PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in August 2010 in HMP Wandsworth

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Wandsworth in August 2010. I offer my condolences to his family and friends.

The investigation was undertaken by an investigator. The local Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a review of the man's clinical care. Wandsworth co-operated fully with the investigation. I apologise for the delay in issuing this report.

The man was on remand and was extremely worried about the sentence he thought he might receive. In early August, he made an attempt at self-harm, although his friends did not think he seriously meant to take his own life, and did not tell staff. On 11 August, he asked to be moved to another wing. He handed a note to staff in which he revealed that he was feeling suicidal. Staff decided that he should be put on special measures for those thought to be at risk of self-harm and that he should be referred to the mental health team. However, the mental health team could not be raised by telephone and due to an oversight he was not placed on special measures. He was transferred to another wing and placed in a single cell. When staff unlocked his cell the following morning, he was found to have hanged himself.

This investigation raises some serious issues. I am concerned by the failure to open an ACCT in the face of a prisoner directly saying he felt suicidal. I am also concerned about the quality of the checks during the roll counts, as it seems that the man was in fact dead when two separate roll counts by different members of staff were made. I make seven recommendations. These concern mental health referrals, the personal officer scheme, written statements from staff, roll checks, passing on information in emergencies, and a recommendation to conduct a disciplinary investigation.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2012**

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SUMMARY

1. The man was one of four men who were arrested and remanded to Wandsworth together. He had sustained some injuries during his arrest, and his police interviews had had to be delayed while he received hospital treatment. He arrived at Wandsworth on 17 May.

2. His co-defendants noticed that he was extremely concerned about the charges he faced. He seemed to have become convinced that he would be receiving a long prison sentence. His concentration was poor, and he seemed to have difficulty in focussing on anything other than the forthcoming court case. On 5 August, staff noticed that he was in a low mood and referred him to the mental health team. There were no indications that he had any intention to harm himself, so a routine referral was made.

3. After their initial reception into Wandsworth, the four co-defendants were all housed on A wing and were sharing two cells between them, two in each cell. The cells had bunk beds and the man was in the top bunk in his cell. One morning in early August, his cellmate saw him apparently fall from his bed. When he looked to see if he was hurt, he noticed that he had a bedsheet tied around his neck. The sheet was loosely tied and did not appear to be tied to the bed at the other end. Although the cellmate was concerned for his friend's state of mind, he did not think it a serious attempt to harm himself. Rather, he thought it an attempt to express how he was feeling. He told the other co-defendants, who agreed not to tell staff, but to keep a close watch on him.

4. On the morning of 11 August, the man asked to be moved to another wing. Staff made arrangements for the move, and while it was in progress he passed a note to an officer in which he said that he felt suicidal and had recently made an attempt on his own life. The wing Senior Officer spoke to him, then to his co-defendants, and they confirmed to him the recent attempt at self-harm. The Senior Officer asked two officers to ensure that he was put onto special support measures for prisoners thought to be at risk of self-harm, and for the prison's mental health team to be asked to see him urgently.

5. One officer telephoned the mental health team, but only got through to an answering service. He left a message but no contact was made that day. The officer who was asked to put the man on special support measures was called away on other duties and subsequently forgot to do so. He was meanwhile transferred to D wing.

6. As he had not actually been placed on special support measures, staff on D wing were unaware that he was vulnerable. He was therefore allocated a cell on his own.

7. After being locked up for the night, staff carried out a roll check (ensuring that the correct number of prisoners are in the cells) at approximately

9.00pm. About half an hour later, two prisoners in the cell next to the man's heard some noise coming from his cell. The noise was described as banging, as if a chair had fallen over.

8. Unless prisoners are on special support measures, they are not checked during the night. The next time staff looked into the man's cell was for roll checks at 5.45am and 6.45am the following morning. The staff carrying out these checks did not notice anything which caused them alarm.

9. When staff unlocked the cells shortly before 8.00am, they found him with a ligature made from bed sheets around his neck, tied to the bed frame. Officers cut and removed the ligature and medical staff attended, but he had clearly died and there was evidence of rigor mortis. Medical staff took the decision that to attempt resuscitation would be inappropriate.

10. We make eight recommendations. These concern mental health referrals, the personal officer scheme, written statements from staff, roll checks, passing on information in emergencies, and the opening of ACCT documents, and consideration of disciplinary action.

THE INVESTIGATION PROCESS

11. HMP Wandsworth provided the Ombudsman's investigator with the man's prison record. The investigator also obtained his medical records. Unfortunately the note that he passed to staff on 11 August could not be located. The investigator tried to obtain a copy from the prison, the police, and the Coroner's office, but none were able to find the original or any copy.

12. The investigator visited the prison to open the investigation and returned on two occasions to conduct interviews. He met with the Deputy Governor and spoke to staff and prisoners who knew the man. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact my investigator. No further information was received.

13. The Metropolitan Police conducted an investigation into the circumstances surrounding the man's death. No charges were subsequently brought, but the investigator maintained ongoing contact with the police throughout the investigation.

