 14 October 2005, the man arrived at HMP Gartree.
17. An F2052SH (a self-harm/suicide monitoring document used prior to the general introduction of the ACCT) was opened on 17 October 2005 at Gartree after the man barricaded himself in his cell on H wing and threatened to self-harm with a razor blade. Again, the man said that he was scared of other prisoners and did not want his cell door unlocked. On 19 October, he was moved to the healthcare wing.
18. On 22 October, the F2052SH was closed without any incident of self-harm. The same day, the man was seen by the Mental Health Liaison Team at Gartree and a clinical risk management assessment was completed. The assessment concluded that the man had an abnormal fear of coming to harm, and his behaviour could become unpredictable in panic causing situations which might result in self-harm. The advice given was to remove the man from any such situation. Neither the barricading incident and subsequent ACCT, nor the assessment, was recorded in the continuous medical record.
19. My investigator interviewed the head of healthcare at HMP Gartree. The head of healthcare explained that the man had remained on the healthcare wing following his initial self-harm episode. She said that although it is a healthcare wing staffed by nurses, the majority of the prisoners are those deemed to have difficulties coping on the main wings and potentially vulnerable. The man was considered to be in this category. She said that these men are not necessarily classed as patients, but as prisoners who occupy healthcare because it is considered to be quieter and staff are able to give more time to them as individuals. The prison has no other facility for 'poor copers', nor a vulnerable prisoner wing.
20. The 14 cells in healthcare are all single occupancy and lead from one corridor. The head of healthcare described the regime as "very relaxed". She explained that prisoners "can still access all that the prison offers but they reside in the healthcare." However, if prisoners do not want to mix with prisoners from the rest of the prison, they can remain on the wing during the day.

21. At Gartree, the man settled well. He made good progress with his reading and writing and worked in healthcare as a cleaner and painter. In February 2007, he became an enhanced prisoner. He was popular with staff and prisoners. A friend on the wing said that, despite his size (he was six feet tall and of heavy build), he remained very afraid of prison and had difficulty in understanding things unless they were properly explained.
22. On 20 September 2006, the man made an application to determine his suitability to undertake the offending behaviour courses available at Gartree which were necessary for him to achieve his Parole Board goals. The man's IQ had been assessed prior to his sentence and was found to be low. This prevented him from attending the courses. He was referred by the psychology department to a psychiatrist to see whether a referral to a specialist service was needed to help him progress. A number of appointments were made but were cancelled at short notice by the visiting consultant psychiatrist. The man made a number of formal complaints about this.
23. The man first applied for accumulated visits in January 2006. Accumulated visits can be arranged for prisoners who are unable to receive visits in their current prison. The reasons may be due to the travelling distance involved for friends or relatives, or their inability to travel due to age or ill health. In the man's case it was a combination of both these reasons. Prisoners are required to have saved a minimum number of visits before applying. The application process also requires staff who have direct contact with the prisoner to provide information on their behaviour and other factors that may have a bearing on their suitability. The man's initial application was to go to Wormwood Scrubs to receive his visits.
24. Following this initial request, the man made regular applications to go to any of the London prisons. These requests were not facilitated because of the population pressures at the time. When his applications were not granted, the man often followed them up with formal complaints. He became increasingly concerned about the health of his elderly friend who had become ill. On a number of occasions in 2007, he said that he would harm himself if he did not get his visits.
25. As well as formal applications through the standard process, the man wrote directly to Governors as suggested to him by the IMB. In June 2007, the man wrote to the Governor of Wandsworth. He agreed for the man to be transferred to Wandsworth for the purpose of receiving his visits.
26. In interview, the head of healthcare was asked about her perception of the man and her support for his application. She felt that he was so keen to go, and so desperate to see his family, that along with the progress he had made she had no hesitation in recommending that he went. The head of healthcare also mentioned that, in her view, if the man had been unable to go, he would have been at risk of self-harm. The head of healthcare said that she spoke with the man about how he would cope in a London prison. He told her he would be fine, and that he was not going permanently, and was reassured that his cell would be kept for him at Gartree.

27. On 8 August 2007, one of the man's friends in the healthcare wing died in his cell from natural causes. It is believed that the man was quite upset by this and was reported to have asked to see a Listener later that day. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.)
28. On 14 August, the man received the news that he was going to Wandsworth for his accumulated visits. Coincidentally, the same day a member of the IMB had planned to see him in response to an application he had made about his request for visits. The IMB member told my investigators that she met the man on the wing, that he was very happy about the news, and had said how much he was looking forward to going. He ripped up his IMB application in front of the IMB member and the head of healthcare and thanked them both for their help. The head of healthcare saw the man on the day he left for Wandsworth on his way to reception. She said that he was, "over the moon, skipping up the wing and everyone was clapping and cheering and patting him on the back."
29. A senior officer who had often processed the man's accumulated visits applications, was asked whether he ever had any concerns about the man's ability to cope at Wandsworth. He said he had not because he knew that the man had been to other prisons, including Wandsworth before. He went on to say that he was unsure whether or not staff at Gartree had been aware of the man's full history. The senior officer said that he had not been aware of the man's previous self-harming and he had never presented as having such problems in healthcare.
30. On 15 August, the man arrived at Wandsworth from Gartree. Copies of various documents would have been attached to the man's application for accumulated visits and viewed in advance of his arrival. His medical record arrived with him. In reception, the man was interviewed and a cell sharing risk assessment completed (this assessment is used to identify a prisoner's suitability to share a cell and any potential risks from locating one individual with another). The man said that he had no concerns about sharing a cell. He was deemed at low risk of self-harm. Based on the information provided by the man, he was considered suitable for any location and was therefore placed in cell C1-13 of the induction wing.
31. In June 2007, Wandsworth had started to monitor prisoners transferred in through a 'Singular Move Register'. My investigators were told that this had been set up because prisoners were arriving without any record of which member of staff had authorised the move. However, the man had not been included on this list and it was not possible to find out who had authorised the move and what preparations had been made for his arrival. Given that he was a lifer, and in Wandsworth for accumulated visits, it might have been appropriate to have located the man on a wing for long-term prisoners rather than have processed him through C wing as an ordinary newly-remanded prisoner.

