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

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

The man was 31 years old when he died in March 2010, in his cell at HMP Wandsworth. He was found hanging. Originally imprisoned in December 2002, he had been released on licence on 16 July 2007. However, he was deemed to have broken the conditions of his licence and was recalled to prison on 11 September. Since then he had been to a number of prisons before finally transferring to HMP Wandsworth on 19 October 2009. For the purpose of this report, I have concentrated in the main from the time when the man arrived at Wandsworth.

The investigator and Family Liaison Officer join me in offering our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of Wandsworth for making the necessary facilities and information available to the investigator. I also thank the prison Liaison Officer for his assistance.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment the man received in custody. A clinical reviewer was appointed by the Chief Executive for the Primary Care Trust to undertake a clinical review on my behalf. He has not made any recommendations.

I make four recommendations. All four recommendations relate to suicide prevention procedures at the prison. Although the issues identified had no direct bearing on the man's death, they are matters which require attention and include one matter regarding post closure reviews for ACCT documents which needed to be addressed urgently.

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

Jane Webb
Acting Deputy Prisons and Probation Ombudsman **November 2010**

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SUMMARY

The man was originally imprisoned on 20 December 2002 after being found guilty of a serious offence. He was sentenced to eight years imprisonment. In July 2007, he was released from prison on licence, but broke the conditions of that licence and was recalled to prison custody in September 2007.

On 19 October 2009, he was taken to HMP Wandsworth. He was allocated to the Onslow Unit (which holds vulnerable prisoners), which is where he lived until his death. In the meantime, arrangements were being made for him to be released in March 2010 to accommodation away from his original home area, something he said he was looking forward to.

The man had, on several occasions, been monitored by the Prison Service as a potential suicide or self harm risk. At the time of his death, he was not considered to be at risk and therefore he was not being monitored.

However, this investigation has identified a number of concerns regarding suicide and self harm procedures at Wandsworth. There is evidence of managers routinely not carrying out daily checks and of others not following written instructions. Additionally it has been identified that well embedded procedures have not been carried out. As a result I make four recommendations relating to those procedures, including one which, at the time of the investigation, required urgent attention.

THE INVESTIGATION PROCESS

1. When the Ombudsman's office was notified on 1 March 2010 of the man's death, the investigation was allocated to a senior investigator. He contacted the prison and arranged to open the investigation on 4 March.

2. On 4 March, the investigator met the prison liaison officer and Deputy Governor. Following the meeting, he went to the cell where the man had been found. He was able to view the inside of the cell and see where the ligature had been attached. After viewing the cell, he arranged to return at a later date to continue with the investigation.

3. Before leaving the prison, the investigator briefed a senior manager about the investigation process and the issues he had identified as the Governor was not available. He followed up the feedback in writing to the Governor.

4. On 29 March, the investigator returned to the prison to continue the investigation. On this occasion he carried out a number of interviews, some of which were informal, whilst others were recorded. Those recorded are attached as annexes to this report.

5. Two days later and before leaving the prison, the investigator met the Governor and Deputy Governor. At that meeting, he gave feedback on what he had identified at that stage, some of which he believed required urgent attention. He told the Governor that it was likely that there would be four recommendations in the draft report. The Governor welcomed the feedback and agreed to keep him informed of progress.

6. The Senior Family Liaison Officer spoke to the man's sister by telephone on 25 March. His sister explained that Wandsworth had been very supportive and described them as "brilliant". There has been no further contact prior to the issue of this report.

7. On 14 July, the clinical reviewer forwarded his clinical review to the investigator. The doctor did not make any recommendations.

8. The investigator left the Ombudsman's office in July 2010, having completed an initial draft version of this report. The report has been completed by an Assistant Ombudsman.

9. Following the issue of the draft report, a prisoner at Wandsworth approached another investigator to provide some further information about the man and several other prisoners. The prisoner said he had spoken to the man, who had told him that officers had picked on him. The Assistant Ombudsman asked the prisoner to provide more detail about his allegations, but, some two months later, the prisoner has still not provided this information. In the circumstances, I feel that I am not able to investigate further. However, I have sent a copy of the letter to the Coroner in case it will assist with his enquiries.

