PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2014, while a prisoner at HMP Wandsworth

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 died in July 2014, after he was found hanged in his cell at HMP Wandsworth. He was 22 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was undertaken. The prison cooperated with the investigation.

The man had previously shared a cell with another prisoner, who was found hanged in their cell in early March 2014. My investigations into the deaths of both men were suspended for some time because of the need to ensure our investigation into the cellmate's death did not impede ongoing police enquires. I am sorry for the consequent delay in issuing this report.

The man left a letter in which he said that he was being bullied and could not cope. During his time at the prison he had made four separate allegations of bullying, including that he was being bullied to pay his former cellmate's debts. Despite these allegations, a witnessed assault on him by one of the alleged bullies and two separate allegations of sexual assault, staff at the prison did not begin to manage him under victim support procedures until four days before his death.

In my investigation into the man's death, I raised serious concerns about bullying, and the safety of vulnerable prisoners on C Wing at Wandsworth. I was also concerned about the management of suicide and self-harm prevention procedures. Sadly, the same issues are repeated in this report.

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 **June 2015**

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SUMMARY

1. The man was remanded to HMP Wandsworth on 26 October 2013, charged with rape, attempted rape and attempted murder. He had a history of self-harm by cutting. He had been in prison before. Because of the nature of the charges against him, he was allocated a cell on C Wing, as a vulnerable prisoner. He was convicted on 13 June 2014 and was waiting to be sentenced when he died.

2. Prison staff managed the man under Prison Service suicide and self-harm prevention procedures, known as ACCT, five times between 26 October 2013 and 12 May 2014. He made four allegations of bullying, was physically assaulted by one of the alleged bullies and made two separate allegations that he had been sexually assaulted, but little was done to investigate or support him.

3. In March 2014, his cellmate hanged himself in their cell. The man had been close to him and received counselling after his death. Doctors prescribed him anti-depressants. Our investigation into the death of the cellmate found significant evidence that he had been bullied and had money extorted from him. In April 2014, the man told staff that other prisoners were bullying him to pay his cellmate's debts.

4. In July 2014, the man was discovered with a mobile phone. He told staff that another prisoner had coerced him to carry it for him, but he would not say who it was. On 29 July, an officer found him hanged in his cell. Staff performed cardiopulmonary resuscitation promptly and paramedics arrived quickly. The paramedics took him to hospital for treatment, but he died the same evening. He had left a note in his cell saying that he was being bullied and could not cope any longer.

5. We repeat the concerns raised in our investigation into the death of the cellmate about:

   - the tackling anti-social attitudes (TASA) policy at Wandsworth particularly the operation of victim support procedures
   - the management of prisoners under ACCT
   - the safety of genuinely vulnerable prisoners on C wing.

6. We make four recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices about the investigation to staff and prisoners at HMP Wandsworth inviting anyone with information to contact her. No one responded.

8. The investigator obtained relevant documents about the man's time in prison. She interviewed a number of staff and prisoners at Wandsworth and two prisoners at HMP Belmarsh. She informed the prison about the initial findings of the investigation.

9. A clinical reviewer reviewed the clinical care that the man received at Wandsworth, on behalf of NHS England, London Region.

10. We informed HM Coroner for Inner West London of the investigation and have sent her a copy of this report.

11. One of our family liaison officers informed the man's family about the investigation. The family liaison officer and investigator met the man's mother, stepfather, and their legal representatives on 24 September 2014. They asked the investigation to consider:

    - The circumstances of how he was found in July and what times he had been checked
    - What action was taken on allegations of bullying
    - Details of what happened after his cellmate's death
    - Information about how he was managed on suicide and self-harm monitoring
    - The impact on him of his cellmate being bullied
    - Whether other prisoners knew about his offence and whether he was vulnerable as a result
    - Whether there are enough prison officers on duty to properly do their job

    The man's mother and step-father received a copy of the draft report. The solicitor representing them wrote to us raising two issues that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP WANDSWORTH

12. HMP Wandsworth is a local prison in south west London that holds over 1,250 men and primarily serves the courts in south London. St George's Healthcare Trust provides healthcare services at the prison.

Her Majesty's Inspectorate of Prisons

13. The report into the most recent inspection Wandsworth in February/March 2015 has yet to be published. However, we understand from initial feedback that inspectors had concerns about safety at the prison. There was no effective violence reduction policy and procedures to address and monitor bullies had not operated for some time. Processes to support victims were weak. Inspectors found that the quality of ACCT documentation was mixed, but too many records were poor with insufficiently detailed and often late reviews, poor recording of triggers and poorly focussed care maps.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its 2013/2014 annual report, the IMB noted that a victim support process had been introduced to support those suffering from violence or threats of violence. Due to staff shortages, monitoring of ACCT was not always as thorough as it should be. The IMB reported a marked increase in violent incidents over the previous year. Their main concern was further reductions in staff.

Previous deaths

15. The man's death was the fifth self-inflicted death at Wandsworth since 2010. In March 2013, his then cellmate hanged himself in their cell. This investigation has identified similar concerns about bullying, the management of prisoners at risk of suicide and self-harm and the safety of vulnerable prisoners. There have been two further apparently self-inflicted deaths at the prison since the man died.