32. As part of the reception process, the man was assessed by medical staff. The nurse saw him and wrote in his Inmate Medical Record (IMR), "seen in reception, to see MO (Medical Officer) – on medication." When the nurse was interviewed, she recalled nothing of significance about the man and said she referred him to the doctor as he was receiving medication. The prison doctor wrote in his MR, "seen today, Simvastatin 20mg OD – for high cholesterol, Erythromycin 500mg BD for spots, was here before, used to Wandsworth, Nil suicidal ideation, Plan – prescribe meds." The man's prescription chart indicates that he was given the medication in-possession for 28 days.
33. Later that evening, the man made telephone calls to family and friends whom he was hoping would visit. A recording of a telephone conversation was made available to the investigators. The man sounded very excited about being at Wandsworth and said that he would see someone the next morning and would send out the Visiting Orders (VOs). (A visitor must be in receipt of a Visiting Order to visit. These are sent out by the prisoner in letters and enable the visitor to book a time with the prison.) The process for accumulated visits can differ from one prison to another, and it is not unusual for them to be arranged only when the prisoner has reached the establishment where the visits are to be held.
34. The following day (16 August), the man completed an application form. He wrote, "...have come from HMP Gartree to this prison on the 15/8/07 for accumulated visits. I have been at Gartree since 14/10/05. I have had no visits at Gartree and have no Gartree VOs." According to the form, an officer checked and confirmed that the man was entitled to visits and he was given 22 VOs.
35. The man made another very short telephone call on 16 August. Again he spoke about the visits and said that he was sorting them out. Some time during the day, the man and his cellmate were moved from C1-13 to C3-06. This would have been a routine move from the first night cells to another part of the induction wing.
36. The following day (17 August) at 11.05am, the man rang his friend again and sounded slightly confused and not as upbeat as two days previously. He said that he thought a visit had been booked but nobody had turned up. (This would not have been possible as the VOs had not been sent out.) Again, he said that he would be sending out some VOs and finished the conversation. (Following his death a number of VOs were found amongst his belongings in his cell. This would indicate that he had not sent out all, if any, of them.)
37. During the early hours of 18 August, the prison officer responded to the man ringing his cell bell. The officer told my investigators that the man had cut his arm and he gave instructions to the man to tie a towel around the wound. The man had made a significant cut as the wound went lengthways from his wrist to his elbow. At this point, the prison officer was unable to gain immediate access to the cell (night staff do not carry keys on security grounds). He therefore went and called the night orderly officer. (The night orderly officer is in charge of the prison during the night and carries keys to access cells in an emergency.) The

man was taken to the treatment room and treated by a nurse with the night orderly officer present.

38. While the man's injuries were being dressed he was asked by the night orderly officer why he had self-harmed. The man said that he had heard people talking and felt threatened on the wing. He went on to tell the night orderly officer that his self-harm was a way of getting moved from the wing. The man asked the night orderly officer to be located in a single cell but, after it was checked if there were any available, the man was taken to the Care and Separation Unit (CSU). The CSU is an area that is separate from other wings of the prison and normally used to locate prisoners who are disruptive or who have committed offences against prison rules. Wandsworth's safer cells are located in the CSU although it was not felt necessary to place the man in one of these cells. The CSU is temporarily housed on an upper floor of the healthcentre while building work is carried out on a new unit.
39. Whilst in the treatment area, the man also told staff that "something may happen when C3-06 is opened in the morning." These remarks were recorded in the observation book. The night orderly officer said he wrote this because the man seemed to believe that prisoners would come to the cell next day looking for him. The other prisoner located in the cell with the man was a Polish national. He had returned to Poland by the time my investigators visited Wandsworth.
40. In interview, the night orderly officer described the man as subdued and vulnerable. He took the man to the CSU after the nurse had treated his injuries. Once located in the CSU, the man settled for the remainder of the night. The nurse completed an Initial Segregation Safety Screen which is required when a prisoner is placed in the CSU, whatever the reason. No concerns were expressed by the nurse.
41. After moving the man, the night orderly officer opened an ACCT document at 1.35am. This process enables prisoners considered to be at risk of self-harm or suicide to be closely monitored and offered additional support. The person opening the ACCT is required to record the reason. It is also a requirement to note action to be taken to keep the individual safe until a full assessment can be conducted. In the man's document, the night orderly officer recorded that he would be located in the CSU until "such a time as space becomes available on Heathfield unit". Heathfield refers to the main prison, excluding the Onslow Centre which holds vulnerable prisoners.
42. At 8.40am, an officer completed relevant documents as the man had asked to be segregated for his own safety. This meant that he would be placed away from the general prison population with other prisoners considered to be at risk.
43. At 9.35am, An ACCT assessor from the CSU completed the ACCT assessment with the man. (ACCT assessors are trained to carry out assessments with prisoners at risk of self-harm and to formulate a care plan structured to the individual's needs.)