HMP WANDSWORTH

10. The prison is situated in South West London. Originally built in 1851, the prison has undergone extensive refurbishment and modernisation. It is the largest prison in the United Kingdom and provides accommodation for adult remand and sentenced males.

Her Majesty's Chief Inspector of Prisons

11. Her Majesty's Chief Inspector of Prisons reports on all prison establishments. Inspections are either announced in advance, which allows the prison being reported on to prepare for inspection, or unannounced, when the inspection team arrive with no prior warning.

12. In the introduction to her latest report on Wandsworth, following an announced inspection conducted in June 2009, the Chief Inspector made the following comment which is relevant to this investigation:

> "the suicide prevention policy, while comprehensive, focused on process rather than the specific needs of prisoners at the establishment … there were good support resources available for some prisoners at risk … but there were weaknesses in the assessment, care in custody and teamwork (ACCT) process".

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) made up of members of the public and their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

14. In their latest report covering the period June 2008/May 2009, the Board said:

> "It is very encouraging to be able to report that Wandsworth has continued upwards in performance improvement. There are significant improvements in a number of areas compared with last year and overall it is a better place than it was this time last year".

Under the heading "Suicide prevention", the Board said that, although much improved, the quality of ACCT recording remained variable. They also said the immediate action plans were not always completed within an hour of the ACCT being opened.

Prison officer grades

15. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

16. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

17. Principal Officers (POs) were the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

18. In addition to prison officers, there are a group of staff known as Operational Support Grades (OSGs). OSGs wear prison uniform and carry keys (but not cell keys) and do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example, the front gate to the prison. Additionally, they carry out night patrol duties. These duties often mean they have indirect contact with prisoners, which is limited to seeing and talking to them through a hatch in a cell door.

Prison Service Orders (PSO)

19. Prison Service Orders contain long term instructions which are intended to last for an indefinite period. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT monitoring requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the prisoner will be seen by a trained ACCT assessor and have a case review meeting, which is a multi disciplinary meeting. The meeting draws up a care and management plan, known as a Caremap, and a member of staff is nominated as the case manager. Wing managers are specifically trained to take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

Anti Ligature Knives

21. Staff in contact with prisoners are issued with specially designed knives to use in an emergency to remove a ligature. The knives have a concealed blade which is placed against a ligature and which can be pushed forward to cut it without harming the prisoner.

Emergency response codes

22. In the event of urgent medical assistance being required, a number of prisons have chosen to adopt codes to alert medical staff to particular incidents. The most common code used is code red and code blue, although some prisons have opted for code one and code two. At Wandsworth, “code one” is used to alert staff to incidents involving prisoners with breathing difficulties. This includes any prisoner found hanging.

23. In prisons where codes are used, healthcare departments have created emergency response bags which contain the necessary equipment to deal with the particular incident. This ensures that medical staff takes the correct emergency equipment with them and helps provide the necessary medical care as quickly as possible.

Police investigations of deaths in custody

24. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman’s investigators begin their own investigations.

Care team

25. Each prison has its own care team. Care team staff are drawn from all areas of the prison and trained specifically to help and support prison staff. Following any serious incident, they provide an invaluable role to any member of staff who requires support.

KEY EVENTS

26. The man was originally imprisoned on 20 December 2002. He had been found guilty of a serious sexual offence and was given an eight year prison sentence.

27. Due to the nature of his offence, he was monitored under the Multi Agency Public Protection Arrangements (MAPPA), which are designed to manage high risk offenders in the community. There are three levels of MAPPA and he was monitored under level three:

    - Level one MAPPA is normally managed by a single agency and is the lowest monitoring procedure available under the MAPPA system.

    - Anyone identified as falling into the level two heading would be managed by more than one agency, very often probation and the police, and possibly more if the circumstances warrant it.

    - Those subject to level three are considered as being the highest risk cases, where more than one agency will take responsible for the management of the person concerned.

28. In July 2007, the man was released from prison on licence (the licence sets out certain conditions that the prisoner must comply with, or risk being recalled to prison). He breached the conditions of that licence and, on 11 September, was taken back to prison to continue his original sentence.

29. From then on, the man remained in prison custody and as part of the normal sentence progression he went to a number of prisons. On 19 October 2009, he was taken from HMP Belmarsh, which is where he had been imprisoned while pending a transfer, to Wandsworth. When he arrived at Wandsworth he was allocated to Onslow Unit as a vulnerable prisoner because of the nature of his offence. (Vulnerable prisoners are often segregated from other prisoners for their own protection.)