Assessment, Care in Custody and Teamwork (ACCT)

16. 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 the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance

on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Management of violence, bullying and anti-social behaviour

17. Prison Service Instruction (PSI) 64/2011 requires prisons to have procedures in place to identify, manage and support prisoners who are at risk to and from others, and to reduce that risk. Governors should ensure reasonable steps are taken to obtain all relevant information about prisoner safety. This information must be recorded, shared and acted upon within the prison and between service providers and other relevant agencies.

18. At Wandsworth, prisoners identified as bullies, or who are thought to be involved in anti-social behaviour, are expected to be monitored under tackling-social attitudes (TASA) procedures. Prisoners subject to TASA can lose their privileges. TASA requires that victim support procedures are opened to support and monitor victims of bullying through formal interviews, reviews, frequent observations and action plans involving the victim.

KEY EVENTS

19. On 23 October 2013, the man was arrested in connection with a serious sexual assault on an elderly woman. At the police station that evening, he said he had previously cut himself twice in different prisons when he had felt low. Officers checked him every 30 minutes and removed objects that he might use to harm himself. He told a doctor he had a history of depression but was not currently taking medication. The next day, he told another police doctor that he had seen a psychologist a year previously about his self-harm. The doctor considered that he was at raised risk of self-harm and recommended that he should be watched on CCTV as well.

20. On 26 October 2013, the man was charged with rape, attempted rape, and attempted murder and taken to Wandsworth. When he arrived, he asked to be held separately from mainstream prisoners under Prison Rule 45 for his own protection. He was allocated a cell in the prison's vulnerable prisoners unit (VPU) on C Wing. Because of the charges, he was initially regarded as a potential category A prisoner, which meant that he could not share a cell.

21. At an initial health assessment, the man told a nurse that he had self-harmed in the past by cutting. He said he had no current thoughts of suicide or self-harm but appeared tearful and unsure of his feelings. She therefore began ACCT procedures. A doctor saw him and said that he was low in mood, tearful, and worried about his children. The doctor referred him to the mental health team.

22. An officer completed an immediate action plan and the man was checked hourly until he had an ACCT assessment. The officer changed his cell sharing risk assessment to standard risk so he could share a cell that night. (He did not become a category A prisoner and shared a cell for the rest of his time in Wandsworth.)

23. A Supervising Officer (SO) carried out an ACCT assessment the same afternoon. The man said his biggest concern was being back in prison and the nature of his offence. He said that he not harmed himself recently, but had a history of self-harm by cutting when he was depressed. He was very tearful during the assessment and said he was feeling very low but had no thoughts of suicide. Staff allowed him to use the wing office telephone to call his family.

24. The next morning, 27 October, a SO held the first ACCT case review. No one else was present. The man said the phone call to his family had not gone well. He was keen to start work or go to education. The SO wrote two actions in the caremap. The first was for him to phone his family, which was marked as completed. The second was for him to apply for education. Later the same day, an officer recorded in his ACCT document that someone had stolen his tobacco from his cell.

25. On 28 October, the man told a healthcare assistant that he had harmed himself with a razor. He said another prisoner had called him a kiddie fiddler

and accused him of carrying a mobile phone and drugs. He said he was very depressed. She noted in his medical record that he had made three scratches about nine centimetres long on his stomach. She said she would tell an officer. She also noted that he had said that the prisoner had spat on him and his cellmate.

26. The healthcare assistant reported the man's allegations to the escorting officer who submitted an intelligence report alleging that a prisoner was bullying him for tobacco. The officer said he had told the C Wing SO and made an entry in the wing observation book about this. The security department sent the report to the C Wing manager and the violence reduction team.

27. The man completed a complaint form (Comp1) on 29 October. He said the prisoner was bullying him to phone his family and ask them to transfer money into his prison account. He said he was scared, did not want to leave his cell and did not feel safe on the landing. A custodial manager replied (there is no date on the reply) that she had asked the wing SO to interview him and use the victim support procedures. She said two SOs would put together a support plan to ensure his safety and take appropriate action against anyone else involved. There is no evidence that this happened.

28. On 4 November, a SO chaired the man's second ACCT case review, which a senior forensic clinical case manager from the mental health in-reach team - MHIRT and a member of the prison's substance misuse recovery service attended. The man said he was anxious about a court appearance on 8 November and was still waiting to hear about getting a prison job or an education place. He was very tearful and too upset to talk to his family but said he had written to them. He did not want to be referred for counselling but agreed to speak to someone from the chaplaincy.

29. On 6 November, Sutton police intercepted a letter from the man to his ex-partner in which he said he wanted to kill himself. An officer spoke to him about this and reported that he was feeling low. A few hours later, he told the officer that he was depressed because he was not allowed to see his ex-partner and children and his family had turned their backs on him. He said he had run out of money and tobacco.

30. At a third ACCT review on 11 November, the man told a SO that he was feeling much better and had a job in the kitchen, which kept his mind occupied. No one else was present. On 14 November, a nurse from the primary mental health team (PMHT) assessed him after the reception GP's referral. He told her he was working full time in the kitchen and coping well.

