



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at
HMP Wandsworth in June 2014**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Wandsworth in June 2014, just a few hours after arriving at the prison. He was 20 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Wandsworth was undertaken. Staff at Wandsworth co-operated fully with the investigation.

The man was remanded in custody in June and arrived at Wandsworth that afternoon. He moved through the reception process relatively quickly and, by 6.00pm, was locked in a cell on his own for the evening. Shortly after 9.30pm, a member of staff found him hanging.

I am concerned that reception and first night staff did not adequately identify the man's known risk factors (including his age, alleged offence and that this was his first time in prison), which should have resulted in him being managed under suicide and self-harm prevention procedures. Instead, staff relied on his physical presentation and his polite manner to conclude that he did not intend to harm himself.

While staff did identify the man as vulnerable to attack by other prisoners because of the nature of his alleged offence, this actually worsened his first night experience. As a result he spent the evening isolated in a cell by himself, unable even to call his family. Arriving at prison for the first time can be a particularly daunting experience and Wandsworth needs to ensure that all new prisoners are appropriately supported on their first night – a time of heightened vulnerability.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. On 11 June 2014, the police arrested and charged the man with rape. He appeared at Magistrates' Court. Court custody staff told us that he was quiet and polite and they identified no risk of suicide or self-harm.
2. The court remanded the man to prison and he arrived at HMP Wandsworth at around 2.55pm. Although he had a number of risk factors for suicide and self-harm, for example that it was his first experience of prison, his age and the nature of his offence, prison staff did not regard him as at risk of suicide and self-harm when he arrived at the prison.
3. The man declined vulnerable prisoner status (which would have meant that he was separated from the general prison population because of the nature of his offence) when reception staff suggested this. He later changed his mind. Prison staff in the prison's first night centre, said that they thought he did not initially understand what it meant and the implications.
4. When he agreed to be kept apart from the general population as a vulnerable prisoner, the man was no longer allowed to associate with the other prisoners in the first night centre. This meant that he spent the evening locked in a cell on his own, while other newly-arrived prisoners were able to mix with each other. Officers did not allow him to make a telephone call to his family as they believed, incorrectly, that public protection procedures prevented this. They did not offer to call his family on his behalf, as they could have done under national Prison Service instructions.
5. At 9.37pm, a member of staff conducting a roll check, found the man hanging in his cell. She immediately radioed for emergency help. An officer began cardiopulmonary resuscitation and nurses took over, although they reported some initial problems using some of the resuscitation equipment. Ambulance staff took him to hospital, but hospital staff pronounced him dead shortly after they arrived. The police broke the news of his death to his family, rather than a member of prison staff as national instructions recommend.
6. The investigation found that prison staff should have identified that the man was at risk of suicide and self-harm when he arrived and begun suicide and self-harm prevention procedures. Staff placed too much reliance on his personal presentation rather than the known risk factors. We do not consider that he was sufficiently well supported when he arrived and he should have been allowed to speak to his family. There is a need to ensure that emergency equipment is checked regularly and that arrangements to inform families and support staff after a death are in line with national requirements. We make six recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and inviting anyone who had relevant information to contact him. One prisoner responded.
8. Another investigator went to Wandsworth on 18 June 2014 and visited the first night centre and the man's cell. She met the Governor, the prison's family liaison officer and a member of the prison's Independent Monitoring Board. She obtained a copy of his prison records.
9. The investigator interviewed 13 members of staff and a prisoner at Wandsworth between July and September. During his first visit, he went to the prison's reception area and the first night centre and saw the cell where the man had died. He viewed closed circuit television (CCTV) coverage of the time that he spent in the first night centre.
10. The investigator interviewed nine members of staff at Wimbledon Magistrates' Court.
11. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. The clinical reviewer joined the investigator for interviews with prison healthcare staff.
12. We informed HM Coroner for Inner West London of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. On 1 July 2014, one of the Ombudsman's family liaison officers contacted the man's brother, who represented his parents. He did not identify any specific issues for the investigation to address.
14. The family received a copy of the draft report. They did not make any comments.