14. The local Primary Care Trust (PCT) conducted a clinical review of the man's care and treatment. This was undertaken by a clinical reviewer. The investigator discussed the report with him.

15. The investigator formally interviewed five members of staff and three prisoners, and those interviews were recorded. The interviews were transcribed and interviewees invited to sign and return copies, confirming their accuracy. He was unable to interview the officer who raised the alarm on the morning of the incident, as she had resigned and left the prison service. After disclosure of the draft report, the police disclosed a statement they had taken from the officer and the information from this now forms part of this report. Another officer, who had dealings with the man on 11 August, was also unavailable for interview due to long-term sick leave. The investigator provided feedback to the Governor of Wandsworth during the course of the investigation.

16. One of this office's Family Liaison Officers contacted the man's wife to explain our investigation and offer the family the opportunity to raise any questions or concerns. They said that he had become stressed and depressed in the weeks before his death. They wondered whether it was right that he was in a cell on his own and whether the risk of him harming himself had been properly assessed. They also asked whether he had been medically assessed and if he had been given any medication. Before going into prison he had been prescribed some medication by his own doctor for depression, and the family wanted to know whether the prison knew about and continued this medication.

17. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report.

The investigator has remained in contact with the Coroner's office through the investigation.

18. The report was issued in draft form and responses to the recommendations from the Prison Service are included. The man's family did not respond to contact from the PPO to receive the draft report. We apologise for the delay in issuing this report.

HMP WANDSWORTH

19. HMP Wandsworth is the largest prison in the UK, currently able to hold 1665 prisoners, and is one of the largest prisons in Western Europe. The prison was built in 1851, and the residential areas remain in the original buildings. Since 1989, 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 the more recent installation of in-cell electricity. Wandsworth is a local male prison, accepting all suitable prisoners from courts within its catchment area.

20. The main prison has five wings, each with four landings. A and B wings are general population wings, holding remand and convicted prisoners. C wing is the induction wing. D wing had been used to hold convicted prisoners, but recently has been used to hold prisoners with drug treatment needs. E wing holds the First Night Centre, the Care and Separation Unit, and the Detoxification Unit. The Onslow Centre is the Vulnerable Prisoners Unit, with three wings. The Mick Knight Centre is a drug treatment unit for prisoners involved with the Rehabilitation for Addicted Prisoners Trust (RAPt). The Kearney Unit is for prisoners involved in a programme addressing alcohol misuse.

Roll counts

21. During periods when prisoners are locked in their cells, staff undertake roll counts. This ensures that prisoners are where they are supposed to be. Officers will patrol the landings and check that each cell has the correct number of prisoners. They then report the numbers to the senior member of staff on the wing, who confirms that the total tallies with the expected number.

Suicide and self harm monitoring

22. Assessment, Care in Custody and Teamwork (ACCT) is in place in all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on an ACCT plan, the prisoner is supported and observed at regular intervals according to their perceived level of risk.

23. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people, forming a case review team, who know the person at risk or are involved in their care.

24. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment and it is for the case review team to decide the most appropriate place to locate an individual prisoner.

25. An ACCT plan can be opened by any member of staff working in the prison. A Concern and Keep Safe form (which opens the ACCT plan) should be completed when anyone has any concerns whatsoever that a

prisoner may be at risk of harming him or herself. This should be completed by the person who has or unearths the concerns.

Prison Service policy on resuscitation

26. Prison Service policy on resuscitation of prisoners is contained in the Prison Service Order (PSO) 2700. This PSO, which relates primarily to suicide prevention and self-harm management, states:

> "**Resuscitation**: Policy remains that staff should continue to attempt resuscitation – as appropriate to the injury – until told to stop by a healthcare professional, e.g. a member of the Ambulance Service or a doctor, or rigor mortis has clearly set in…"

Previous deaths at Wandsworth

27. The man was the fifth prisoner in two years to apparently take his own life in the custody of HMP Wandsworth. Since he died, there have been a further two deaths which were apparently self-inflicted. We have previously made recommendations about responding to information in medical records, urgent mental health referrals, the operation of the personal officer scheme, use of the emergency call system, and on two occasions communications with the mental health team.

Her Majesty's Inspectorate of Prisons' report

28. The last report published on Wandsworth by HM Chief Inspector of Prisons followed an announced inspection in June 2009. The report found some failings in the personal officer scheme, and recommended that a named member of staff should be allocated to individual prisoners. There is also information that a prisoner who had made a serious attempt to harm himself was not placed on ACCT support, although the circumstances of this were different to those of the man.

Independent Monitoring Board (IMB) report

29. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers appointed by the Secretary of State for Justice from the local community. The IMB is responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The annual report published by the IMB for Wandsworth for the period 2009-10 notes that few prisoners knew who their personal officer was.