44. During the assessment, the man told the ACCT assessor that he felt his current problems were due to him becoming overwhelmed by his situation. He also believed that people thought he was a sex offender and were making threats towards him. With regard to the man's mental state at the time of the assessment, the ACCT assessor recorded that he appeared stable, felt a lot safer in the CSU, and wished to go to the vulnerable prisoners unit (VPU). The man also expressed a wish to get involved in education. The ACCT assessor's notes of the assessment referred to the man as possibly having a low IQ or learning difficulty which the ACCT assessor had picked up during the interview. He said that the man spoke about "mummy" and looking forward to seeing her. The ACCT assessor said that the man was open and candid about his offence during the interview. He referred to the injury to the man's wrist and the scar from an earlier incident of self-harm which he described as being from elbow to wrist rather than across the wrist. (The significance of this is that making the cuts along the arm is thought to cause a greater loss of blood than a cut made across the wrist.)
45. Following the assessment, a case review was held to decide what interventions the man required and to determine his level of risk of further self-harm (the three levels being low, raised and high). The man was considered to be of raised risk. The ACCT assessor recorded that the man should have three quality interactions per day and to be observed "regular nocte" (at night). A routine referral was also made to the mental health in-reach team. The ACCT assessor did not perceive the man to be such a risk as to be placed in the healthcare centre.
46. Given that the man was deemed suitable for the Onslow Centre, the officer telephoned the unit to enquire about a space. In interview, the senior officer from the Onslow centre recalled this phone call and had told the officer that they were unable to take any further prisoners as they were full. The senior officer suggested that it would be better if the man stayed where he was until Monday when spaces might become available. However, the senior officer recalled the duty governor informing them that they had to find a space.
47. At 10.00am, the man was taken to the Onslow Centre. The senior officer was in the office when he arrived and recalled the man being fine. An officer in the Onslow centre wrote in the ACCT, "received onto Onslow from CSU, given bed pack, seems in good spirits at present." When interviewed, the officer explained that he was the office manager and part of his duty was in relation to the movement of prisoners. In this capacity it was his job to allocate the man to a cell. He said that the wing was pretty cramped and there were limited spaces. The officer was made aware that the man was on an ACCT. He explained that they always try to put someone on an ACCT in a double cell so the man was placed in cell K3-10.
48. Another prisoner was already in the cell. His wing history sheet was subsequently made available to my investigators. The officer confirmed that, prior to putting two prisoners in a cell together, their cell sharing risk assessment forms are read and checked for any high risk. The officer knew the other prisoner in the cell and said he was "very quiet and not a problem". (This

was not a view shared by all staff, some of whom commented on the other prisoner's vulnerability as well as his lack of personal and cell hygiene.) The officer said that there was nothing about the state of the cell to worry him and that a number of prisoners have hygiene problems. The senior officer on the centre said that, given that both men were quiet, he felt they would be compatible. He also mentioned that the position of the cell was such that it was near the staff tearoom and quite visible. However, it was not anywhere near the wing office.

49. Following the man's death, it was discovered that the prisoner had been subject to a section 37 Mental Health Act order, issued by the court on 10 August 2007. (This meant that he needed to be transferred within 28 days to an outside hospital.) It would seem that none of the wing staff was aware of this as it had not been communicated to anyone and had not been recorded in his wing file. The day after the man's death, the prisoner was taken to an outside hospital. My investigators did not have access to the prisoner's medical records.
50. The prisoner's history sheet indicates that a second prison officer gave him an IEP warning about the state of the cell on 14 August. In interview, the officer said that he had tried to place a new prisoner in K3-10 but did not consider it fair to do so as the cell smelled so bad. The second prison officer was aware of the man as he had been working the night he self-harmed. When he heard that the man was in cell K3-10, he assumed that the man's cellmate had been persuaded to clean his cell and himself. A further entry in the prisoner's history sheet indicates that the principal officer spoke to him on 16 August about his cell and wrote that it would be monitored from then on. There are no further entries and it is not known what action, if any, was taken by staff to assist the prisoner. When my lead investigator visited the cell after the man's death, she commented to staff about its very poor state.
51. My investigators spoke to a prisoner, who was in an adjacent cell at the time of the man's death. He had spent ten days in K3-10 with the man's cellmate and had found the experience very uncomfortable. He said that he thought that the prisoner was mentally ill and unable to care for himself. The prisoner who was in an adjacent cell also said that the man's cellmate had been targeted by other prisoners and called names. The prisoner also described being threatened through his cell door on one occasion.
52. At weekends, there are fewer staff available and, according to the landing officer in Onslow Centre that day (Saturday, 18 August), they were very short staffed. At midday, the landing officer wrote in the man's ACCT document, "declined his meal. Appears fine." However, in interview, the landing officer gave a fuller description of how the man presented. The man was apparently very scared and covering his head with a blanket. The landing officer observed him to be quite disturbed. However, he did not feel he was at risk of self-harm and, when he asked the man how he was, he replied he was "fine". He said he wanted to get out of Wandsworth and did not want the cell door open or the light switched on. The landing officer saw the man a number of times over the weekend and told my investigators he appeared the same each time. He said

that he spoke to other staff, including the senior officer, about the man's behaviour.