30. The man's Offender Supervisor is based at the prison. One of her responsibilities was to act as the link between the prison and his Offender Supervisor in his home area. She told the investigator that as part of the preparation for the man's release from prison, which was scheduled to take place 19 March 2010, arrangements were in place for him to be housed at a Trust in another part of the country. The Trust offers specialised accommodation for ex offenders with mental health problems. She said the reason for allocating him to the Trust was because of a MAPPA condition which said he could not return to his home area.

31. During the informal meeting with the investigator, the Offender Supervisor said the man had been fully aware that he would be going to the Trust at the end of his sentence. She said he had been looking forward to going there and had

said he did not want to return to his home area. She added that he told her that his family would visit him at the Trust.

32. From what has been gleaned from his prison record, the man settled in well at Wandsworth and was employed as a wing cleaner, a job he enjoyed. The investigator has spoken to a number of people about him and they all describe him as a friendly man but "obsessed" with cleaning.

33. At 3.10pm on 31 December, Officer A opened an ACCT document as she was concerned about the man. In the concern and keep safe section of the form, the officer said he felt low and had attempted suicide several times in the past. She added that he had been emotional and unsure as to whether or not he would harm himself.

34. The document was passed to the wing manager who then completed the immediate action plan. Shortly after an ACCT assessment was carried out, followed by an "Action Following Assessment" review meeting.

35. In the case summary, the manager completing the section, SO A, said the man had a number of frustrations because of his OCD (obsessive compulsive disorder, an anxiety disorder often characterised by repetitive behaviour patterns). He also made a note that the man had been concerned about his mother's health. The SO recommended that a referral should be made to the prison in-reach team (the team providing mental health services in the prison), although he added that this was not urgent. The level of observation was set at three times during the day and hourly both at night and during the times he was locked in his cell.

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36. On 1 January, the first case review meeting was held. The case manager, SO B, was the chair of that meeting and the ACCT record shows that it was just him and the man who attended. The SO made a note that the man said he felt unsupported and that he had been hitting his head against a wall. He added that the man had "let out his aggression" and "felt better". However, there appeared to have been no exploration of why he was hitting his head, or whether any injury had resulted. The SO made an entry in the review that a member of the in-reach team should be invited to the next case review meeting. The level of observation remained unchanged.

37. Four days later, on 5 January, the second case review meeting took place. On this occasion, three members of prison staff, the man and a member of the in-reach team all attended the review.

38. The chair of the meeting, SO C, summarised the meeting. In the summary, the SO said the man had been upset about his mother's health. He also had a hospital appointment for a wrist injury which he wanted to ensure took place. It was further noted that he was keen to work and was possibly working too hard. The level of observation remained unchanged.

39. That day, despite the ACCT document being opened for six days, the first daily management check took place. The check sheet shows that the manager concerned had reminded prison staff that a photograph of the man still needed to be attached to the ACCT document.

40. It was a further three days before the next daily management check was carried out. Once again, it was noted by the manager that a photograph was required. Similar entries appear in the check sheets on 9 and 10 January.

41. On 11 January, the third case review meeting took place. On this occasion, the man and SO C attended along with the chair of the meeting, SO D. They agreed that the ACCT document should remain open. Once again, it was recommended that a member of in-reach be invited to the next meeting. There was no change to the level of observation.

42. The next entries on the daily management check sheet were 15 and 16 January. On both occasions the manager concerned has noted that a photograph of the man still needed to be added to the document. There are no further management checks recorded after 16 January and no photograph attached.

43. Eight days later, on 19 January, the final case review meeting took place. In addition to the case manager SO D and the man, there was a representative from the prison chaplaincy team, a crisis counsellor and a member of the prison CARATs team (CARATs - Counselling, Assessment, Referral, Advice and Throughcare services – provide substance misuse treatments in prisons). It was noted that his outlook appeared to have sufficiently improved for the meeting to agree the ACCT document could be closed. A post-closure interview was arranged for 26 January, but there are no records confirming that this took place.