KEY EVENTS

30. The man was born in London in 1955. He was married, and he and his wife had a son and a daughter.

31. He had a number of previous convictions dating back to 1974. He had served previous periods in custody, being released from his last prison sentence in May 2009.

32. The man was arrested on 14 May 2010. Papers from his time in police custody show that he had been quite badly injured during the course of his arrest. On arrival at the police station he was suffering from pain in his back and ribs and from a cut over his right eye. He needed to see the police medical officer to ensure that he was fit to be interviewed. The doctor assessed him and noted that he was suffering from significant pain across his body, with several areas of deep bruising. He also noted cuts and grazes to his face. He referred him to hospital, called an ambulance, and wrote a letter for the doctor he would see in hospital. He was taken to hospital that afternoon. He was found not to be suffering from any fractures to his ribs and returned to police custody that evening with painkilling medication.

33. He said that he was also taking painkillers to help with injuries to his leg, received in a road accident the previous week. He also said that some months previously he had been diagnosed with depression and was receiving medication for this. The police custody officer's assessment form was marked to indicate that he was not a vulnerable detainee. He was, though, to be subject to observations every 30 minutes. The police papers do not indicate why.

34. The man was remanded into custody and taken to HMP Wandsworth on 17 May (where his three co-defendants were also remanded). In addition to the information available in the police papers, at his initial health screening he said that he suffered from gout (a medical condition usually characterised by recurrent attacks of acute inflammatory arthritis - a red, tender, hot, swollen joint). He was prescribed allopurinol (a treatment for gout), diclofenac sodium (an anti-inflammatory painkiller), paracetamol, and zopliclone (a drug used to aid sleep). His medical file notes that his mental state as normal and that he expressed no thoughts of self-harm.

35. After spending short periods on the first night centre and the induction wing, the man was moved to A wing. His co-defendants were also located on the same wing.

36. After initially seeming to be coping normally, his co-defendants noticed that his mood was becoming low. He had been injured during his arrest and was suffering some pain and, in addition, was very concerned about the criminal case against him. He had been expecting to be charged with theft, but said that the police had indicated that the charge might be

robbery, which carries a higher sentence. He said he was worried that he might receive a sentence in the region of 15-20 years.

37. Over the following weeks, the co-defendants said that he became obsessed with the forthcoming trial, which was still some months away (scheduled for November 2010). His concentration was poor and he continued to worry considerably. Towards the end of July, his friends noticed that his mental state seemed to get worse. He would forget things and seemed unable to focus his attention on anything or to speak about any subject apart from the trial for very long. His co-defendants felt that his concerns seemed to be slightly unreasonable and he was concerned about things that they didn't think were likely to happen.

38. The four co-defendants were sharing two cells, two men in each. The man was sharing a cell with a co-defendant. The man had the top bunk bed, the co-defendant the lower. On 2 August, the co-defendant had an appointment with his solicitor. When he returned to the cell, the door was closed. He looked through the observation panel, and saw the man standing at the window, holding a piece of string or cord which he had tied to the window. He was holding the co-defendant's lighter (the man was a non-smoker). The co-defendant went into the cell, and could smell burning. He asked what he was doing, and he said that he was not doing anything. He noticed a red line around his neck, as if something had been tied there. He again asked him what he had been doing, and he again replied that he was not doing anything. The co-defendant did not report this to anyone.

39. Some time shortly afterwards (the co-defendant could not recall the exact day but said it might have been Thursday 5 August) he was awoken at about 6.30am by the sound of the man falling from his bunk. He looked out to see if he was hurt, and noticed that he had tied a bed sheet around his neck and apparently fallen from the bed deliberately. The sheet was only loosely knotted around his neck, and the other end of the sheet did not appear to be attached to anything. He asked him what he was doing, and he played the incident down. The co-defendant said to the investigator that he did not think that it was a serious attempt to hurt himself, but rather a way of expressing and drawing attention to how he was feeling.

40. The co-defendant told his other co-defendants what had happened. Between them, they agreed not to tell staff. They did not think him likely to make a serious attempt on his own life, but agreed that they would monitor his behaviour between them, and try to manage his depression as friends.

41. A note in the man's medical file dated 5 August shows that he was feeling low in mood. There were no indications that he intended to cause harm to himself, so he was referred to the mental health team for an appointment in due course.

42. Most prisons operate a personal officer scheme. How this functions varies from prison to prison, but generally prisoners will have a named officer with whom they have regular contact and who would be their first port of call for any problems or queries. On A wing, the man was on the landing where the cleaning workers were. Prisoners on this landing are not allocated a designated personal officer. If he needed to speak to staff he would have had to speak to the landing officer.

43. At approximately 8.45am on Wednesday 11 August, Officer A had a conversation with the man. He said that he was unhappy on A wing and would like a move. He had not had much time out of his cell of late. Furthermore, he said that he had been having some problems, not getting on with staff and prisoners. The officer and he discussed a move to a different wing, and agreed that would be beneficial.

