Investigation into the circumstances surrounding the death of a man at HMP Wandsworth in March 2011

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report of an investigation into the circumstances of the death of a man who was found hanging in his cell in HMP Wandsworth in March 2011. He was 57 years old.

I extend my sincere condolences to the man's family and friends for their loss. I apologise for the delay in issuing this report .

This investigation was undertaken by one of my senior investigators. A review of the man's clinical care was carried out by a clinical reviewer on behalf of Wandsworth Primary Care Trust.

The man had been at Wandsworth for a little over four months by the time of his death. He was well used to prison life having served many custodial sentences through the course of his adult life. He complied with prison rules and regulations and staff and other prisoners described him as a quiet man. Nothing occurred to cause staff or prisoners with whom he interacted to feel particular concern about his safety.

Neverthless, the report does identify some learning from this man's tragic death and makes seven recommendations. One concerns improvements to the personal officer scheme, one relates to general concerns over bullying and one on managing excessive staff turnover on the Onslow unit. Other recommendations relate to healthcare issues, including ensuring up to date clinical records, effective use of emergency calls and the availability of defibrillators. The clinical reviewer makes three recommendations. Two of these are contained within my report and the other can be found in the clinical review.

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 **May 2012**

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SUMMARY

1. The man was 57 years old and was found hanging in his double cell in HMP Wandsworth in March 2011. He was alone in the cell at the time and his death was discovered when his cell-mate returned from a morning class.

2. The man was remanded in custody at Wandsworth in November 2010, having been charged with burglary and theft. He had been in prison custody on more than ten previous occasions across a time span of over 30 years. He was still un-convicted of the latest offences at the time of his death.

3. When he arrived at Wandsworth, the man asked to be placed on the prison's vulnerable prisoners unit, the Onslow unit. He believed that other prisoners in Wandsworth believed him to be a sex offender, even though this was not the case.

4. Staff spoke of the man as a quiet and well behaved prisoner who did not come to their attention. Two prisoners, who knew the man, spoke of him in similar terms. His only contact with the outside world was a friend, who he telephoned on a fortnightly basis. Their last conversation was on the day before his death, which ended with the man saying that he would telephone again in a fortnight.

5. Nothing occurred on the morning of the man's death to suggest that he was at any heightened risk of harming himself. He spoke briefly with his cell-mate in the morning and had a lengthy conversation with another prisoner during exercise. He also had brief exchanges with two of the officers. All thought that he was his normal self.

6. When the man was found hanging, staff entered the cell, cut the ligature and attempted to resuscitate him. An ambulance was summoned and paramedics also attempted to resuscitate him. Unfortunately, all their efforts proved unsuccessful.

7. This report makes seven recommendations. One concerns the personal officer scheme, one concerns bullying, one on managing staff turnover on the Onslow unit. Two recommendations relate to clinical records and another is about coding of emergency calls. The last is about supply of defibrillators. The clinical reviewer makes three recommendations. Two of these are contained within this report and the other can be found in the clinical review.

THE INVESTIGATION PROCESS

8. The investigator first visited HMP Wandsworth on 22 March 2011, when he met staff from the prison's safer custody team, one of the prison's family liaison officers, a representative from the Prison Officers' Association and a member of the Independent Monitoring Board. (Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community to help ensure that standards of decency and care are maintained. Members of the Board have access to every part of the prison and all prisoners held there.)

9. The investigator visited the man's cell and was shown around the wing. He was given a copy of the man's prison and health records. He was also given a recording of recent telephone calls made by the man. Notices were issued to staff and prisoners informing them about the investigation and inviting them to contact the investigator if they wished to be involved in the investigation.

10. The investigator subsequently interviewed nine members of staff and two prisoners. No other prisoners came forward in response to the notices about the man's death.

11. The investigator contacted the Coroner's officer and a copy of this report will be sent to the Coroner to assist her enquiries.

12. I apologise for the delay in issuing this report and for any additional distress this may have caused. The delay was caused through workload pressures

13. The clinical reviewer, a trained nurse, carried out a review of the man's clinical care and treatment on behalf of Wandsworth Primary Care Trust.