31. On 19 November, the man told a SO at a fourth ACCT review that he was feeling much better and had received good news from his solicitor and was going to apply for bail. He was enjoying his kitchen job and said he was as happy as possible in prison. On 24 November, he began sharing a cell with a cellmate.

32. On 11 December, a SO chaired a fifth ACCT review, which another SO and an officer also attended. The man said he had come to terms with being in prison and found that working full-time helped. He said he felt able to cope without the support of ACCT. Everyone present agreed to close the ACCT. They reviewed the caremap but did not update it.

33. Less than an hour later, the officer supervising the evening meal on C Wing saw a prisoner repeatedly punch the man. The man did not retaliate. The officer subsequently submitted an intelligence report and recorded that the prisoner had been charged with a disciplinary offence under Prison Rules and was now being managed under the tackling anti-social attitudes policy (TASA). The officer noted that it was not possible to move either man because they were both vulnerable prisoners and would have to be managed on the wing. The security department sent the report to C Wing staff and the violence reduction team.

34. On the morning of 9 January 2014, the man's cellmate was taken to hospital after he said that he had swallowed a razor blade and nail clippers during the night. He stayed in hospital for observation. At 6.38pm the same evening, he told a nurse that he had accidentally cut his hand about three hours previously. She advised him to wash the wound and listed him to see the GP the next morning. At 1.40am that night, he told an officer that he had swallowed some razor blades because he missed his family. The officer opened an ACCT. He said he did not want to move into another cell with someone else while his cellmate was in hospital. The officer called the night nurse but he refused to talk to him. The night nurse also put him on the GP's list. Staff checked him hourly until he had an ACCT assessment.

35. An officer assessed the man at 3.00pm the next afternoon. He said he missed his family and children. He felt depressed but had no intention of cutting himself. He said his family were supportive but he did not want his wife [he usually referred to his ex-partner as his wife] to visit him. He said he would like the extra support offered by the ACCT process and wanted to see a chaplain. The officer held the first case review with him immediately afterwards. No one else was present. He wrote two actions on the caremap: pastoral support from the chaplaincy and staff to support him through regular checks. The officer telephoned and emailed the chaplaincy to ask someone to speak to him. He marked the action of staff support as achieved because he was already on hourly checks.

36. Shortly after the review, a nurse from the mental health in-reach team assessed the man, who repeated that he had swallowed three razor blades. He said it had been a cry for help and he did not want to die. He said he was waiting for pre-sentence reports to be completed and was expecting a long sentence. The nurse noted that he was booked to see the duty GP about the razor blades. There is no record that he did so. On 12 January, the cellmate returned from hospital and shared the cell with the man again.

37. On 17 January, an officer asked a nurse to assess the man. The nurse noted that he appeared in low mood and quiet. He told her he was not eating and

had swallowed nail clippers. He said his child was ill in hospital. She wrote on the ACCT record that she was concerned he was sharing a cell with another prisoner who had also allegedly swallowed objects. She spoke to a SO and the orderly officer that day, who suggested that both prisoners should have ACCT reviews. (He had been due to have an ACCT review on 14 January but this had not taken place.)

38. Within an hour, a SO chaired a case review with an officer. The man appeared depressed and said he was missing his son and had no contact with his mother. He said he got on well with his cellmate and wanted to continue sharing a cell with him, even though they were both going through a difficult period. The SO wrote that he had agreed with both men that they would work hard to support each other. The SO updated the caremap with three new actions: for him to have pastoral support from the chaplaincy, for him to contact his mother and for him to get treatment for an upset stomach. The SO marked all three as achieved because he had given him his mother's address and the chaplain and the nurse had seen him that day and would provide on-going support. (Later that afternoon his cellmate went back to hospital.)

39. During the night, the man complained of abdominal pain and told a nurse that he had swallowed a number of nail clippers and razor blades a couple of days ago and was supposed to report symptoms. He said that he had reported being in pain during his ACCT review the previous day but a nurse had not examined him. He denied knowing the reason why his cellmate was in hospital. The nurse took his blood pressure and pulse, which were normal. An officer checked him with a metal detecting wand, and the machine found no indication of any metal. (As these are designed for external body searches, it is not apparent that it would be able to detect swallowed objects.) His cellmate returned to Wandsworth on 20 January.

40. On 23 January, a SO chaired an ACCT review with another SO. The man was in a much better mood. He said he had written to his mother, spoken to the chaplain and was back at work full time. The SO closed the ACCT and noted that he had said he was grateful for the help and support staff had given him. On 25 January, he went to court. The next day, he was sacked from his job in the kitchen (it is not clear from the records why he was sacked). In February, he started work in the Fine Cell workshop. (Fine Cell work is a social enterprise that trains prisoners in skilled needlework.)

41. In March 2014, the man's cellmate hanged himself. The following account is taken from our investigation into his death, which included an interview with the man in July 2014:

"The deceased's cellmate, the man, told the investigator that, at lunchtime he left their cell to collect his food, but his cellmate stayed behind and did not go to collect his lunch. He said that they later argued in their cell about cigarettes because the cellmate felt that he was taking advantage of him by using his tobacco. He said that his cellmate 'got nasty' but after they had argued, he (the man) had fallen asleep.