HMP WANDSWORTH

15. HMP Wandsworth is a local prison in London which holds over 1,250 men. Since January 2014, the prison has held remanded young adults aged 18-20. St George's Healthcare Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons last inspected Wandsworth in May and June 2013. Inspectors found that reception procedures for new prisoners were swift but process-driven and lacked meaningful engagement. However, they reported that new arrivals received a good quality first night risk interview and that staff handover arrangements and care during the first night were good.
17. Inspectors also reported that the numbers of self-harm incidents had reduced significantly and that prisoners who were subject to ACCT procedures were well supported with appropriate consideration given to their individual circumstances.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its latest published annual report, for the year ending May 2013, the IMB noted that Wandsworth received 11,000 new prisoners during the year. They said that reception officers were more welcoming than previously and that the quality of information for prisoners in the reception area had improved significantly. The IMB reported that induction procedures had improved, although they were concerned that some vulnerable prisoners experienced delays.
19. The IMB noted that that prison staff were proactive in opening ACCTs when they identified a prisoner was vulnerable. They reported that there were delays getting ambulances into the prison and sought assurances that robust procedures would be implemented to improve this.

Previous deaths at HMP Wandsworth

20. The man was the second of four prisoners apparently to have taken their own lives at Wandsworth between March and September 2014. There had been no other self-inflicted deaths at the prison in the previous three years. Our investigations into other deaths at the prison have identified a need to improve local emergency response procedures.

Assessment, Care in Custody and Teamwork (ACCT)

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that prison staff might take to reduce this and the extent to which staff

need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multi-disciplinary reviews and should not close the ACCT plan until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

22. At around 9.15am on 11 June 2014, the Metropolitan Police arrested the man in connection with a serious sexual offence that had occurred the previous weekend. He was 20 years old and had no previous criminal convictions. He was born and raised in Sri Lanka and reports suggest that he had lived in the United Kingdom for around one to two years. All prison and court staff we spoke to said that he spoke and understood English well.
23. The man arrived at a police station at 9.52am on 11 June and the police completed a risk assessment shortly afterwards. They did not identify any physical or mental health issues and he said he had never tried to harm himself. When asked how he was feeling at the time, he said that he wanted to go home and look after his mother. He spent the rest of the day in police custody.
24. The police charged the man with an offence of rape and he appeared at Wimbledon Magistrates' Court on 12 June. A Person Escort Record (PER) accompanies prisoners on all journeys to communicate information, including about risk factors. The police did not identify any risk of suicide or self-harm on the escort record. He arrived at the court at around 8.40am and spent the morning in the court cells. A Prisoner Custody Officer (PCO) was working in the cells area that morning and told us that the man was quiet, polite and raised no issues. Another PCO was also a cells officer that morning. She said that the man engaged appropriately and nothing about him stood out.
25. Later in the morning, a PCO realised that the man was charged with a serious sexual offence and arranged with the deputy court custody manager to move him to a single cell. The PCO told us that he appeared to be getting on well with the person he was sharing a cell with, but she thought she should move him for his own protection, because his alleged offence might make him vulnerable to attack from other prisoners.
26. The man appeared in court at around 12.00pm and the court remanded him to prison custody. He waited in the court cells before leaving for HMP Wandsworth at around 2.00pm. Court staff did not identify him as a risk of suicide or self-harm on the escort record.
27. Staff arranged to get the man's parents' telephone number from his mobile phone (which the police had held as evidence) and gave it to his solicitor to pass to him. His solicitor told us that she met the man for the first time on 12 June. She said that he was quiet but upset and the main thing he said to her was that he wanted to go home to his mother. She told us that she did not think that the man would harm himself. The man's solicitor said that she had told court staff that he was very upset about being remanded, had not been in prison before, and wanted to go home. Only two of the staff who worked in the court cells area on 12 June remembered speaking to the man's solicitor. One said that she could not recall the solicitor saying anything about him being upset.