14. One of the Ombudsman's Family Liaison Officers spoke with the man's brother to inform him about the Ombudsman's role and responsibility and invited him to raise any concerns to be explored as part of this investigation. His brother raised no specific issues but did express an interest in knowing the outcome of the investigation. The man's children were also contacted and his daughter requested a copy of the draft report. In her response to another Family Liaison Officer, the man's daughter said she was concerned by the findings of the investigation and supported the recommendations to improve practice for the benefit of other prisoners. His daughter said she felt the Prison System had let her father down in many ways and believed her father might still be alive had he received more appropriate care and support. She was also surprised to hear her father described as a quiet man by prison staff, as this was not the person she knew. We would like to thank the man's family for their consideration of the report.

HMP WANDSWORTH

15. Wandsworth is the largest prison in England and Wales, holding up to 1,665 convicted and remanded adult men. Its catchment area includes courts in central and south west London and neighbouring Home Counties. Wandsworth is a category B local prison. (Category B prisoners are those who do not require maximum security, but for whom escape needs to be made very difficult.) Some prisoners will serve the whole of their sentence at Wandsworth, while others will be moved to other prisons, including lower category ones, as appropriate.

16. The Onslow unit, where the man was housed, is a large unit comprising three wings, and is for vulnerable prisoners (those who need to be, or ask to be, separated from other prisoners for their own safety. Most usually, this is due to the nature of their offence).

17. HM Chief Inspector of Prisons last inspected Wandsworth in March 2011. Among other matters, the Chief Inspector found that:

> "Prisoners had no confidence in the personal officer scheme. Most staff told us that they did not have the time to undertake meaningful contact with prisoners in this role. Few prisoner records indicated effective and meaningful engagement by personal officers."

18. Compared to other wings in Wandsworth, prisoners on Onslow were much more positive when asked by the inspection team if staff treated them with respect and whether there was an officer they could speak with if they had a problem.

19. Every prison is overseen by an Independent Monitoring Board (IMB). The IMB is made up of local people who visit regularly and monitor conditions within the prison. Each IMB reports annually in writing to the Secretary of State about the prison. In an annual report spanning the period of the man's time at Wandsworth, the IMB reported a concern about staffing shortages on the Onslow unit. The IMB found that staff on Onslow were often redeployed to cover shortages in other areas of the prison. The IMB found that this had impacted on the personal officer scheme[1] that in the past has worked better on Onslow compared to other areas of the prison.

20. In the two years prior to the man's death, there were six other self-inflicted deaths at Wandsworth. In two of those cases, recommendations were made about the system for referring prisoners to mental health services. There were also two recommendations made about the personal officer scheme.

[1] Most prisons operate a personal officer scheme. Among other things, the personal officer is a prisoner's first port of call if they have questions, complaints or need advice.

KEY EVENTS

21. The man was born in Burnley, Lancashire, in June 1953. He reported that his father's work resulted in frequent family moves and so he attended a succession of schools. He had one sibling, a brother. The man left school at the age of 16 with six CSEs (Certificate in Secondary Education). Following school, he served a five year apprenticeship as a print compositor and then spent a further two years working in that industry. After leaving this job, he seems to have had a sporadic career working in a variety of trades including factory work and as a self-employed painter and decorator. He married in the early 1970s and was divorced ten years later. He and his wife had two children.

22. The man first appeared before the courts at the age of 17 and thereafter had many convictions for numerous offences. The majority of his offences were of car theft along with other motoring related offences. He served more than ten custodial sentences, dating back to 1977.

23. Having been conditionally released from custody on 9 March 2010, the man was re-arrested on 2 November and charged with offences of trespass and theft. After spending one night in police custody, he was remanded into HMP Wandsworth the following day.

24. Upon his arrival at Wandsworth, the man was seen for medical screening by a doctor and a nurse. He reported that he suffered from acid-reflux (acid coming up the oesophagus from the stomach) and he was prescribed medication for that condition. He also reported a history of depression, although he denied having any thoughts of self-harm. He said that he had harmed himself in the past, but that had been 20 years before. He was found fit for to be accommodated on a standard prison wing.

25. After going through the reception process, the man was moved to a double cell on the fourth landing of Wandsworth's Onslow centre. The Onslow centre is the prison's vulnerable prisoners unit (prisoners are usually located on vulnerable prisoner wings as the nature of their offence makes them vulnerable to violence or threats from other prisoners). It was not the man's offences that put him at risk in this way. Instead, it seems that during the years that he had been in and out of various prisons, other prisoners had come to believe that he was a sex offender. As a result, he routinely applied to be housed on the vulnerable prisoners' wing.

