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

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

This report considers the circumstances surrounding the death of a man at HMP Wandsworth on 30 October 2007, just over a year after he was first received into custody. The man was found hanging in his cell at approximately 7.15am. He was 40 years old. I offer my condolences to the man's family and others who have been touched by his death. The man received considerable support from his family whilst in the community and it is very sad that his death coincided with their first visit to see him in prison.

I would like to thank the Governor of Wandsworth for his cooperation and that of his staff during my investigation. I am also grateful to Wandsworth Primary Care Trust (PCT), and South London and Maudsley National Health Service (NHS) Trust, for providing a clinical review of the man's care at HMP Wandsworth. In addition to this clinical review, South West London and St George's Mental Health NHS Trust carried out a serious untoward incident review. It was shared with my investigator and its findings incorporated are into this report.

I must apologise for the considerable delay in issuing this report and any undue stress this may have caused the man's family and staff at Wandsworth.

The man had a difficult and traumatic life, which contributed to a long history of mental health problems, self-harm and substance misuse. He had served in a militia during the Lebanese civil war, lost family members, was a prisoner of war, and had a difficult marriage. The man moved to the United Kingdom in 1999 and was granted indefinite leave to remain in 2005. Whilst in the UK, the man was treated for chronic mental illness and his tendency to self-harm by a community mental health team. Despite this care and support, the man's mental health remained unstable, he was still suicidal and his substance misuse worsened. In September 2006, he committed an offence that led to a remand in custody and an indeterminate sentence of imprisonment for public protection (IPP).

The man's time in prison was troubled, and he received continuing care from both the prison and community mental health teams. During his first few weeks, the man underwent a detoxification programme. He was offered ongoing support, which he did not fully utilise. Indeed, the man continued to misuse illegal and prescribed drugs. However, he complied with most aspects of the care plan provided for him, but remained preoccupied with his prescribed medication and expressed doubts that counselling was likely to be of any help.

For a long time, the man was subject to monitoring under the Prison Service's procedures to support those at risk of self-harm and suicide. These began immediately after he entered custody and came to an end during August 2007 after a period of stability and low risk. Staff believed that, once he had been sentenced, the man had a more positive outlook and seemed to abandon his thoughts of self-harm and suicide.

The man's preoccupation with using medication to mask his depression and anxiety contributed to his use of illegal substances, non-prescribed medication and

homemade alcohol. During 2007, there were a number of occasions when contraband (including mobile telephones) was found in his cell and for which the man admitted responsibility. Security incident reports suggest he was involved in the supply and use of contraband. Since his death, the extent of the man's involvement has been the subject of some speculation. It has been alleged that the man had bank accounts under false names and that these were used to pay for drugs coming into the prison. It has also been suggested that the ongoing pressure of his own drug debt, and fraudulent activity on his bank accounts on 29 October 2007, led to the man's death.

I have been unable to determine whether there is any substance to this speculation. A police investigation has taken place but I understand that it has not been possible to trace the man's bank accounts. Despite this lack of evidence, I conclude that the man did feel under considerable pressure on 29 October 2007, as this was noted both by prisoners and staff. It was thought by staff that the difficulties with his accounts had been resolved in the interim, and he appeared calm when last seen alive at midnight on 29/30 October.

Although the man was involved in the supply and use of contraband, I do not believe that this was the sole factor contributing to his death. The man was a very troubled man with a burden of anxiety and depression that he could not overcome or fully share with those providing his care.

I make six recommendations in this report, two relating to healthcare and four on suicide and self-harm monitoring processes. I also make one housekeeping point regarding the recording of drug tests.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2009**

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SUMMARY

The man had a long and troubled mental health history, coupled with substance misuse and self-harm issues. They were not identified or addressed until he moved to the UK in 1999. In 2005, the man was granted indefinite leave to stay.

On 12 September 2006, the man was arrested and taken into custody at HMP Wandsworth. This was his first time in prison in the UK. During the reception process the man's history of drug dependency, mental and physical ill-health, and self-harm were all noted. The man said during a medical assessment that he had been prescribed medication that he should continue taking – an antidepressant, diazepam, a sleeping tablet, and medication for respiratory and gastric problems. Healthcare staff requested confirmation of the prescription from his doctor in the community.

The man immediately started on a detoxification programme and an Assessment, Care in Custody and Teamwork (ACCT) form was opened to monitor his risk of self-harm and suicide. Two days later, a fax was received confirming the man's prescription. The doctor also sent a letter recommending that the man receive an urgent psychiatric review, and asked that a member of healthcare contact him to discuss further.

The man's community mental health team (CMHT) wrote to Wandsworth's healthcare department on 14 September. Based on this letter, an urgent referral was made to the Prison In-reach Team (PIT) which provides psychiatric care. Staff from the team met the man and concluded that, whilst he was undergoing the detoxification process, they were happy for him to remain under the care of the substance misuse team. However, he was referred for a review by the team's psychiatrist. In the meantime, the man was placed under the care of the dual diagnosis team (DDT). (The DDT provides both substance misuse and mental health support.) He frequently took issue with DDT and healthcare staff about his medications.

During the following months, the man remained on ACCT monitoring. He was reviewed weekly and was also seen regularly by one of the DDT's nurses. A nurse from the PIT also saw the man during a number of his ACCT reviews. This ensured that there was ongoing mental health input whilst the man remained at risk of self-harm. In both his DDT and ACCT reviews, the man continued to say that he felt his medications were not helping him and that he continued to think about harming himself.

On a number of occasions, the man claimed to have stopped eating. Whilst there were definite periods where he ate sporadically, there is no evidence that he stopped eating completely or was placed on a food refusal register. (This is an official register used by the prison to monitor prisoners who have not eaten for 72 hours.)

In preparation for his court hearing, the man's solicitors requested a psychiatric review. Consideration was given to whether a transfer to hospital might be appropriate. However, it was ruled out as the man did not meet the criteria.

Concerns were raised that the man was drinking alcohol, and wing staff confirmed that home brewed alcohol had been found in his cell. There were also occasions where cell searches found drugs and mobile telephones, and the man admitted they belonged to him. The man received warnings from staff about his conduct and, on occasion, lost privileges as a result of disciplinary hearings.

The man's consultant psychiatrist from the community mental health team visited on 27 April 2007. He recorded that the man had talked about previous suicide attempts outside of prison. The man told the doctor that he intended to have a more planned approach, rather than be impulsive. The consultant psychiatrist noted that the man seemed unchanged from their sessions in the community and had a moderate long-term risk of suicide.

Over the next couple of months, the man's mental health appeared to slowly improve, although he did occasionally report not eating. On 20 June 2007, he was given an indeterminate public protection sentence with a four year and three month tariff. Staff noted that the man appeared to be more settled after sentencing and his ACCT record was closed on 20 August. The man seemed more stable and responded well to counselling sessions. An ACCT was briefly opened by his counsellor on 19 September as the man would not say if he had any suicidal intention. An ACCT assessment took place that day, but it was decided that the man was not at risk of harm and the form was closed.

The man's involvement with drugs and mobile phones continued. Whenever the man was placed on a disciplinary report for being found with contraband, he became distressed. (After his death, it was suggested that the man had become involved with drug dealers on the wing and had accrued debt. The extent had not come to staff attention whilst the man was alive.)

On 29 October 2007, the man was visibly distressed and made several telephone calls. He told a senior officer that he was concerned that someone was trying to take money out of his bank accounts. The senior officer helped the man phone his bank for advice. After speaking to his bank, the man appeared calmer. He requested the help of his previous cellmate to write letters instructing the bank not to authorise any transactions. (After his death, the cellmate told my investigator and the senior officer that the man had intimated that he wanted to kill himself. However, he had not regarded this as serious threat.)

At 11.15pm, the man rang his cell bell. An officer went to speak to him and saw that he was distressed. The man asked to speak to the Samaritans. After a long telephone call (approximately 50 minutes), the man returned to his cell. The officer asked the man how he was feeling, to which he replied that he was fine. Assured that the man was calmer, the officer returned to his duties.

This was the last time that a member of staff saw the man until the early morning roll count. The first check took place at around 5.50am. The first officer saw the man standing by his cell window. He did not consider this suspicious and carried on with his duties. At approximately 6.55am, a second officer began a second roll count to verify the number of prisoners. He also saw the man by his window. The second count highlighted a discrepancy in numbers and so a third count took place at

7.15am. On this occasion, the second officer found the man in the same position. He thought that this was odd and on looking closely, saw that he had a ligature around his neck. A third officer who had been assisting the second officer, alerted staff by using her whistle. They both went into the cell, cut the ligature and laid the man down. A nurse shortly followed and assessed that the man was dead and could not be resuscitated. Paramedics confirmed this on arrival.

During this investigation, concerns have been raised about the availability of contraband in Wandsworth and the man's involvement in the trade. There was a suggestion that a prisoner might have been implicated in the transfer and withdrawal of money from the man's bank accounts. A police investigation has been unable to determine what happened or who was involved. I understand that following a security audit in early 2008, the Governor has taken further steps to tighten security at the prison.

Whilst the man received ongoing support at Wandsworth for his mental health condition and substance misuse, I conclude that there were some initial gaps in his care. In addition, I have highlighted where Prison Service guidance on the ACCT process has not been followed. Despite these areas of concern, there is no evidence to suggest that they directly contributed to the man taking his own life. I have been unable to determine a particular trigger for his actions, but it is apparent that suicide had been an underlying risk throughout the man's adult life.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 31 October 2007 and arranged to visit the prison the following day with her colleague. During their visit, my investigator discussed the issues surrounding the man's death with the Governor. She was provided with all documentation relating to the man's time in custody.

2. My investigator conducted interviews at HMP Wandsworth during December 2007 and January 2008 with two of her colleagues. The clinical reviewer from Wandsworth Primary Care Trust, used the interview transcripts and the man's medical record to conduct a clinical review. The clinical reviewer sought further expert opinion on the man's mental health care from South London and Maudsley NHS Trust. A Consultant Forensic Psychiatrist and Clinical Director, Adult Mental Health, at Lambeth Forensic Services, produced a short report, which has been incorporated into the clinical review. The clinical review was not submitted to my office until September 2008 and this has contributed to the significant delay in the issuing of my report.

3. One of my family liaison officers (FLOs) first contacted the man's brother on 9 November 2007. His brother welcomed a visit to discuss any concerns surrounding the man's time in custody. However, due to an illness in the family, the man's brother had to leave the country. The family meeting was postponed until 2 April 2008. As the brother was still overseas, my investigator and FLO met with his wife, the man's sister-in-law. She had been asked to act on behalf of her husband and represent the family. The man's sister-in-law had instructed a solicitor who was present during the visit.

4. The family have asked that the following questions are addressed during the course of this report:

    - How many times had the man tried to commit suicide whilst at HMP Wandsworth?

    - Why was the man placed in a single cell?

    - Why did prison staff fail to obtain all relevant medical records and reports relating to the man at the beginning of his sentence?

    - Was sufficient action taken to provide the man with the medical care he required throughout his prison sentence? His brother explained that every time he spoke to the man he said that he was not being provided with his proper medication.

    - Why was the man was taken off 'suicide risk' and not placed in a safe cell?

    - Why did the doctor refuse to see the man the day before he died?

- Why was no action taken to consider whether the man required any further assistance following his telephone conversation with the Samaritans?

- Why was he not subject to regular checks by prison staff following this conversation?

- Why was the man left hanging in his cell for such a long period of time before he was discovered?

- Have other prisoners been interviewed about the circumstances of the man's death and in relation to the allegations that he was involved with drugs within the prison. His brother does not accept that the man had any dealings with drugs within the prison.

- Why were prison staff not concerned when they first checked the man's cell to see him standing so still at the window, and why they did not notice that he was hanging from a sheet.

5. The family's solicitor has raised some additional questions:

- How did the prison handle security incident reports regarding the man's involvement with contraband (smuggled goods)?

- What measures were taken to address his possession of contraband?

- What knowledge did staff have of the level of debt the man had accrued in funding his substance misuse?

- Were staff aware of the man's vulnerability?

My investigator has considered all of these points within the main body of this report.

HMP WANDSWORTH

6. HMP Wandsworth is a large local prison in South West London. (A local prison serves the courts and mainly holds prisoners remanded in custody pending their court cases or who are serving short sentences.) It is the largest prison in London with an operational capacity of 1,644 since May 2008. It is one of the largest prisons in Western Europe.

Accommodation

7. The prison was built in 1851. The residential areas remain in the original buildings; however, they have been extensively refurbished and modernised. All cells have in-cell sanitation and electricity, and privacy screens are provided for cells occupied by more than one prisoner.

8. The main prison is called the Heathfield Centre. It has five wings, each with four landings. The wings are allocated as follows:

    - A wing - long-term prisoners
    - B wing – 'drug free' wing, voluntary testing unit, counselling, assessment, referral, advice and throughcare (CARATs)
    - C wing – induction
    - D wing – long-term prisoners and violence reduction unit
    - E wing – first night centre, detoxification unit, care and separation unit.

17. Aside from the main prison there is the Onslow centre - the vulnerable prisoners unit. This has three wings, G, H and K and holds up to 330 prisoners. The K1 Mick Knight Rehabilitation of Addicted Prisoners Trust Unit (RAPT unit) provides a 12-step substance dependency treatment programme. There is also an inpatients healthcare unit, Addison Unit.

Healthcare

18. The healthcare service at Wandsworth was put out to tender in March 2007. Secure Health was selected as the new provider and its contract with Wandsworth Primary Care Trust commenced on 1 July 2007. Secure Healthcare has overall responsibility for the provision of healthcare and is directly responsible for the provision of primary care services, apart from dentistry which is provided directly by the PCT.

19. There is a consortium of other organisations which also contribute to the services provided within the prison. The South West London and St George's Hospital Mental Health Trust provide mental health (including in-reach) and substance misuse care.

20. The mental health team (known as the Prison In-Reach Team) receive referrals from any member of staff in the prison. This is a psychiatric team and it is responsible for the care of people with severe and enduring mental illnesses and those who are known to secondary care mental health services in the

community.

HM Chief Inspector of Prisons

21. The most recent inspection by HM Chief Inspector of Prisons, Dame Anne Owers, took place in July 2006. Compared to previous inspections, when Wandsworth was noted to have a history of overcrowding, low levels of prisoner activity and a negative staff culture, the 2006 report highlighted some positive steps. Dame Anne found that more time out of cells was provided for prisoners and there was evidence of improved safer custody. However, staff attitude and behaviour towards prisoners in some areas of the prison remained negative. Support in the first night and vulnerable prisoners unit was good, but this was not reflected in the main prison.

Independent Monitoring Board annual report

22. The Independent Monitoring Board's (IMB's) annual report for June 2007 to May 2008 also recognised the Governor's efforts to address the issues raised by Dame Anne Owers. In particular, the report refers to the Governor's action taken in disciplining and dismissing staff for racist incidents or those found to be compromising security (in particular, bringing in contraband). The IMB echoed Dame Anne's findings that the majority of prisoners spent longer periods out of their cells. Improvements had also been made to healthcare and there were new education and training facilities.

23. Despite these positive steps, the IMB found other issues which needed to be addressed. Overcrowding and staff shortages continued to be a significant problem. There was also an ongoing major concern over the availability of drugs and mobile phones to prisoners. The IMB believe that there were links between the use of mobile phones, the drugs trade and bullying in prisons.

24. The IMB stated that it had raised concerns regarding the availability of drugs in Wandsworth in its last five annual reports, asking for more resources to be given to the prison to tackle the problem. In the last three years, the IMB had asked the Ministers for Prisons to implement a strategy to block the widespread use of mobile phones in the prison. The IMB said that such systems had proved successful in prisons elsewhere in Europe and North America. This aside, the report acknowledged that the Governor was taking steps to curb the supply of drugs.

Foreign National prisoners

25. Overall, around 14 per cent of prisoners are foreign nationals. At Wandsworth, the figure in January 2008 stood at 485 (33 per cent of the local prison population) and comprised approximately 68 different nationalities. Forty per cent of these men spoke little or no English, and the number of foreign national prisoners is increasing steadily.

26. The Big Word telephone translation service is used across the prison and an induction booklet, produced in six of the most commonly spoken foreign

languages, is distributed on the induction wing. Staff in the Foreign Nationals department are also using a new initiative of document translation for legal papers, faxes to lawyers and the like. They also hope to extend the service to help prisoners keep in touch with their families.