44. Consequently, at 9.45am, the officer escorted him across to B wing. He left him with the B wing's duty movement officer. However, he told the movement officer that he had some problems with remaining on B wing. The officer therefore brought him back to A wing. Officer A tried to get him to explain why he did not want to stay on B wing, but he would not. He asked the officer to move him to another wing or to the vulnerable prisoners unit (VPU). The officer said that prisoners were only moved to the VPU if there was a good reason to do so, but he would try to arrange a move for him to D wing. He contacted D wing and they agreed to accept him. They said he should be brought over after 11.00am. He said that he was content with this, so the officer escorted him to the holding cell on A wing. (A cell not designed for ongoing occupation but to hold prisoners in transit from one area to another).

45. Officer B was also on duty on A wing that morning. He escorted some prisoners to the holding cell and, as he walked away, the cell call bell was activated. He went back to the cell, and the man said that it was he who had pressed the bell. He told the officer that he did not wish to be left with other prisoners as he had some problems. He didn't ask what the problems were, but the officer therefore took him from the holding cell and left him in the general area outside the A2 landing office. As the officer turned away, he handed him a piece of paper but he did not say anything. The officer made an assumption that it was intended for Officer A, who was supervising prisoner movements, so took it into the office and handed it to him. He read the note, but realising that it was not related to the man's move, handed it back to the other officer. The note said that he had tried to take his own life on two previous occasions, and that he might try to do so again. A Senior Officer (SO) was also in the office at the time, and Officer B passed the note to him.

46. The SO read the note then went out of the office and spoke to the man. He asked him what was the matter, but he would not say. He told the SO that he felt "wobbly", but would not expand on what he meant by that. The SO said that he was happy to assist him with his request to move

wings, but again asked what was bothering him. Again he was reluctant to give a reason for his request to move.

47. Having spoken to the man, the SO went back into the office. The accounts vary as to the order of what followed, but the SO said he told both officers that an ACCT should be opened and that the mental health team should be contacted as a matter of urgency to see him that day. Officer A telephoned the mental health team but only reached an answering service. He left a message.

48. After speaking to the officers, the SO went onto the A wing landing. Two of the man's co-defendants approached him, and asked if he was alright. The SO queried why they would ask that, and it was at this point that the man's cellmate told the SO that he had tied a sheet around his neck some days previously.

49. At one point Officer B went into the A3 wing office, and noted an officer opening an ACCT. He initially assumed that this was for the man, but it soon became apparent that it was for someone else. He therefore made his way back to the A2 landing office to open the man's ACCT, but as he arrived he was told that the prisoners who had been off the wing were returning and needed supervising. He went back onto the landing and assisted with supervising the prisoners back to their cells. He then immediately supervised the serving of lunch. Once that had finished, his scheduled shift had come to an end. He asked the SO if he could go home, and once agreement was given, he left the prison at 1.15pm. He forgot to open the ACCT for the man.

50. In the meantime, at approximately 11.30am, an officer had escorted the man from A wing to D wing. As movements officer, Officer A was dealing with the administration for the moves on and off the landing. He noted that the man did not have an ACCT open, but assumed that it had been considered and the idea subsequently rejected. He did not check with the SO or Officer B why the ACCT had not been opened.

51. On arrival on D wing, because there was no ACCT in place, staff were unaware that the man had been identified as possibly being vulnerable. He was therefore given a single cell on D2 landing. That afternoon, an officer was working on D2. Having previously been a cleaning officer when the man was a cleaner, the officer knew him. Slightly surprised to see him arrive on D wing, he asked him why. He simply said that he had moved. The officer did not think that he seemed in any way depressed, but presented much as he always had. Knowing that he was a good worker and having got on with him previously, the officer was pleased to have him on the wing.

52. Staff were not aware of any problems with the man throughout the rest of the day. After the evening meal the prisoners were locked in their cells and, as the day staff hand over to night staff at approximately 8.30pm, a roll count is made. Staff going off duty go to each cell and, check

through the observation panel, to ensure that the correct number of prisoners are in the cells. The night staff then come on duty and the incoming staff also conduct a roll check. Unless prisoners are on special observation, they are then not checked again until the following morning when the staff shifts change again. The roll count was made as usual on 11 August, and all was okay. The check was completed by 9.00pm.

53. At approximately 9.30pm, the two prisoners in the cell next to the man's heard a loud noise, as if a chair had been knocked over. Such noises are not uncommon on the wing and the prisoners thought it may have been a fight between other prisoners.

54. As no ACCT was in place, staff did not carry out any further observations on the man's cell until the roll check the following morning before the staff change shifts. An officer conducted the roll check on the man's landing at approximately 5.45am the next day. In interview, he said that morning checks are primarily to ensure that the cell contains the prisoner(s) that it is supposed to. At this time in the morning most prisoners are asleep. Unless someone is obviously in distress, staff do not wait to ensure that prisoners are breathing or moving. He looked through the observation panel and saw the man sitting in his cell. He did not think that there was anything untoward, and moved on to the next cell.