26. On 8 November, the man submitted a written request for a consultation with Wandsworth's mental health in-reach team. He explained that he believed he had some "mental health issues" for which he wanted counselling. He did not specify why he wanted counselling, although his probation documents refer to him having OCD (obsessive compulsive disorder) resulting in a compulsion to steal cars. A referral was made to the in-reach team the following day, but was then re-directed to a counselling psychologist.

27. The man's records contain no further information about what happened to the referral. However, in its response to the draft report the Prison Service explained that the staff in the counselling service were employed by the prison service, not by healthcare. As a result, they had limited access to prisoners' clinical records. Within the clinical records, staff would make a brief entry that a prisoner had been referred to and assessed by the service, and whether they were suitable for psychological intervention. Notes maintained by the counselling service, but were kept separate from the prisoners' clinical records. Further enquiries showed that after being assessed by the counselling service, he attended a mood management group based on the Onslow unit. He attended six sessions in total.

28. On 23 November, the man consulted a doctor after reporting gastric problems. The doctor prescribed omeprazole capsules (used to treat conditions caused by excess stomach acid). This was a chronic condition for the man and he received repeat prescriptions from this time onwards. He was able to retain this medication in his own possession, having been assessed as suitable to do so.

29. The man had a further healthcare consultation on 28 December. This time with a nurse. He complained that he was "feeling unwell", but his temperature, blood pressure and pulse were all within the normal range. The nurse gave him some pain relief and advised him to ask for more if he continued to feel unwell.

30. The man did not have a job at Wandsworth, although he attended information technology and creative writing courses three mornings per week. His Incentives and Earned Privileges level was 'standard'. (Prisons provide a system of privileges that can be granted to prisoners in addition to their minimum entitlement. This is managed through the Incentives and Earned Privileges scheme when privileges above the minimum are earned by prisoners through good behaviour and performance in work or education. 'Standard' is the middle of the three levels covered by the scheme)

31. On the afternoon of 2 March, the man had a ten minute telephone conversation with a friend. She was the only outside friend with whom he had any contact during his time in Wandsworth and he seems to have telephoned her every fortnight. The investigator listened to a recording of the conversation. Much of the conversation is made by the friend informing him of her news. Towards the end of the call he asks whether he can telephone her again or whether he should write. The friend responds by indicating that he can do either.

32. The man's cell-mate told the investigator that the man attended education twice a week, but otherwise spent most of his time in the cell. He did not tend to come out of the cell during association periods, which his cell-mate attributed to him being a timid man who did not want to risk the possibility of a confrontation with other prisoners. He had had two or three friends with whom he spoke, but when they were transferred to other prisons he seemed to have no one else to talk with. His cell-mate said that he and the man did not talk much as they did not have a lot in common. He expressed an opinion of the man being a negative person who did little to help himself. For instance, he spoke about preferring to be at HMP Littlehey where his friends had been transferred, but

when his cell-mate suggested that he should apply to transfer there, he replied that he would allow that to happen through its own accord. He also made no clear response to his cell-mate's suggestion that he apply for a prison job and also said that he did not have much to look forward to when he left prison.

33. One of the man's personal officers told the investigator that the man was very quiet and well behaved. Although he would say "good morning" that was the limit of conversation with him. He said that a person would have to have spent some time with the man to have gained any insight into him. He said that staffing levels on the unit did not allow staff to spend too much time with individual prisoners. In addition, staff on the Onslow unit were often deployed to other wings in the prison to cover shortages. The investigator raised with the officer the lack of recording in the man's electronic records about his daily activities. The officer said that when such entries were made on paper he would try on a monthly basis to update the records on progress of those prisoners to whom he was personal officer. He was finding that difficult however with the electronic system as updating records had to be done away from the wing. He said that Wandsworth was planning to introduce a change to the weekly regime to allow staff dedicated time to update prisoners' electronic records. He added that due to a period of leave and night shifts, he had no contact with the man for the two or three weeks before his death.

34. The investigator spoke with a number of other officers. One told the investigator that the man was a very quiet and polite prisoner who adhered to the wing rules. He never raised any concerns or complaints with the officer.

35. Another officer also found the man very quiet and could not tell the investigator anything to help establish if there were any matters that were causing him concern.

36. A further officer described the man in similar terms to the other officers, adding that he was shy, insular and even timid. The only time that the man approached him for help was when he had a problem with his canteen[2], which the officer was able to resolve with a telephone call.