"At 12.45pm, an officer saw the cellmate in the cell when she made a lunchtime count of prisoners and did not have any concerns about him. At 2.00pm, two officers began unlocking prisoners on C wing for work. At 2.05pm, an officer opened the cell and the man left the cell, leaving the door ajar. They worked together [in the Fine Cell workshop] and the officer said she thought it was strange that only he had come out of the cell. When she asked him, he said he did not know where his cellmate was.

"The man told the investigator that he had been asleep when the officers unlocked him for work. He said he had jumped off his bed and put his trainers on and went straight out. He said that his cellmate often spent a long time in the toilet and he had assumed that he was in there."

42. After the man left, the officer noticed the door to the toilet was wedged shut with a crutch with cord round it. She summoned help from a colleague and they discovered the cellmate hanging from the window bars.

43. A nurse from the primary mental health team saw the man that afternoon and noted that he was shaken and said that he felt guilty because he had argued with his cellmate about petty things that morning. He asked for anti-depressants but the nurse explained that these would not give immediate relief. She suggested zopiclone to help him sleep and said she would ask the GP to prescribe a short course for him. The next day she asked a psychotherapist, who provided a service through the prison chaplaincy, to arrange counselling for him.

44. Staff opened an ACCT that day and moved the man to another cell with a Listener (prisoners trained by the Samaritans to provide confidential support to other prisoners) overnight and checked him every hour. A SO assessed him as part of the ACCT procedures. He said his cellmate had "touched him up" several times, but he had been too scared to tell anyone. He said he was feeling low and sad about him dying. Although he had been disturbed about him touching him, he said he had also liked him. He said he sometimes cut himself to relieve stress but had no plans to harm himself and did not feel suicidal.

45. The first case review took place immediately after the assessment and two SOs and an officer attended. A SO completed the caremap. She identified two issues; low mood due to the death of the cellmate and allegations that he had touched him inappropriately. The SO wrote the following actions; prevent deliberate self-harm, explain other methods of coping with stress, access to Listeners and to check if the man wanted to speak to the police about his allegations against his cellmate.

46. On 4 March, a SO took the man to the Fine Cell workshop and explained to the workshop staff what had happened the previous day. He told an officer that he was upset because he had had an argument with his cellmate and had not had a chance to make up with him before he died. His cellmate asked if he could share a cell with another prisoner and he moved into C2-18 with him

immediately. The man had a follow up appointment with a nurse and spoke to an officer about using the counselling service.

47. On 5 March, a SO held an ACCT review and the man said he was still extremely sad about his cellmate and was even more upset because his stepfather was ill. The SO noted that he was very tearful and struggling to cope. He said he would contact the chaplain and ask him to speak to the man.

48. An intelligence report submitted on 5 March, noted that another prisoner had said that the man's cellmate had been using cannabis before he died and had been concerned because he was in debt to a "non-English" prisoner. Another intelligence report on 8 March, noted information from another prisoner that the cellmate was in debt to two prisoners for tobacco and cannabis and that he owed £800 to another prisoner on the wing. The report also indicated that one of the prisoners was upset that the cellmate had owed him money.

49. On 10 March, a SO held a third ACCT review, which a drug worker attended. The man was tearful and said he was experiencing flashbacks to his cellmate's death. He said he had settled with his new cellmate and was hoping his issues would pass with time. The SO did not review the caremap, but reduced the number of times that staff were expected to have and record conversations with him from five to three during the day.

50. On 13 March, the man had a preliminary meeting with a psychotherapist and agreed to have 16 weekly counselling sessions. She told the investigator that the sessions are confidential but the counsellor is able to share information in the following categories:

- actual or intended self-harm
- harm or threat to anyone
- circumstances in which the welfare of a child is at risk
- the planning of a crime, or information about an unreported crime including terrorism
- a breach in prisons security, including any information related to drugs or alcohol.

She made brief entries in his medical record about when she had met him but these did not cover the content of their discussions. .

51. On 17 March, a SO held a fourth ACCT review, attended by a worker from the substance recovery team, a clinical case manager and a nurse, both from the mental health in-reach team. The man said he was finding it hard to come to terms with his cellmate's death but this had eased since he had moved in with another prisoner. He said he had no thoughts of suicide and the SO closed the ACCT. He did not review the caremap.

52. On 20 March, the man was unable to attend an appointment with a nurse and his first counselling session with the psychotherapist because of a legal visit. He saw the psychotherapist at their next scheduled appointment on 27 March,

and she noted on his medical record that he had been concerned about his forthcoming court appearance and a lack of visits from his solicitor.

53. On the evening of 1 April, the man made several superficial cuts on his stomach and a nurse dressed the wounds. The nurse referred him to the primary mental health team and noted in his medical record that officers would open an ACCT. Staff carried out ACCT observations that night, but there is no other documentation about the ACCT being opened.