28. A PCO worked on the van that took the man to Wandsworth. He told us that, before he got on the van, the man's solicitor had told him that the man wanted to telephone his mother. The PCO said that the man was very quiet on the van and said he was fine. The man told him that he wanted to speak to his mother and asked when he would be able to see her. The PCO told him that he would get a phone call at the prison and they would explain how he could arrange visits.
29. The man arrived at Wandsworth at around 2.55pm and waited initially in a holding room. Reception staff checked and recorded his property with him. The PCO told us that he identified the man to the desk officer as he was required to highlight any potential vulnerable prisoners (those who might need to be kept separate from the general prison population for their own protection due to the nature of their offence).
30. The duty supervising officer, an SO, then interviewed the man. Because of the charge he was facing, he offered the man vulnerable prisoner status, but he declined. The SO told us that he did not recall the man and could not therefore say why he did not want to be held separately from the general population. The PCO confirmed that he had overheard the SO suggest this to the man two or three times and advise him to speak to an officer if he changed his mind. Neither the SO nor the man signed the form which potentially vulnerable prisoners are required to complete to confirm whether or not they want to be held separately.
31. The SO did not open an ACCT document. He speculated that this was because the man had not come from court with a suicide and self-harm warning form and that it was likely that he appeared well when he spoke to him. The SO did not consider whether he had any other risk factors which increased the likelihood of suicide and self-harm.
32. Reception staff then searched the man before a prison nurse carried out a routine health screen. He did not identify any physical or mental health issues. The nurse noted that the man was calm and polite and said he had no thoughts of harming himself. The nurse had no concerns about the man and did not open an ACCT document.
33. At 3.37pm, the man arrived on E wing, the prison's first night centre. A table and chairs are set out on the landing so that new prisoners can sit and talk when they arrive. CCTV coverage shows that the man spent most of the next two hours sitting at the table, occasionally speaking with other new prisoners or Insiders (experienced prisoners who work in the first night centre to give advice to new prisoners and answer questions). At around 4.50pm, he collected and ate a meal.
34. A prisoner who lived on the landing above the first night centre told us that he had looked down from his landing during the afternoon and noticed the man. He said that the man looked "stressed out", was sitting by himself and seemed upset.

35. At around 5.40pm, two officers interviewed the man as part of the first night induction procedures. Officer A led the interview, while Officer B made notes on the prison's computer system. The purpose of the interview was to complete the cell sharing risk assessment (CSRA, to determine whether there are any risks involved in the prisoner sharing a cell), to assess any risk of suicide or self-harm, and to explain various prison rules and regulations. Officer A told us that the man stood out because he was particularly polite and very well presented. He said that the man had a calm demeanour and he did not therefore think he needed to open an ACCT document. He spoke to the man about vulnerable prisoner status and told us that he thought that the man had not understood what this meant when he had declined it in reception. He persuaded the man that it was in his best interests and he signed the application form.
36. After this interview, an SO spoke to the man in the wing office. He gave him a wash kit and smokers' pack (tobacco, cigarette papers and matches) and recorded various basic details. The duty SO normally gives new prisoners a personal identification number (PIN) and initial credit to use the prison telephone system. The SO told us that, because of the nature of his offence, the man's telephone numbers had to be cleared by the prison's public protection unit before he could use the telephone, a process which takes up to 48 hours. (Wandsworth's local public protection policy does not specify which prisoners should have their telephone numbers checked before they are permitted to make a call.)
37. As a result, the man was unable to make a telephone call to his family on his first night in prison. The SO told us that the man said this was fine and he would call his family the next day. The SO said that there was nothing about the man's demeanour that differentiated him from most other new prisoners. The SO did not consider the man was at risk of suicide or self-harm so did not open an ACCT document.
38. As the man had agreed to be kept separately as a vulnerable prisoner, he was now unable to mix with prisoners from the general population and could share a cell only with other vulnerable prisoners. As a young adult he was also unable to share with an adult prisoner (age 21 and over). There were no other new prisoners who met the criteria to share with him, so he was allocated to a double cell, E2-24, on his own. As he could no longer associate with the other prisoners on the landing, an officer took the man straight to his cell and locked him in. This was at 5.57pm. The cell was next to the Insiders' desk and a table where other prisoners were associating.
39. Shortly afterwards an officer spoke to the man at his cell door. The man asked if he could have a shower. The officer told him that this was not possible at the time, because he was a vulnerable prisoner and could not come out of his cell while the rest of the prisoners on the landing were unlocked. She told the man that he would be able to have a shower the next day when he moved to the vulnerable prisoners' unit. The officer told us that he appeared to be satisfied with this.