44. On 11 February, the Offender Supervisor met with the man as part of her normal routine for prisoners who will soon be discharged from prison. At that meeting she explained the rules of the Trust and also the conditions of his release licence to him. She explained to him that, whilst at the Trust, he would only be allowed out of the building for three hours each day, and that he would be escorted at all times. She said he was unhappy about the restriction and had become tearful and angry. The meeting ended shortly afterwards.

45. At about 8.30pm, Officer B opened an ACCT document for the man. Under the heading “Concern and Keep Safe”, the officer wrote:

> “He made attempts to cut himself on the neck. He reckons that he is not being treated fairly by staff on the wing and probation staff as well, considering the work he puts in on the landing daily”.

[In the wing history sheet, Officer B wrote that “the man was standing in his cell with a razor blade in his hand. He made threats to cut himself in the neck. The razor was taken off him”].

46. Officer B told the investigator that after opening the ACCT document, he made an entry in the Wing Observation Book to alert staff that an ACCT had been opened. In addition he telephoned the prison control room to tell them the ACCT had been opened and obtained a log number [921/10]. After being given the log number, he telephoned a manager to explain what he had done and to pass on the log number. (I understand that whenever an ACCT document is opened at Wandsworth, the centre manager is informed. The reason for this is so that the manager can add the information to a daily briefing document, which is prepared for the Governor. There is no requirement for that manager to do anything other than record the information.)

47. Once Officer B had completed the telephone call, he left the prison, as it was the end of his working day. In response to the draft report, he has stated that, as standard, when he finishes a shift he hands over any ACCT documents to night staff.

48. The following morning, Officer C, one of the prison's ACCT assessors, interviewed the man. At interview he told the investigator that, the man had been "very upbeat" when he saw him and had said he was not going to hurt himself.

49. Whilst completing the assessment, the officer noticed that the "Immediate action plan" section had not been completed the previous evening. Realising that it was meant to have been completed within 60 minutes of the ACCT being opened, he completed it, after which he handed it over to a manager in preparation for a case review meeting to take place.

50. At interview Officer C said the man was not available to attend a case review meeting that morning, as he was attending a "job club" interview. The officer said the case review was arranged for the afternoon, but as he would be unavailable, he had spoken to SO B about the assessment. He said he told the SO that in his opinion the ACCT document did not need to be opened and that the SO should consider closing it. The officer said he had no concerns about the man's safety and no concerns when he later learned that the SO had closed the ACCT document.

51. At about 3.00pm, SO B carried out an ACCT case review, at which the man was present. At interview, the SO said that before holding the review, he had spoken that morning to Officer C about his assessment of the man. The SO confirmed that Officer C had told him that the man was unavailable to attend a review meeting that morning, as he was going to a "job club", but that he would be available in the afternoon. The SO said the officer told him that in his opinion, the man did not need to be monitored under ACCT and that the man wanted the document to be closed.

52. The investigator showed the SO the ACCT document and asked him why the conversation with Officer C had not been recorded as part of the case summary. The SO said it was a mistake on his part and that he should have made a note of what he had been told.

53. As part of the case review, SO B wrote a summary of his meeting with the man, after which he closed the ACCT document. He arranged a post closure interview for 16 February.

54. At interview, the SO told the investigator that once an ACCT document has been closed and a date arranged for the post closure interview to take place, it remains a live document. He said the normal routine is that the post closure date is entered into a prison computer system, which diaries the information and, on the scheduled date, it appears as a piece of work to do that day. However, he told the investigator that although he made a note in the ACCT document of the post closure date, he had not entered into the computer system.

55. In the meantime, the man had met his Field Offender Supervisor and Offender Supervisor. He mentioned his concern at the restriction placed on him relating to leaving the Trust, but at that time he was more concerned at not being able to carry his own money. The Offender Supervisor said the Field Offender Supervisor explained the reasons to him, which were to do with ensuring other residents could not take his money from him. He appeared to accept this. The man was told that he would be taken to another prison and from there he would then be taken to the Trust. She said he was happy with the arrangements.

56. Operational Support Grade (OSG) A told the investigator that she had met the man on a number of occasions. She described him as always being friendly and that he would often speak to her about his mother. She remembered him telling her that he was due to be released and that he would be going to Lancashire. He told her that he was not going to return to his home area in Kent and that he was looking forward and excited about making a fresh start in a new area.