37. One officer spoke of the man in slightly different terms to others. It seems that he found the man a little more talkative than did his colleagues, although even their exchanges seemed more about resolving outstanding domestic issues.

38. The man telephoned his friend once more on the afternoon of 16 March. Again they spoke for ten minutes and again the friend updated him with her news. The man informed his friend that he had few clothes and was still waiting to hear from a mutual acquaintance to whom he had written for assistance. His friend informed him that the mutual acquaintance was still storing two crates containing the man's belongings. The conversation ended with him saying that he would telephone her again in a fortnight.

[2] The word canteen refers to the prison shop. Prisoners are able to spend their own money on items such as tobacco, toiletries and sweets. They submit their orders by completing canteen sheets.

The day of the man's death

39. An officer told the investigator that he unlocked the cells on the man's landing that morning. This would have been just after 8.00am. As usual, he would have asked the man if he was alright and whether he had any problems. As usual, the man replied that he was fine and said no more than that. He went out for exercise.

40. A prisoner on the Onslow unit at that time told the investigator that he made a point of speaking with the man as he seemed to have few if any friends. The man began to engage more with him in the final weeks of his life. He spoke about a possible transfer to HMP Littlehey, where he hoped he might obtain work. However, he seemed disillusioned about his future beyond prison. The prisoner said that on that final morning he and the man spoke for an hour while out for exercise. The man seemed fine and there appeared no concerns about his welfare.

41. The man would have returned from exercise at just before 9.00am and an officer took him back to his cell. At about the same time his cell-mate left the Onslow unit to attend a course. He told the investigator that the man appeared his usual self. His cell-mate said to him "see you later".

42. An officer said that there were a number of cells on the Onslow unit that were in need of redecoration and that morning he was asked by a principal officer (PO) to check what work was needed for these cells. He went into the man's cell at around 9.45am. The man was sitting on his bed and the officer told him about the checks he was making. Compared to some of the other cells, his was in quite good condition so the officer told him that he did not think anything needed to be done. The officer asked the man if there was anything he wanted and he replied that he was okay.

43. Not long afterwards, the man was being unlocked for "social and domestics" (time during which prisoners come out of their cells to make telephone calls, to take showers and to clean their cells). An officer saw the man again at about 10.45am when he locked him back in his cell. The man said once more that he was fine.

44. At around 11.50am, the man's cell-mate returned to the wing but found the cell locked. He looked through the observation hole but the cell light was off and there seemed no sign of the man.

45. An officer told the investigator that, with two of his colleagues, he was unlocking cells to allow prisoners to collect lunch. When he reached the man's cell, his cell-mate was standing outside. The officer unlocked the door and moved to the next cell. He heard a noise and when he turned around saw that the man's cell-mate had collapsed to the floor. The officer and one of his colleagues went into the cell and found the man hanging from a ligature that was tied to the cell window bars. The officers summoned help by blowing their emergency whistles. They cut the ligature and lowered the man to the floor. One of the officers checked for a pulse, but found none.

46. An officer on the second landing responded to the alert and used his radio to inform the prison's control room that there was a code blue incident (indicating a prisoner having breathing difficulties) and that the emergency response nurse was needed.

47. A principal officer and senior officer arrived at this point and commenced attempts at CPR (cardio pulmonary resuscitation). In addition, the senior officer radioed the control room to request an ambulance.

48. The emergency response nurse for the day was in the healthcare unit when she received a radio call from the control room asking her to attend the Onslow unit (which was two to three minutes walk away). That initial call was followed-up almost immediately and announced as a code blue call. The nurse said that, while on the way to the Onslow unit, she received a further radio transmission for her to attend as soon as possible. On receiving the message she asked the control room operator to instruct an officer to collect an emergency bag (a bag containing emergency equipment such as oxygen and a defibrillator[3]).

49. The nurse said that when she arrived at the cell three officers were treating the man, while another officer confirmed that an ambulance was on the way. The emergency bag had still not been brought to the landing so she instructed an officer to collect it. Due to lack of room in the cell, the nurse asked the staff to move the man onto the landing. She checked for signs of a pulse and breathing but could not find any. She instructed the officers to resume CPR while she checked the man with the defibrillator which had by then been brought to the Onslow unit (Wandsworth had three defibrillators which were kept at three different locations). The defibrillator showed no electrical activity in the heart and instructed that CPR should be continued. While officers rotated in giving chest compressions, the nurse gave oxygen. One of Wandsworth's doctors arrived and he authorised intravenous adrenalin (a drug used when a patient is in cardiac arrest). Ambulance paramedics also arrived and they also assisted in trying to resuscitate the man. Unfortunately, all efforts proved unsuccessful and he was pronounced dead at just after 12.20pm. He had not left behind any note or letter indicating his intentions.