KEY FINDINGS

27. The man was remanded into custody at HMP Wandsworth on 12 September 2006. He had no recorded previous convictions and this was his first time in custody in the UK.

28. On arrival at prison, a risk assessment was carried out to assess the man's suitability to share a cell. The officer who conducted the assessment acquired the information directly from the man and also from documents supplied by the police and prison escort staff. During the assessment it was noted that the man had a history of drug and alcohol abuse as well as self-harm. Although no obvious concerns were raised about the man sharing a cell, it was decided that he might be a medium risk to others due to his offence, which included possession of a weapon. (Medium risk means there was no immediate risk to others, but the situation should be kept under review.)

29. After the cell sharing risk assessment a member of healthcare staff, the reception nurse, undertook a first reception health screen with the man. The reception nurse was given the prisoner escort record (PER) and police paperwork to aid his assessment. (The PER is a form that accompanies prisoners during journeys. It provides a chronological record of the escort, such as meals served, medical attention, times the journey started etc. It also serves as a communication tool about risks a prisoner poses on escort or transfer.) The nurse also noted a possible risk to others, but his assessment was based on the man's symptoms of acute psychosis. Further reference was made to the possible risk of self-harm because of the man's health.

30. During this health screen, the man told the reception nurse that he had been a psychiatric patient at St Mary's Hospital in Paddington, London. The reception nurse noted the man's history of substance misuse and that he was displaying symptoms of drug withdrawal. The symptoms included stomach cramps, agitation, anxiety, dilated pupils, depression, hot and cold flushes, and pains in his back and legs.

31. The reception nurse referred the man to the prison doctor who assessed him the same night. The man was treated for heroin and crack cocaine dependency. He told the doctor that he heard voices and suffered from depression. The doctor asked if the man took any medication. He told the doctor that his general practitioner (GP) in the community had prescribed 30mg diazepam to be taken daily.

32. The man was taken to the first night centre and an induction officer carried out an induction interview. During the interview, the man repeated that he had mental health problems, heard voices, suffered from depression and had previously attempted suicide. The induction officer concluded that the man was a risk to himself and needed support. An Assessment, Care in Custody and Teamwork (ACCT) form was opened. (This is a document used by the Prison Service to provide active and ongoing monitoring and support to prisoners who are considered to be a risk to themselves.)

33. It is not clear from the ACCT form who had opened the document as the appropriate page is not signed. However, the first entry on the ongoing record is by the induction officer. Any member of staff (healthcare, discipline, chaplaincy or voluntary) can open an ACCT. When an ACCT is opened an immediate keep safe action plan should be completed as soon as possible. It puts support measures in place until the first assessment and case review takes place. The review should occur within 24 hours of opening the form. The keep safe page is missing from the man's form, which means I am unable to comment on specific measures that were put in place.

34. At 8.30am on 13 September 2006, a member of the substance misuse team told the man that he would be moved from the first night centre up to the detoxification unit. He declined the move and said that he would prefer to undergo his detoxification on the induction unit. This was permitted.

35. The detoxification programme comprises lofexidine (for reducing the symptoms of heroin withdrawal) and diazepam (to reduce tension and anxiety). The lofexidine can be used in two ways, either on its own or in conjunction with methadone. In the man's case, it was prescribed for use without methadone. The initial dose is 0.2mg twice daily. This increases by 0.2 - 0.4mg per day up to a maximum of 1.6mg, depending on the clinical need of the individual. The man's maximum dose was 0.8mg. The maximum dose was maintained for three days before reducing by 0.2mg and then stopped. Diazepam was also prescribed on a decreasing dose. The man started with 25mg and this was reduced by 2mg to nothing by 29 September.)

36. Approximately two hours later, at 10.40am, a fourth officer held an ACCT assessment interview with the man. The assessment attempts to identify why the person is at risk and if there are any obvious triggers. The findings are used to consider what action should be taken by staff and the prisoner to reduce their risk. During the assessment the man said that he had lost everything and had nothing to live for. He explained that he had been in the Lebanese army and lost many colleagues during the civil war. He also said that his marriage had failed and he was no longer in contact with his daughter in Germany. The man told the assessor that he had last harmed himself four days earlier. He explained that he had started to self-harm in 1986, whilst a prisoner of war in Syria. Since then he had continued to self-harm on a regular basis. The fourth officer decided to refer the man to the mental health team, known as the Prison In-Reach Team (PIT).

37. The PIT is a team of psychiatric staff who provide care for people with severe and enduring mental health conditions. The team can receive referrals from any member of staff in the prison. Those referred are seen at a time based on the level of urgency determined by the person who makes the referral - either within 24 hours, seven days or four weeks. At this stage, the man's referral was not marked as urgent and so he would not expect to be seen within 24 hours.

38. Immediately after the fourth officer's assessment, the ACCT first case review took place. The fourth officer remained present, along with a Senior Officer and

the man himself. During the review, the man said that he wanted to die. It was noted that he appeared distant, disorientated, very low in mood and tearful. The man described feelings of hopelessness and dying. It was decided that the man presented as high risk and required an urgent referral to the PIT. A review date was set for 18 September and it was recommended a representative from the PIT attend. It was decided that in the interim the man should be observed hourly, both day and night, and three meaningful entries should be written in the ongoing record. (A meaningful entry should provide detail of a conversation with the individual.)

39. Later that afternoon (4.15pm), a senior nurse from the Substance Misuse Team (SMT) spoke to the man about his history of substance misuse. The man said that he had not abused drugs and had only taken cocaine on two occasions, with the specific intent to harm himself. He also denied taking any other illegal substances. He said that the only drug he took with any regularity was venlafaxine - an antidepressant prescribed by his doctor. The nurse decided not to refer the man to the dual diagnosis team (who deal with both mental health and substance misuse) until there was confirmation from his doctor regarding previous treatment and prescriptions. In the interim, the man was given zopiclone by the prison doctor to help him sleep.

40. At 10.15am on 15 September, two PIT nurses (both forensic community psychiatric nurses in the PIT) spoke to the man following the mental health referral. They noted that the man was on a detoxification programme under the SMT. As the withdrawal from drugs can blur an assessment of a person's mental health, they decided there would be little value in conducting a thorough assessment until the detoxification had ended. Both the PIT nurses decided that, in the meantime, an onward referral could be made to the dual diagnosis team (DDT). They were satisfied that the man was being adequately supported by the SMT and through the ACCT process.

41. (At this time, the DDT consisted of primary care mental health nurses and a doctor, the DDT doctor. DDT nursing staff were employed by directly by the prison, whereas the PIT staff were employed by South West London, St George's Mental Health Trust. Despite the distinction between the teams, there was a crossover due to the similarity in clients. The boundary between the two teams later became further blurred as the doctor left, leaving the DDT without a doctor. On the DDT doctor' departure, the PIT worked more closely with the DDT to provide cover.)

42. Later that day the man's community doctor sent a fax to the prison to confirm his prescription. Until this point, the man had not received any of his previously prescribed medications. The community doctor confirmed the following medications:

- venlafaxine 150mg (antidepressant)
- diazepam 10mg (for anxiety)
- omeprazole 20mg (for treating acid in the stomach)
- salbultamol (short acting relief inhaler for asthma)
- beclomethasone (asthma prevention inhaler)

- salmeterol 25mg (long acting relief inhaler for asthma)
- zopiclone 7.5mb (sleeping tablet).

43. A letter, also dated 15 September, was sent by the community doctor to the healthcare unit. It stated:

> "I have just spoken with the man's solicitor, who tells me he has had no medication since his arrest on Sunday 10 September…
>
> "It is most important he receives his regular medication, in particular his zopiclone and diazepam, as well as his antidepressants. He is at risk of seizures should he not receive his benzodiazepines as soon as possible, and he has a history of severe depression with psychosis…
>
> "He also has a history of post-traumatic stress disorder and may find his incarceration at Wandsworth extremely difficult. I would urge an early review therefore with the prison psychiatric service."

The community doctor listed the man's prescription again, as in the fax and asked that a member of the healthcare telephone to discuss the man's care further.

44. An entry in the medical record by one of the primary care mental health nurses indicates that a conversation took place with the DDT doctor about the man's medication. The DDT doctor was not willing to prescribe any medication other than those listed and confirmed by the man's GP. There is no evidence that anyone telephoned the community doctor.

45. During the next week, the man reported experiencing blackouts, hearing voices, feeling distressed, and being confused and frightened. He was referred to a community psychiatric nurse (CPN) and doctor. The man told healthcare staff that he was feeling agitated because of his medications - the venlafaxine and diazepam (the latter was part of his detoxification). He was told that his medication would be reviewed. The doctor referred again to the fax sent by the man's own doctor. It was decided that his medications should continue as per his own doctor's instruction, supplementary to a four day prescription of zopiclone. Despite returning to his usual prescription, the man continued to report disturbed and difficult sleep. It seems that once the diazepam dose ended, as per the detoxification programme, the previous maintenance dose was not issued. There is no reference in the man's medical record to explain why it was not resumed as the community doctor's letter had requested.

46. On 23 September, an urgent referral was submitted to the PIT prompted by a letter from South Paddington, Community Mental Health Trust (CMHT), and medical reports sent by the consultant psychiatrist and the man's community keyworker (dated 14 September). The letter detailed the man's mental health history and care received outside prison. It also indicated that the man had long abused his prescribed medication, including zopiclone and diazepam. The man had previously stated that he took extra tablets to help him sleep. He was also known to become very anxious when he ran out of medication and CMHT

staff suspected that he had bought diazepam illegally.

47. The report confirmed that the man had received extensive care whilst in the community and so should be seen by the PIT urgently. Reference was made to previous attempts at self-harm and suicide. The man had cut his wrists on several occasions, once resulting in surgery. He had also taken overdoses of his prescribed medication and had told the consultant psychiatrist and the man's community keyworker that he had bought a gun with the intention of killing himself. They noted that the man became more chaotic and suicidal after negative events that involved his family, particularly his mother's ill health. It is not clear from the man's medical record why this letter was not seen or acted upon any sooner.

48. The following day, 24 September 2006, the man announced to wing staff that he was going to start a "hunger strike" because he believed he had not been prescribed the correct medication. A member of healthcare staff visited him. The man told the member of staff that he wanted his medication reviewed because his head "felt like it was constantly spinning". The man was reminded that a referral had been made to the PIT and primary mental healthcare staff. It is noted in his ongoing ACCT record that the man said he was satisfied with this course of action and later ate his evening meal.

49. Two days later, the man again asked to see healthcare staff about his medications. He said he did not agree with his prescription and that his head was still spinning. Although the man reported that he did not think his medication was effective, no change was made to his prescription.

50. On 28 September one of the dual diagnosis nurses (DDNs), spoke to the man. The DDN noted that the man was unhappy that the zopiclone (the sleeping tablet) had been stopped. The man also said that he felt he was being prescribed the wrong dose of antidepressant and wanted it increased. (Zopiclone is a strong sleeping tablet and is generally only prescribed for short-term relief to prevent developing a dependency.) The next day, the man again announced that he was going to begin a "hunger strike" unless he saw a doctor. There is no record of the man seeing a doctor on this occasion.

51. An ACCT review was held on 5 October with the man, a senior officer, an officer and the first PIT nurse. The man said that he was feeling dizzy and depressed. It was noted by the review panel that the man was waiting to see a psychiatrist and that the PIT would follow up the appointment. There is nothing in the man's medical record to indicate that an appointment with a psychiatrist was pursued further. (The level of observations remained the same and did not change until March 2008.)

52. The man said during the next two ACCT reviews that he did not feel like harming himself, however he still felt scared, dizzy and vague. It is noted in the ongoing monitoring section of the document on 20 October that his cellmate was concerned about him. The cellmate relayed his concern to an officer, but no actual detail is noted in the record.

53. On 23 October, the man was seen by the DDN for a follow-up assessment. The man refused to communicate so the DDN decided to reschedule the visit. Three days later, the man's cellmate reported that the man was being abusive to him and had been hitting him. Despite being warned, the man would not stop and so staff moved him to another cell.

54. By early November, the man was noted to be taking more care over his appearance and to be more communicative. During his ACCT review on 10 November, he said that he was feeling better, but had still not seen a psychiatrist. It was documented on his case review that this appointment would be followed up. As in his previous case review, the man said that he had no thoughts of self-harm at that time.

55. On 16 November, a joint PIT and dual diagnosis assessment was supposed to take place, but the man was not available as he had gone to education. The DDN said that he was happy to review the man another time and would liaise with PIT about his medication.

56. It is noted in the ongoing ACCT record that the man tried to harm himself on 21 November. He had attended a court hearing the day before. There is nothing documented in the man's record to suggest the level of harm caused, or whether it was as a result of his court appearance. However, the man did say that he felt his medications were not helping him and that he was experiencing pain in the whole of his body. He said that when he talked it felt as though "someone was breathing on his feet".

57. The DDN next met the man on 28 November. He again found him reluctant to talk, apart from saying that he wanted to see a psychiatrist and have his prescription reviewed. The DDN told the man that he would again liaise with PIT regarding the psychiatric appointment. He wrote in the man's ACCT record that it looked like he had been crying. The man had said, "I just want all these voices to stop screaming."

58. The man's next DDT review took place on 7 December and it was noted that he seemed more relaxed. An entry in his ACCT the following day supports this comment. Although the man was still low in mood, he said that he was happier knowing that he had been referred to a psychiatrist.

59. On 22 December, the DDN was on leave and a second DDN saw the man for the regular dual diagnosis appointment. The second DDN found the man to be nervous and anxious. He noted that the man understood English, but had difficulty expressing himself during this session. The man reported having trouble sleeping and appeared low in mood. He told the second DDN that his prescribed medications did not work. The man explained that he hallucinated, could smell a dead body and described experiencing a moving sensation under his feet. He said that he had felt suicidal in the past. The second DDN therefore decided to make an urgent referral to the PIT.

60. It was noted in the man's ACCT record on 28 December that he was concerned about people thinking he was mentally unstable. He did not perceive himself as

such and did not want others to think this of him. The same day, another prisoner told wing staff that the man had not eaten in the last three days. (Procedurally, if a prisoner is noted to have refused his meals for longer than a 72 hour period he should be placed on the food refusal register and regularly monitored by staff. Once a prisoner is on this register, healthcare should be notified and the food refusal should also be recorded in the person's medical record. Typically, this would also trigger a psychiatric referral.) My investigator checked the food refusal register but the man's name did not appear on the list.

61. Despite this being brought to staff attention there is no record of any conversations with the man as to why he was not eating. It is, however, noted in his ACCT record on 30 December that the man did not go for lunch. He stayed in his cell with a towel wrapped around his head.

62. A psychiatrist from PIT saw the man on 3 January 2007 to assess him and review his medication. The PIT psychiatrist noted a superficial cut on the man's forearm, which he said he had made two days before. The man complained of feeling sweaty, dizzy, having headaches and a numbing sensation in his arms. He said that he was feeling worse and did not know if anyone could help him. The PIT psychiatrist saw from the man's medical record that he had missed doses of venlafaxine in the days before Christmas. He said that he had been taking venlafaxine (150mg) for approximately nine years. The man told the PIT psychiatrist that he had stopped taking the medication, of his own volition, on 28 December. The PIT psychiatrist found the man's appearance to be consistent with an abrupt withdrawal of venlafaxine. She recommended that he restart the antidepressant, but at a slightly reduced dose, and then he would be reviewed again within five days.

63. There is an entry in the ACCT record on 3 January, which says that the man had not eaten since Christmas. My investigator spoke to the PIT psychiatrist and the first PIT nurse about the man's eating patterns and asked whether his refusal to eat had been brought to their attention. The first PIT nurse said that the man often said that he was not eating. His impression was that the man would skip the odd meal here and there, but never consistently refused food.

64. On 5 January, the man applied for enhanced status on the incentives and earned privileges (IEP) scheme. The purpose of IEP is to encourage and reward responsible behaviour. There are three tiers to the scheme:

    - Basic – prisoners are placed on basic if they fail to meet the requirements for standard. All prisoners on basic will continue to receive the entitlements laid down in prison rules in relation to visits, letters, telephone calls, provision of food and clothing etc, and any other minimum facilities provided locally for all prisoners, apart from those in segregation. They will continue to participate in normal regime activities, including work, education, treatment programmes and religious services, be allowed access to the prison shop, exercise and association, and attend offending behaviour programmes as necessary.