55. The staff shifts changed and another officer came on duty at approximately 6.00am. He was given a handover briefing and, at some point between 6.30am and 6.45am, he made a roll check. At the man's cell he looked through the observation panel and, in interview, said that he thought he remembered that he was sitting by his bed. Like the previous officer, he did not see anything that gave him cause for alarm, and he continued along the wing.

56. From 7.45am staff began to unlock the prisoners' cell doors so they could come out for exercise. Officer C arrived at the man's cell door at or shortly before 7.50am. She looked through the observation hatch, and could see that he was sitting on the floor by his bed, facing away from her. He had a ligature made from a bed sheet tied around his neck, knotted at the back, and pulled taut from being attached to his bed. Staff in Wandsworth carry whistles to alert colleagues when they require assistance, and she blew her emergency whistle as she went into the cell.

57. An officer was on duty on D wing, and responded to the officer's whistle. As he made his way along the landing, the officer was shouting for assistance. He followed her voice into the cell, and found her cutting the sheet from the man's neck with her anti-ligature knife. He lifted him to relieve the pressure on his neck and to allow the officer to cut the ligature more easily. Other staff arrived in response to the emergency whistle. Two officers lowered the man to the floor and the control centre was

informed. At 7.55am the control centre requested an emergency ambulance.

58. A Senior Officer (SO) was on duty that morning, and was one of the staff who went to the man's cell. The SO is also a qualified nurse and, as she arrived at the cell, other staff stood aside to allow her access. She examined him and looked for signs of life. She noted that rigor mortis (stiffening of the limbs) was present and she thought he was clearly dead.

59. The staff nurse on shift was the designated medical emergency responder. She received a call over the healthcare emergency radio asking her to attend an emergency on D2 landing on D wing. Her statement estimates that this call came through at approximately 7.30am. All other documentation, however, indicates that the alarm was raised at 7.49 or 7.50am. The incident log indicates that she arrived at the cell at 7.56am. It seems likely, then, that her estimate of the time is not correct, and the emergency call went through shortly after 7.50am.

60. On arriving at the cell, the nurse saw the man lying on the floor, his head towards the door and his feet towards the window. She examined him and could find no signs of life. Rigor mortis was present and it was clear to her that he had been dead for some time. She made the decision that to attempt resuscitation would be inappropriate.

61. The ambulance arrived at 8.08am and the paramedic staff went to the man's cell. The nurse informed them of the situation and the paramedics examined him. They were also unable to detect any signs of life.

62. When the prison doctor arrived in the prison, he and the nurse went to the cell. He officially pronounced the man dead at 9.28am.

Informing the man's family

63. A prison governor was appointed as the family liaison officer, and identified the man's wife as his next of kin. He obtained her address and he and an officer went to inform her of her husband's death. They arrived shortly after midday on 12 August, but she was not home. They telephoned her and asked her to return home, which she did, and they broke the news of her husbands' death.

64. The SO, who Officer B had spoken to, was on A wing when he heard that the man had died. Officer B was not in the prison that morning, so the SO telephoned him at approximately 8.00am. Not being able to reach him, the SO Charles left a message for him to telephone as soon as possible. The officer returned the call at 8.30am, and spoke in a three-way conversation with the SO and a Developmental Prison Service Manager (DPSM). The SO asked him if he remembered the man, and he replied "Oh no, I forgot to open his ACCT yesterday". The SO told

him what had happened. He asked him to come into the prison to speak to the Governor and to the police.

65. It is usual in light of the death of a prisoner to hold a debriefing session with staff involved in his or her care. These ensure that staff have an opportunity to discuss any issues arising, and for support to be made available. Records show that a debrief was held at 8.40am on 12 August, chaired by a Governor. A member of the prison's Post Incident Care Team (PICT) attended the meeting to provide support to any staff who might require it. The DPSM asked the duty Imam to speak to Officer B and ensure he was looked after. Other members of staff also offered their support.

Support for prisoners

66. Staff identified the man's co-defendants. Once they were sure that his family had been informed of his death, the SO, DPSM (A wing manager), chaplain and the Head of Safer Custody asked the co-defendants to meet them in the A wing office. They then informed them of the man's death. They all said that they were aware that he had tried to harm himself the previous week, but had not told staff as they felt that this would be a betrayal of confidence. Between them they had known him for many years and, while they knew he was depressed, none of them thought he seriously wanted to take his own life. Staff reminded them that support was available should they feel that they needed it.

67. As is required after a death in custody, all prisoners on ACCT plans had their situation reviewed on 12 August.

Post Mortem

68. A post mortem was carried out on 13 August 2010. The doctor concluded that death was due to hanging. In reference to the prisoners in the cell next to the man's saying that they heard a disturbance at approximately 9.30pm on the night he hanged himself, said that the time of him hanging himself would be consistent with that.

Funeral

69. The prison held a memorial service for the man on 2 September. His family were invited to attend.

70. In line with the relevant guidance, the prison provided a financial contribution to the cost of the funeral. At the family's request the prison service were not represented at the funeral.