50. The man's cell-mate was moved to a cell with two other prisoners with whom he was on friendly terms. One of the prison chaplains offered him his support.

51. The man had declined to identify any next-of-kin when he arrived at Wandsworth. However, in answer to a question about any other person to be notified in the case of an emergency, he named a friend who lived in Middlesex. This was the friend whom he had telephoned on 16 March. Two of Wandsworth's staff visited the friend to inform her in person of the man's death. She told the staff that the man had seemed "a bit down" during their recent telephone conversation but not to the extent that it had given her any cause for concern.

[3] A defibrillator measures electrical activity in the heart and emits audible instructions on management of the patient.

52. Wandsworth later identified some of the man's blood relations, including a brother with whom he had not had any contact for around 30 years. There were telephone numbers but no addresses for these contacts. Wandsworth telephoned the man's brother who confirmed the information about the length of time since he had last spoken with his brother. He told the staff that his and his brother's mother was still living and that he would break the news to her. The man's daughter subsequently contacted the prison and staff spoke with her about her father's death. She took charge of the funeral arrangements and Wandsworth contributed to the funeral expenses. Wandsworth also held a memorial service on the Onslow unit

Hot debrief

53. At a hot debrief meeting to consider possible learning arising from the man's death, a number of matters emerged. One was the use of the code blue call. Code blue, signifying breathing difficulties, and code red, signifying bleeding, had been introduced in the previous October. This replaced a numerical system where the number one, two or three would be used depending on the perceived level of severity. The emergency response nurse had not realised in the first instance that the incident to which she was being called was a serious medical emergency. (She clarified at interview with the investigator that a code blue call would also be used in the case, for instance, of a prisoner experiencing an anxiety attack.)

54. There was also a delay of around ten minutes in the summoning of an ambulance as the control room received the first call asking for a healthcare response but did not receive a second call asking for an ambulance. Another matter raised was a delay in bringing all of the emergency equipment. Oxygen was brought quite quickly but there was a delay in bringing a defibrillator. The investigator was told that while all of the prison's treatment rooms held small emergency 'grab bags', the prison had only a limited number of large emergency bags containing full equipment. The investigator was also told that a change to the emergency call system was due to considered, as was the purchase of additional emergency bags.

ISSUES

Assessment of the man's risk

55. The man arrived in Wandsworth on 3 November 2010 and took his life just over four months later. He left no note of explanation so assessing his motives would be speculation. However, in terms of any apparent risk, there was great consistency in the evidence from all the staff and prisoners with whom the investigator spoke. All spoke of him as a quiet man and none of them noticed any change in his attitude and outlook at any time.

56. His cell-mate spent more time with him than any other person. However, his evidence was that he and the man did not have very much in common so they did not speak very much and it seems had no in-depth conversations. One conversation they did have was about HMP Littlehey. The man said that he would prefer to be at that prison as friends of his had transferred there. But when his cell-mate suggested to him that he should apply for a transfer, his response was that he would allow such a transfer to occur of its own accord.

57. The other prisoner to whom the investigator spoke said that he made a point of speaking with the man as he seemed to have few if any friends. The man indicated that HMP Littlehey would be a better option for him, but he indicated being disillusioned about his options after prison. .

58. All of the officers referred to him as being a quiet man who complied fully with the prison regime. He had served more than ten prison sentences dating back to 1977, so he would have been well aware of the structures surrounding prison life and the advantages of abiding by prison rules and regulations.

59. One of the officers appears to have found the man a little more talkative than his colleagues, but even their contact seemed largely based upon minor day-to-day domestic problems that he might have. In common will all his colleagues, the officer identified no reason for concern about the man's wellbeing.

60. The man had regular contact with only one person outside prison. This was a friend whom he telephoned every fortnight. Their last conversation was on the day before the man's death during which he said nothing to give his friend any cause for concern. Instead, part of their discussion was about him waiting to hear from a mutual acquaintance who was storing his belongings. Their conversation ends with the man saying that he will telephone again in a fortnight.