- Standard – prisoners on standard level will be provided with a greater volume of the allowances and facilities at basic level, plus any additional privileges available locally. Typically, they will include more frequent visits, more time for association and the provision of in-cell television. Standard level prisoners are also eligible for higher rates of pay for work, subject to those on the enhanced level being considered first for particular jobs, and a higher allowance of private cash.

- Enhanced – prisoners on enhanced level will receive the same privileges as those on standard level, but in greater volume with additional visits. Where possible, visits may take place in better surroundings with increased flexibility over times. Additional time for association may be provided (subject to local resources), more private cash and priority consideration for higher rates of pay.

65. On entering custody, all prisoners are placed on standard which is reviewed within the first month. It seems that the man remained on standard and it is unclear why he had not applied for enhanced status sooner.

66. The PIT psychiatrist and the DDN conducted a joint PIT and dual diagnosis assessment of the man on 8 January. It was noted that the man had restarted his venlafaxine. He said that he still had trouble sleeping and that it felt like there were people touching him even though there was no one there. The PIT psychiatrist noted that he was still sweating, but less anxious than at their last meeting. She observed that the man did not appear significantly depressed. The man said that he had no thoughts of suicide or self-harm. He said that prior to being in custody he had regularly taken zopiclone and diazepam for ten years. The man said that in prison he had not taken any diazepam since his detoxification ended. He said that he really needed them, but added that he had not taken any illicit drugs whilst in prison.

67. The PIT psychiatrist checked the prescription provided by the man's doctor in the community. She saw that the man had long-term prescriptions for both diazepam and zopiclone. The PIT psychiatrist told my investigator that she believed the man was dependent on the medications as a coping mechanism for his chronic mental health problems, depression, substance misuse and suicidal thoughts. The PIT psychiatrist considered that the man's appearance at that time could be consistent with a diazepam withdrawal. A benzodiazepine such as diazepam, is a class of psychoactive drug that slows down the central nervous system. It is used to treat anxiety, insomnia, agitation, seizures, muscle spasms, alcohol withdrawal and to counteract any anxiety-related symptoms that occur with initial use of antidepressants. Recreational drug users often use benzodiazepines as a means of "coming down" from a substance induced high. Long-term use of benzodiazepines can cause a physical dependence, and the drug is usually only prescribed in the smallest dose possible to provide an acceptable level of symptom relief.

68. Before prescribing any more diazepam, the PIT psychiatrist decided to check with the pharmacy whether it was permissible to prescribe a maintenance dose

of a benzodiazepine. She also requested that the man undertake a urine drug test to see if he had taken any additional substances. The results were negative. The pharmacy told the PIT psychiatrist that she could prescribe a maintenance dose of diazepam (5mgs twice a day) and zopiclone (7.5mg) to help the man sleep better. The PIT psychiatrist explained to my investigator that a low dose start dose of both medications was given because they can cause a high dependence and stay in the patient's system for a long time. As a person adjusts, the dose can increase. If the dose had been started at the previously higher level of 30mg and then increased, it could have led to over-sedation. The PIT psychiatrist explained that it is ideal practice to keep the dose as low as possible.

69. In addition to the prescriptions and drugs test, the PIT psychiatrist said that she wanted to arrange for the man's community keyworker, South Paddington Community Mental Health Team (CMHT), to visit. A message was left with both the pharmacy and with the man's keyworker asking him to contact the PIT. Another drug screen test was taken the next day and again the results were negative.

70. Two days later (11 January 2007), an ACCT review took place. The man said that he was worried about going to court, but was pleased to be attending education. It was noted that the man became distressed again the following week, cutting his arm during the early hours of 19 January. His cellmate had raised the alarm to alert staff. When he went to the cell, an officer found the man to be uncommunicative. He would not give any reason for self-harming. The man was taken to the treatment room and tended to by a nurse.

71. On 22 January, the PIT psychiatrist and the DDN reassessed the man. He was more communicative than usual and no longer complained of feeling sweaty, dizzy or having headaches. The PIT psychiatrist told my investigator that she attributed these improvements to the reintroduction of diazepam. Despite the improvement, he still reported feeling low in mood and had ongoing persistent thoughts of suicide. He told the PIT psychiatrist about his self-harming three days before. He said that, despite his actions, he had no current intention of committing suicide, but did see it as an option when he left prison. The man said, "I don't want this life any longer." He asked the PIT psychiatrist for his prescribed medication to be increased, to which she agreed and raised the dose to 10mg in the morning (which was the time of day he said he felt the worst).

72. During the next ACCT review on 25 January, the man was very tearful. He told another senior officer, the first PIT nurse and the chaplain that he wanted to be straight with them as he was not often open with people about his feelings. The man said that he felt guilty for being alive. He explained that he had been a commander in the Lebanon. During this time, he was shot, captured and tortured by the Syrian army. He also said that he had some difficulties in his relationship with his daughter. The man said that the combination of all these factors made him feel like he was losing his mind. He went on to say that he had a split personality, half of which tried to make him insane. He said that he had felt this way for the last ten years, and saw no value in any further

treatment.

73. On the basis of the man's appearance, the ACCT review panel decided that he should not attend his court hearing the following day. The man had said that the hearing was contributing to his already heightened anxiety. As well, the panel would liaise with his dual diagnosis nurse (the DDN) and the PIT psychiatrist. A healthcare nurse was asked to monitor the man's blood pressure and weight. It was decided that, as the man was still vulnerable, the ACCT document would remain open for a further week.

74. An unplanned ACCT review took place on 29 January as another prisoner had died. (This is usual practice.) The second senior officer was the case manager. No new concerns were raised and it was noted that the man seemed to be in a more positive frame of mind. Despite the improvement, another prisoner on the wing reported to staff that the man had not been eating properly. The man was questioned and he said that he did not want to eat as it made him feel sick. An entry was made on the ACCT care map for staff to encourage the man to eat and keep watch to see that he collected his meals. (Prisoners collect meals from the servery on the wing and can eat in their cells.) It was decided that the reviews could be reduced from weekly to fortnightly.

75. The man's care was officially transferred from the dual diagnosis team to the PIT on 6 February. His community psychiatric nurse (CPN) was the first PIT nurse. In practical terms, there was no significant change to the continuity of his care, as the first PIT nurse was already involved in assessing and treating the man alongside the DDT through his input at ACCT reviews.

76. The man's application for enhanced IEP status was granted on 7 February. Failure to comply with the criteria for an enhanced prisoner would trigger a review and he could revert to standard. Special consideration also needs to be given during an IEP review to any vulnerability. Removing privileges from a prisoner subject to an ACCT document could have an adverse effect and worsen the situation. (This explains why the man's enhanced privileges were not removed later despite him being found with contraband in his cell].

77. The first PIT nurse and a psychiatrist spoke to the man on 13 February. The man told them that he felt scared when there were other people about. He now said that he felt there were three or four sides to his personality and they all talked to him. The man spoke of hallucinating that someone was trying to hurt him because of his involvement in the Lebanon. He felt that the impact of being in prison had worsened his mental health. When asked about eating, the man said that he had not eaten for 17 days. However, he was now eating bread. (Entries in the ACCT between 29 January and 13 February do reflect that the man sporadically ate during this period. There are comments from Officers noting that the man told them he did not feel like eating. He promised Officers that he would start collecting his food and, from entries in the ACCT, it appears that he did so at most mealtimes.)

78. The man's solicitor had requested that a consultant psychiatrist provide an assessment before his next court hearing on 16 February. The first PIT nurse

and the psychiatrist decided to contact the PIT psychiatrist and consider whether a transfer to a secure hospital would be appropriate. The first PIT nurse wrote to the consultant psychiatrist (South Paddington CMHT) to request an assessment of the man. As the consultant psychiatrist had treated the man previously, he was also asked to discuss possible treatment options, including arranging a transfer to hospital.

79. The first PIT nurse detailed the man's mental state and treatment in his letter to the consultant psychiatrist. He explained that the man talked of being split into three or more people. One part was his true self, one wanted to torment him and the other told him to kill himself. The first PIT nurse wrote that the man was not eating very well and had visibly lost weight. The man had explained his refusal to eat by likening food to biting into his own flesh. The first PIT nurse described the man's paranoia. The man felt fearful of other prisoners, but was not specific as to why. Prison officers were supporting the man by allowing him out of his cell during quiet times on the wing to lessen any distress. The man had described the other prisoners as all looking the same and moving slowly. Despite this, the first PIT nurse said that the man did socialise with selected peers at times, but with difficulty. The first PIT nurse commented that his mental health appeared to have deteriorated in the last few months. However, it was possible that, because the man had become more comfortable about discussing his symptoms and problems, that it was not deterioration but a reflection of the true extent of his mental illness.

80. An ACCT review was held the following day. Two senior officers were on the review panel. They found the man to be more communicative than of late, but still had some complex issues to address. The man said that he did not feel like self-harming and the panel believed him. He also reported that he was now eating and feeling more settled. Healthcare wrote to the court stating that the man could attend his hearing. An appointment was arranged for the man to see a second psychiatrist on 19 February. (The second psychiatrist is a psychiatrist who was asked to conduct an independent assessment for the court.) However, the appointment did not take place. The man told staff at the review that the second psychiatrist had been told that he was no longer at Wandsworth prison.

81. During the early hours on 26 February 2007, the man cut his right wrist and told an officer that he had swallowed a razor blade. It states in his medical record and history sheet that the man was seen by a member of healthcare. His cuts were tended to, but it is not clear what action was taken in response to his claim to have swallowed razor blades. No additional ACCT review took place in response to the man's actions and the observation levels remained the same (hourly observations during the day and night, and three meaningful entries throughout the day).

82. The first PIT nurse assessed the man on 2 March and asked why he had cut himself on 26 February. His answer was that he had intended to kill himself. The man explained that he "felt in two minds about being alive". Despite the self-harm, the first PIT nurse found the man to be more animated than at their last meeting, less tearful, and he offered more positive comments. The man

said that he was looking forward to seeing the consultant psychiatrist. During their conversation, the man asked for his zopiclone dose to be increased. He claimed that he had been prescribed 30mg by his doctor in the community, whereas the PIT psychiatrist would only prescribe 7.5mg.

83. The man's next appointment took place on 7 March with the PIT psychiatrist and the first PIT nurse. He repeated his claim that he had deliberately swallowed razor blades on 26 February and they had become stuck. He told the PIT psychiatrist that he had cut his wrists in order to make himself suffer. His suffering had been going on for over 20 years and he had no idea why he was not dead yet. The man said that he felt low and suicidal, but had no plans to kill himself. The team noted that the psychiatrist's appointment set for 19 February had not taken place. The man repeated that the psychiatrist had been told that he was no longer at Wandsworth, but it is not clear where he had obtained this information. The PIT psychiatrist suggested in the medical notes that perhaps the missed appointment had triggered the man's self-harm.

84. Throughout the conversation, the man maintained that he was unhappy with his medications. He said that his venlafaxine used to be 300mg in the community and it was only 224mg in prison, and his zopiclone remained at 7.5mg. He asked for both to be increased. Aside from these two medications, the man said that he was content with his daily dose of diazepam at 15mgs.

85. The PIT psychiatrist noted that she thought that this session was not an accurate reflection of the man's state as he appeared to be under the influence of alcohol. He seemed vague, his speech was unclear and he smelt of alcohol. She also noted that, despite the man saying he had swallowed razor blades and was not eating, he looked physically well and it had been reported he was eating normally. It was decided that the man should continue with his medications at the same dose and that his ACCT should remain open.

86. Both the PIT psychiatrist and the first PIT nurse spoke to the wing officers about the suspected alcohol intake. Wing staff confirmed that hooch (home brewed alcohol) had been found in the man's cell. In addition, they told the primary healthcare team that the man reported swallowing razor blades. The PIT psychiatrist said that nonetheless he looked physically well. There was no indication of the physical problems expected after swallowing razor blades.

87. My investigator asked the PIT psychiatrist why she did not consider increasing the venlafaxine dose as the man had requested. She explained that 300mg was above the recommended prescribing limit of 225mg. The PIT psychiatrist explained that doctors have the discretion to prescribe above this limit. However, in a prison environment caution is exercised. She said that she wanted to undertake a more in-depth assessment over a period of time before determining if an increase would be suitable. In addition, as the man was thought to be under the influence of alcohol and claimed to have recently self-harmed, these incidents would have affected how he appeared and would not have aided a clear assessment. The PIT psychiatrist added that increasing a dose could also result in greater side effects.

88. Over the next few weeks, the man continued to say he felt low in mood and was concerned about his medications. During a PIT review on 16 March, he said that for the first time he felt like hanging himself. He told the team that being around people made him feel anxious and he preferred to spend time in his cell. His zopiclone dose was increased to help him sleep better. A subsequent ACCT review on 25 March said that the man had "his highs and lows", but that his risk overall remained low. His observation levels were set at three meaningful interactions throughout the day and hourly observations throughout the night. During the review, the man asked to be placed in a single cell as he had a problem with his cellmate. (There is a subsequent entry, dated 30 March, which says that the issue was resolved and that he wanted to continue sharing with his cellmate.)

89. Two days later, the man was subject to an adjudication (a prison disciplinary hearing) because he had been found with an unauthorised item in his cell. He pleaded guilty and his earnings were stopped for seven days and his IEP privileges suspended for three months.

90. The man supplied the senior officer with information about contraband on A wing which was filed in a security intelligence report on 3 April. The man claimed that two prisoners were dealing in drugs and mobile telephones. They were currently holding onto and awaiting payment for a phone for an A wing prisoner. The man knew about this because the prisoner had asked him to help raise the money for the mobile. He also provided more information about prisoners from other wings who were runners, and about an unnamed member of staff who was alleged to be bringing in drugs. A target search was ordered. I am unaware of the outcome.

91. On 5 April, the man asked for his venlafaxine to be increased. He was feeling anxious about his next court appearance on 12 April. The day after court, the man told an officer that he did not get on with his solicitor. He said that he had pleaded guilty when he felt he should not have done so. Two days later, (15 April) the man dismissed the solicitor.

92. The first PIT nurse conducted a mental health review with the man on 20 April. He found the man to be more emotionally stable than several months earlier. Nevertheless, the man described panic attacks and anxiety, saying that he felt scared all the time. He stressed that he did not like being around other prisoners. Again, he said he felt suicidal, but had no intention of taking any action.

93. An ACCT review should have taken place later that day attended by the first PIT nurse. However, he was unavailable and the review was postponed until the next day. When the review took place, the man was noted to have improved, but the review panel wanted the ACCT to remain open.

94. On 21 April, the man was assessed by a psychiatrist from Springfield University Hospital. The psychiatrist had been asked to review the man's mental health history to date for the court. The review took place and the psychiatrist's report was submitted during May.

95. The man's next fortnightly ACCT review occurred on 26 April. The first PIT nurse was present, along with the second senior officer (who had been the case reviewer on many occasions). During this review, the man seemed to be improved and taking more pride in his appearance. The second senior officer noted that the man was due to see the consultant psychiatrist (his consultant psychiatrist from South Paddington CMHT) the following day. It was decided that the ACCT should remain open and the next review was set for 9 May.

96. During his session with the consultant psychiatrist on 27 April, the man described how he had tried to shoot and kill himself after his offence took place. It is noted that the man "said with sorrow how all his impulsive attempts at suicide have failed and now he intends to plan his suicide". The consultant psychiatrist noted that the man seemed unchanged from his sessions with him outside prison. He assessed the man's long-term suicide risk as being moderate.

97. The consultant psychiatrist then wrote that his visit had taken place to maintain a connection with the man and his intention was to avoid any comments or therapeutic intervention as he was already being treated by a psychiatrist. He noted that he would see the man again at the PIT's discretion.

98. There is nothing significant in the man's medical record between the entry on 27 April and 15 May. The man's fortnightly ACCT review should have taken place on 9 May and there is no recorded reason why it was missed. The only documented information for this period is on 15 May in A wing's observation book. This says, "once he has cleared his name at court he would end his life". The officer who wrote this entry (the name is illegible) informed both safer custody and the PIT. An entry was also placed in his ACCT record.

99. The next day the man was assessed by the first PIT nurse. The man appeared low in mood and said that life no longer mattered and he hated himself. He believed that he would feel worse if he was out in the community and acknowledged the support offered to him at the prison.