53. At 1.45pm, the man pressed his cell call bell. This was answered by an officer who wrote in the man's ACCT document:

"Rang cell bell. Stated that he needs to go the block otherwise he is going to do something stupid. Requested not to have his cell door unlocked as there are people on this unit that have come over from C wing that he knows. I informed the man that I would pass info onto SO on his return at 14.15hrs."

54. The officer has since left Wandsworth but agreed to speak with my investigators. She said that when she got to the cell the man was standing in front of the cell door, and was excitable and distressed. She told him that everyone was at lunch but she would pass on her concerns. She felt that by the time she left the man he had calmed down considerably. The officer said that she passed on her concerns to the senior officer and he sent two other officers, both ACCT assessors, to see the man.
55. The next ACCT entry is from a member of the chaplaincy team who saw the man in cell while routinely visiting the wing at 2.15pm. A note in the ACCT document says, "appears agitated about location". At 3.10pm, the fourth prison officer saw the man and wrote in the ACCT:

"The man requesting to return to CSU as he states that there are prisoners on unit who will harm him. Explained to the man that a move to CSU will not take place today. However, he is happy to be located on 2's landing on unit, also explained this will not take place until Monday. Has requested to remain in cell and separate unlock for meals until this has taken place. States he has no thoughts of self-harm at present."

56. In interview, the fourth prison officer said that the senior officer had asked her to go and speak to the man and she had attended with the third prison officer. (In interview, the third prison officer said he could not recall anything about the man.) The fourth prison officer said that the man was "fine" after speaking to them.
57. The officer recalled that she and the fourth prison officer tried to find another cell. As they could not find anywhere suitable, it was decided that the move would not take place until Monday. She was not aware of any discussion about the man moving back to the CSU. The duty governor recalled a conversation with staff from the Onslow Centre about the man being moved to a single cell. She had told them that the man was not suitable as he was on an open ACCT.
58. The reason why the moves were not possible until Monday are unclear, and the movements book for Onslow Centre indicates that a move to K2 landing was considered and was then crossed out of the book. The movements book on

the unit, which records the arrival and departure of all prisoners, indicates that the man was the only person to move onto the wing during that weekend.

59. At 4.20pm, the landing officer wrote in the ACCT, "... declined his meal. Stated that he was fine." The next entry at 7.30pm states, "... laying in bed. Asked if ok, stated that he was feeling fine."
60. Night staff begin their duty at 8.45pm but they often arrive at around 8.00pm. At this time, the wing was staffed by three night officers who were responsible for patrolling the wing and carrying out and recording checks on those prisoners subject to ACCT documents. Before starting their duty, the night staff carried out a roll check and reported their numbers. In the Onslow Centre, there were five prisoners on open ACCTs over the weekend. One of the night duty officers, commented to my investigators that this was fewer than usual.
61. Between 9.00pm and 5.20am, the man was observed nine times by one of the three officers on nights. Each time, the man was described as asleep. After the check by the night staff at 5.20am, the man was not seen again until 7.45am. The observation book indicates that the first night officer handed over to another officer at 6.00am.
62. At 7.45am, the landing officer wrote in the man's ACCT document, "... appears fine, asked if he could be moved off the wing, I told him to write to the Governor to come off the rule." When interviewed, the landing officer confirmed that he had asked the senior officer about the man's request and relayed to the man the response that he would have to write to the Governor. The landing officer said that the man presented in the same way as he had the day before, with the blanket over him and saying he was scared.
63. At 10.05am, the fifth officer wrote in the ACCT form, "The man seems very scared and considers almost everyone to be a threat. He has asked to remain locked in his cell during association." At 12.00 noon, he wrote, "The man declined his lunch despite the fact it was brought to his door as he says he is too scared to leave his cell. He was encouraged to eat but said if he is not moved to a different prison he will kill himself."
64. At interview, the fifth officer said that he remembered the encounters with the man clearly. He said that the man was quite distressed so he spent some time trying to reassure him that the wing was a safe place. He said that both the man and the other prisoner wanted to stay in their cell, and the other prisoner had his own concerns about being verbally bullied on the wing. Despite this, he recalled the other prisoner trying to reassure the man. The fifth officer told them both they could use the cell bell if they needed to do so and not just as an emergency, and he felt that they were reassured by this. He also asked a prisoner, as a 'buddy', to speak to the man.
65. This prisoner worked on a voluntary basis offering a sort of buddying role. In interview, he confirmed that the fifth officer had asked him to go to cell K3-10 on Sunday afternoon to see if he could reassure the man. The buddy prisoner said that the man seemed very agitated and afraid. He recalled that he said,

“They are out to get me.” The buddy prisoner thought the cell was in a very bad state.