57. The following day, the man spoke to his Offender Supervisor again. She said that on this occasion he was “worrying” about not being allowed to have his mobile telephone whilst at the Trust. She said this and other conditions had been explained to him during the meeting about the rules in place at the Trust and that he understood what was required.

58. On 25 February, OSG A was in the Onslow Unit. During an informal meeting with the investigator she said the man had noticed her and had then run towards her. She said he grabbed her hand and said he wanted to say goodbye and that she thought he must have been told he was moving. The OSG said she did not have any concerns about him and described him at being very happy at that time.

1 March

59. At about 8.15am, the Offender Supervisor was in the Onslow Unit and had spoken to the man. She said the conversation was a general chat with him. She remembered asking him how he was and him saying he had felt better, but had not explored what he meant. The investigator asked her whether she had been concerned about the man's safety. She said that she was not.

60. Shortly after speaking to the Offender Supervisor, the man collected his medication from the Onslow Unit dispensary. Registered General Nurse (RGN) A told the investigator that she had given him his ibuprofen (it is unclear from the records why he had been prescribed ibuprofen) and that he appeared fine. She said she had no concerns about him.

61. At the time of this investigation, and due to the lack of available cells in the main prison, a number of cells on the Onslow Unit were being used to temporarily hold some prisoners from the main prison overnight. To ensure vulnerable prisoners were not at risk from the other prisoners, they would be temporarily locked up whilst the relocated prisoners moved from the unit into the main prison.

62. At about 8.40am and because prisoners from the main wing were moving out of their temporary cells on the Onslow Unit, the vulnerable prisoners were locked up for a short while. Officer D was one of the officers locking prisoners up to allow the movement to take place. At interview, she told the investigator that when she went to the man's cell he questioned why he was being locked up. She said he was upset and had told her that on the previous day he had been warned by an officer about pressing his in cell emergency call button. She said that after assuring him that he was not in any trouble he smiled at her. The officer told him he would be unlocked once the other prisoners had left the wing. The investigator asked the officer if she had any concerns at that stage about his safety. She said that she did not.

63. Once the relocated prisoners had left the Onslow Unit, wing officers began to unlock the remaining prisoners to allow them to leave their cells. At about 9.30am, Officer D looked into the man's cell through the door observation panel to ensure she would not hit him with the door when she opened it. When she looked inside the officer saw him hanging by a ligature which had been attached to the cell window bars. She told the investigator that his feet were on the ground and that his body was slumped forward. The officer said she immediately went into the cell and attempted to lift him up as she wanted to take the pressure off of his neck. Unable to lift him, she shouted for assistance.

64. Officer D said Officer E was the first person to arrive and that he had used his whistle to alert other staff that assistance was required. Officer E went into the cell and whilst he lifted the man, she used her anti ligature knife to cut the ligature just below where it had been attached to the bars. Having cut the ligature they laid him onto the cell floor. As they did so, Officer F arrived and

when he went into the cell he saw that the ligature was still around the man's neck. Using his own anti ligature knife, he cut it away.

65. Once the man was on the floor, Officer D checked for signs of life, but did not detect any. She said his skin colour was blue and so she began chest compressions. At the same time, SO A, who had also arrived, began mouth to mouth breathing.

66. In the meantime, Officer F left the cell and, using his prison radio, asked for urgent medical assistance. Although there is a radio code to be used in this situation (code one), he could not remember if he had used it or simply asked for assistance. He said that soon after asking for medical assistance, healthcare staff arrived and took over from Officer D and SO A.

67. At the time when the whistle was blown, RGN A was in the Onslow Unit. She told the investigator that she heard the whistle and, although she was not sure why it had been blown, she went to offer assistance. She said an officer shouted to her telling her that it was the man and that he had no pulse.

68. When RGN A arrived at the man's cell, she saw him on the floor with two officers carrying out CPR. The nurse said she went into the cell and checked for signs of life, but did not detect any. She said his lips were blue and his skin colour pale. She asked for additional medical assistance after which she assisted with cardio pulmonary resuscitation (CPR) by taking over the chest compressions from Officer D. The nurse told the investigator that CPR was carried out at a rate of 30 chest compressions to two breaths.