100. The psychiatrist's report became available for the court and was copied to the PIT on 21 May. The psychiatrist diagnosed the man as having an emotionally unstable personality disorder, post traumatic stress disorder and poly-substance misuse. The psychiatrist did not consider his mental health to warrant detention under the Mental Health Act. The psychiatrist recommended that the man continue with his current medications:

- venlafaxine – 150mg in the day and 75mg at night (for depression)
- diazepam – 10mg in the day and 5mg at night (for anxiety)
- zopiclone – 7.5 mg (for sleep).

102. He also suggested that the man be referred to a psychologist to come to terms with past events. During his interview with the psychiatrist, the man had said that he had a long history of mental health issues, predominantly depression. He also said that he began self-harming at 18 years old and had made

numerous suicide attempts. The man described ongoing thoughts of suicide and self-harm, but denied any plans to harm himself at that time. He did say that he felt low in mood and anxious.

103. Three days later (24 May 2007) the man had the next PIT appointment with the first PIT nurse. The man said that his suicidal thoughts would last for up to ten minutes and then he would change his mind. He explained that he wished he had not pleaded guilty at court, denying he committed any offence. It was noted in his medical record that the man could be considered for placement in a therapeutic community (secure hospital) or a personality disorder unit. This was being discussed with the consultant psychiatrist.

104. The first PIT nurse also took part in the man's ACCT review that day. The case manager on that occasion was the third senior officer, who had chaired a number of the man's reviews. The man said that he was going through a particularly low point and he could not identify the reason. He told the third senior officer and the first PIT nurse that he had thought about killing himself on 23 April, but changed his mind. The first PIT nurse said that he would make a further appointment to see the man the following day along with one of the PIT consultant psychiatrists. The next ACCT review was set for 14 June and a member of the PIT was to attend.

105. The next day, a third psychiatrist, and the first PIT nurse assessed the man. The third psychiatrist wrote that the man seemed calm and settled, but complained of feeling indecisive. He denied any current thoughts of self-harm and said he found his cellmate to be very supportive. The man explained that he had recently paid for some drugs, but had changed his mind about collecting them. He said he felt hopeful having seen the consultant psychiatrist recently as the consultant psychiatrist had kept him alive for the past ten years.

106. The man then requested that his diazepam be increased to 80mg. (The PIT psychiatrist told my investigator that this is a very high dose.) He also asked for zopiclone be increased from 7.5mg to 30mg (well above the maximum prescribed dose). The third psychiatrist decided not to increase either. He noted that increasing the dosage would not be beneficial, and referred the man to the day centre for more structured activity and support.

107. During the evening of 8 June on A wing, officers reported that the man was drunk in the evening. An officer wrote in his history sheet that the man had been found in possession of a fermenting liquid. The officer also noted that, due to the man's current mental state, he should be monitored. On a more positive note, she wrote that the man was polite, respectful to staff and had enrolled with the gym and education unit.

108. On 13 June, a community psychiatric nurse (CPN) from the PIT reviewed the man. She noted that he was due to be sentenced the following Friday (20 June). The man was unwilling to discuss potential outcome. He said, "I can't think, my head is too full." The CPN noted that it was difficult to speak to the man as he was very softly spoken and she had to keep asking him to repeat himself. The man denied any current thoughts of self-harm of suicide, but

followed this up by saying that he could be impulsive.

109. The next day, the man was issued with a warning under the incentive and earned privileges (IEP) scheme for failing to report for activities (either education or the gym). The man was an enhanced prisoner and therefore the warning could have resulted in a reduction to standard and a loss of privileges.

110. An entry was also made in the A wing observation book explaining that the man was distressed at being found with contraband and worried that this would mean he would not be entitled to buy items from the canteen. (The canteen is the name for the prison shop where prisoners can buy or order goods each week to a limited value. It mostly sells foodstuffs, confectionery, stationery, toiletries and tobacco products. Spending is linked to IEP, so that prisoners may spend their earnings, plus a sum of private cash.) An officer assured the man that, although he had been given a warning, he would still receive provisions. The officer noted that the man remained distressed and tearful and requested that staff make regular checks on him. The man was told that Listeners and phone access to the Samaritans would be available to him if he wanted.

111. The ACCT review scheduled for 14 June was delayed until 18 June. No member of the PIT was present and there was no explanation as to why the review was late. It was noted that the man was upset and very emotional. He cried and said that he did not know what was going to happen to him at court. It was explained that he could speak to a Listener or the Samaritans at any time, but he was not interested in doing so. (Listeners are prisoners trained by the Samaritans to provide confidential emotional support to other prisoners in distress.) He said that he trusted officers and would continue to talk to them when he felt low or was thinking of harming himself. A fourth senior officer noted that all staff on A wing should be aware that the man was at his lowest point. Despite the man's state of mind, the fourth senior officer decided that there was no need for his ACCT document to be reviewed for a month. The next meeting was arranged for 19 July.

112. The man was sentenced on 20 June. He was given an indeterminate public protection sentence (IPP) with a four year and three month tariff. This would be the minimum amount of time he would serve in prison. (Before an IPP prisoner can be released he must satisfy the Parole Board that he is fit for release and does not pose any threat to the community.) The man said on return to prison that he did not know if he was going to kill himself.

113. Later that day the seventh officer found the man in his cell, upset, crying and pacing up and down. The man told the officer that he was upset because the judge had not taken his circumstances into consideration. The PIT was asked to speak to the man. He asked for his medications to be increased as he felt a building pressure in his head. However, this was not granted and he remained on his existing prescription.

114. Three days later, a prisoner on the wing reported to staff that the man had a mobile phone. A security incident report (SIR) was submitted and his cell was

searched on 24 June. (A SIR is a form used to record security information. The form is passed to the Security Department and placed on a prisoner's security intelligence file.) Officers found a mobile phone, SIM card and cannabis under the man's pillow. An adjudication hearing was held on 26 June at which the man pleaded guilty. As he was on an open ACCT, consideration had to be given to ensuring his actions were adequately addressed, without causing undue stress. An immediate loss of earnings was imposed for seven days. His personal officer wrote in the man's history sheet:

> "has had a very poor week. Was sentenced IPP for four years. Was very tearful during an ACCT review I sat in on. Stated his head was muddled and he didn't know if he was going to kill himself."

115. On 29 June, there is an entry in the man's ACCT record noting that he claimed not to have eaten for nine days. Five days later (4 July), the man said that he had lost eight kilograms in weight. There is nothing in his medical record to suggest that this was followed up or that he was weighed. However, the entry remained on his ACCT care map, at the front of the form, to remind staff to encourage the man to eat.

116. The man told a member of healthcare on 5 July that he had been supplying information to staff about drugs coming into the prison in the hope that the drug dealers would retaliate and kill him. He then said that he no longer wanted this to happen. There is no documented evidence to suggest that the man was being targeted or bullied by other prisoners.

117. There are few entries in any of the man's records for July, aside from the ACCT. An urgent chest x-ray was requested on 13 July after the man complained of a cough and told healthcare that he had been diagnosed with tuberculosis in 1986. Aside from this, the man was moved into a single cell at his own request (he reported not getting on with his cellmate) and seemed far more settled.

118. The third senior officer conducted the man's ACCT review on 19 July as planned. He was the only member of staff present – this is not usual, and neither is it good practice. The third senior officer wrote:

> "The man has been in a single cell and appears far more settled than he has for a long time. He appears to feel safe now that his trial is over and he is sentenced.
>
> "He is working full time, eating well, attending the gym and associating with other prisoners.
>
> "Next review in one month with a view to closure if he continues with his current improvement."

The third senior officer made a note to invite a member of the PIT and/or the chaplaincy to the next review. The date was set for 20 August.

119. After referral from the PIT, The man began a series of sessions with a trainee counselling psychologist on 1 August. (He had not been referred previously because he had not demonstrated an ability to talk as freely about his mental health.) The counselling psychologist works with the crisis counselling service at Wandsworth. Prisoners who have been identified as at risk of self-harm or suicide are seen as a priority. The counsellors offer six to nine sessions of individualised one to one therapy.

120. During his first session, the man told the counselling psychologist that this was not the first time he had received counselling and in the past he had found therapy to be a mistake. The counselling psychologist told my investigator that he initially found the man hard to engage with. It took time to build up trust and encourage the man to be open with him. In the first meeting, the man explained to the counselling psychologist that he could feel his mind moving too quickly. However, he also said that he was feeling better after being moved into a single cell.

121. The counselling psychologist asked the man how he was generally coping. The man said that he was having nightmares and, when he felt scared, he would take his diazepam. He also told the counselling psychologist that he liked to self-harm as it made him feel better. He followed this by saying that he had not recently self-harmed.

122. The man's cell was searched again on 5 August and staff found what was suspected to be cannabis. A SIR was submitted and it was suggested that the man take a mandatory drug test. My investigator asked the prison for copies of the results of all mandatory or voluntary drug tests taken by the man. Wandsworth's drug co-ordinator told her that there were no testing records for the man, although the PIT psychiatrist had requested two tests that proved to be negative during January 2007.

123. The man had the second counselling session with the counselling psychologist on 8 August. During this session, the man spoke about the recent cell search. He told the counselling psychologist that he had a telephone so that he could contact his family. The man said that he felt dead. He talked about problems with his family (particularly his wife), his time in the Lebanon as a combatant, substance misuse, suicide and self-harm. In talking about his prison sentence, the man said that he thought more charges were going to be brought against him. He told the counselling psychologist that he did not want to go to court and he was not going to appeal against his sentence.

124. On 10 August, another cell search took place. Again, cannabis was found, plus a stockpile of aspirin (20 packets). A security information report (SIR) was submitted and healthcare, the safer custody team and the A wing manager were informed. The security manager asked for a review of the procedures regarding prisoners buying aspirin in large quantities. It was suggested that Aramark (suppliers of items for the prisoner canteen) should be informed of the prisoners on ACCTs to prevent them stockpiling drugs. Wing staff were reminded to be more vigilant during cell checks, particularly for those prisoners on an ACCT. The safer custody unit and healthcare were also made aware of

the incident. Despite the concern about what the man intended to do with the stockpile, no additional ACCT review took place.

125. The man was placed on a disciplinary charge again for possessing the cannabis. In response, he said that he would start a "hunger strike". Aside from a mention in the man's medical record and in the A wing observation sheet, there is no other reference to the "hunger strike" so it is not clear whether he proceeded with the protest. As before, my investigator checked the food refusal register and the man's name does not appear.

126. On the morning of 14 August, the man fainted and an officer asked for healthcare assistance. The man was conscious, but said he felt dizzy and unable to sit up. The nurse asked if he had taken any illegal substances, to which the man said no. Half an hour later, the man told staff that his mother, who lives in Kuwait, was dying of cancer. He believed that passing out was proof that he could die at any time. The man told a member of staff the next day that he thought that he had fainted because of the news about his mother's illness.

127. During the afternoon, a SIR was submitted based on prisoner information indicating that the man had asked a named prisoner on the wing to get him a mobile phone and a "package". The prisoner was later seen giving the man his bank account details. The prisoner was known to be a supplier of contraband on the wing. It was suggested by security that the man's cell be searched again. My investigator is unaware of the outcome of this particular search.

128. The man's monthly ACCT review took place on 20 August. The case manager was a fifth senior officer, accompanied by the fourth senior officer (who had been the case manager on previous occasions). Again, no one from the PIT was present during the review, despite the recommendation made by the third senior officer on 19 July. The fifth senior officer noted that due to a prolonged period of good progress and improvement the ACCT could be closed. Although the man was still experiencing nightmares about his time in the military, it was considered that this did not warrant the ACCT procedures continuing. A post closure review was set for 27 August. There is no documentary evidence that this review took place.

129. In the next counselling session with the counselling psychologist, the man said that he was feeling more relaxed. He had not self-harmed and was feeling good. He still preferred to spend time in his cell rather than associate with other prisoners. The man said that he found his concentration had improved and he was attending education. He attributed this to the fact that he was now consistently taking his medication. The counselling psychologist asked the man to keep a diary of his feelings, which he did not seem keen to do. The man contradicted his previous statements by saying that he had blacked out the day before and that he had not eaten in a week. (There are no records to confirm this statement because once the ACCT document was closed there was no requirement for such close monitoring.)

130. During his counselling session the following week (12 September), the man told

the counselling psychologist that he had been in prison a year to the day. He said that he could not face going to court again or appealing against his sentence. The man said that he was coping better now and starting to enjoy himself. After a further session on 19 September, little more than a month since the previous ACCT had been closed, the counselling psychologist decided to open another ACCT document. He cited the following reasons for his concern:

> "In a one to one counselling session, the man stated he is thinking clearly again – he is very angry that he is in prison. He also blames himself for the predicament he is in and feels that he should be in hospital. When asked about suicidal intent he stated that he cannot tell me – however he does not want to be on an ACCT."

The man also said that he did not think he was receiving the right medication and that he wanted to have cancer.

131. The counselling psychologist opened the document at 11.00am. He noted on the "concern and keep safe" top page of the ACCT document that he felt the man's behaviour was unusual. He also referred to his not eating meals as a trigger or warning sign prompting a further review of the man's state of mind.

132. The ACCT document was then passed to an eighth officer at 3.00pm for an assessment interview. During the interview, the man said that he was only distressed because prison medical staff were not giving him what he believed to be his proper medication. He said that appointments were made to review his prescriptions, but that medical staff did not keep the appointments. The man said that he kept seeing different doctors, none of whom prescribed him what he wanted.

133. The eighth officer noted that, although the man felt low, he did not appear to be suicidal at this time or likely to self-harm. Reference was made to his previous self-harm which was because he was fed up with living and did not want to be in prison.

134. When the eighth officer asked the man if he had any current plans to self-harm or take his life, the man did not make himself clear. The officer noted that the man said he was just upset with himself. The reason he gave for living was that a friend outside of prison would not respect any actions to harm himself.

135. The last comment box on the assessment form is to note other areas of discussion. In this box the officer wrote:

> "The man states he wouldn't want officers if they were to take him off the ACCT to get suspended or fired due the fact he lied in interview. He also states he respects the fact officers are trying to get him help, but the medical health team isn't trying hard enough to help him."

136. At 3.07pm, the first ACCT case review was held with the fourth senior officer (who had been present during the closure of the previous ACCT), the senior

officer, an officer and the man. The summary of this review is as follows:

> "The man stated that he does not feel suicidal however he is concerned about his medication, i.e. not getting the right dosage. During the review the man did not come across as being suicidal or self-harm [sic]. Based on the above the board has decided to close the ACCT and review in seven days time."

The risk assessment was set as low, the ACCT form closed and the post closure review date was not set. Again, there is no evidence to suggest that one took place.

137. The next day the man was given another IEP warning for failing to report for activities. His personal officer, the man's personal officer, noted this in the man's history sheet. There is little else in the man's records for the rest of the week, apart from an entry in his medical record stating that he had still not received an urgent chest x-ray. The man was still suffering with a cough and felt wheezy. A request for an x-ray was resubmitted.

138. The counselling psychologist held his sixth and final counselling session with the man on 26 September. He told the counselling psychologist that he was coping well on the wing and had attended education for the first time in a while. The man felt things were improving. He had a new solicitor and had made a friend on the wing. The man also said that he felt comfortable talking to a senior officer on A wing, the third senior officer. Despite this, the man was worried about becoming ill again and remembered what he was like when he first came into prison. He did not want to go back to feeling like that.

139. The next day, the Border and Immigration Agency (now known as the UK Border Agency) served the man with papers relating to his immigration status, indicating liability for deportation. The letter stated that the man had 28 days to appeal against deportation and justify why he could not return to his home country. To appeal, the man needed to supply a written statement setting out why he should be allowed to stay in the United Kingdom.

140. On 28 September, the man was subject to another adjudication hearing and found guilty of the unauthorised use of a controlled drug. His earnings and privileges were stopped for 14 days and a suspended penalty of three days cellular confinement was imposed.

141. The first PIT nurse saw the man for an assessment on 3 October. The man reported not sleeping or eating well, but felt that his mood was improving. The man said that he remained concerned about his sentence, but no longer thought of self-harm or suicide. He asked for his diazepam dose to be increased.