66. The observation book indicates that the duty governor visited the Onslow Centre at 2.20pm. In interview, the senior officer said he spoke to the duty governor and told him that staff were trying to deal with the man and help settle him down. When approached by my investigators, the duty governor could not recall any discussion concerning the man.
67. At 4.15pm, the fifth officer wrote, “... declined association and his tea meal. He continues to say he will kill himself if not transferred.” The fifth officer said that this was passed on to the senior officer and staff on the wing. He thought he could remember the man being discussed at a lunchtime briefing. He said that he had tried to reassure the man that he was safe and to allay his fears. He told him he would be moved the following day. The senior officer said that he continued to encourage his staff to build up a rapport with the man.
68. By this time, the man had made several statements, recorded in his ACCT document, that he would “kill himself”. He had also declined all meals since his arrival in the Onslow Centre. Despite this, there was no case review on his ACCT and no change to the level of observations.
69. The cleaning officer was responsible for monitoring prisoners coming for their meals. In interview, he said that he was aware that the man had not come down for his meals but had been told that the man had declined them. He said that declining food can be different from refusing it as prisoners have access to food other than that from the servery. He also explained that a food refusal log is not started until after three days of food refusal.
70. Following the serving of the tea meal at around 5.15pm, all prisoners were located in their cells and the wing reduced to minimum staffing (known as patrol state). Staff continued to check on the man. They recorded these checks in his ACCT document throughout the evening until the arrival of the night staff.
71. From 9.00pm on Sunday 19 August until 5.30am on Monday 20 August, the man was seen nine times by the three officers on night duty. Each time the officer commented that the man appeared asleep. In interview, the third night officer said she could recall that the man was fully dressed and lying on top of the bed. She said that this was not especially unusual for prisoners but did mean that she remembered the man.
72. The observation book indicates that at 6.00am the first night officer, who was the orderly assist officer, handed over to another officer and the roll was 386. At this point, the three night staff left the wing despite their shifts not officially finishing until 7.30am. This left the other officer responsible for counting the whole of Onslow Centre as well as checking the prisoners on ACCT documents. The officer did not recall any handover discussion with the first night officer about the man that morning. The officer was on a day shift which officially started at 7.15-7.30am. However, in interview he said that he typically arrives for work early and takes over from the night officers regardless of his

start time. He said he would come in and do the count. He would also check and sign for those on ACCTs and let the night staff go.

73. At 6.00am, the day officer completed an entry in the ACCT stating that the man was “on left side, appears to be asleep”. According to the documentation, this was the last time that the man was seen alive.
74. The landing officer began his duty at 7.30am on 20 August. After the routine early morning meeting (where the man was discussed), the landing officer went to see him. He intended to help him write the letter to the Governor. On arriving at the man’s cell, the landing officer looked through the observation panel and saw the other prisoner asleep in bed. The man appeared to be standing at the back of his cell. The cell was quite dark as the man had previously asked that the light should not be switched on. However, when the landing officer opened the cell and approached the man it became apparent that he was hanging.
75. The landing officer immediately blew his whistle to alert other staff. (There are alarm bells situated around the wings and officers have radios, but they also carry whistles in order to raise alarms quickly.) On hearing the whistle, staff were quick to respond. The senior officer and the fifth officer were two of the first to arrive and, while the senior officer supported the man, the fifth officer cut the ligature from the window bars. The fifth officer recalled that the ligature was not very long and the man appeared to just be standing at the back of the cell. The senior officer cut the ligature from around the man’s neck. Whilst this was being done, the two landing officer’s escorted the man’s cellmate out of the cell. The other prisoner had been asleep and awoke when the landing officer raised the alarm.
76. Once the ligature had been removed, the man was initially placed onto his bed but was then laid on the floor to enable Cardio Pulmonary Resuscitation (CPR) to be administered. The officer who had responded to the initial call for assistance, began CPR.
77. There are variations in the accounts of the staff present, and it is not be possible to give a definitive version of exactly what then happened. However, two nurses were already in the Onslow Centre and went to the cell having collected some emergency equipment on the way. A call had been put out for Hotel 3 the emergency nurse. The first nurse began to give the man mouth to mouth resuscitation while the officer continued with the chest compressions. However, when interviewed, the officer that gave CPR told the investigators that he felt that the mouth to mouth had not been administered correctly. He explained that when the first nurse was blowing into the man’s mouth his chest was not rising, an indication that the air was not reaching his lungs. The other nurse then produced an oxygen cylinder and a manual oxygen mask which the nurse attempted to place on the man’s face. However, the officer told the investigators that this had been placed upside down by the nurse. In his frustration, he took the mask from the nurse and handed it to a fellow officer, the fifth officer, and told him what to do while he continued chest compressions. In interview, the fifth officer also stated that the nurse had placed the mask on

the wrong way and that he had been compressing the bag under the instructions of the officer giving CPR. However, the two nurses said in interview that they were using the equipment correctly and performing CPR effectively. Emergency nurse arrived at some point during the resuscitation attempt.