69. In response to her request for additional medical assistance, another nurse and Doctor A arrived. They had responded to the first radio message and had taken emergency medical equipment including oxygen and a defibrillator to the man's cell. (A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer.)

70. Doctor A told the investigator that when he arrived at the cell, RGN A and an officer were carrying out CPR. He said the man's skin colour was pale and blue. The doctor said he took over mouth to mouth resuscitation and that CPR continued for a further 15 minutes. He said that although the defibrillator pads had been attached to the man's chest, it had not advised shocking him, which he said meant there was no cardiac output.

71. At 9.45am, the doctor checked the man's condition. He said the pupils were dilated and fixed and there was no pulse. At that point he stopped any further attempt to resuscitate him and pronounced him dead.

72. The doctor said that once he had pronounced death, he and the nurses left the cell. He said he met a paramedic who had arrived in response to an emergency call and told him the man had died. He said the paramedic then left the prison.

Following the man's death

73. After it had been confirmed that the man had died, the prison's Family Liaison Officer travelled to the man's home town to break the news to his family. When he arrived there was no one in and so he telephoned the man's father who at that time was at work. Unfortunately he had to break the sad news over the telephone, after which the man's parents returned home to meet him

74. I understand the man's parents asked the Prison Chaplain to carry out the funeral service for their son. Additionally the prison offered assistance with funeral costs and offered them the opportunity of visiting the prison, something they decided they did not want to do at that time. At the request of the man's parents, the prison's Family Liaison Officer was asked to contact their daughter in the first instance.

75. On 29 March, after speaking to the man's sister the previous week, the Ombudsman's Family Liaison Officer wrote to her summarising their conversation. In that letter the Liaison Officer said she had been told by the man's sister that the prison hade been "brilliant and extremely supportive" and that her brother had kept in regular contact and had been helpful. The Family Liaison Officer also noted that his property had been returned to his family.

76. In addition the man's parents had said they had received a letter from the prison which described their son as hardworking and polite, which they had found comforting. The Family Liaison Officer said the man's parents had spoken highly of the help and support provided by the Prison Service.

77. During the conversation with the Family Liaison Officer, the man's sister told her that her brother had telephoned his parents on three occasions the week before his death, which she said was unusual. However, although this was unusual, she said he had given no indication that anything was wrong. She said he told his parents he loved them and that he was looking forward to being released and that he had given up smoking.

78. I understand that all prisoners who were being monitored under the ACCT procedure were reviewed. This is normal practice and done to ensure they are properly supported following a death. In addition, prison staff received support from the prison care team and their own line managers.

ISSUES

Assessment Care in Custody and Teamwork (ACCT)

Immediate action plan

79. Once an ACCT document has been opened, and the concern and keep safe section completed, the next action is for the unit manager to complete the immediate action plan section. As a reminder, and at the beginning of the immediate action plan, the following mandatory instructions tell the manager completing the form what to do:

> "The immediate action plan should be done by the unit manager immediately following concerns and keep safe have been raised. This plan must be in place within 60 minutes.
>
> "The purpose of this immediate action plan is to keep the vulnerable prisoner safe until a full assessment of the prisoner's risks has been made, then reviewed in "Action Following Assessment", and CAREMAP has been started".

80. The Governor at Wandsworth also issued a revised local "Suicide Prevention Policy Strategy Document" in September 2009. At section nine of that document, the Governor stressed by writing the following in bold letters:

> "The immediate action plan needs to be put in place within one hour of the ACCT plan being open ... "

81. On this occasion and contrary to both the ACCT instructions and local policy document, the immediate action plan was not completed on 11 February, but on the following morning, some 12 hours later. It was completed by Officer C after he realised during the ACCT assessment that it had not been done the previous evening.

82. The ACCT procedure is a long established, well embedded system throughout the prison estate and helps provide a level of care which might otherwise not be made available. Considering it is not a newly introduced procedure, there is no excuse in my mind for basic failures such as the one identified here.

The Governor should carry out a review of ACCT procedures and satisfy himself that the systems are robust and in line with PSO 2700 and his own local policy.

Case review

83. On 12 February, SO B chaired an ACCT case review meeting, at which the man was also present. It is clear from the interviews with the SO and Officer C that the SO had spoken to the officer that morning about the man. Also clear is that the SO did not record his conversation with Officer C in the ACCT case manager summary.