40. CCTV footage shows that an officer spoke to the man at his cell door at 7.22pm, the last person to do so. We do not know what this was about as the officer told us that she did not recall the man and did not remember speaking to him.
41. At around 9.35pm, the night patrol officer, an operational support grade (OSG), began a roll count to check all prisoners were present in their cells in the first night centre. She arrived at the man's cell at 9.37pm. When she looked through the door observation panel, she saw him hanging from a ligature made from a television electrical lead, tied to the bed frame. She immediately radioed a 'code one' emergency call for help. The prison's control room then requested an emergency ambulance, in line with local and national policy.
42. An SO ran to assist and he unlocked the man's door 20 seconds after the OSG had arrived at the cell. While he unlocked the door, the OSG got her anti-ligature knife ready and passed it to the SO to cut the lead from around the man's neck. The SO said that he did not find any signs that the man was breathing. He laid him on his back and began cardiopulmonary resuscitation (CPR).
43. There were two duty response nurses on duty. When they heard the call for assistance, Nurse A went straight to the cell and Nurse B collected the emergency bag (which contained equipment such as a defibrillator and an oxygen cylinder). Nurse A arrived at the cell 25 seconds after the door was unlocked, followed around 40 seconds later by Nurse B. The night orderly officer (the person in charge of the prison at night) arrived around the same time and assisted the SO with the resuscitation attempt.
44. Nurse B applied the portable oxygen cylinder, but told us that there was initially a problem with the flow rate, which he corrected. The night orderly officer told us that he had noticed that the bag was not inflating correctly when he took over chest compressions. The nurse told him that the valve was faulty, but he told us that he thought it had not been switched on. The nurse said initially he had some difficulty applying the defibrillator pads, as he was unfamiliar with the model. When the pads were applied, the defibrillator delivered a single shock, after that it advised no further shocks.
45. The ambulance arrived at the prison at 9.49pm. However, the prison's vehicle gates were jammed and prison staff had to escort the ambulance crew on foot to the first night centre. They arrived at the cell at 9.57pm and took over emergency treatment. At 10.28pm, they took the man to the ambulance, which prison staff had now driven into the prison. The ambulance took him to hospital, but doctors pronounced him dead at 10.49pm, shortly after he arrived.
46. The man had left a note in his sock written in Tamil and addressed to his family. In the note he said that he had made a difficult decision and asked for their forgiveness.

47. At around 11.30pm, the night orderly officer informed one of the prison's family liaison officers of the man's death. (The prison family liaison officer is Head of Operations at Wandsworth.) He was concerned about going to an unknown area at that time of night and said that the night orderly officer agreed to pass his concerns on to the duty governor. The duty governor said that, as the family liaison officer was unavailable, he was concerned about how quickly the news of the death could be broken and, when the police offered to do this, he agreed that this was the quickest means available. A police officer visited the man's family at around 2.20am. At around 10.30am, the family liaison officer met several members of the family at the hospital.
48. The night orderly officer held a short debrief after the man's death. Most staff we spoke to felt well supported after the death, although the night orderly officer and Nurse B thought that they could have received additional support. Staff reminded prisoners that they could get support from Listeners and Samaritans if they had been affected by the death, and those being monitored under ACCT arrangements were checked by staff.
49. The funeral took place on 26 June and the prison contributed towards the costs in line with national guidance. A post-mortem examination established the cause of death as hanging.