61. The man had interactions with a number of people during the morning of his death. He and a fellow prisoner on the Onslow unit chatted during morning exercise and the man's cell-mate also spoke to him briefly before going to his course. An officer visited the cell around mid-morning to see if the cell was in need of decoration. The man was sitting on his bed and he told the officer that he was okay when asked if there was anything he needed. A further officer also had passing contact with the man through the morning while locking and

unlocking the cell a number of times. There would appear no reason for anyone to have believed that the man was at risk.

The personal officer scheme and P-NOMIS

62. In common with the majority of other prisons in England and Wales, Wandsworth, in principle, operates a personal officer scheme. The local policy in place when the man was in Wandsworth was published in March 2009 and was entitled the "Wing Officer Scheme". The policy has since been updated, but in most respects has remained unchanged. In practice, groupings of three officers are allocated responsibility for prisoners occupying a run of cells. According to the policy, personal officers are expected to have a "formal" conversation with their prisoners at least once a fortnight and to record this in each prisoner's record. The policy specified areas that should be mentioned in the record, such as the prison's attitude and behaviour, their interaction with other prisoners and any current concerns either in prison or in their private lives. In addition to formal conversations, personal officers are also expected to have informal conversations with their prisoners whenever on duty, even if only to say "good morning".

63. The policy also contains instructions for senior officers, whose role includes checking prisoners' files to ensure that fortnightly conversations are being recorded.

64. Although he was at Wandsworth for over four months, the man's records contain no entries by his personal officers. One of the contributory factors might be the introduction of P-NOMIS (an electronic record keeping system that has replaced paper based records). At interview with the investigator, several staff complained that there were an insufficient number of computer terminals available. They also pointed out that to use a terminal meant taking themselves away from the landing leaving just one or two officers to deal with prisoners. The investigator discussed the matter with the manager of the Onslow wing. He was aware from his own checks that there were problems with entries being made on P-NOMIS. He said that entries were being made in the case of prisoners with issues or problems that needed to be resolved. However, entries were not being made in the case of prisoners such as this man. He said that the solution identified was to lock down the unit for one hour each afternoon to allow staff the time to make personal officer entries.

65. Another possible factor contributing to the lack of records might have been officers from the Onslow unit being cross-deployed to other wings to cover staff shortages. Cross-deployment was a matter of concern expressed by the Independent Monitoring Board in their last annual report. Similarly, in his last report on Wandsworth, the Chief Inspector of Prisons reported staff across the prison saying that they did not have the time to undertake meaningful contact with prisoners in their role of personal officer. (Although the Chief Inspector also reported positive answers from prisoners on Onslow when asked if there was an officer they could speak with if they had a problem.)

66. Similar issues on the operation of the personal officer scheme on the Onslow unit were identified in an investigation by this office that was completed during the early part of 2010. We made a recommendation about the operation of the personal officer scheme. Wandsworth responded that a review of the scheme would be conducted once re-profiling of officers' roles and the introduction of P-NOMIS had both become "embedded". We reissue a form of the same recommendation:

The Governor should ensure that the local personal officer scheme is operating effectively across the prison and in accordance with policy, including the requirement for fortnightly entries on P-NOMIS

Other issues relating to the Onslow unit

67. In addition to concerns about P-NOMIS and cross-deployment of Onslow unit staff, officers from the unit raised two other concerns at interview with the investigator. One of these was the transfer onto the Onslow unit during the previous year or so of prisoners who would not ordinarily be housed on a vulnerable prisoners unit. The officer gave, as an example, a prisoner who might have built up debts on other wings and ultimately be moved to the Onslow unit because there was no other wing remaining on which they could be housed. The officer said that such prisoners were often younger than those commonly found on the Onslow unit. They would then realise that they were one of the stronger people on the unit and would become bullies. (There is no evidence that the man subject to this investigation was bullied while in Wandsworth.)

The Governor should ensure that appropriate measures are taken to deal with incidents of bullying

68. The other matter raised was about staff turnover. In keeping with practice for most other vulnerable prisoner units, officers do not have permanent attachments to the Onslow unit. Officers serve four-year attachments and then transfer to other wings or other duties. An officer reported that just before the time of the man's death, six or seven officers completed their four-year terms at around the same time and all left the unit. This will have had an impact in terms of continuity.