54. On 2 April, the daily safer custody complex case meeting, attended by representatives from offender safety, the mental health teams, probation and the prison chaplaincy team discussed the man briefly. The minutes noted that he was "feeling bullied", as had been his cellmate. The meeting concluded that a nurse should see him and someone from the offender safety team would check if he was being monitored under victim support procedures.

55. The nurse saw the man after the meeting. The man told him he was feeling bullied and could not get over the death of his cellmate. The nurse told him about the prison's victim support policy, but it did not appear that he had been supported through these procedures.

56. One of the prison chaplains spoke to the man that afternoon. He told her that he was extremely concerned that his old cell was still sealed with his property inside. He was very stressed about this because he said he needed his papers for a court appearance. He said his 'wife' had left him and he wanted to arrange access to his children. He said that a SO had told him someone would speak to him about his ACCT but no one had. She said that he appeared quite vulnerable. She spoke to the SO, who emailed the security department about the locked cell.

57. At 6.15pm on 2 April, a SO completed the initial pages of the ACCT document. He said the man had rung his cell bell and an officer said he had insisted on speaking to him alone. The SO said he was new to C Wing and thought that he might have asked to see the SO rather than for him by name, as he did not know him. He told him that he had self-harmed the night before because he was depressed about the death of his cellmate and was being bullied to pay back his cellmate's debts. He was also worried that he was likely to receive a long sentence. He said he felt he could talk to members of the chaplaincy team and the SO said he would arrange this.

58. The SO completed the warning signs/triggers section of the ACCT document. (This was the first time anyone had done this, although this was the fourth ACCT that had been opened for the man during his time at Wandsworth.) The SO listed:

- death of cellmate
- lack of tobacco
- settling debt for cellmate
- court appearance (22nd) most worried about.

59. On 3 April, the man missed his second scheduled counselling session with the psychotherapist again because he had a legal visit. An officer spoke to him briefly, but did not record what they spoke about.

60. On 4 April, an officer interviewed the man for an ACCT assessment; three days after the ACCT had been opened. He said the man had been feeling very anxious, mostly because of his cellmate's death and because of the debts he had left behind. He said he felt personally responsible for those debts. He said other prisoners were "on his case" and every time someone mentioned his cellmate, it brought back bad memories. He had not rung his mother on Mother's Day because he had no phone credit and other prisoners were borrowing tobacco from him constantly. He said he had cut himself to get relief from pent up anxiety and stress and it was not a suicide attempt. He was also anxious about forthcoming court appearances and said his solicitor had cancelled or not turned up for at least two legal visits. The officer said they discussed how he could deal with the burden of his cellmate's death and the fact people were taking advantage of him.

61. There was no first case review after the assessment, no level of risk set and no caremap. Two SOs held the first review on 7 April, seven days after the ACCT had been opened. There was no member of healthcare staff present. The man said he had had a better week coming to terms with his cellmate's death, but he was still concerned that he could not get his papers from their old cell, which continued to be sealed. One SO said that he should get access to it that week. He said he had no thoughts of suicide and wanted them to close the ACCT, which they agreed.

62. The man attended court on 11 April. An officer recorded on an ACCT post-closure phase summary sheet that the man did not raise any issues when he came back. On 13 April, a SO wrote that he had spoken to him at length because he had had a difficult day the day before, collecting his property from his old cell.

63. On 17 April, the man had a counselling session with the psychotherapist, after which she opened another ACCT. She said that he was in a low mood, had expressed a strong desire to self-harm and was making active plans to do so. She said he was worried that a lack of activities and work over the Easter weekend would make things worse. Recent court appearances and a lack of visits from his family had increased his anxiety. He was not sleeping well.

64. A SO completed the immediate action plan and wrote 'long periods behind his door' on the triggers page. An officer completed the ACCT assessment. He said the man was worried that, if he were released, he would have nowhere to go because he would not be able to go back to his home area. He was also worried about the reasons his children had been given to explain why he was in prison. He said he felt unable to talk to anyone about his feelings and concerns. He said he had cut himself on 12 April to relieve stress but had told no one. The cuts were on his stomach so he could hide them. He was anxious about the outcome of his court case and about his family. He said he

was not suicidal and looked forward to seeing his children and his mother and brothers. He said he found the sessions with the psychotherapist helpful.

65. A SO held the first case review with an officer, immediately after the assessment. As previously, there was no healthcare representative present. They officers discussed available support and the man said that he was happy for the ACCT to be open as a temporary measure over Easter and to have a low level of observations. The SO put one action on the caremap, to help reduce likelihood of him self-harming over Easter weekend asking staff to facilitate out of cell activities - dependent on staff resources. His level of risk was assessed as low. Staff were required to have and record three quality conversations with him during the day and observe him five times during the night.

66. On 22 April, two SOs held an ACCT review. The man said he still had bad memories of his cellmate's death and would like the support of the ACCT being open, especially overnight. He had a counselling session with the psychotherapist on 24 April. She noted in his medical record that the ACCT should remain open for the near future. Later that day, a nurse treated him, after he made a superficial cut to his right wrist.