142. A prison doctor saw the man on 8 October. The man had again been complaining of occasional wheezing, sweating, headaches and feeling dizzy. The doctor noted that the man had an appointment for a Computerised Tomography (CT) scan at St Mary's Hospital on 6 September but had decided

not to attend. (A CT scan is a detailed x-ray of the body using computerised images.) In addition to missing this appointment, the man had still not had his chest x-ray. The doctor wrote in his medical record that the man should have the x-ray. He would write to the neurology department at St Mary's about another scan appointment and, in the meantime, the man should continue taking his asthma medication.

143. The man's medical record contained a letter sent to him from Wandsworth Counselling Services on 9 October saying that he had been placed on their waiting list. The list was long and he would be contacted as soon as an appointment became available. In the meantime, the man would be able to access the Listeners service, the Samaritans or the mental health in-reach team whenever he needed. My investigator tried to ascertain who made this referral and what this counselling service was going to provide above that the man was already receiving. She was unable to get a clear answer from any of her interviewees.

144. On 10 October, one of the prison doctors wrote to a consultant neurologist at St George's Hospital in Tooting, South London. Her letter said that the man had been experiencing dizziness, fainting and headaches over the last two months. The doctor said that over the years (but not in custody) the man had experienced many assaults, which had involved a blow to the head. She mentioned the scan at St Mary's Hospital that the man did not attend. Although his symptoms had subsided at the time, they had returned in the last two months and this concerned the doctor. She asked for a neurological examination.

145. On 28 October, the man responded to the Border and Immigration Agency. His letter was written with the help of another prisoner as the man's written English was not very good. He explained that he had already been granted indefinite refugee status and could reside in any country apart from the Lebanon. The man made reference to a blue British passport that he had which was in his brother's possession.

29 October

146. On this day, the man appeared highly agitated to both staff and prisoners. During the morning, the man asked to speak to a prisoner who was the violence reduction representative on A wing. The prisoner was unable to speak to him at the time, but said that he would do so later in the day.

147. At approximately 3.00pm, the first PIT nurse passed through A wing. The man called the first PIT nurse over and asked if he could talk to him. The first PIT nurse told my investigator that the man seemed keen to speak to him, but he had another appointment to attend. He asked if the following morning would suffice. The first PIT nurse told my investigator during interview that he sensed no real urgency in the man's request. He acknowledged that the man did seem very keen to speak to him, but the first PIT nurse did not detect any levels of distress or potential risk of harm.

148. The man told the first PIT nurse that this would be fine. He had a doctor's appointment in the morning, which he was willing to miss because he was keen to speak to the first PIT nurse before a visit in the afternoon. (The man's brother and sister-in-law were due to visit for the first time since he had been in prison.) The first PIT nurse recommended that the man kept his doctor's appointment and, if he was not available to speak to the man afterwards, he would find him later in the morning. He noted in the man's medical record that he appeared excited about his brother's visit.

149. In addition to planning their meeting the following morning, the man also asked the first PIT nurse about arrangements for his next review. He was keen for the consultant psychiatrist (community mental health team) to be present. The first PIT nurse told my investigator that he felt their encounter was particularly positive because the man mentioned three future activities and was in good spirits regarding his family's visit.

150. During the rest of the day both staff and prisoners noticed that the man made a number of telephone calls which seemed heated. My investigator was given a print-out of the list of calls made. The man had used the phone seven times between 10.09am and 6.29pm. Half of these were to his brother and the rest had been made to the same number.

151. The man spoke to the third senior officer saying he was worried about his bank accounts and thought someone was trying to take his money. The third senior officer told my investigator that he spoke to the man at length during that afternoon. The man had approached him and said that he needed to contact the Post Office to cancel a bank account. He said that he was unable to do this on the PIN phones available for prisoners. (The telephone banking service uses an automated menu selection and the PIN phones do not allow this function. Under the PIN phone system, each prisoner is given a unique personal number to access their account and they are only able to dial authorised numbers.) To help the man, the third senior officer allowed him to use the office telephone. The man told the third senior officer that he was very worried that an unnamed person was trying to take money out of his bank account. He mentioned a figure of £11,000. The third senior officer said that the man was not clear if this amount had already been taken or if this was a sum he feared would be stolen from him.

152. The third senior officer remained present during this conversation. The man told the Post Office that he had set up an account for the son of the other prisoner on A wing . (My investigator has since established that the third party was intended to be the prisoner's brother, not his son.) From what the third senior officer could glean, the man was told that in order to access his account and make any changes he would need to present his passport at a Post Office. According to the third senior officer, the man was content that his account could not be accessed without the passport. In the meantime, he would need to write a letter to the Post Office instructing them to put a stop on the account.

153. The third senior officer told my investigator that he knew that the two prisoners had been spending time with each other and he believed this relationship was

benefiting the man. He was under the impression that the prisoner was going to help the man appeal against his sentence by putting him in touch with a solicitor. The third senior officer also thought that the prisoner had been helping the man find a solicitor to deal with family issues relating to his ex-wife and daughter.

154. The man went back to his landing and wrote two letters - one to the Post Office and another to the Halifax Building Society regarding putting a hold on his accounts. The third senior officer said that the man had asked to go to the cell of his old cellmate during the early evening as he would help him write the letters. The man and his old cellmate got on well.

155. After dinner at 6.00pm, the third senior officer unlocked the man and the man's old cellmate's cells so that the man could visit him. The man's previous cellmate told my investigator that the man was a complicated man with a lot of problems to sort out – with his ex-wife, property and his mental health. He said that the man was a little paranoid and always thought that "someone was out to get him". The man had previously told him that he had two bank accounts, both containing large sums of money. He told his old cellmate that he did not want his brother to assist with his finances, but needed some help. He asked the man's old cellmate if his mother would help by holding his money in her bank account, but the man's old cellmate said this was not possible. He later heard that the man had approached the other prisoner and asked him for help. The man's old cellmate had been told that this had not ended well and the man had been "ripped off" by the other prisoner.

156. The third senior officer told my investigator that the following day, the man's old cellmate said that the man had told him he wanted to kill himself that night. The man's old cellmate told the third senior officer that he said, "Don't be silly, we can sort this out." He said that the man had told him on many occasions when they shared a cell that he had felt suicidal, but he had never acted on these thoughts. The man's old cellmate told the third senior officer that he did not believe the man's intentions were serious and therefore did not mention their conversation to staff. The man's old cellmate said during interview that he felt in hindsight that he should have seen the man's death coming. However, at the time he genuinely did not believe that the man meant what he had said.

157. The man's previous cellmate confirmed during his interview for this investigation that he had helped the man. He also said that the man told him that someone was trying to take money out of his accounts without his consent. The man had spent a long time with him that day and at the end of the day he had thanked his old cellmate and said, "This life is not for me."

158. Later on, during the association period, the man went to the staff office with his two letters. (Association is a period in the day when prisoners are able to leave their cells and associate with each other.) The third senior officer said that the letters were partially addressed so he added a line to both. The man asked the third senior officer if he wanted to read the letters, to which he replied there was no need as he knew what they were about. The third senior officer told the man that they would be sent the following morning and hopefully his financial

problem would be resolved.

159. My investigator asked the third senior officer how the man appeared at this time. He said that he seemed "okay". The third senior officer said that he did not have any further concerns about the man because he seemed relieved to have addressed his situation. The third senior officer did not see the man again that evening and went off duty at 8.00pm.

160. Prisoners' accounts of the man's mood during the evening vary. The violence reduction prisoner again saw the man out on the wing. He told my investigator that this second time the man gave no reason to feel concerned about his wellbeing. However, another prisoner said that the man was acting strangely on the wing. During their conversation, the man said to the other prisoner, "See what happens in the morning." He also gave the prisoner his stereo. The prisoner told my investigator that he did not read anything suspicious into this gesture because the man owed him money. The prisoner assumed that the stereo was given as collateral for a debt.

161. At 11.15pm, the man rang his cell bell and an officer went to his cell. The man told the first officer that he had a lot of issues going round in his head and he needed to talk to someone. The first officer told my investigator that he seemed nervous and worried so he asked the man what was wrong. The man repeated that he had things going round in his head and he was not sure what to do. The first officer asked the assistant orderly officer to come to the cell. The assistant orderly officer said that the man could be allowed out of his cell to use the Samaritans' phone.

162. The call to the Samaritans lasted until 12.05am. The first officer told my investigator that at the end of the call the man appeared more relaxed and was quite talkative. The officer stressed that the man did not seem vulnerable and was happier after speaking to the Samaritans. The man returned to his cell and did not come to staff attention again that night.

163. My investigator asked the first officer if the man's behaviour seemed unusual or alarming to him. The first officer said that the man often looked nervous and could appear introverted; he did not feel that his mood on this occasion was exceptional. My investigator asked whether the officer felt the need to check on the man again during the night. The first officer said that he had not thought this necessary as the man's concerns seemed allayed after speaking to the Samaritans. The man was not on an open ACCT and therefore would not have been subject to any additional checks during the night. He did not consider that it was necessary to open an ACCT document. The next routine check was due to take place at around 5.30am.

164. At 5.50am, the first officer began the early morning roll check. (This is a visual check to count the number of prisoners and pass the roll to staff coming onto the day shift. It is a brief check and consists of the officer looking through the observation panel of the cell door. The officer is not required to get a response from the prisoner.) The first officer recalls seeing the man standing by his window. He thought that he might have been praying because he could see

that his head was tilted downwards. The officer did not think this was unusual behaviour as he often saw prisoners praying or standing in their cells during the early hours. The first officer carried on with his checks.

165. By this time, day staff started to come on to the wing. At 6.55am, the second officer conducted his own roll check on the wing. (This check is to confirm the numbers provided by the night staff before the count is submitted to the orderly officer for confirmation. The numbers are then submitted to the control room.) The second officer's check differed and he had one prisoner too many. Both he and the first officer checked the numbers of prisoners who had been collected to go out to court with the centre office and resolved the error.

166. My investigator asked the second officer if he remembered seeing the man during his first check. He confirmed that he did and said that the man was standing by the window. He did not think that this was unusual.

167. A third officer arrived on duty at 7.05am, relieving the first officer. The second officer decided to check the wing again due to the earlier confusion over numbers. He asked the third officer to assist him. This third officer check started at 7.15am. When they reached the man's cell, the second officer noticed that he was still in exactly the same position, which he thought seemed strange. It was still dark outside and the light was off, so it was difficult to see the man clearly. On looking more closely, the second officer saw what looked like a bedsheet suspended from the window. The officer shouted to the third officer that he thought the man was hanging. The third officer blew her whistle to get the attention of other staff.

168. The second officer unlocked the door and went into the cell. He lifted up the man's body by his waist to take the weight off the ligature. The third officer followed him inside and helped support the man's body. The fifth senior officer had heard the whistle and came to the cell. The second officer gave the senior officer his anti-ligature knife to cut down the bedsheet. They then moved the man onto his bed.

169. There is a healthcare treatment room situated at the end of A wing. It is where Hotel 3 (the call sign for the emergency response nurse on duty) is based. Once the whistle was blown, the nurse was alerted to an incident on the wing. Other staff who also heard the call for assistance had arrived at the cell. Two of them, the man's personal officer and nurse (Hotel 3), entered the cell. The fifth senior officer instructed the two officers to leave the cell.

170. The nurse told my investigator that as soon as she walked into the cell and saw the man she could tell that he had been dead for some time. She assessed that he had no signs of life and rigor mortis (stiffness of limbs) had already set in. The man's body was very cold to touch and he had a deep mark on his neck from the ligature. Due to his condition, the nurse made the decision that attempting resuscitation would be futile.

171. During the staff response, an ambulance was requested at 7.23am. The paramedics arrived at 7.30am and confirmed that the man was dead. They left

the establishment at approximately 7.40am. The prison doctor certified the man's death at 8.35am.

Events after the man's death

172. The mood on the wing during the morning was unusually quiet. The other prisoner was moved off the wing for his own safety, as there were rumours that he had been implicated in the man's financial troubles. Support was offered by staff to those prisoners who felt vulnerable and those on open ACCTs received case reviews. Staff affected by the man's death were offered support by the Staff Care and Welfare Team.

173. A hot debrief was held at approximately 9.30am by the Deputy Governor. (A hot debrief is a meeting to discuss an incident, find out whether the correct action was taken and if any lessons could be learned from the response.) Many staff attended the meeting, but not all those directly involved in the discovery of the man were present. Both the nurse and the fifth senior officer were absent. Staff reported that the man gave no obvious indication on 29 October of his intentions, nor in the days before.

174. During the debrief, the family liaison officer and staff from the chaplaincy discussed how to inform the man's family. This was particularly urgent as the man's brother and sister-in-law were known to be visiting him that afternoon. Regrettably, the prison was unable to contact the man's family in time. They had already left their home during the morning and the prison did not have mobile phone contact details. They were met at the visitors centre and taken to a private area to be informed of the man's death. This was an unfortunate set of circumstances but could not have been avoided.

175. During the subsequent police investigation a drawing was found amongst the man's property. The drawing was in an exercise book and he had drawn a man hanging. Written clearly next to the picture were the words "Guilty always? Way? Don't know?" Beneath the picture he had written, "I am going to hang myself", which had been scribbled out. Whilst this is not a suicide note, it is clear that the man was at least considering hanging himself. I must stress that this drawing had not come to staff attention whilst the man was alive. There is no date on the page so it is not possible to ascertain which period it relates to.

ISSUES

Clinical

Record keeping

176. Wandsworth Primary Care Trust produced a clinical review of the man's care in custody. To support his review, the clinical reviewer sought the opinion of a doctor from South London and Maudsley NHS Trust, who has considered the man's mental health care. Both reports can be found at annex 1.

177. The clinical reviewer concludes that the care provided to the man by both discipline and healthcare staff was appropriate and thorough. His only concern was that the clinical records were difficult to read, as the handwriting was at times illegible. The clinical reviewer therefore recommends the use of computer based records.

178. At the beginning of 2008, Wandsworth introduced EMIS, a computerised medical records system used NHS-wide. Both the primary care and the mental health team use this system. In addition, access is also given to the Head of the Safer Prisons team for those prisoners who are subject to monitoring under the ACCT procedures. The Head of Safer Prisons is a clinical psychologist and some members of her team are also clinicians. Those who have clinical backgrounds are granted access to the medical records, but remain bound by medical confidentiality. This is an excellent example of multidisciplinary information sharing.

Mental health

179. The doctor from South London and Maudsley NHS Trust review concentrates on the man's mental healthcare. In relation to psychiatric care, the man was reviewed regularly by the dual diagnosis team and the mental health in-reach team (Prison In-reach Team, PIT). The doctor found these interventions to be appropriate and reasonable.

180. The doctor makes reference to the man's history of suicidal thoughts and his traumatic past. He concludes that, given the man's history and presentation in prison, he should have been considered a chronic risk of suicide. This is in line with the consultant psychiatrist's assessment on 27 April 2007 when he said that the man's long-term risk of suicide was moderate.

181. The doctor says that some of the entries made by the clinical team describe why they believed the man would not move from suicidal ideas to actual intention. The man's views on his family appeared to have been a deterrent to him taking his life. The doctor says that in hindsight it might have been useful if the clinical team had explored this further to develop interventions or support mechanisms involving his family.

182. The doctor comments that the psychological interventions and counselling responses to problems identified by the clinical team had not been described in

enough detail. Appropriate observations were recorded, but no actions or treatment other than medication and changes to levels of observation or supervision had been noted in the medical record. He recommends more explicit record keeping where decisions on care are made.

The Head of Healthcare should ensure that any decisions taken regarding psychological, psychiatric or counselling interventions are clearly recorded in the patient's medical record.

183. Whilst the man saw the DDT doctor shortly after coming into custody, he did not see another psychiatrist again and neither were his prescriptions reviewed in detail until January 2007. It was not until he met the PIT psychiatrist that his benzodiazepine withdrawal was noticed and diazepam reintroduced. Whether this would have made any difference to the eventual outcome it is difficult to say, but the man was clearly distressed during those first few months and was correct when he said that he had not been receiving his previous prescription. The man made repeated requests to be seen by a psychiatrist during his dual diagnosis and ACCT reviews between September and December 2006.

184. In addition to the doctor's criticisms of the level of recorded detail, I am concerned about the timeliness of the man's clinical interventions. From the beginning of the man's time in custody, both his doctor in the community and the consultant psychiatrist highlighted the need for urgent psychiatric input and for his medications to be prescribed. Both letters and a fax were sent stressing that the man needed antidepressants, diazepam and zopiclone. It is not clear why the letters took so long after being sent (14 and 15 September 2007) to be recognised and actioned by healthcare. It was not until 29 September that an urgent PIT referral was made on the basis of the letter from South Paddington CMHT.