78. The healthcare officer arrived at the cell and brought with her a portable defibrillator. When applied to a patient, the defibrillator will tell the user whether or not a pulse is present and if appropriate will administer a shock in order to restart the heart. Someone suggested that in the man's case the machine had indicated a pulse was present. There appears to have been much confusion at this point, and the man was placed in the recovery position as some staff believed that a pulse had been found. The nurses said that they continued to work on the man.
79. The paramedics arrived a short while later and were briefed as to what had been done. They entered the cell and continued to administer first aid, but after a short while they pronounced the man dead. A record of their actions confirmed that when they reached the cell the man was in the recovery position. The man was pronounced dead at 8.31am. Following the man's death there was a hot debrief in which all staff involved were advised of the care and welfare services available to them.
80. Staff broke the news of the man's death to his next of kin after obtaining the details from Gartree. His next of kin then informed the man's family. The prison's family liaison officer kept in close contact with family members and next of kin, assisting them in resolving difficulties. The liaison officer showed great tact and sensitivity in supporting the two families through a very difficult situation.

ISSUES

Should Gartree have provided more information to Wandsworth?

81. When the man applied to take accumulated visits, Wandsworth required information about him from HMP Gartree. The form used to request the information appears to be one that is used across the prison estate. It is fairly brief and does not ask any specific questions about the individual's past custodial behaviour, such as previous self-harm. It asks only for a brief write-up on the individual's behaviour. The man had been residing for some time in the healthcare wing at Gartree as a non-patient prisoner. His behaviour on the wing had been very good, he had built up a good rapport with the staff, and this was conveyed on the form. At this stage, the man was not in any way vulnerable as he was very comfortable on the wing amongst staff and prisoners he knew well. He also had his own relatively spacious and comfortable cell.
82. However, the man had initially been moved to the healthcare wing on constant observations after self-harming, albeit that this had been in October 2005. He had also self-harmed at other establishments soon after arriving. In addition, the man had learning difficulties which made it more difficult for him to understand things. None of these details had been shared with Wandsworth. At the very least, the ACCT information should have been disclosed.
83. This information does not appear to have been deliberately withheld by Gartree. After residing in healthcare for a period of time, the man was not perceived as a 'poor copier'.
84. During the investigation it became apparent that the healthcare centre at Gartree is used more for the purposes of housing those prisoners who find it difficult to cope than those needing in-patient care. In fact only two of the 12 beds are assigned to those requiring medical attention. Most prisons have a wing, similar to the Onslow Centre, dedicated to accommodating vulnerable prisoners, but Gartree uses the healthcare centre for this purpose. The interaction between nursing staff and the prisoners is very good, but they tend not to regard them as vulnerable as they perhaps would in any other prison. Consequently, when completing the form for Wandsworth, the man was not described in such terms.
85. The clinical reviewer comments that the information about the man's previous problems was not clearly made available to the staff at Wandsworth. He makes a recommendation which I fully endorse.

The Prison Service should ensure that, when a prisoner who has had behavioural problems in the past is transferred for any reason, the sending prison clearly highlights the issues so that a suitable risk management plan can be put in place. This is particularly pertinent if there has been ACCT monitoring.

86. Once Wandsworth agreed to have the man for a period of time for accumulated visits, his details should have been placed on their 'Singular Transfer Register'.

As a life sentence prisoner, some plans could have been put in place. Instead, it was left to the man to make an application for his VOs, and his telephone calls suggest that this caused him some degree of confusion.

The Governor should remind relevant staff of the importance of keeping a transfer register.

Was the other prisoner a suitable cellmate?

87. When the man arrived at the Onslow Centre he was on an open ACCT document. He was placed in cell K3-10 with the other prisoner who was himself extremely vulnerable. During the investigation it transpired that the other prisoner was awaiting a transfer to an outside hospital for a mental health assessment. However, this information had not been shared by healthcare with the Onslow staff who were responsible for looking after him.

The Governor should ensure that all departments within the prison, including healthcare, share between them all information that might be important in respect of the well-being of a prisoner and others.

88. The officer who found the cell for the man said that space in the unit was very limited and, having checked the other prisoner's cell sharing risk assessment, he deemed him a suitable cellmate. The other prisoner did not have any risk markers and was not a threat to the man. However, he was highly vulnerable and his wing history document made reference to warnings he had been given in relation to his personal and cell hygiene. One entry even said that it had not been possible to place another person in the cell with him, but this had not been read before the man was allocated to the cell.
89. The other prisoner was described to the investigators by at least two other prisoners as having mental health problems. A prisoner who had previously shared with him said that other prisoners had threatened the other prisoner by shouting through the door. He also said that the condition of the cell was unbearable. It is hard to imagine that the staff did not notice these things.
90. In this case, two extremely vulnerable and at risk prisoners were locked up together. Due to their individual problems they were incapable of offering each other support. In fact, despite the attempts by staff to reassure the man that he was safe, he was locked up with a mentally ill individual who was the target of bullies. This probably did little to ease his fears. However, there is no suggestion that the man was at risk from the other prisoner and they were described as appearing to get on well together.

The Governor should remind staff that, when allocating prisoners to cells, in addition to information in the cell sharing risk assessments, they must take account of all relevant factors regarding the suitability of the existing occupant and the condition of the cells.