Police investigation

71. The Metropolitan Police investigated the death. No criminal proceedings were subsequently brought.

ISSUES

Monitoring of the man's mental state

72. Prior to his imprisonment, the man had seen his doctor about depression. This is noted on the police papers which came to prison with him, but his prison medical file makes no reference to it. His friends all noted that he was extremely anxious about his forthcoming trial. His wife said that in the weeks before he died she could tell that he was in low spirits.

73. The clinical reviewer notes that he had little contact with the healthcare team. He goes on to say that when he reported feeling in a low mood on 5 August, he was correctly referred to the mental health team. There were no other factors which indicated that a more urgent response was required.

74. Although the man told staff that he had no thoughts of harming himself, we do feel that his recent contact with his doctor for depression should have been noted. It was documented on his police papers, which were available to prison staff. We appreciate that a high number of prisoners come into Wandsworth and pose a challenging array of issues. But, while there was no reason on his arrival into prison to suspect that he needed urgent mental health attention, records do not make clear whether he was specifically asked about his anti-depression medication. In view of his recent history of depression, a referral to the mental health team should have been made.

    The Head of Healthcare should ensure that new prisoners with a recent history of depression or other mental health issues are systematically referred to the mental health team.

75. In the nine days leading up to his death, the man made two apparent attempts to harm himself. His friends were aware of these but, believing them not to be serious attempts on his own life, did not bring them to the attention of staff. Rather, they wanted to try and manage it between themselves. There was no opportunity, therefore, for staff to raise the priority on his referral to the mental health team.

76. We note that it is the policy at Wandsworth for cleaners to be on the same landing and not to have a designated personal officer. It is not clear why this is the case. Any comment on whether a personal officer might have noticed the man's mood deteriorating would of course be speculation. But we do consider that the lack of an assigned officer meant that no single officer had the responsibility to build a rapport with him. As a result an opportunity, however remote, to identify his low mood was lost. Both the IMB and HMIP have commented on deficiencies in the personal officer scheme in Wandsworth, and we believe that the current arrangements should be reconsidered.

The Governor should review the operation of the personal officer scheme at Wandsworth and make changes to ensure it is effective.

Missed opportunity to open an ACCT

77. On the morning of 11 August, the man told Officer A that he wanted a move to a different wing. He said that the reason he did not want to remain on A wing was because he was having problems with other prisoners. His friends told the investigator in interview that they believed he had not had difficulties with other prisoners and that this must have been an excuse to ensure that he got the move that he was seeking.

78. Officer A did, though, accept his request. He arranged for him to go to B wing, but on arrival he said that he was unwilling to stay there, so was returned to A wing while an alternative was arranged. It was during that wait that he passed the note to Officer B, indicating that he felt that he might harm himself. After the note initially passed between both officers, they realised its importance and brought it to the attention of the SO. He spoke to him and, although he was unable to find out from him what was causing the problem, he correctly identified that he needed support. He told the officers that they should ensure that an ACCT was opened and the mental health team contacted.

79. The man's vulnerability was correctly identified and his request to move wings was accepted. It was recognised that the mental health team should be involved and, most importantly, it was agreed that he required the support of an ACCT plan. However, neither the referral nor the opening of the plan happened.

80. In his clinical review, the clinical reviewer comments on the fact that Officer A tried to contact the mental health team but only managed to reach an answering service. In the event of a psychiatric emergency, this presents a risk that the mental health team cannot be reached when needed. This sadly seems to have been the case on this occasion. He recommends that the means of contacting the mental health team should be reviewed. We agree.

The Head of Healthcare should review arrangements for contacting the mental health team to ensure that urgent referrals are not delayed.

81. The fact that no ACCT was opened is a significant concern. We must bear in mind that being on ACCT procedures in themselves cannot guarantee that a prisoner will not succeed in harming or killing himself or will be prevented from doing so. However, had an ACCT been opened, a Concern and Keep Safe form would have immediately been opened, identifying the issues and potential support mechanisms. The ACCT would then have been reviewed within 24 hours. Unless the warning signs are so considerable that it is believed that the prisoner will make a serious attempt on his own life imminently, prisoners will not be observed

continually but at predetermined intervals appropriate to their individual situation. The man would, though, have been assessed as to the level of risk he was thought to present, and he would have been subject to more frequent observations by staff. This would almost certainly have included checks during the night. Moreover, the opening of an ACCT is about more than simply observing the prisoner. Support can be provided in a number of ways, tailored to the situation and the problems the prisoner feels he is facing.