67. On 1 May, the man attended another counselling session with the psychotherapist. Afterwards, she told a SO that she was worried about him because he was in a very low mood. The SO spoke to him, who said he was very depressed. He said he was not sleeping and still had nightmares about his cellmate's death and he was concerned about his new cellmate. The SO agreed that he should share with another prisoner instead. He named another prisoner who he said had sexually assaulted him in his cell two days before. That prisoner had now transferred to HMP Brixton. The SO called the police and informed them of the allegation. He also submitted an information report to the prison security department. (The police spoke to him about the allegation the next day, but there is no record of any further action.)

68. An ACCT review took place immediately afterwards attended by a SO, an operational manager, the psychotherapist, a nurse and the managing chaplain. The man said he did not want to be on a constant watch because he wanted to be able to talk to someone in a shared cell. He asked to move to a wing-based job from the Fine Cell workshop. He said he felt like harming himself but was not suicidal. The nurse said he would talk to the GP about prescribing anti-depressants and the operational manager agreed to talk to him in private about the alleged sexual assault. His risk was assessed as high and he was checked four times every hour until his next review. A prisoner moved into cell C2-18 with him after the review.

69. Later that afternoon, the nurse assessed the man, as the psychotherapist had asked him for this to be done urgently. The nurse said he appeared very low and depressed. He scored 23 on PHQ9 (patient health questionnaire 9 – a tool used to monitor the severity of depression) indicating he was severely depressed. The nurse recommended that he should start anti-depressants and that he should continue to be monitored under ACCT procedures.

70. The operational manager spoke to the man that afternoon. He explained the police investigation process, which the man said he was aware of from previous experience. He seemed more relaxed and promised to ring his cell bell if he felt low.

71. An entry on the ACCT record for 2 May at 9.30am, (signature illegible and no corresponding entry on the medical records) reported a one-to-one session with the man. He said he was happier sharing with the prisoner, but was finding it difficult to come to terms with recent events. He said he was due to start anti-depressants and had recently smoked Spice (a new psychoactive substance, sometimes known as 'legal highs'.) A security intelligence report for the same day reads, "This morning I met with a prisoner, during the session he disclosed that he had been smoking spice and was getting it from C Wing mains. He was paying for it with his canteen. The person accepts money from the outside that can be paid into his prison account". The security department sent the report to the drug search and dog section.

72. At 10.30am on 2 May, a SO and a clinical case manager held an ACCT review. The man said he still felt low but had no thoughts of suicide or self-harm. He said he was feeling more stable and was happy to be sharing with a prisoner. He began taking sertraline, an anti-depressant, that day. His risk was reduced to low and the observations reduced to hourly. Nothing was added to the caremap. The clinical case manager wrote on the medical record that the man said he had self-harmed about 20 times during his life as a means to relieve stress, but these were not suicide attempts. He said his counselling sessions were helping him.

73. On 6 May, a SO held another ACCT review. The man said he was coping well and wanted the ACCT closed. She said she could not close the ACCT on her own without a multi-disciplinary review. She said there was no change to his risk but reduced the observations to three quality observations a day and hourly observations at night. On 8 May, he had a counselling session with the psychotherapist. She wrote on his medical record that he had agreed that his ACCT should stay open on a lower level of observations and that he would say this at his next review.

74. On 12 May, a SO chaired an ACCT review with a worker from drug and alcohol services and a clinical case manager to assess the man's progress. He said he felt a lot better. He had spoken to his mother for the first time in six months and was feeling positive. The review team considered that he was no longer at risk and agreed to close the ACCT. There is no record that the fact that he was about to start his trial was discussed at the review.

75. The man had further counselling sessions with the psychotherapist on 15 and 22 May. They agreed that they would resume their sessions if he remained at Wandsworth after his trial, which was due to start the following week. He was missed scheduled counselling sessions on 29 May, 5 and 12 June, as he was at court.

76. On 13 June, the man was found guilty at court. He was due to return to court to be sentenced on 4 August. There is no evidence that anyone assessed his risk or suicide and self-harm after his conviction.

77. On 19 June, the man, did not attend his counselling session with the psychotherapist. He saw her again on 26 June and agreed to attend weekly until end of July to complete their agreed 16 sessions. On 3 July, he did not attend his session but went to work instead.

78. On 4 July, a psychiatrist from the mental health in-reach team assessed the man and found no evidence that he was suffering from severe mental illness. He said the man was expecting to get a life sentence. He had no thoughts of suicide or self-harm but would require extra support around the time of sentencing. The psychiatrist concluded that the man did not need to be on the caseload of the in-reach team or the primary care mental health team.

79. On 10 July, the man missed another counselling session with the psychotherapist. The next day, a nurse assessed him and described him as cheerful and communicative. She agreed that he could keep his medication in his possession, rather than having to collect it daily.

80. On 17 July, the man spoke briefly to the psychotherapist. They agreed that if he were still at Wandsworth at the end of August (after he had been sentenced and she had taken her annual leave) they would meet again and decide whether to commit to further counselling sessions. That day, the psychiatrist re-prescribed him anti-depressant medication. He revoked the nurse's decision to allow him to keep his medication in possession because of his history of self-harm, vulnerability in prison and possible imminent long sentence.

81. On 21 July, an Assistant Ombudsman and Senior Investigator from this office interviewed the man as part of our investigation into his cellmate's death. As they were aware that they had raised memories of the death, they asked an officer to check him afterwards to see that was OK, which she did.