The Governor should ensure that there are not mass departures of experienced staff inside a brief time frame from a single wing

Clinical care

69. The clinical reviewer identified several areas where care could have been improved. The first of these was that, while the man had no significant physical health problems, Wandsworth did not request the records from his community GP (general practitioner). The clinical reviewer has made the following recommendation, which we endorse:

The head of healthcare and the Governor should ensure that community GP records are always obtained, provided patient consent is given

70. The clinical reviewer considered it an example of good practice that the man was able to refer himself to a counselling service as that would not be something that a person would ordinarily be able to do in the community. However, at the time the reviewer was making her enquiries, the counselling service was coming to an end due to lack of funding. She was unable to obtain any further information about what happened with the referral as it appeared that no records were made.

71. The Service later explained that the counselling service had made records, but these were kept separate from the man's prison healthcare records. It seems that following assessment by the counselling service, the man attended a mood management group and attended six sessions.

72. No evidence emerged during interviews with staff and prisoners to suggest that the man was displaying any overt symptoms of mental ill health. However, he clearly believed at one point that he would benefit from some form of mental health support and there was no indication from his records to explain what form of support he was seeking, to explain why his request had been forwarded to counselling services and what ultimately happened following the referral. It would have been helpful if appropriate notes had been made in his records.

The head of healthcare should ensure that all providers of healthcare services make clear and detailed entries in the clinical records.

73. The clinical reviewer found that the clinical staff who attempted to resuscitate the man were up to date with their CPR training and used appropriate techniques, equipment and medicines. However, she also found that the response was not as smooth as should have been the case. It is clear from the emergency response nurse's evidence that she did not realise that she was being summoned to a serious medical emergency. It was only upon issue of the third call to her that she realised the urgency of the situation. She explained at interview that the previous numerical system for coding emergency calls would indicate whether or not it was an emergency call. In contrast, she gave an example under the new system of a code blue call being used for a prisoner experiencing an anxiety attack. There also appears to have been some confusion on the part of other staff. It would seem to have taken around ten minutes for an ambulance to be called and it took several trips for all of the emergency equipment to be brought to the cell.

74. It is essential that coded messages provide the receiver with as much relevant information as possible to allow them to respond in the most appropriate way. We make the following recommendation to ensure clarity among staff about coded messages and their meaning:

The head of healthcare and the Governor should ensure an effective system for designating emergency calls. The system must be understood by all staff to ensure healthcare staff respond without delay, to ensure

that appropriate emergency equipment is brought to the scene and an ambulance summoned without delay

The Primary Care Trust and the Governor should ensure that all wing treatment rooms in the prison hold a defibrillator

CONCLUSION

75. The man was 57 years old and had completed very many prison sentences through the course of his adult life. He believed that other prisoners considered him a sex offender and, fearing reprisals, asked to be placed on Wandsworth's vulnerable prisoners' unit. However, this was something that he did as a matter of course and had done before during previous sentences.

76. Staff at Wandsworth only established a cursory relationship with the man. There would seem to have been two main reasons for this. One would be his quiet and compliant nature. The other would be the fact that the personal officer scheme was not operating effectively at the time.

77. No evidence emerged to indicate a trigger for the man's actions on the day of his death. He telephoned a friend the previous day and their conversation ended with the man saying that he would telephone again in a fortnight. On the morning of his death, he had a lengthy conversation with another prisoner who noticed nothing untoward. Nor did his cell-mate who exchanged a few words with him before going to a morning course.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should ensure that the local personal officer scheme is operating effectively across the prison and in accordance with policy. This includes the requirement for fortnightly entries on P-NOMIS.

   Recommendation accepted
   The personal Officer Scheme has been reviewed and the policy stipulates that Personal Officers should make two entries per month into the Nomis Files of their prisoners. Management checks are in place to monitor this and every prisoner now has the name of their personal officer noted on the door of his cell.

   Progress to date: *Month on month improvements have been noted by sample checks. At present most prisoners are receiving at least one entry per month which is an improvement to build upon.*

   (While we accept that the personal officer scheme was not running as well as it should and while it is an important scheme to enhance staff/prisoner relationships it should not be assumed that effective staff/ prisoner relationships do not exist without the personal officer scheme. Several officers described their efforts to engage with the man.)

2. The Governor should ensure that appropriate measures are taken to deal with incidents of bullying.

   Recommendation accepted
   Although there were anti-bullying procedures at the time, these have been reviewed since then to ensure a more user-friendly document that has a more intervention based focus and is closely linked with the IEP (Incentives and Earned Privileges) scheme. The document is called TASA (tackling antisocial attitudes) and has been implemented across the prison over the past six months. This appears to be effective in that it is used significantly more than the previous document and there has been a noticeable decrease in the level of violence and antisocial behaviour across the prison. Violent incidents and prisoners on TASA are now discussed at a daily meeting with a variety of departments and agencies (e.g. probation, mental health) to ensure a more multi-disciplinary approach to managing violence and antisocial behaviour.