91. The clinical reviewer comments in his report that the medical documentation in October 2005 clearly said that the man, if stressed or anxious, was likely to

self-harm or exhibit other abnormal behaviour. He also mentions the advice noted by the mental health team at Gartree for the man to be removed from stressful situations immediately. The clinical reviewer says that moving the man in with another prisoner with a disruptive behaviour pattern clearly did not provide an environment with a reduced level of stress, and (while this is to speculate) may well have contributed to his suicide.

Should the man's ACCT observations have been increased?

92. When the man was relocated from the CSU to Onslow Centre there is no evidence of a case review being carried out. It is a requirement within the ACCT procedures for a case review to be held whenever a prisoner arrives on a new wing. The purpose of this case review is to enable the prisoner to inform staff of any concerns that they may have, and to ensure that the appropriate level of observations has been assigned. When the man arrived on the Onslow Centre, the officer who was in charge of movements at the time and the senior officer spoke with him briefly. The man was then taken to his cell.
93. When a prisoner is placed on ACCT monitoring, the case review will determine how often staff should interact and observe them. These observations and interactions should be re-assessed at all case reviews. In addition, a case review must be held following any further acts of self-harm, or if there are any other significant events that may increase the individual's risk. It is expected that, if a prisoner continues to self-harm or gives cause for concern, their level of observations would be increased.
94. The man was distressed from the moment he arrived on the Onslow Centre. He not only refused meals, but also refused even to venture outside his cell. His landing officer told my investigators that he asked for the light to remain off in his cell. In addition, the landing officer said that he constantly had a blanket over his head and spoke about his fear of other prisoners.
95. Within four hours of arriving on the Onslow Centre, the man informed a member of staff that he needed to return to the CSU otherwise he "was going to do something stupid". These comments were recorded in his ACCT document and passed to the wing SO. There was also an entry in his ACCT from a member of the chaplaincy team who had seen the man while visiting the wing over the lunch period. The entry said, "appears agitated at location". When an officer who had been sent to see the man by the wing SO tried unsuccessfully to find another cell, it was agreed to keep him locked in his cell, and opened separately for meals. This was recorded in the ACCT document. However, this was not a case review and no change to the frequency of observations was made.
96. The man continued to refuse his meals and remained in his cell. On Sunday 19 August, he told a member of staff that if he was not moved he would kill himself. He repeated this later in the day. Despite this significant threat, and his refusal to eat or leave his cell, no case review of the ACCT monitoring took place and no increase in the level of observations was made.

The Governor should assure himself that staff are properly trained in the monitoring of prisoners under the ACCT procedures, with a particular focus on conducting case reviews and being responsive to new information.

Roll checks

97. During the investigation, it became apparent that there were differences of opinion in the way that staff at Wandsworth viewed the roll check procedures. The Prison Service has a National Security Framework (NSF) that specifies the required systems to be used for various procedures, including roll checks. The NSF says that there should be at least four routine roll checks within every 24-hour period.
98. This was reiterated to staff at Wandsworth in a Governor's order issued on 25 February 2005 relating to roll checks during the day. It says that roll checks must be carried out on at least four occasions, one of these being "when day staff come on duty to relieve night staff". The order also says that, on completion of the checks, staff will sign for each landing in the book provided on each wing. The documentation provided during the investigation indicates that these mandatory instructions were not being followed at the time of the man's death.
99. At Wandsworth, the staff detailed to work a night shift begin their duty at 8.30pm and finish at 7.30am. When they commence duty, the night staff carry out a roll check to confirm the number of prisoners in their care before day staff leave. A further count of all prisoners is conducted at 6.00am.
100. On arrival, day staff should conduct another count to confirm the number of prisoners before night staff leave. A record of the figures is held on each unit. The numbers are reported to a central point where numbers from all wings are collated and confirmed before prisoners are unlocked.
101. However, the investigation found that the numbers recorded for the Onslow Centre were those recorded by night staff from their 6.00am checks. This appeared to be the case in all the records examined. It was also found to be common practice for day staff to arrive for duty as early as 5.30am, and in some cases for a single member of staff to relieve up to three colleagues. This would leave just one officer to manage an entire wing and monitor those prisoners who were considered at risk of self-harm. This was the case on the morning of the man's death. My investigators interviewed a number of staff responsible for these checks and all confirmed that these practices were commonplace.
102. There was no recorded evidence of roll checks being conducted by day staff between 7.15am and 7.30am. In fact the roll checks recorded at 7.30am in the wing log were often those signed by night staff (following their 6.00am checks) who had left the establishment at least an hour before, after being relieved by early day staff.

The Governor should take measures to ensure that roll checks are carried out at the correct times and by the staff responsible for conducting them.