84. I have considered carefully the actions of SO B. I am satisfied that he had spoken to the ACCT assessor, Officer C, in an effort to gain as much information as possible for the case review meeting. He recognises that he should have recorded that conversation in the ACCT summary and had made a mistake by not doing so. I am concerned, however, that ACCT documents are sometimes closed by an officer by themselves, and that on this occasion a Care Review Team approach (in which more than one officer, or representatives from other disciplines within the prison) was not taken.

Post closure interviews

85. Following the closure of the ACCT document opened 31 December 2009 (the ACCT was closed on 19 January), a post closure interview was scheduled to take place on 26 January. It is clear from the ACCT document and wing computer system that it had been entered into the diary. However, there is no evidence, either on the computer or within the ACCT document, to show that the post closure review took place.

86. After taking the decision to close the ACCT opened on 11 February, SO B's next action was to arrange a post closure interview. Although he wrote into the ACCT document that he had arranged for the post closure interview to take place on 16 February, he failed to enter the information into the wing computer system. This meant that there was no electronic record of the review for the man which is why the post closure interview did not take place.

87. SO B is an experienced manager. He recognises that this was a serious error and that he should have ensured the proper arrangements were in place to protect the man.

88. I accept that, after the ACCT document was closed, the man did not end his life immediately, but it is disappointing that the correct processes were not followed to ensure the post closure review was completed. It concerns me that on at least two occasions there is evidence to show that post closure interviews were not held.

89. Clearly there is a problem which requires urgent remedial action to be taken. Having identified the problem on 30 March, the investigator raised the matter with the Onslow Unit Senior Manager and Unit Manager that day. They accepted the finding.

    The Governor should review and consider what action to take in relation to the management of the man's ACCT documents whilst at Wandsworth.

Daily management checks

90. When an ACCT is opened, a "Management Quality Assurance Sheet" is attached. Section one of the sheet is titled "Daily Wing Manager Check". The sheet lists certain quality checks that must be made. One of the checks is to ensure that a photograph has been attached to the front cover, and another

which states that a “Wing manager to quality assure all ACCT documents daily”. Additionally it adds that the manager should note deficiencies and rectify any deficiencies “immediately”.

91. The quality assurance sheet on the ACCT opened on 31 December shows that management checks were not being carried out on a daily basis. There were also numerous requests for a photograph to be attached, but these were acted upon.

92. A new ACCT document has since been introduced into the prison. Section J/K of the document is titled “Senior Officer’s Daily Management Check”. It follows similar lines to the previous document in that it is a daily check, but covers a number of key areas in greater detail including identifying whether previous deficiencies have been rectified.

93. In addition to the daily wing management checks there is now a weekly check of all open ACCT documents carried out by a member of the senior management team. Section L has ten sections which are then broken down into specific action points. One of the actions is that the senior manager should check and confirm the daily management checks are being carried out.

94. As part of this investigation, on 31 March, the investigator examined two open ACCT documents for prisoners who were living in the Onslow Unit. One of the documents had been open for 19 days. During that period, there had been 11 daily checks and each requested that a photograph should be attached. Additionally there had been one senior management check. At that check there was no mention of daily management checks not being carried out, but it had been noted that a photograph was required.

95. The second ACCT document that the investigator examined had been open for nine days. During that time there had been four daily management checks and one senior management check. The senior manager had not commented on the lack of daily checks.

96. From the evidence, there appears to be a lack of management accountability and poor quality control. It is evident that instructions and guidance are available, but are seemingly being ignored. It is important that the ACCT procedure is robustly managed and that all staff do what is required. Deficiencies need to be dealt with promptly and anyone not carrying out the required piece of work challenged. In the two random checks, and in the case of the man, there is evidence of a lack of management control which must be rectified. If there is to be confidence in the ACCT procedure at Wandsworth, there has to be strong management control.

The Governor must satisfy himself that the ACCT procedures at Wandsworth are being effectively monitored and robustly managed. The Governor should consider how best to quality control and audit the ACCT procedure.

Family support

97. I have been pleased to learn how much the man's family appreciated the support received from the family liaison officer. As can be appreciated, it is a difficult role and not one that can be given to anyone to do. The value of having proper family support in place is self evident.