82. Both officers and the SO clearly identified the need for the man to be given the support he would receive on ACCT, and the decision was taken to open one. Because he was in a sterile area awaiting transfer off the wing, no note was made in the wing observation book. Officer B was aware that he should open the ACCT by completing a Concern and Keep Safe form, but was distracted by other work and did not do so. The man was transferred off the wing and his paperwork accompanied him. The SO would therefore not have been in a position to notice that the ACCT was not opened. When Officer A arranged his transfer from A wing to D wing, he noted that an ACCT plan was not in place. Even though he had been present when the SO had said that an ACCT plan should be opened, he assumed that a decision had subsequently been taken not to do so. He did not check with anyone why that decision might have been made.

83. We have serious concerns over this chain of events. The man had brought his problems to staff's attention. He was clearly struggling with some demons and had written down that he felt as if he wanted to take his own life. Three members of staff were aware of this, yet nobody took full responsibility for opening an ACCT.

84. In interview, it was clear that the SO had taken the man's safety seriously. He spoke to him himself, he spoke to his friends on the wing, and he told both officers to ensure that an ACCT was opened and that the mental health team were contacted.

85. Officer A had seen the note and was in the room when the SO said that it should be opened. He contacted the mental health team, although he was unable to speak to them directly. Later that afternoon, however, he arranged the man's transfer off the wing and, despite noticing that no ACCT was in place, did not query this. Prisoners' safety is the responsibility of all staff and we are disappointed that Officer A did not think to check why, in view of what he had seen and heard earlier, the man was not on an ACCT.

86. On hearing of the man's death, Officer B immediately accepted full responsibility for forgetting to open the ACCT. When the investigator spoke to staff in Wandsworth, the officer seemed to be a respected officer for whom such a lapse was completely out of character. This, though, is a serious oversight and, only a few hours later, a man died. It our view that, notwithstanding these mitigating factors, the Governor

should consider whether there should be any disciplinary action taken in light of the man's death.

The Governor should conduct a disciplinary investigation into Officer B's actions.

Roll checks

87. It seems that the man was alive when the roll checks were completed on the evening before he was found. It is likely, however, that he was dead when the morning roll checks were carried out at 5:45am and 6:30am. The officers who conducted these checks either remembered or thought that they remembered that he appeared to be in a sitting position. Neither officer noticed that anything was wrong.

88. Unfortunately, Officer C did not make a written statement to the Governor of what happened that morning. She subsequently left the Prison Service and it was not possible to interview her as part of this investigation. The only record the prison has of what she saw when she unlocked the cell is a note in the wing observation book that was written by a SO. We ask the Governor to ensure that in future, unless there are exceptional reasons why they cannot do so, all staff involved in such an incident are requested to make written statements immediately following the occurrence.

The Governor should ensure that staff who have to deal with deaths in custody are asked to complete written statements immediately following the occurrence.

89. We have since been able to obtain a copy of Officer C's statement to the police. She looked through the observation panel and saw the man sitting in the middle of his cell, facing away from her. Although all she could see was his back, neck and head, she could tell that he had a piece of green material tied around his neck. She could see that it was knotted at the back, with a gap between the knot and his neck where his weight had fallen forwards. She could also see that the material was pulled tight from where it was attached to the bed. She was clearly able to discern that something was amiss via the observation panel. She could see enough to provide a good level of detail in her police statement about the ligature around his neck. This begs the question of why she saw something that the other two officers did not.

90. It seems to be accepted that the purpose of roll checks at Wandsworth is to ensure that the correct number of prisoners are on the wing and nothing more. In interview, the officers who conducted the checks that morning said that there was not time to conduct any kind of wellbeing check, only to ensure the numbers were correct. This means that, unless subject to special observation, prisoners' wellbeing may not be checked for up to ten hours.

91. We appreciate that in a large prison such as Wandsworth, staff conducting roll checks are pressed for time. Both officers who conducted the morning roll checks on the man's cell in the morning said that they did not notice anything wrong, but that they were not doing anything more than a short visual check to confirm the prisoner was in their cell. The fact remains, though, that two members of staff looked into the cell when the man was in all likelihood dead, yet did not notice. This is concerning. If we are to accept the roll checks were completed, it is evident the check was brief and cursory.

The Governor should ensure the effectiveness of roll checks in terms of prisoner welfare. This should include staff being reminded of the importance of this aspect of the checks.

The reaction when the man was found unresponsive in his cell

92. When Officer C found the man hanging, she raised the alarm by blowing her whistle and immediately began to cut the ligature from his neck. Staff were quickly with her to assist, and an ambulance was summoned.

93. The medical emergency responder was quickly summoned. We note that she said in interview that she was called to the emergency without being told what the situation was. No code was used. She said that sometimes codes were used and sometimes they were not. Some prisons use emergency code systems which clarify the type of emergency (Code Red, for example, means that a prisoner is bleeding, Code Blue means they are not breathing). It did not make a difference to the outcome in this case, but the Governor should remind staff that when summoning medical help in an emergency as much information as possible should be provided, including a code.

The Governor should remind staff that, when summoning healthcare staff to an emergency, as much information as possible should be relayed, including the use of appropriate codes.