ACCT monitoring

103. Of five prisoners on ACCT monitoring on the weekend of 18-19 August 2007, my investigators were able to see documents for two of them, including the man. Both had significant gaps between the 6.00am check and the next time they were seen. This meant there was a period of time in the morning where some at-risk prisoners had only been checked once during a period of three hours. The prescribed number of checks during the night for prisoners subject to an ACCT is hourly. Staff at Wandsworth appeared to have conflicting views as to when the night state actually ended and the core day began. This in turn gave rise to inconsistencies in the frequency of the checks during the early hours before shift handover.
104. Due to day staff arriving early for their shifts, all staff treat their arrival as being the start of the core day. This means that the prescribed hourly checks for prisoners on ACCTs are ending early. Core day ACCT checks are in some cases less frequent. This was true of the man's observation requirements.
105. On 20 August, the man was last seen at 6.00am by a member of the day staff who had arrived early for duty. He recorded this check in the man's ACCT document. There were no further entries or observations until the landing officer discovered the man hanging at 7.40am.
106. According to the correct ACCT observation procedures for night staff, the man should have been seen at least twice before 7.40am. Night staff are not due to finish their shifts until 7.30am, the official end of night state and beginning of the core day. Therefore, a check in relation to the ACCT document was missed at 7.00am. It is also the case that, if a roll count had been carried out by the day staff at the beginning of their shift, the man would have been observed again between 7.15am and 7.30am.
107. It is not known at what time the man took his own life, but he was last seen alive at 6.00am. Accordingly, if the ACCT and roll checks that should have taken place in the 95 minutes preceding the discovery of his body had been conducted, this might have led to earlier discovery and more timely intervention.
108. Following feedback to the Governor, my investigators were informed that an internal investigation was to be conducted and a number of staff had been temporarily re-deployed. Although I have no wish to point the finger at individual members of staff, this is as it should be. However, my investigators were concerned that these shortcomings were not the inactions of a small number of staff, but appeared to be longstanding common practice that had the full knowledge of some senior and principal officers. Checks of ACCT documents would have revealed that prisoners were not being checked during the early morning period and that, as in the case of the man on 19 August 2007, were not in fact observed until 7.45am.

The Governor should ensure that all members of staff at every level are made fully aware of the importance of conducting ACCT checks as prescribed.

The Governor should assure himself that a robust system is put in place to ensure that managers and senior staff regularly check ACCT documents and that all procedures are correctly implemented.

The resuscitation attempts

109. The clinical reviewer looks in detail at the resuscitation attempt and comments:

“Resuscitating this man would have been very unlikely to succeed. There did seem to be some confusion about the actual attempt. If a review could take place immediately after any such resuscitation attempt, the sequence of events could be clearly documented and agreed on, and therefore any learning could be identified.”

110. Comments made by the staff involved in administering first aid to the man indicated that there had been confusion. Rather than the situation becoming more controlled when the nursing staff arrived, evidence suggests that communication in the cell broke down, with officers and nurses disagreeing as to how treatment should be given.

111. There was further confusion amongst the staff as to whether or not the man had a pulse, and this led to a member of staff giving an instruction for the man to be placed in the recovery position.

112. The clinical reviewer states:

“There was some disparity between the account of the prison staff and the ambulance crew. When the ambulance crew arrived at the resuscitation attempt it is clear from their records that the patient was lying in the recovery position and that no active attempts were taking place to resuscitate him. Two of the nurses that I interviewed were quite clear that they were actively resuscitating him when the ambulance crew arrived. I must admit that I find this slightly puzzling and would tend to accept the ambulance crew’s description of events as they are more used to dealing with these situations.”

113. Furthermore, the clinical reviewer comments on the management of the man’s airway and makes the following recommendation which I endorse:

The airways used by the nursing staff seem very basic and it would be of benefit if staff likely to be involved in resuscitation attempts are provided with adult pocket face masks as used in the NHS.

Conclusion

114. Although the man had been assessed as having an 'abnormal fear of coming to harm' that could lead to self-harm in challenging or stressful situations, he had been excited by the prospect of receiving visits from his friends and family. However, it is clear from his records that he experienced great anxiety on two previous occasions when he moved from one prison to another. We cannot be certain of the reasons why he apparently took his own life. However, it is clear that a number of failings, including poor communication between staff and a lack of adherence to monitoring procedures, may have increased his opportunity to do so.

RECOMMENDATIONS

- 1. The Prison Service should ensure that, when a prisoner who has had behavioural problems in the past is transferred for any reason, the sending prison clearly highlights the issues so that a suitable risk management plan can be put in place. This is particularly pertinent if there has been ACCT monitoring.**
- 2. The Governor should remind relevant staff of the importance of keeping a transfer register.**
- 3. The Governor should ensure that all departments within the prison, including healthcare, share between them all information that might be important in respect of the well-being of a prisoner and others.**
- 4. The Governor should remind staff that, when allocating prisoners to cells, in addition to information in the cell sharing risk assessments, they must take account of all relevant factors regarding the suitability of the existing occupant and the condition of the cells.**
- 5. The Governor should assure himself that staff are properly trained in the monitoring of prisoners under the ACCT procedures, with a particular focus on conducting case reviews and being responsive to new information.**

The Governor feels that recommendations five and eight relate to the same issue and should be incorporated as one.

- 6. The Governor should take measures to ensure that roll checks are carried out at the correct times and by the staff responsible for conducting them.**
- 7. The Governor should assure himself that a robust system is put in place to ensure that managers and senior staff regularly check ACCT documents and that all procedures are correctly implemented.**
- 8. The Governor should ensure that all members of staff at every level are made fully aware of the importance of conducting ACCT checks as prescribed.**

The Governor feels that recommendations five and eight relate to the same issue and should be incorporated as one.

- 9. The airways used by the nursing staff seem very basic and it would be of benefit if staff likely to be involved in resuscitation attempts are provided with adult pocket face masks as used in the NHS.**