98. Prisons and prison staff do not always receive the credit for what they do. It is clear from the family that they appreciated the help and support they received from the prison. A simple letter of condolence containing a few details about their son's behaviour in prison meant a lot to them and gave comfort at a very difficult time. Although I make no formal recommendation, I invite the Governor to share my comments with his staff and to thank them for the care and kindness shown to the family.

Clinical review

99. In his clinical review, the clinical reviewer has summarised his findings regarding the man's medical history. He has not made any recommendations.

100. The clinical reviewer said that the man's medical notes show that he had previously suffered a scaphoid fracture (the scaphoid is a small bone in the wrist). He said the injury had failed to heal and as a result he was awaiting surgery to repair the damage.

101. The man told prison staff that he was suffering from Obsessive Compulsive Disorder (OCD). The clinical reviewer was asked to comment on the condition and its effect on him. In his report, the doctor said there is no evidence in the medical notes of any formal diagnosis having ever being made. However, he adds that whilst at HMP Rye Hill, which is one of the prisons he had been to, he had been reviewed by both a psychiatric registrar and a psychologist. The reviewer said the registrar felt OCD was in fact a self diagnosis by the man. He adds the psychologist had suggested he had a personality disorder. The reviewer went on to say the medical notes show there had been some discussion as to whether or not he had some degree of learning difficulty. It was thought that it may have been brought on following a head injury as a child. However, he said that this was never confirmed.

102. The clinical reviewer said that throughout his time in prison, the man's mood had been variable and volatile and that his history of harming himself was an ongoing pattern of behaviour. That behaviour led to him being monitored under the ACCT procedure.

103. The clinical reviewer said it was clear from the man's medical notes that when he died on 1 March, his pupils were fixed and dilated and there was no shockable rhythm detected by the defibrillator. This suggests that there was little chance that he would be successfully resuscitated when he was found.

Emergency response

104. When Officer D called for assistance on finding the man, she received immediate help from Officer E. He then summoned further assistance by using his whistle. Officer F attended and, after cutting the ligature from the man's neck, radioed for medical assistance.

105. Although Officer F cannot remember clearly whether the used the term "Code 1" when alerting staff to the emergency, it is clear that staff responded quickly. I am therefore satisfied that he gave appropriate information to his colleagues. While I do not make a recommendation on this issue, however, the Governor might wish to remind staff of the relevant codes for use in emergency situations.

106. The doctor also attended promptly and, after attempting CPR for 15 minutes and using a defibrillator, he pronounced that the man had died. At this point, paramedics arrived. It is unclear when they were called and by who, although it is likely that this happened after Officer F's radio message, and I would suggest that the Governor might wish to assure himself that an ambulance was called immediately. However, given that the doctor and other healthcare staff attended very quickly, and with the correct equipment, I am satisfied that the emergency response was appropriate.

CONCLUSION

107. The man was recalled to prison and arrangements were in place for him to live at the Trust once he was released. The evidence suggests he was looking forward to moving to the Trust and making a fresh start. That said he was concerned about the requirement for him to be accompanied outside of the premises. Whether he fully understood the reason for the restriction is not known, but from the evidence provided, he did.

108. His family have told me that he telephoned them on a number of occasions. At no stage were they concerned about his welfare.

109. I am satisfied that he was settled at Wandsworth and that he had engaged with prison staff and that they had engaged with him. He was approaching his release date and so what made him take the decision to end his life is not known. It may have been an impulsive act but that would be speculation.

110. It concerns me to learn of the failings in the ACCT procedure. It is a well embedded procedure and in my mind there is no excuse for some of the poor practices found during this investigation. I am satisfied that none of the findings contributed directly to his death. However, they are matters which require remedying quickly and which the Governor will wish to satisfy himself have been properly dealt with.

RECOMMENDATIONS

1. The Governor should carry out a review of the ACCT procedures and satisfy himself that the systems are robust and in line with PSO 2700 and his own local policy.

2. The Governor should consider and review what action to take in relation to the management of the man's ACCT documents whilst at Wandsworth.

3. The Governor must satisfy himself that the ACCT procedures at Wandsworth are being effectively monitored and robustly managed.

4. The Governor should consider how best to quality control and audit the ACCT procedure.