94. The Senior Officer who responded is a trained nurse. When she arrived at the cell shortly after Officer C raised the alarm, she checked for signs of life but found that rigor mortis had set in. The nurse was there soon after and again, having checked for signs of life, noted that rigor mortis was present. Prison Service Order (PSO) 2700 contains guidance to staff on the actions which should be taken on finding a prisoner hanging. The PSO states that resuscitation should not be attempted if rigor mortis has set in.

95. In this instance, the clinical review concludes that it was appropriate that staff did not attempt to resuscitate the man as it was quite clear that he was dead. Notwithstanding the comments above about the roll checks, once it had been established that he had harmed himself, the response seems to have been appropriate.

CONCLUSION

96. The man was a 54 year old man who had previous experience of prison. He had a recent history of depression, for which he had seen his doctor. He was injured while being arrested in May 2010. He and his 3 co-defendants were subsequently remanded to Wandsworth.

97. On arrival, some minor health issues were identified, but he was not judged to be at risk of harming himself. However, fearing a long prison sentence, he began to obsess about the trial. His friends and family noted that he was low in mood. On 5 August, he was referred to the mental health team but as there was no indication that any more urgent assistance was required he was given a routine referral.

98. On two separate occasions, the man's cellmate one of his co-defendants) found him making apparently suicidal gestures. They did not, though, appear to be serious attempts to hurt himself but more an indication of his state of mind. The cellmate discussed what had happened with his other two co-defendants. They agreed not to tell staff, but to monitor his mood between them.

99. The morning before he was found hanging, the man asked a member of staff to help him move to a different wing. He said that he had some problems with other prisoners where he was on A wing, although this seems likely to have been an excuse he made up to help him get the move he wanted. The move was agreed and he was taken to B wing. However, on arrival, he said he could not remain there and was taken back to A wing while another move was arranged. At this point, he passed a note to a member of staff.

100. Staff in the office read the note. It said that he had made two attempts to take his own life recently. He felt that he was going to try again. The Senior Officer spoke to him, then went back to the office and told the two officers there to open an ACCT plan and to contact the mental health team.

101. One officer contacted the mental health team by telephone, but only reached an answering service. He left a message. The other officer was called away on other business and forgot to complete the Concern and Keep Safe form, which effectively opens the ACCT plan. The man was transferred to D wing with no ACCT plan in place. There was, therefore, no indication for staff receiving him that he had been identified as vulnerable. He was allocated a single cell.

102. The last time staff saw him was approximately 8.30pm when a roll check was made. Prisoners in the next cell heard a disturbance from his cell at around 9.30pm.

103. The man was not checked upon again by staff until roll check the following morning. One check was made at around 5.45am, and another

at around 6.45am. Both of the officers who made these checks remembered seeing him in a sitting position, but did not notice anything that alerted them to a potential problem. It was not until the cells were unlocked at approximately 7.50am that it became clear that he had hanged himself. Staff cut the ligature and called for medical assistance, but it was clear that he had been dead for some time.

104. We make seven recommendations. These concern mental health referrals, the personal officer scheme, written statements from staff, roll checks, passing on information in emergencies, and a recommendation regarding a disciplinary investigation.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that new prisoners with a recent history of depression or other mental health issues are systematically referred to the mental health team.

   The National Offender Management Service accepted this recommendation.

2. The Governor should review the operation of the personal officer scheme at Wandsworth and make changes to ensure it is effective.

   The National Offender Management Service accepted this recommendation.

3. The Head of Healthcare should review arrangements for contacting the mental health team to ensure that urgent referrals are not delayed.

   The National Offender Management Service accepted this recommendation.

4. The Governor should conduct a disciplinary investigation into Officer B's actions.

   The National Offender Management Service did not accept this recommendation. They said:

   "The Governor considered a disciplinary investigation into Officer B's actions. However, as he had immediately accepted full responsibility for accepting to open the ACCT, it was decided that there would not be anything to gain from commissioning a disciplinary investigation into his actions. However, he was given "Advice and Guidance" which involved attending further ACCT awareness training and this element of his role being monitored in his performance and development plan."

   … A review to consider the issues identified as a result of the man's death against current practice and procedures to ensure they are sufficiently robust was conducted."

5. The Governor should ensure that staff who have to deal with deaths in custody are asked to complete written statements immediately following the occurrence.

   The National Offender Management Service accepted this recommendation.

6. The Governor should ensure the effectiveness of roll checks in terms of prisoner welfare. This should include staff being reminded of the importance of this aspect of the checks.

The National Offender Management Service partially accepted this recommendation and said:

"The purpose of roll checks is primarily to ensure that the correct numbers of prisoners are held in custody. The act of checking involves a brief observation of the prisoners in each cell, and within this episode there is limited opportunity for any 'welfare check'. That said we will remind staff that they should be alert to any prisoners who are observed to be in crisis and respond accordingly."

7. The Governor should remind staff that when summoning healthcare staff to an emergency, as much information as possible should be relayed, including the use of appropriate codes.

   The National Offender Management Service accepted this recommendation.