82. On 24 July, a SO searched all the prisoners leaving the workshops after a pair of tweezers went missing. He used a metal detecting security wand, which indicated something in the area of the man's backside. As a result, he was strip searched and handed over a mobile phone. He told a SO that the phone was not his and he was holding it for someone. The SO charged him with a disciplinary offence for a breach of Prison Rules.

83. The man appeared at a disciplinary hearing the next morning on 25 July. He told the manager conducting the hearing that he had been bullied to hold the phone and did not want to say whose phone it was. Because of the seriousness of the charge, the manager referred the case to an independent adjudicator – a visiting district judge.

84. After the hearing, an officer began a victim support plan. The man continued to decline to say who was bullying him, but said he felt threatened and

unhappy and needed to be supported. However, the section on support plan on which staff are supposed to list the actions they need to take to address the identified issues, was left blank. An officer completed an information report saying that he was being bullied to hold a mobile phone, and would not say who was threatening him. The security department sent the information to supervising officers and to a custodial manager, the prison's anti-corruption officer.

85. The SO took the man back to C Wing and told him that they could transfer the bully to another prison if he named him. He said the person concerned had friends and was not operating on his own. He said he was worried about reprisals and would rather not give any names.

86. There were three more entries on the victim support daily supervision record, two on 28 July and one on 29 July. The last entry (signature illegible) reported that the man seemed fine.

Events of the incident

87. An officer told the investigator that he spoke to the man when he locked him back in his cell after morning medication. (The wing CCTV shows this was at 8.13am.) They talked about his disciplinary hearing and the officer told him he would soon be unlocked again for a social and domestic session (when prisoners can clean their cells, make phone calls and have a shower). His cellmate had already gone to work as normal. The officer did not know why he was not going to his job that day.

88. Just before 9.00am, the officer returned to C Wing with a colleague to conduct fabric checks of each cell. When they went into the man's cell the officer found him hanging by a sheet from the window in the cell toilet (which is separate from the main cell). His colleague supported his weight while he cut the sheet, from the window. He laid him on the floor of the main cell, removed the ligature from his neck, checked and found no sign of breathing or a pulse. He said the man was cold and there were no signs of life. He began cardiopulmonary resuscitation, while his colleague radioed a code 1 to indicate a life-threatening emergency. In response, the control room called and ambulance immediately, at 9.00am.

89. Nurses arrived within three minutes and gave the man oxygen. A defibrillator was attached but it advised no shock. The nurses continued resuscitation until paramedics arrived. The paramedics found a pulse but it is not clear from the records at what point they detected it.

90. CCTV shows that both officers went into the man's cell at 8.58am. The second officer used his radio outside the cell 15 seconds later and went back in. At 8.59am, he radioed from outside the cell again and then ran down the landing. At 9.00am, a SO and another officer arrived. The first nurse arrived at 9.01am, followed by two other nurses and the second officer at 9.02am, carrying a large emergency bag and oxygen. At 9.04am, one of the female nurses left the cell and came back a minute later with a defibrillator. Two

paramedics arrived at 9.12am. The paramedics, helped by prison staff, took the man to the ambulance on a stretcher and then to hospital.

91. The staff left the man's cell unattended and with the door open. The CCTV footage shows that, at 10.04am, another prisoner went into the cell and stayed there for just over half a minute. When he came out, he spoke to an officer, who then locked the cell door.

92. At 10.30am, a manager held a hot debrief for the staff involved in the emergency response and offered them support. A SO went to the Fine Cell workshop and told the cellmate what had happened. Staff moved him to a different cell and checked him regularly.

93. At hospital, emergency treatment was unsuccessful and the man was declared dead at 9.50pm.

94. The man had left a note in his cell, which said, "I am sorry but I can't cope. I'm being bullied and I can't do it no more". His parents later found an undated letter in his property. In it, he said that someone on the wing had bullied him to hold a mobile phone and he had been caught. That person was now bullying him for his canteen as payment for the lost phone. He said he felt very low and depressed. He said he was looking forward to seeing his parents the following Monday. (4 August, when he was due to be sentenced.)

95. On 3 August, the prison held a memorial service for the man.

Family liaison

96. At 10.43am, a custodial manager telephoned the man's stepfather and brother to let them know what had happened and that he had been taken to hospital. The family went to the hospital and were with him when he died, later that evening.

97. The prison returned the man's property and offered appropriate financial assistance with his funeral in line with national prison guidance. The prison arranged for his family to visit the prison to see where he had lived.

Evidence from prisoners

98. The prisoner who lived in the cell next door to the man thought he had problems coming to terms with what he had done and his biggest concern was his offence. However, he had not discussed this with him. He said the man was outwardly quite 'laddish' but underneath quite timid and fragile. The prisoner said he saw him and his cellmate frequently smoking Spice supplied by a prisoner. He thought that something had happened to the man a few days before he died that had had a profound effect on him and had made him withdrawn. He was not aware that he was being bullied. He was shocked and surprised by his death.