3. The Governor should consider staggering officer appointments to the Onslow unit to avoid mass departures of experienced staff inside a brief time frame.

   Recommendation accepted
   We are currently reviewing our approach to staff rotations and redeployment at Wandsworth. The intention is to ensure we have a system that is fair and transparent for all, but also provides sufficient time and development for staff going into new roles. The principle here is that we maintain the quality of delivery by taking a better planned and structured approach to staff moves. We are commencing consultations with the Prison Officers' Association about how best to achieve this and we have postponed all redeployment until such time as this new process has been developed and agreed. ***Target for completion: 31 March 2012***

4. The head of healthcare and the Governor should ensure that community GP records are always obtained, provided patient consent is given.

Recommendation accepted
Verification from a community healthcare provider is sought in cases where a new prisoner is on medication or has existing healthcare needs. Part of this process is obtaining signed patient consent to obtain these records, with the exception of circumstances where there are issues of patient capacity.

If the patient is transferred from another establishment that uses SystmOne then records are transferred electronically once the prisoner is registered on the system at first night. Any further verification required from a community GP/hospital will be sought as above.

5. The head of healthcare should ensure that all services providing healthcare make clear records.

Recommendation accepted
The patient medical record system, SystmOne, is fully electronic and all interventions and communications are recorded on SystmOne, with the exception of referral forms. (SystmOne has been used by healthcare department at HMPW since 15th November 2010.)

The importance of accurate and contemporaneous record keeping, in line with Nursing and Midwifery Council (NMC) guidelines, was reiterated to staff in a memo on the 20th September 2011 from Acting Head of Healthcare.

A system of peer review of GP records will be discussed to ensure the quality of clinical records. ***Target for completion: 30 March 2012.***

Discussion to take place with Trust Health Records Manager regarding the undertaking of an Offender Healthcare records clinical audit. ***Target for completion: 30 March 2012****.*

6. The head of healthcare and the Governor should agree on a system for designating emergency calls. The system must be understood by all staff to ensure healthcare staff respond without delay, to ensure that appropriate emergency equipment is brought to the scene and an ambulance summoned without delay.

Recommendation accepted
At the time of the patient's death, the code blue and code red call system was being used. Code blue designated collapsed patient/not breathing and code red designated that the patient was bleeding.

In a Governor's Notice dated 18 April 2011, the call system was changed to code 1 (code blue) and code 2 (code red) respectively.

The Hotel 3 nurse is called by radio for all emergencies as designated above. If the correct call is used then the full set of emergency equipment including a defibrillator is taken to the scene.

Hotel 2, 6 and 7 will attend 'code blue' emergencies to assist Hotel 3, as appropriate.

Once Hotel 3 has assessed the situation an ambulance may or may not be summoned depending on clinical assessment. This is done through control and a series of questions are asked relating to the patient so they can give correct information to London Ambulance Service (LAS) control.

In some situations, the officers will contact control directly where an ambulance will definitely be required (eg. in cases of hanging or cardiac arrest). This process was reinforced by the Chief Executive of the National Offender Management Service's directive on 'Emergency access to establishments for ambulance services'. This was first sent in February 2011 and re-sent in December 2011.

Guidance to be drafted and circulated to all healthcare staff which will include information regarding radio call signs and the relevant information from the Chief Executive of the National Offender Management Service's directive about ambulance access. ***Target for completion: 1 March 2012****.*

7. The Primary Care Trust and the Governor should ensure that all wing treatment rooms in the prison hold a defibrillator.

Partially accepted
Defibrillators are held in the following in three main treatment areas that deal with emergency care: trauma room (on the Centre), Jones Unit and Onslow treatment room.

The Prison have purchased five further defibrillators which will be placed in areas such as visits, Centre, Prison gym, industries and Onslow centre for easy access to prison officers should a prisoner collapse in their area of work. This will ensure that defibrillators are available to officers, who are unable to open treatment rooms to obtain emergency equipment. (Separate healthcare key)

Training for prisoner officers (POs) to take place, which will enable POs to be able to use the defibrillators in emergency situations. ***Target for completion: 31 April 2012.***