The Head of healthcare and the leader of the Prison In-Reach Team should ensure that any urgent referrals and prescription information provided by community doctors and mental health teams are recorded and processed immediately upon receipt.

185. The doctor also explores the difficulty in managing a prisoner with chronic risk of suicide who is serving a long sentence and unlikely to be moved to a hospital setting. He asks a number of questions about what protocols are in place for managing prisoners at risk in prison:

- Is ACCT the only process used for managing people who are at risk of suicide in Wandsworth prison?
- What does it mean when someone is placed on an ACCT?
- Is this a process understood by both healthcare and discipline staff?
- What is the risk threshold for initiating the ACCT process?
- Is this threshold affected by external pressures, e.g. number of vulnerable prisoners and staffing resources?

I have explained the ACCT process in the next section of this report.

186. The doctor notes that entries in the man's medical record in August 2007 refer to his fluency in the English language. He questions whether the man was fully understood by staff when he talked about his mental health, medication and other issues. The doctor suggests there would have been benefit in using an Arabic interpreter who would be familiar with his background in Lebanon. However, there was no suggestion from the staff interviewed by my investigator that the man was unable to make himself understood during conversations and assessments. Had there been any difficulty, staff could have used the Big Word, a professional translation service.

187. Neither the clinical reviewer nor the doctor comment on the continuity of care on moving between the dual diagnosis and prison in-reach teams, or the man's ongoing requests to change his medication. An internal review produced by Mental Health and Substance Misuse team at HMP Wandsworth submitted to the South West London and St George's Mental Health Trust covers continuity of care. The full review can be found at Annex 2.

188. The internal review states that the man's care was transferred from the dual diagnosis service to the PIT on 6 February 2007. Prior to this, the man had been assessed by The PIT psychiatrist in early January, whilst he was still under the supervision of the dual diagnosis team. (The PIT psychiatrist was one of the consultant forensic psychiatrists working for the PIT.) This joint working took place because at the time the dual diagnosis service had no medical cover.

189. This earlier overlap in medical care meant that the man's transition to the PIT in February did not result in any gaps in his care. At this time, the PIT was also in regular contact with the consultant psychiatrist to discuss his previous treatment, future options, and to identify a suitable placement for him following release. I am satisfied that action was taken to make sure that the man's care was consistent at this stage.

190. The internal review concludes that the man's mental health appeared to be progressing. Both he and the PIT were looking towards planning a long-term care plan approach and discussing future placements following his release.

<u>Medication</u>

191. My investigator spoke to the first PIT nurse and the PIT psychiatrist about the man's persistent belief that his medications were unsuitable. She asked both parties what had been done about his requests and why no substantial changes were made to the man's medications until January 2007. The first PIT nurse explained during interview that the man frequently asked for increased doses of zopiclone and diazepam. At the time, he spoke to the consultant psychiatrist about this issue. The consultant psychiatrist agreed that the prescriptions should not be increased. Increasing the diazepam would only provide short-term relief. Diazepam would not cure his distress; it acted as an emotional suppressant. Higher dosages increase dependency and this is not thought to be the most beneficial or appropriate means of managing anxiety. The PIT and the consultant psychiatrist were concerned that the man was

avoiding fully dealing with his mental health issues and trying to mask them with prescribed drugs.

192. The PIT psychiatrist echoed these concerns during her interview. She explained that diazepam is licensed for short-term use because it is highly addictive and causes dependency. The PIT psychiatrist said that a patient becomes accustomed to a dose and then the medication stops being as effective and has to be increased. A patient with chronic mental health issues (like the man) needs to be treated cautiously when commencing a course of benzodiazepine. She explained that it is very likely that such a patient would end up taking a high dose over the long-term, resulting in an addiction.

193. The man had already taken diazepam over a long period in the community. When he came into prison he was forced to withdraw because he did not receive his previously prescribed maintenance dose. It seems that the only reason he received any dose of diazepam when he came into custody in September 2006, was because he was placed on a heroin detoxification withdrawal programme. Diazepam, in this context, is used to help reduce the anxiety experienced whilst withdrawing. Once the programme ended, his prescription was discontinued. The PIT psychiatrist explained that the gap in his prescription would mean that he could not have restarted at his quoted higher dose of 30mg. She also said that to restart benzodiazepines once a person had been detoxified was unusual. The PIT psychiatrist said that she had only reissued the prescription because the man seemed to be displaying signs of distress and withdrawal. She exercised caution by only prescribing a low dose (5mg, twice daily).

194. The PIT psychiatrist said that she was happy with the decisions that both she and the rest of her team took with regard to the man's care. She explained that, if medication had been the answer to the man's problems, he would have started to recover over the years. The PIT psychiatrist knew from the CMHT notes that whilst he was in the community, he had received high doses through self-medicating above his prescribed doses, and also by using other medications or illegal substances.

195. The PIT psychiatrist believed that the man had chronic psychological difficulties who had not reached the point where he could engage in any ongoing in-depth psychological treatment. She said that, if the team had responded to his requested to increase medications, he would have repeatedly returned to ask for more. The man needed to face the underlying issues and was not able to do so.

196. The PIT wanted to find a more constructive way of dealing with the man's anxiety alongside his medications. This was how the man came to be referred to the crisis counsellor and another outside agency (which he did not see before his death). The first PIT nurse explained that the man was not content with this element of his care plan. He was also unhappy about being confronted with questions about his substance misuse and alcohol consumption. The first PIT nurse told my investigator that he was aware that cell searches had revealed that the man was using illegal substances and

drinking. He said that the man's use of drugs and alcohol made it difficult to assess the true extent of his mental health problems. The first PIT nurse said that the man could be inconsistent in his presentation during assessments and this made it difficult to take what he said at face value.

Suicide and self-harm

Closing ACCT monitoring

197. The Prison Service uses the ACCT process and form as a tool for monitoring and providing support to prisoners identified as being at risk of self-harm or suicide. ACCT is now used in all prisons and has replaced an older system (the F2052SH) for managing risk of self-harm. All staff should receive basic ACCT training and be able to open a form as well as make appropriate entries in the ongoing record. The basic training includes identifying signs of risk. Some staff receive more in-depth training to conduct assessment interviews and take part in case reviews. A trained member of staff should undertake the first assessment interview. Subsequent case reviews should ideally be multidisciplinary, comprise no fewer than two members of staff and also include the prisoner. Once the staff conducting the reviews determine that the risk is no longer evident, the ACCT document can be closed. A post-closure review should take place seven days later to confirm that the risk remains reduced.

198. During his time in custody, the man was monitored under the ACCT procedure for a long period of time – nearly 12 months, from 12 September 2006 until 20 August 2007. The use of the ACCT in monitoring the man was broadly in accordance with Prison Service guidance. He received regular reviews with good continuity of staff on the panels, and there were appropriate comments on his on-going record.

199. Throughout the period, the man showed improvement in mood and his risk remained low through July and August 2007. His review on 19 July, undertaken by the third senior officer, found that the man appeared more settled than he had been in a long time. On the basis of this positive review, the third senior officer recommended that, if this progress continued, consideration could be given to closing the ACCT document.

200. The third senior officer noted that a member of the PIT and/or the chaplaincy should attend the next review. Unfortunately, neither attended. Instead, two Senior Officers were present. They were familiar with the man and had been involved in previous reviews as care managers. The summary of the review reads:

> "He is now on full time education and is eating and sleeping well, although he still has come nightmares relating to his time in the army. He stated he has no suicidal thoughts or any intentions to self-harm.

He is in a good mood and being in a single cell has helped him overcome his problems.

"He is keen to go to the gym.

"Due to the prolonged period of good progress and continues to show marked improvements the ACCT can be closed [sic]. He was keen to close the ACCT. Explained to him that we will have another chat in a week's time."

201. The fifth senior officer noted that a post closure review would take place on 27 August. Having read these last two reviews (spanning two months) and the ongoing record for this period, it seems reasonable to conclude that the man was at a sufficiently low risk to justify the closure of the ACCT document at this time and that the decision was appropriate.

202. However, I am disappointed to learn that the review did not take place with a member of either the PIT or the chaplaincy present as stipulated in the review conducted by the third senior officer. It would have been better practice to have had a multidisciplinary team, particularly given the man's known mental health issues and history of self-harm. The guidance for the ACCT process indicates that it is good practice for case reviews to be multidisciplinary and for key people who know the person at risk to be present. The panel at this review consisted of discipline officers alone and no one from the PIT or psychology was present.

203. In considering the documentation, I would have preferred the decision to close the ACCT to have been deferred until a member of the PIT could be present. It is not clear why there was no representation from the team.

204. My investigator spoke to the first PIT nurse who explained that he was aware that closing the ACCT had been carefully considered during August. He did not provide a written contribution for the panel to take into consideration during the final case review. At the time of closure, the man had already been in a single cell on his own for some time and was demonstrating significant improvement in his attitude towards self-harm and suicide. He and wing staff were confident that the man no longer appeared to be at risk and had not for some time.

205. The counselling psychologist told my investigator that he had also seen a positive change in the man's demeanour during August and felt that he was making good progress. He too maintained that he was confident the man's risk was sufficiently reduced.

The Governor should remind staff that it is good practice for ACCT case reviews to be multidisciplinary and include key people who know the person at risk or are involved in his care. This is particularly important when a review results in the closure of an ACCT.

206. My investigator also spoke to the third senior officer about the closure of the ACCT. He too believed that the man had improved considerably since the case

review in July. The third senior officer said that the man appeared more positive and calm after his sentencing. The man started going back to education and would come out of his cell during association more. Previously he would decline and stay behind his door. The third senior officer said that he was not surprised or worried by the closure of the ACCT and thought that the timing was appropriate.

207. Given the evidence of the first PIT nurse, the PIT psychiatrist, the counselling psychologist and the third senior officer, I believe that deferring the closure would almost certainly not have changed the outcome. The man had shown improvement and did not appear to be actively suicidal or likely to self-harm.

208. On 19 September 2007, five weeks after the closure of the initial ACCT, the counselling psychologist recommended that another ACCT form be opened. This document remained open for four hours. My investigator spoke to the counselling psychologist in relation to this ACCT. The counselling psychologist had opened the document as a direct result of one of their counselling sessions. He said that he felt sufficiently concerned to open the document and was surprised to learn that it was closed only four hours later.

209. Both the assessment and case reviews concluded that the man did not seem to be suicidal or at risk of self-harm. His risk was considered low and a decision was made to close the form. I am again concerned that this decision was taken without consulting a member of the mental health team, particularly as the process had been opened by a crisis counsellor.

210. The first PIT nurse told my investigator that the PIT was not aware this ACCT form had been opened. The internal review submitted to the Mental Health Trust also raises this concern. The internal review says that, if the PIT had been informed, it would have automatically triggered a mental health assessment. It is not acceptable that the PIT were not notified. The internal review recommends that the PIT liaise with the Safer Prisons Team to explore better ways of communicating the opening and closing of ACCT documents of prisoners under the care of the team. I agree.

The Governor should remind staff that, when an ACCT is opened for a prisoner receiving mental health care, those providing the care must be kept informed. In particular, the Prison In-Reach Team should liaise with the Safer Prisons Team to determine ways of improving communication when opening and closing ACCT documents relating to prisoners under the care of the PIT.

211. Whilst it is not clear whether keeping this second ACCT form open would have made any difference to the outcome, I am not impressed with the way that this process was handled. Little time appears to have been devoted to the process, especially given a decision was made that no risk was posed. Consideration should have been given to keeping the document open for at least 24 hours to properly determine that the man's risk was low.

<u>Post-closure reviews</u>

212. In both cases, no post-closure ACCT review took place. The ACCT guidance notes state that a significant number of people have killed themselves soon after ACCT monitoring has stopped. To prevent this happening, part of the aftercare support is a post-closure review. One or more follow-up interviews should take place to discuss how the individual is feeling, whether any further support is needed, or indeed if the ACCT should be re-opened. The guidance stipulates that there must be at least one post-closure interview.

213. My investigator spoke to a member of the Safer Prisons team about post-closure reviews. She told my investigator that there is now a requirement in place that any ACCT closed for a prisoner receiving mental healthcare must have a member of the PIT on the panel. It is also recommended that a member of the PIT is present on all case reviews. I am pleased to see that these measures have been taken to ensure multidisciplinary participation in assessing risk.

214. The member of the Safer Prisons team also told my investigator that any new ACCT document opened is listed on the daily briefing sheet, which is published on the prison's intranet site. The information provided includes:

- the prisoner's name
- prison number
- location
- ACCT log number
- reason for opening the ACCT

The Governor should remind staff that post-closure reviews must take place when an ACCT document is closed.

<u>Should an ACCT have been opened on 29 October?</u>

215. The clinical review raises the question of the likelihood of the man hanging himself if he had been on an open ACCT. It is impossible to answer this question with any certainty. My investigator asked the first PIT nurse, the PIT psychiatrist and officers on A wing whether the man appeared to be at risk of suicidal behaviour during the weeks before his death. All of them answered no, saying that the man had made marked progress since he was sentenced.

216. Throughout his time in custody, the man received regular input from the PIT, which continued after his ACCT was closed on 20 August. As a result, although he was not subject to ongoing ACCT observation, his mental health remained subject to ongoing review.

217. It is true that the man was noticeably distressed on the day before his death. Staff on A wing recognised this and gave support throughout the day. In particular, the third senior officer spent a lot of time with the man, trying to calm him down and help him resolve the problems with his bank accounts. The third senior officer said that at no time did the man appear at risk of self-harm. It is

unfortunate that the one person whom the man did speak to about the extent of his feelings, the man's old cellmate, had not mentioned their conversation to staff. However, the man's old cellmate explained to my investigator and to the third senior officer that they had many conversations about self-harm in the past and nothing had come of it. The man's old cellmate did not think that the man's intentions were serious that night.

218. It could be argued that, had the man's old cellmate, the first PIT nurse or the third senior officer erred on the side of caution, an ACCT might have been opened. However, this is a matter of judgement and no party felt that the man was actively at risk of harm at that time.

219. During his interview, the first officer maintained that on the night of the man's death he had not felt sufficiently concerned to keep checking his cell during the night. He thought that, after the telephone call to the Samaritans, the man appeared both calmer and happier. The first officer believed the man when he said that he was fine and would see him in the morning. With hindsight, he considered that he should have checked on the man, but at the time it genuinely did not seem necessary. The man did not seem to be an active cause for concern. It should be noted that the first officer's decision to allow the man to come out of his cell during the night to speak to the Samaritans was good practice.

220. Although staff thought that opening an ACCT at this time was not necessary. I am somewhat uneasy about the fact that the man was not checked again during the night. Unless a prisoner is on an open ACCT, there is no formal requirement for extraordinary checks on them during the night. However, in the event that a prisoner has asked to speak to a Samaritan or Listener during the night or has appeared visibly upset, I would encourage staff to make random checks. This would at least provide interim support until there is an opportunity in the morning to review the situation.

I recommend that the Governor consider introducing interim visual checks for prisoners who are not on an open ACCT, but who have required and received Listener or Samaritan support during the evening or at night. The National Offender Management Service (NOMS) Safer Custody and Offender Policy Group may also wish to consider issuing national advice.

221. My investigator spoke to the PIT psychiatrist about her impression of the man's depression and suicidal ideation. She said that the PIT and the consultant psychiatrist (CMHT) had discussed the man's mental health on many occasions. It had been decided that whilst the man had a chronic illness, it was symptomatic and his previous hospital stays had not brought any great improvement to his health. Both teams tried to alleviate his symptoms and provide ongoing support within the prison environment. The PIT psychiatrist explained that the man was quite changeable. One day he would seem significantly more relaxed and able to engage, whilst on others he would be stressed and anxious, and would self-harm. She said that something very

obvious would always trigger self-harm such as missing his appointment with his psychiatrist or attending his trial.

222. The PIT psychiatrist said that the man did not seem able to alert others to his stress levels and say "this is how I am feeling". Instead, he would hurt himself and talk about it afterwards. She said that this response seems indicative of the man's reaction to the stress he was under the day before his death. However, the PIT psychiatrist stressed that the man had appeared to settle after his sentencing and was more positive in his interactions. She thought that he had made progress, so it was a great surprise when the man died.