ISSUES

Assessment of risk of suicide and self-harm

50. Staff judgement is fundamental to the ACCT system and relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action".
51. When he arrived at Wandsworth the man was a young adult and it was his first time in prison. He had been charged with a serious, violent offence and was facing a long prison sentence if found guilty, and possible deportation afterwards. None of the reception and first night staff we spoke to indicated that they had considered whether any of these factors increased his risk of suicide and self-harm. The SO could not recall the man, but said it was likely that he did not open an ACCT in reception because he did not arrive with any suicide and self-harm warning form and that he had appeared well. The nurse who assessed the man noted that he was calm and polite and said he did not intend to harm himself.
52. Officer A, who carried out a first night interview with the man, considered that he had rejected vulnerable prisoner status in reception out of naivety. He did not consider whether this apparent lack of understanding of the prison system could also have been viewed as an indicator of increased risk. He said that because the man had a calm demeanour he did not need to open an ACCT. As with the others, he did not consider the man's wider risk factors and told the investigator that many prisoners arrived with these factors.
53. PSI 64/2011 and PSI 74/2011 (Early Days In Custody), both list a number of risk factors and potential triggers for self-harm and suicide. These include those in prison for the first time, early days in custody, young age, being charged with a violent offence against another person, potential deportees and those on remand. All of these factors applied to the man, yet there is no evidence that staff fully considered them. Instead, they relied, firstly, on his statements that he was fine and had no thoughts of suicide or self-harm and secondly, on his quiet and polite demeanour.
54. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.
55. We consider that staff at the prison should have given more weight to the known risk factors in comparison to the man's presentation. It is possible that a fully considered assessment would still have concluded that an ACCT was not necessary, but it is concerning that there is little evidence that these

factors were taken into account. We accept that little was known about the man, which made it difficult to assess his risk, but, in our view, the range of risk factors should have pointed towards an ACCT document being opened to help ensure that he received appropriate support. Some of the staff we interviewed said it had been some years since they had had any ACCT training and they seemed unsure about assessing risk. We consider there is a management responsibility to ensure that staff required to assess risk are fully trained to undertake the task and that the processes are fit for purpose. We make the following recommendation:

The Governor should produce clear local guidance and training about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff fully consider and record all the known risk factors of newly-arrived prisoners and open an ACCT when indicated.

First night procedures for vulnerable prisoners

56. Prisoners can request to be held separately from the general population. This can be for a number of reasons, such as the nature of their offence or indebtedness to other prisoners. Such requests have to be authorised under Prison Rule 45. In many prisons, including Wandsworth, vulnerable prisoner units allow these prisoners to mix with other vulnerable prisoners and have a full regime.
57. The duty supervising officer identified the man as potentially at risk from other prisoners because of the charges he was facing and offered him vulnerable prisoner status in reception, but he declined. He accepted vulnerable prisoner status at his first night interview with Officer A that evening. The officer told us that he did not think the man had understood what it meant when he was offered it at reception and what the implications of not accepting might be. However, as a vulnerable prisoner, the man did not receive the same level of support as other first night prisoners.
58. PSI 74/2011 sets out the minimum requirements for a prisoner's first night in custody and notes as key outcomes that prisoners are kept safe and supported during their first night in prison and their immediate needs met. It emphasises that the first night, when family and community links are broken and the future is uncertain, is one of the most stressful times for prisoners and notes that many self-inflicted deaths and self-harm incidents occur within the first 24 hours, and shortly afterwards, particularly among younger prisoners. Among other things, it requires that all newly-arrived prisoners must be given access to a telephone (an issue we discuss in the next section) and a bath or shower before they are locked up for the night. The PSI notes that prisoners can find their first few days in the establishment overwhelming and emphasises the need to ensure safety.
59. Because of the first night arrangements at Wandsworth, the consequence of the man being held separately from other prisoners under Prison Rule 45, a

system designed to protect those at risk, actually exacerbated his risk. Other prisoners experienced a more supportive first night. The man was locked in a cell on his own, while other newly arrived prisoners were able to associate freely with each other, which must have heightened his sense of isolation. He wanted to take a shower, which might have helped him feel better, but was told that because he was a vulnerable prisoner he would have to wait until the next day.