Food refusal

223. There are several references to the man refusing to eat or stating that he was on "hunger strike" during his time in custody. As I had said earlier in this report, the man's name does not appear on the food refusal register. My investigator asked the first PIT nurse about the man's statements of food refusal. The first PIT nurse said that there were times during his earlier contact with the man when he had started to look emaciated and displayed depressive symptoms. He explained that not eating can be a sign of depression. Having said this, the first PIT nurse went on to explain that the man's weight and appearance fluctuated. Sometimes he would be better presented and look like he had gained weight. At other times, he would look dishevelled and thinner. This would correlate with his mental state.

224. My investigator asked the first PIT nurse if he knew about the food refusal register and support mechanisms in place for prisoners who refused to eat. The first PIT nurse said that he did not think that the man was completely refusing food. However, he acknowledged that at times the man did seem to have been eating noticeably less. The first PIT nurse recalled that there was a period not long before the man's death when he had fainted (14 August). The man told the first PIT nurse that he had fainted because he had stopped eating. He then said that after fainting he started to eat. The first PIT nurse explained to my investigator that the man's actions were more like a control mechanism or self-harm. As the man was already on an open ACCT, The first PIT nurse believed he was receiving sufficient ongoing support.

225. Although the first PIT nurse thought staff were unaware that the man had stopped eating, this was not the case as the ACCT care plan clearly indicated that staff should encourage the man to take his meals and eat. Officers played an active role in supporting the man during late July and August. The man responded well and began eating with more regularity.

226. In interview, a ninth officer also acknowledged the man's sporadic eating and said he had spoken to the man about it. The man said that he did not like prison food and preferred to eat what he had bought through the canteen. The officer believed this was why the man was distressed after an adjudication hearing resulted in a loss of privileges. The man had been worried that he would not be able to buy items from the canteen, but this particular privilege

had not been withdrawn. The officer added that the man would never eat two consecutive evening meals. His impression was that there were times when he ate less, rather than stopping completely.

227. During his interview, the man's old cellmate said that the man's eating habits were at times sporadic. Sometimes he would not collect his meals. If he did collect them and then did not want to eat, he would put the food down the toilet. This explains why staff may not have always noticed if the man had not collected his meals for 72 consecutive hours.

228. It is interesting that the records faxed from the South Paddington CMHT refer to the man's poor eating habits as self-neglect. He was noted to have lost weight during 2005 due to his habit of not eating. This suggests that his actions were not attributable to any specific issue within the prison. Instead, it is more likely that his food refusal was linked to his mental health, like the substance misuse, self-harm and suicide attempts. Although the man's poor eating habits were noted, I am surprised that his periods of noticeable weight loss were not documented in his medical record.

Contraband and debt

229. During the course of this investigation, information came to light that the man had been buying drugs and mobile phones. Discussions with A wing prisoners supported the evidence in the man's prison records (history sheet, security incident reports, medical record and drug tests) that he had been using illegal substances and drinking alcohol whilst in prison. Four prisoners were interviewed, all of whom confirmed that the man bought drugs from others on the wing and that he owed money. The man was said to be buying heroin, large amounts of cannabis and prescribed drugs (mostly subutex, benzodiazepines and dihydrocodeine, also known as DF118).

230. One of the prisoners said that the man would pay vastly higher prices for drugs and mobile phones. Prisoners knew that the man was a vulnerable man. He freely told them that he had a lot of money and was prepared to spend large sums on drugs.

231. There were also rumours that the man had bank accounts under false names and was using them to launder money and pay unnamed staff to bring street drugs into the prison. My investigator was told that, despite the man's claims that he had a lot of money, he was in considerable debt to others on the wing. A prisoner on A wing told my investigator that the man did not seem to be aware that he was being taken for granted by other prisoners on the wing who were using him to help pay for and bring drugs into the prison.

232. Prisoners gave different accounts of the man's relationship with the other prisoner. Some alleged that the prisoner had befriended the man and was taking money from him. The accusation was that the prisoner had convinced the man to sign his bank accounts over to his brother. The prisoner's brother would help the man find another solicitor to resolve issues with his ex-wife. In addition, by having authority over his bank accounts, the other prisoner's

brother could prevent anyone trying to steal his money. The other prisoner's brother would then send the man money each month to his prison account. The man had apparently agreed to this course of action.

233. The violence reduction prisoner told my investigator that the other prisoner was helping the man to stop getting into any more debt with the dealers. He said that he thought the other prisoner's brother had legally taken control of the man's bank accounts to help protect his money. After the man's death, the violence reduction ptisoner had heard that £6,000 had been taken out of his bank account and he had allegedly argued with the other prisoner about this.

234. The man had also told prisoners and some staff on A wing that there was someone outside the prison, an old business friend, who was trying to steal his money. On 19 August, he was desperate to try and protect his money from external parties. The man seemed convinced that large amounts of money had either been taken from his bank accounts or this was imminent.

235. A security incident report (SIR) was submitted by a prisoner after the man's death. A redacted version of the report was released to my investigator. (The prisoner wanted to maintain his anonymity and therefore my investigator was unable to interview him.) The report claimed that the man had told him that he was being bullied by a group of prisoners on his wing. The group of prisoners were said to be pressurising the man into buying drugs and mobile phones for them.

236. The prisoner alleged that unnamed staff were also implicated. Phones would be found during cell searches and then given back to the alleged bullies. The bullies would then resell the phones back to the man. The man was aware of this scam as he had noted the serial numbers. The prisoner said that the man was being protected by the other prisoner, who would give him his phone credit and canteen when he had run out of money.

237. The SIR stated that the man had also told this prisoner that his solicitors had his bank account details and had been making daily withdrawals of £600 over a series of days. He found this distressing and told the prisoner that he felt unable to cope.

238. Although my investigator was unable to speak to the prisoner who had submitted this information, she did interview the other prisoner. He told my investigator that the man and he were friends. The other prisoner said that he would write letters on his behalf because the man's written English was not very good. He also said that the man owed a lot of money to prisoners on the wing. To his knowledge, the man was a prolific drug user. He had also noticed that on occasion the man would stockpile aspirin or paracetamol in his cell.

239. With regard to drug related debt, the other prisoner said that he had paid these debts for the man and warned the drug dealers to leave him alone. In addition to paying the debts, the other prisoner confirmed that he used to double what he spent on canteen items (for example, extra food or phone credit) to share his purchases with the man when his privileges were reduced or withdrawn.

The other prisoner said that he suspected the man of trading these items for drugs.

240. The other prisoner said that, although the man had agreed to transfer his bank accounts to his brother, this had not happened before his death. He told my investigator that approximately six weeks after the man's death, his brother had received a letter from the Post Office. After seeking legal advice, the other prisoner's brother returned the letter to the Post Office telling them that the man had died.

241. The police made enquiries with both the other prisoner and his brother. They concluded that there was nothing untoward about the other prisoner's offer of assistance. An attempt was made to trace the man's bank accounts with the Halifax and the Post Office. Both had no record of accounts under his name which suggests that, if the man had accounts with either bank, they were in a false name. The accounts remain untraceable.

242. The other prisoner described the man as paranoid. He said he thought that officers were "out to get him" and wanted him dead. The other prisoner said that the man was a victim on the wing. Due to his trust in other prisoners, all the man's money had been taken and he was in debt to sustain his drug habit.

243. My investigator also spoke to the third senior officer about the man's involvement with mobile phones, drugs and the bank accounts. The man had spoken to the third senior officer about drug use on A wing. He gave details of who was supplying, placing orders, the bank account numbers for where the money was held, and had said that staff were implicated in bringing drugs into the prison. The third senior officer said that he submitted a SIR detailing the man's information. My investigator has not seen a copy of this SIR as it is not within the man's security file. (However, a similar SIR was submitted on 3 April 2007 by the senior officer. This indicates that the man did offer intelligence on occasion.)

244. The man told the third senior officer that he had used his own bank account to pay for drugs brought into the prison. However, he said he was unable to give information as to when the drugs would arrive because he had not placed an order himself. He would only be given a date if he was expecting a delivery. The third senior officer told the man that he should not put himself at any risk just to supply information to staff. My investigator asked the third senior officer if the man was being pressurised into this activity by other prisoners. The third senior officer said that he did not believe this was the case and that the man was acting of his own accord.

245. Other A wing staff interviewed said that, whilst they knew that on occasion the man had been found with contraband in his cell, they had not noticed any pressure from other prisoners. As staff were unaware and bullying had not been raised as an issue when The man was alive, no anti-bullying measures were in place. Had this been raised as an issue, I would have expected to see the relevant paperwork in the man's prison record.

246. As part of the investigation, my investigator met with a staff member from Wandsworth's security department, to ask how the prison was tackling the prevalence of contraband and alleged staff involvement. The member of staff from the security department explained that there is a two tier system for managing intelligence - a corruption prevention manager who deals with confidential intelligence (regarding staff involvement) and the SIRs. The manager works alongside a principal officer in the security department. Part of the corruption prevention manager's role is to identify and respond to staff corruption. He said that through the corruption prevention system some staff have been identified and subsequently prosecuted. Intelligence gathered informs strategic responses such as moving staff lockers outside of the main prison, imposing random staff checks and an intensive staff search programme. Member of staff from the security department stressed that there is zero tolerance regarding staff corruption.

247. At the lower level, SIRs are used to identify prisoner activity and can trigger target searches and mandatory drug tests. Prisoners found guilty of acquiring or using contraband are subject to adjudication hearings. Member of staff from the security department explained that the mandatory and voluntary drug testing process is used as an indicator of what kind of illegal drugs are prevalent in the prison at any given time.

248. Since a security audit in early 2008, the department has been restructured and a unit has been created with designated staff for gathering and analysing intelligence. It is intended that this unit will identify what is coming into the prison, the gang networks, prolific drug users and known dealers. This information will be fed into the security department and into the residential areas of the prison to ensure an operational response - either a searching strategy or moving prisoners. Member of staff from the security department said that since the new strategy had been in place there have been increased contraband finds and the quality of information has improved.

Mandatory and voluntary drug testing records

249. During the investigation, my investigator asked for all copies of the man's voluntary and mandatory drug testing records. The man was required to undergo mandatory drug tests on numerous occasions for healthcare purposes and as a result of security intelligence.

250. The Drug Coordinator at Wandsworth told my investigator that there were no records held for the man. She was told that this implied that he had never been tested. However, this contradicts the man's medical records which document two drug tests with negative results. As a point of housekeeping, I would ask the Governor to ask his Drug Strategy Group to improve their record keeping. This is particularly important if these tests are to be an effective tool in combating the misuse of drugs at Wandsworth.

Security incident reports and medication in-possession

251. During The man's time in custody, a total of 19 SIRs were submitted. The subjects of the reports were:

- The man's drug use
- The man buying mobile phones
- The man assisting a prisoner to escape.

Based on these reports, the man's cell was often subject to target searches to find contraband and authorisation was given to monitor his mail and telephone calls. This authorisation remained in place throughout his time in custody. If contraband was found in the man's cell, an adjudication hearing was held.

252. There was an occasion on 10 August 2007 in which approximately 20 bottles of aspirin were found during a targeted search. Each bottle contained 16 tablets. The man was an open ACCT at the time. The aspirin was removed from his cell and a memorandum was sent to safer custody and healthcare regarding the find. The aspirin had been purchased through the canteen system. The security manager's comments were that prisoner access to purchasing aspirin in great quantity should be reviewed.

253. Further to this, when my investigator visited the man's cell after his death she saw an excess of boxes of ibuprufen (an anti-inflammatory painkiller). My investigator was unable to ascertain from his medical records why this had been prescribed.

254. My investigator spoke to the head of pharmacy at Wandsworth about in-possession medications. (In-possession means that a prisoner is allowed to keep any prescribed or non-prescribed medication in his/her cell rather than having each dose dispensed by medical staff.)

255. The head of pharmacy explained that medications are broadly categorised into allowed in-possession and not allowed. Each prisoner is risk assessed by a member of healthcare to ascertain whether it would be safe for them to retain their own medication. This includes assessing the potential for using medication as a means of causing self-harm. If a prisoner is deemed at risk, medications that would not be allowed in possession include any controlled drugs, such as:

- anything to be taken intravenously
- anti-psychotic medication
- antidepressants
- paracetamol.

257. Medications allowed in-possession are basic drugs for chronic conditions (such as asthma), some anti-inflammatory drugs, anti-septic creams etc. If a prisoner cannot be relied upon to administer his own medication or comply with the instructions, his medication is dispensed during treatment rounds and not kept in his cell.

258. Patient risk can be reassessed at any time. Reassessment can be triggered by risk of self-harm, non-compliance (failure to take prescribed medication), or if the prisoner is found to be trafficking his medication. In this event, the prisoner would have their medications dispensed to them in single doses according to the prescription requirements. Both the initial risk assessment and any subsequent evaluations should be kept with the prisoner's medical record.

259. The medications found stockpiled in the man's cell were always those categorised as safe for in-possession. He had never been assessed as being at risk. My investigator remained concerned about the number of boxes of aspirin and ibuprofen found in his cell and asked the head of pharmacy whether they could be dangerous if an overdose was taken. The head of pharmacy explained that both aspirin and ibuprofen are less dangerous in excessive amounts than paracetamol, which can cause serious liver damage. She then said that it would be easy to have a stockpile of these medications in the same manner as you could if you were in the community. Aspirin and ibuprofen are routinely prescribed in a weekly or fortnightly (monthly if for a chronic condition) supply. If the whole supply is not used, the prisoner is not expected to return any unused medication.

260. If an officer finds a stockpile of medication during cell checks, they can report it to healthcare and a nurse should inform a prison doctor. If it transpired that the prisoner was not complying with his prescription, no more would be supplied in-possession until this had been resolved. In the man's case, the stockpile of aspirin was confiscated and healthcare were informed. My investigator was unable to ascertain why the stockpile of ibuprofen had been overlooked.

Single cell

261. The man spent a long period of his time in custody in a shared cell. He reportedly had a good relationship with his cellmate. However, this changed when the man's cellmate reported abusive behaviour and requested a cell move, which was approved. The man was also frequently found to have contraband, which his cellmate was unhappy about. If contraband is found in a shared cell, both prisoners may be responsible. The man's old cellmate did not want to be implicated in the man's drug or mobile phone use as it would reflect upon his record and his eligibility for parole.

262. The first PIT nurse told my investigator that his impression was that the man did not get on so well with new prisoners. Wing staff raised with the first PIT nurse the possibility of the man moving to a single cell (at the man's request). It was decided that at this time the man's risk had greatly reduced and he would be safe to be in a cell on his own. The first PIT nurse told my investigator that he had said he had no concerns about the man committing self-harm or suicide and was happy for him to be moved on his own.

263. The second officer confirmed that the man seemed to be much happier in a single cell. He had enjoyed sharing a cell and got on well with the man's old cellmate, but did not want to share with anyone else. The man remained in a single cell after his ACCT was closed in August 2007. The second officer had

noticed that the man appeared more positive in mood after the ACCT monitoring had stopped and he was in a cell on his own.

264. My investigator could find no evidence to suggest that the man needed to be moved back into a shared cell. He did not seem to be an active risk to himself after the ACCT closed and there is no indication of any cause for concern that could have triggered a move.

Incentives and earned privileges

265. The purpose of the incentives and earned privileges scheme is to encouraged reward responsible behaviour. The man was first granted enhanced IEP status on 7 February 2007. At various times while he was in custody, the man's IEP level was subject to review because of his persistent drug taking and contraband finds. Failure to comply with the criteria for remaining enhanced triggered warnings and eventually a review. A review can lead to a reduction in the prisoner's IEP level, but consideration also needs to be given to whether the prisoner is vulnerable. Removing privileges from a prisoner subject to an ACCT document could have an adverse effect and worsen the situation.

266. As the man was known to be a vulnerable prisoner who was sometimes subject to ACCT monitoring, he avoided being reduced to basic. It seems that staff were relatively lenient with the man to prevent causing undue stress and pressure on his already unstable mental health. I think that this was good practice.

267. However, little seems to have been done by staff to find other ways of reducing the man's persistent possession of contraband. He made no effort to change his ways and there is no evidence of staff seeking to address his behaviour other than through adjudication hearings.

Post mortem report

268. A forensic pathologist, undertook a post mortem on 2 November 2007. The pathologist concluded that the man had died as a result of hanging. A toxicology report found traces of:

- diazepam (a prescribed benzodiazepine for his anxiety)
- zopiclone (his prescribed sleeping tablet)
- venlafaxine (his antidepressant)
- alcohol
- cannabinoids (cannabis)
- temazepam – (benzodiazepine, not prescribed to him)
- desmethyldiazepam – (benzodiazepine, not prescribed to him)
- oxazepam (benzodiazepine derivative, not prescribed to him)
- dihydrocodeine (an opioid based painkiller, not prescribed to him).

271. The background information in the post mortem is incorrect. The man's name has been spelt incorrectly and there is also reference to his mother having died two weeks prior to his death. She had not died at this time. The background

statement says that the man was not routinely checked during the night. This statement is misleading. It is true that there were no extraordinary checks made on the man during the night, however there was no stipulated requirement for such checks to take place. He would have been checked routinely at the same time as other prisoners. The first check after he returned to his cell at midnight would have been at around 5.30am. The time of discovery and response is also incorrect. The man was found hanging at 7.25am and no attempt was made to resuscitate him as it was clear he had been dead for some time.

CONCLUSION

272. The man was clearly disturbed and damaged. However, while the man had a long history of self-harm and was subject to self-harm monitoring for much of his time in prison, staff and other prisoners had not thought he was at risk during the couple of months before his death (other than the one occasion when the counselling psychologist opened an ACCT). Indeed, his death came as a great shock to all staff and prisoners interviewed during this investigation. The PIT, his counsellor and wing staff all believed that the man had made progress and was no longer at risk of harming himself. If he had been identified as such, I am confident that an ACCT document could have been opened and necessary precautions taken (for example, placement in a safer cell or sharing with another prisoner).

273. Despite this, it is apparent that suicide and self-harm had always been an underlying concern for the man. During ACCT and mental health reviews, the man often spoke of his impulsivity and preoccupation with his suffering and own death. The drawing of a man hanging, found by the police, is an indication of this. However, whilst the man had attempted to kill himself on numerous occasions outside of prison, he made no serious attempt during custody until 30 October 2007.

274. The events immediately before the man's death remain unclear. Neither this, nor the police investigation, has established who the man feared was taking his money, or the extent of the trouble he may have been in with drugs and debt. Police enquiries have ruled out any malicious involvement on the other prisoner's part. It has not been possible to ascertain whether it was the stress of these events that caused the man to take his life, or if other factors played a part.

RECOMMENDATIONS AND HOUSEKEEPING

Healthcare

1. The Head of Healthcare should ensure that any decisions taken regarding psychological, psychiatric or counselling interventions are clearly recorded in the patient's medical record.

   The Prison Service has accepted this recommendation. A memorandum has been sent to all clinical staff reminding them of the importance of adhering to this practice consistently. I welcome this response.

2. The Head of Healthcare and the leader of the Prison In-Reach Team should ensure that any urgent referrals and prescription information provided by community doctors and mental health teams are recorded and processed immediately upon receipt.

   The Prison Service has accepted this recommendation. All medical records are held on the Electronic Patient Records System (EMIS) where they can be accessed by a member of the clinical team involved in a patient's care. Since the EMIS system was implemented, all such communications are scanned into the electronic medical record; the hard copy is reviewed by the duty doctor or the in-reach team for any action. I welcome this response.

ACCT

3. The Governor should remind staff that it is good practice for ACCT case reviews to be multidisciplinary and include key people who know the person at risk or are involved in his care. This is particularly important when a review results in the closure of an ACCT.

   The Prison Service has said since the man's death in October 2007, significant steps have been taken to improve the quality of ACCT reviews. Every person on an ACCT has a nominated case manager. ACCT reviews are held at appointed times rather than on an ad-hoc basis and most relevant departments have named members who attend reviews for specific wings. Case manager training emphasises that ACCT plans cannot be closed without the presence of a multi-disciplinary review and enhanced reviews are held for prisoners who are prolific in self-harm. I welcome this more structured and multi-disciplinary approach to conducting case reviews.

4. The Governor should remind staff that, when an ACCT is opened for a prisoner receiving mental health care, those providing the care must be kept informed. In particular, the Prison In-Reach Team should liaise with the Safer Prisons Team to determine ways of improving communication when opening and closing ACCT documents relating to prisoners under the care of the PIT.

   The Prison Service has accepted this recommendation. In accordance with the Prison Service Order 2700 (Suicide Prevention and Self-harm Management), all ACCT forms that are opened on a prisoner with suspected mental health

difficulties need to have a mental health screening within one hour of the form being opened. This protocol has been adopted by Wandsworth and is routinely followed. Any concerns are noted with a direct referral made to the Prison In-Reach Team. The Head of Safer Prisons and the Head of Crisis Counselling now have access to EMIS records, which allows for better communication and access to information relating to risk. I welcome the improved access to information and communication.

5. The Governor should remind staff that post-closure reviews must take place when an ACCT document is closed.

   The Prison Service has accepted this recommendation. Previously, there was not a specific protocol around the recording of post-closure reviews. The Safer Prisons Team has issued a Governor's Order which highlights the importance of a post-closure review and this system is now routinely built into the ACCT procedure. The new PSO 2700 stipulates that during a post-closure interview, the prisoner's CAREMAP needs to be consulted, and only when all items on the CAREMAP have been addressed, can the ACCT document be closed. The prisoner is also provided with a copy of his CAREMAP and given a booklet on coping strategies along with details of who he can contact should he begin to feel vulnerable. Case manager training emphasises this aspect of care and stringent audit procedures ensure that wings are complaint with this procedure. I welcome this more structured approach to post-closure reviews and ensuring that the individual's needs have been properly addressed.

6. I recommend that the Governor consider introducing interim visual checks for prisoners who are not on an open ACCT but who have required and received Listener or Samaritan support during evening or at night. The National Offender Manager Service (NOMS) Safer Custody and Offender Policy Group may also wish to consider issuing national advice.

   The Prison Service has not accepted this recommendation. Following a recommendation made to Wandsworth after a previous death in custody, a Governor's Order was issued stating that should a prisoner seek contact with Samaritans or Listeners at night, the wing staff need to have a conversation with the prisoner and assess their mood and mental state. The Prison Service response says that it is clear this procedure was followed in the man's case and that a member of staff was satisfied he was settled. If the staff member had concerns about a prisoner, the correct procedure would be to open an ACCT. I agree with this statement. The second officer was clear that he did not assess the man as being vulnerable or at risk when he returned to his cell after speaking to the Samaritans.

   The Safer Custody and Offender Policy Group (SCOP) of the National Offender Management Service (NOMS) do not consider that it would be appropriate to issue national instructions about visual checks on prisoners who have asked to see a Listener or speak to the Samaritans. SCOP say that prison staff would not know of all such prisoners and this may deter prisoners from speaking to a Listener or Samaritan. I appreciate that staff may not know of all such prisoners during the core day. However, they would be aware of any prisoner

seeking such contact during the night state. Staff would have to allow the prisoner to leave their cell or let a Listener enter. I understand the potential risk that prisoners may feel deterred from speaking to a Listener or the Samaritans if it is known that this will attract greater staff attention. Both services are intended to be wholly confidential and are accessible without question. All prisoners have the right to utilise the services without attracting further pressure.

If a member of staff has concerns about a prisoner (regardless of whether they have asked to speak to a Listener of Samaritans) they are required to use the ACCT process. The Prison Service are clear that this is the tool to be used for managing risk and if there are concerns about a prisoner the ACCT should be used. Under these circumstances I acknowledge the reluctance to apply further measures to observe and monitor prisoners is reasonable.

Housekeeping

7. The Governor should remind the Drug Strategy Group of the importance of maintaining comprehensive records of mandatory and voluntary drug tests.

The Prison Service has partially accepted this recommendation. Although comprehensive records of both mandatory and voluntary testing are kept, it would be good practice to remind the Drug Strategy Group staff of the reasons why such information is maintained and how it is used. This will be issued in April 2009.

Response to the draft report

The man's family responded to the draft report with a number of points for further clarification.

Mental health

The man's family are concerned about the level of psychiatric support he received in the months prior to his death. The PIT psychiatrist last saw the man in March 2007 and it seems the last time a junior doctor from the Prison In-reach Team (PIT) was on 18 June. In particular, the family are concerned that the consultant psychiatrist (The man's psychiatrist in the community) was not more involved in his care in custody. The family ask whether this reduction in contact was appropriate and whether the consultant psychiatrist should have been consulted on a regular basis.

The family continued to be concerned about the levels of medication the man received during his time in custody. His brother maintains that the man received higher levels of diazepam in the community and asks whether it was appropriate to reduce his medication without consulting his external healthcare professionals, specifically the consultant psychiatrist.

The Coroner has commissioned a third independent clinical review to provide a further opinion on the level of mental health care, including medication, which the man received whilst at Wandsworth. A forensic consultant psychiatrist will conduct this review. The findings of the third review will be presented at the inquest.

It was appropriate that the consultant psychiatrist was not more involved in the man's care whilst he was in custody. Whilst at Wandsworth, the man was under the care of the PIT and not his Community Mental Health Team (CMHT). The CMHT was correctly contacted at the beginning of his sentence to confirm diagnosis and any prescriptions. Whilst the man was in prison the consultant psychiatrist was not acting as his primary psychiatrist. Any contact with the man was out of kindness, because the consultant psychiatrist had been his doctor for many years, and in case preparations needed to be made for his release back into the community.

They have also asked whether the level of communication between members of the PIT, the man's counsellor (the counselling psychologist) and the man's Community Mental Health Team was appropriate and sufficient. In particular, the family have asked whether the counselling psychologist shared his counselling session notes with the PIT. My investigator has explained that the counselling psychologist's notes would not have been shared because counselling sessions are confidential. If any concerns arose during a session the counselling psychologist would have informed the PIT or wing staff. Indeed, when the counselling psychologist did consider the man to be vulnerable and at risk he opened an ACCT document and made staff aware of his concerns.

The family have asked the first PIT nurse to provide details of his qualifications and explain why he made a note to contact the consultant psychiatrist in the man's medical record on 14 August. The first PIT nurse now lives in Australia. He has been contacted by the Coroner and asked to provide a witness statement for the

inquest. Within this statement he has been asked to answer the family's questions. This will be read out during the inquest. My investigator did not have a copy of the first PIT nurse's statement at the time of finalising this report.

Suicide and self-harm

In their response to the draft report, the family have welcomed my recommendations on ACCT processes. In particular, the recommendation to introduce interim visual checks during the night for prisoners not on an open ACCT, but who have accessed the Listener service or a Samaritan. However, the man's family are concerned that my recommendations are not mandatory. I do agree that the recommendations should be mandatory, however the ACCT is currently undergoing a review process. Therefore I will feedback my findings and recommendations in this report separately to the Prison Service's Safer Custody and Offender Policy (SCOP) group, who are undertaking the review, for consideration and inclusion in the revised policy and procedures.

I made no recommendations about the need for greater supervision of prisoners with severe and long-term mental health problems within a prison setting. They consider the ACCT procedures alone to be insufficient to ensure the wellbeing of such prisoners, particularly when administered by prison officers. I do not think it is necessary to make such a recommendation because such prisoners do receive supervision above and beyond the ACCT process when they have mental health problems. Those with mental health needs are supported through the PIT, healthcare and counselling services, as required.

All disciplines of prison staff are trained and equipped to use ACCT. ACCT procedures and levels of supervision, observations and care plans are flexible, multi-disciplinary and are set according to need. I do not consider that any prisoner should be disadvantaged in being cared for by trained prison officers when correct procedures and guidance are followed. Even in closing an ACCT. I do not agree with the family's concerns that external doctors need to be consulted during case reviews or the closing of an ACCT. The area I am concerned about in the man's care is multi-disciplinary participation in the ACCT review process. I have made three recommendations about the importance of multi-disciplinary input in case reviews and ACCT closures where appropriate.

The man's family have asked me to consider making a recommendation that specific mental health professionals responsible for a prisoner's care are present at post-closure reviews. Guidance at Wandsworth now stipulates that member of the PIT should attend a post-closure review, but does not specify who should attend. I find this to be sufficient and do not agree there is a need for specific individuals to attend. This would not always be practicable, due to time constraints, absences and so on. Any member of the PIT attending a review will have the benefit of access to the prisoner's medical and mental health history, and therefore would be adequately prepared to provide informed and professional input.

Further concerns have been raised about the decision not to open an ACCT on 29 October. The man's family have said that clearer guidance should be provided to prison staff without formal mental health training on when to open an ACCT. They

ask that a policy be introduced for prison officers to open an ACCT as a matter of course if they have any concerns about a prisoner's wellbeing and where there is a history of mental health problems. Such guidance already exists in the current ACCT procedures. Where concerns are raised an ACCT is opened, however this is a matter of judgement call and is dependent on how the prisoner is presenting at the time. All staff are trained to open an ACCT and recognise signs of risk and vulnerability. This was the case even before ACCT was introduced and the Prison Service used the old self-harm and suicide monitoring procedures. In the man's case, it was deemed that opening an ACCT was not necessary that night. After speaking to the Samaritans at length, the man seemed calmer, not at risk or vulnerable. Had this not been the case the first officer told my investigator that he would have opened an ACCT.

Pegging system

The man's brother has asked for further details about the pegging system and whether if this had been working, he would have been discovered prior to 7.15am on 30 October. My investigator has confirmed that the pegging system was not working on the wing on the night of the man's death. However, if this system had been working, this does not mean that the man would have been seen more frequently. The pegging system is a means of electronically recording that a member of staff has patrolled a wing landing. There is no requirement for a visual check to be made during a patrol.
Visual checks are made during roll checks. The man was seen during the roll checks around 6am and 7am, before suspicions were arisen during a third roll check at 7.15am.

Contraband and debt

The man's brother is concerned that insufficient steps were taken to ascertain whether staff responded appropriately to security information reports (SIRs) received about his involvement in drugs and mobile phones within the prison. In particular, he is concerned that my investigator did not obtain or consider it necessary to review SIRs for all references to contraband within my report. This is not the case. My investigator asked for all security information to be provided. Where there are gaps in SIRs, this is due to the prison being unable to supply the documentation. During the course of this investigation security information has also been sources from other prison documentation (such as history sheets, wing observation books) or through interviews. My investigator has not commented on any evidence that could not be substantiated.

The man's brother has asked what steps were taken by staff in response to the following security incidents:

- The man's alleged involvement in an escape attempt (4 and 15 December 2006).
- Use of alcohol (7 March and 8 June 2007).
- Drugs (29 August 2007).
- Mobile phones (14 and 19 September 2007).

In relation to the suspected involvement in an escape, the Security Department informed the Public Protection Unit (PPU) at the prison and authorisation was given to monitor the man's telephone calls and mail. My investigator spoke to a senior officer in the Security Department at Wandsworth. He confirmed that the PPU initiated random monitoring of the man's telephone calls and letters because he had been implicated in an escape attempt. Later on, there were also concerns that he had been involved with trafficking contraband. The monitoring continued to see if the allegations could be substantiated. My investigator contacted the PPU for further information about the monitoring. She was told that this monitoring continued up until the man's death. This was reviewed periodically and continued due to a sufficient level of concern. No further information was made available regarding the monitoring.

Regarding the use of alcohol, the senior officer told my investigator that if a prisoner is found to have alcohol in their cell, and it is suspected they are responsible, the prisoner would be subject to adjudication. If there was not sufficient evidence to prove the prisoner was intoxicated then the matter would pass. The senior officer explained that prison staff do not have the means to breathalyse or conduct urine and blood tests for alcohol consumption. These are invasive tests and staff do not have the authority to enforce compliance. When the man was suspected of being intoxicated there was insufficient evidence to prove that he was, therefore he was not adjudicated.

A SIR was submitted on 29 August after the second officer smelt some sort of drug being smoked in the man's cell. He detected the smell during his patrol. After submitting the SIR it was suggested that a target search and a MDT take place. Similarly, a target search was suggested when the man was suspected of using a mobile phone in September. It is not clear from the man's history sheet whether either search took place, however appropriate action had been suggested by the Security Department on both occasions.

Single cell

The man's brother remains concerned that he was placed in a single cell. He believes that this move was unjustifiable given his brother's history of self-harm and suicide attempts. As previously explained in the report, the man was moved to a single cell when his risk of harm appeared significantly reduced. This move was assessed by staff and the man seemed happier and more settled once in a cell on his own. My investigator could find no evidence to suggest that the man needed to be moved back into a shared cell.