60. We understand that first night staff tried to find a space for the man in the prison's vulnerable prisoners' unit but, when this was unsuccessful, they did not provide him with some of the basic requirements for his first night at the prison. They did not put in place any additional arrangements to help promote his safety and compensate for his isolated conditions. As a young adult under 21 he was not able to share a cell with anyone else that night. There is little evidence that anyone considered his additional vulnerability in these conditions and he was left locked alone in his cell for over two hours before he was found hanged. We make the following recommendation:

The Governor should ensure, in line with the requirements of PSI 74/2011, that there are supportive reception and first night arrangements for all prisoners, which recognise and address the particular needs of prisoners kept apart from others because of their vulnerability.

Provision of a telephone call

61. PSI 74/2011 has a mandatory instruction that newly-arrived prisoners must be given access to a telephone either in reception or their first night location. It goes on to state that if a prisoner is subject to public protection issues (this would usually be due to the nature of their offence) then a member of staff should make the call on the prisoner's behalf, checking that the recipient is willing to receive the call.
62. At court, the man told his solicitor that he wanted to go home and see his mother. His solicitor told us that she told court staff that he had said this. A PCO also told us that the man asked him how he could telephone his family. It therefore appears that he was anxious to speak to his family.
63. The supervising officer on E wing usually gives newly-arrived prisoners initial telephone credit on their first night to allow them to make telephone calls. However, the duty supervising officer told us that the man's offence meant that he might have been subject to public protection measures and therefore his telephone numbers first had to be cleared by the prison's public protection unit, a process which can take up to 48 hours. This meant that he was not able to telephone his family after he arrived at the prison.
64. Wandsworth's local public protection policy does not specify which prisoners should have their telephone numbers cleared before they can make a call. We are surprised that this was applied to the man, as the circumstances of his alleged offence would not suggest there were any risks involved in allowing him a telephone call to his parents. The national instructions on prisoner

communications services in PSI 49/2011 say “reception staff must read the Prisoner Escort Record and the police/CPS MG6 form to identify whether restrictions need to be placed on the prisoner’s communications”. No such restrictions had been identified for the man.

65. The SO told us that a prisoner potentially subject to public protection measures would be offered a telephone call on their first night (initially made by a member of staff, as set out in PSI 74/2011) if they were identified as vulnerable, on an open ACCT document, or had urgent family matters to resolve.
66. The instructions in PSI 74/2011 are that staff should offer a telephone call to all prisoners, not only those who prison staff judge to be vulnerable. We consider that a telephone call to families is an important safeguard for all newly arrived prisoners, and particularly for young men, like the man, experiencing their first night in prison. We make the following recommendation:

The Governor should ensure that all newly-arrived prisoners are allowed a telephone call in line with the requirements of PSI 74/2011.

Emergency response

67. CCTV coverage shows that prison staff quickly raised the alarm and opened up the man’s cell. The response nurses reached the cell quickly and the SO and the night orderly officer administered cardiopulmonary resuscitation promptly.
68. Nurse B told us that there was initially a problem with the flow rate in the portable oxygen cylinder, which he was able to correct. The night orderly officer said that the nurse told him that this was a problem with the valve, but his impression was that it was not initially switched on. The clinical reviewer noted that any problem with the oxygen cylinder was unlikely to have made a significant difference to the outcome in this case.
69. Nurse B also told us that he had some difficulty applying the defibrillator pads as he was unfamiliar with the model. The clinical reviewer noted that this did not lead to any significant delay in the delivery of a cardiac shock.
70. The paramedics were also delayed in gaining access to the man because of a problem opening the vehicle gates. The night orderly officer told us that this was an occasional problem (we note that, shortly before we issued this report, the prison once again experienced the problem). The IMB also reported ambulances being delayed at the prison gate.
71. While these issues do not seem to have had an impact on the outcome for the man, it is important that emergency equipment works properly, that staff responding to emergencies are confident in how to use the equipment and that paramedics are able to get to the emergency incident as quickly as possible. We make the following recommendation:

The Governor and Head of Healthcare should ensure that emergency response equipment is checked regularly to ensure it works, that all emergency response staff are trained in its use and that there are no delays in emergency services reaching a prisoner.

Family liaison

72. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies. PSI 64/2011 gives a mandatory instruction that, wherever possible, this must be done in person by a family liaison officer and another member of staff. It states that the police should be informed before a visit and, if necessary, be asked to escort the team or remain nearby.
73. The prison informed their family liaison officer of the man's death at around 11.30pm on 12 June. He was at home and told us that he chose not to visit the family immediately because he did not think it was safe to visit an area he did not know at the time of night. The prison did not complete a risk assessment and instead the police visited the family to break the news, unaccompanied by any member of prison staff. The duty governor said that the police offered to do this and, as the family liaison officer had declined to visit during the night, he thought this was the quickest means available.
74. The man's family live just a few miles from Wandsworth. Although we appreciate the difficulties of visiting an unknown area late at night, national instructions are clear that, wherever possible, the family liaison officer and another member of staff must visit in person the next of kin or other nominated person to break the news of the death. The instructions specify that the police should be asked to accompany prison staff if there are any concerns about the risk of a visit. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national guidance.

Debriefing and staff support

75. PSI 64/2011 requires a 'hot' debrief to be held immediately after all deaths in custody, to be led by a senior member of staff and with a member of the prison's care team present. The purpose of the hot debrief, as set out in PSI 08/2010 on post-incident care, is to ensure the immediate needs of the staff involved have been met. A critical incident debrief must also be held within five to ten days of the death. Its purpose is to provide further ongoing support and access to support networks.
76. The night orderly officer held a short debrief immediately following the man's death, although this did not meet the formal requirements of a hot debrief as there was no senior member of staff or member of the care team present. A debrief needs to be held by a manager who was not involved in the incident themselves. There was no critical incident debrief. Some staff told us that

they did not feel appropriately supported in the aftermath of the death. We make the following recommendation:

The Governor should ensure that staff are appropriately supported after the death of a prisoner, in line with national instructions.

RECOMMENDATIONS

1. The Governor should produce clear local guidance and training about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff fully consider and record all the known risk factors of newly-arrived prisoners and open an ACCT when indicated.
2. The Governor should ensure, in line with the requirements of PSI 74/2011, that there are supportive reception and first night arrangements for all prisoners, which recognise and address the particular needs of prisoners kept apart from others because of their vulnerability.
3. The Governor should ensure that all newly-arrived prisoners are given access to a telephone in line with the requirements of PSI 74/2011.
4. The Governor and Head of Healthcare should ensure that emergency response equipment is checked regularly to ensure it works, that all emergency response staff are trained in its use and that there are no delays in emergency services reaching a prisoner.
5. The Governor should ensure that a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national guidance.
6. The Governor should ensure that staff are appropriately supported after the death of a prisoner, in line with national instructions.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should produce clear local guidance and training about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff fully consider and record all the known risk factors of newly-arrived prisoners and open an ACCT when indicated.	Accepted	Local Guidance, consistent with the requirements of PSI 74/2011 and 64/2011, will be produced specifically aimed at reception/First night in custody and induction staff. The guidance will reaffirm the need to consider the safety of those prisoners where known risk factors are present and more specifically the need to consider the opening of an ACCT document. NOMIS will be updated with risk information and the daily complex case meeting will discuss all newly arrived prisoners for whom an ACCT is opened. This will be minuted, the minutes shared with the necessary staff and master copies retained in the safety office	Target date for completion: 30 th Dec 2014 Head of Safety	
2	The Governor should ensure, in line with the requirements of PSI 74/2011, that there are supportive reception and first night arrangements for all	Accepted	The local guidance (referred to in 1 above) will include arrangements for the support and management of vulnerable prisoners in the event that they are unable to share a cell with	Target date for completion: 30 th Dec 2014 Head of Safety	

	prisoners, which recognise and address the particular needs of prisoners kept apart from others because of their vulnerability.		another vulnerable prisoner because no other prisoners are able to share the cell. This will be circulated to all staff by the end of December 2014.		
3	The Governor should ensure that all newly-arrived prisoners are given access to a telephone in line with the requirements of PSI 74/2011.	Accepted	All Managers will be individually advised in writing that when working on the first night in custody unit that all newly arrived prisoners are given access to a telephone and/or a telephone call facilitated in accordance with PSI 74/2011. This will also be added into the Job Specification for the First night in custody managers.	Target date for completion: 30 th Dec 2014 Head of Safety	
4	The Governor and Head of Healthcare should ensure that emergency response equipment is checked regularly to ensure it works, that all emergency response staff are trained in its use and that there are no delays in emergency services reaching a prisoner.	Accepted	Since September 2014 all clinical healthcare staff have been undergoing additional on site Basic Life Support assessment and training given by the St George's Healthcare NHS Trust Resuscitation team who are based at St George's Hospital. This is ongoing. All registered Nurses are required to maintain their ILS (Immediate Life Support) qualification and receive updates via the St George's Healthcare NHS Trust	Completed Head of Healthcare	

			<p>Resuscitation Team</p> <p>The number of emergency bags and accompanying O2 cylinders have been increased to improve response times</p> <p>Locked cupboards have been purpose built to house the emergency bags and oxygen and are located in key areas in order to maximise response times</p> <p>A more light weight version of the O2 cylinder has been introduced which will also assist with improvement to response times</p> <p>A photographic aide memoir has been added to the emergency bag checklist.</p> <p>Each emergency cupboard contains a checklist. Staff are designated to check the seal on every emergency bag daily. A monthly check is required on the 4th of the month where the seal is broken and the contents of the bag checked</p> <p>Monthly audits are to be</p>	<p>Target date for completion: 30th Dec 2014</p> <p>Head of Safety</p>	
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			<p>implemented to ensure that the emergency equipment is being checked from January 2015.</p> <p>Additional random audits will also be undertaken by the NHS Trust Resuscitation team – one was undertaken in December 2014.</p> <p>The emergency response policy is currently being revised to take into account the above changes. Interim guidelines have been issued to staff in the meantime</p> <p>The Governor will ensure that staff responsible for the entrance and exit of emergency vehicles are fully briefed that when such assistance is required their entry to the prison is prioritised and that the preservation of life is paramount. Duty Governors, Orderly Officers and Gate and Control Room Staff will receive written instructions to this effect and Contingency Plans will be reviewed to ensure that the need to expedite the entry of emergency service vehicles into</p>	<p>Target date for completion: Feb 2015 Governor</p>	
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			the establishment		
5	The Governor should ensure that a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national guidance.	Accepted	Duty Governors and Family Liaison Officers will be individually advised (in writing) of the need for a prison service member of staff to inform a prisoners family quickly and in person of the death, in line with national guidelines. The advice will specifically outline the steps to take in the event that a visit to an unknown area, late at night is necessary.	Target date for completion: 30 th Dec 2014 Head of Safety	
6	The Governor should ensure that staff are appropriately supported after the death of a prisoner, in line with national instructions.	Accepted	The death in custody contingency plans will be revised to ensure that all staff are appropriately supported after the death of a prisoner in line with national standards through attending hot and critical debriefs.. Attendance will also be accurately recorded with the records being retained by the Head of Safety. The local duty care team member will also attend the hot debrief and be made available to all staff involved.	Target date for completion: 30 th Dec 2014 Head of Safety	