99. Another prisoner who had mentored the man when he first arrived at Wandsworth and worked with him in the Fine Cell workshop said the man put on a bit of a front and it was hard to get to know the person underneath. He thought that his cellmate's death had affected him badly. The man told the prisoner he was being bullied to pay off the debts his cellmate had left behind. The prisoner said that he did not tell him who was bullying him and he did not witness him being bullied. He thought the biggest thing on his mind was the media coverage he was anticipating when he was sentenced. He last saw him the evening before he died and thought he seemed better than he had been for a while. He said that the man had not gone to work on the day he died because he said he was not feeling well.

100. A prisoner who worked in the Fine Cell workshop with the man said the man used to push him there in his wheelchair. He said the man was full of bravado and plans. The man had told him that he had smoked Spice heavily before he came to Wandsworth. After he died, he said he learnt from other prisoners that the man had smoked Spice in the prison and was being bullied. He said the man was very worried that he would get a long sentence, but he had seen him the night before he died and he seemed in good spirits.

101. Another prisoner knew the man through the last prisoner. He described him as a bit of a 'Jack the lad'. He said he thought the man was quite vulnerable but tried to be cocky. He said the man was frightened of getting a long sentence that would ruin his life.

102. On 3 August, a prisoner told an officer that the man had been holding the mobile phone for the prisoner in C3-26. Since the find, the man had been harassing him for tobacco to compensate. The prisoner said he had told wing staff about this already. The prisoner told the investigator that the man was outwardly loud but was weak and vulnerable to bullying. He said the man had told him that he had been bullied to hold a mobile phone and had been caught with it. The prisoner who was bullying him was angry with him about this. The prisoner said he had threatened the man and told him to leave the man alone. He said the man was worried about being sentenced. He was not aware that the man had been smoking Spice and did not think he had done. He was surprised and upset by his death.

ISSUES

Bullying and the safety of prisoners on C wing

103. As part of its Violence Reduction Strategy, Wandsworth has procedures for dealing with prisoners involved in anti-social behaviour. The process is known as TASA – tackling anti-social attitudes. Examples of anti-social behaviour in the TASA document include bullying, assaults, threats, intimidation and demanding goods or services (including taxing, protection and debt collecting). The definition of violence in the document is, 'Any incident in which a person is abused threatened or assaulted. This includes an explicit or implicit challenge to their safety, well being or health. The resulting harm may be physical, emotional or psychological'. The definition of bullying is: 'Conduct motivated by a desire to hurt, threaten, or frighten someone. It can be physical, verbal, psychological, emotional, or economical, and often very subtle. It is usually repeated behaviour, unprovoked and intended to cause fear or harm to the victim.'

104. The TASA scheme requires staff to challenge any anti-social behaviour based on a zero tolerance approach. It makes it clear that staff can initiate the process based on observation or suspicion and there is no need to wait for a prisoner to report an incident. It requires prisoners to be managed under TASA procedures if they have committed defined acts of anti-social behaviour, including threats to kill or harm a person or bullying. Prisoners subject to TASA are placed on the basic regime and should have interventions to tackle their behaviour.

105. The TASA scheme includes a requirement that victims of anti-social behaviour and bullying should be supported and monitored, if appropriate. The victim support procedures expect that staff have meaningful conversations with prisoners who might be victims of anti-social behaviour at least twice a day and that staff record these and other observations at least twice a day. There is a victim support booklet for observations and care plans and to record frequent reviews.

106. On 28 and 29 October 2013, the man reported being bullied by another prisoner. On 2 April 2014, he told a SO and a nurse he was being bullied for his cellmate's debts. He was also physically assaulted by this prisoner in December 2013 and reported being sexually assaulted in March and May 2014. Despite this, the only time staff used victim support procedures was in July 2014, shortly before his death.

107. On 28 October and 11 December 2013, the security department sent information to the violence reduction team about the man's claim that a prisoner had been verbally abusing him and after the prisoner hit him, but no one began victim support procedures. On 29 October 2013, in response to his complaint that the prisoner was bullying him for money, an officer said that wing managers would discuss a victim support plan with him, but there is no evidence this happened. On 2 April 2014, after he said he was being bullied for his cellmate's debts, the minutes of the complex case review meeting

record an action to check if he was on victim support procedures but this was not done.

108. When staff began victim support procedures in July 2014, this involved only limited monitoring. There were only four entries over four and a half days on the daily supervision record. Under the policy, the minimum required for was period was nine. There was no support plan with objectives and actions to address the man's concerns.

109. Two SOs both told the investigator that they do not begin victim support procedures without the consent of the prisoner concerned. However, the victim's consent is not a requirement in such circumstances and there is a duty to safeguard prisoners. Staff did not complete security information reports each time that the man made an allegation of bullying or assault, as they should have done.

110. It is not clear whether the prisoner was managed under TASA procedures, as he should have been, after the man's allegations against him in late October or whether there was any investigation into the allegations. Staff told us that they could not take action against prisoners suspected of bullying without hard evidence as that would lead those people to complain that they were being bullied. When the investigator named the prisoner another inmate had said had bullied the man to hold a mobile phone, staff said that he had worked in a trusted job on C wing at the time, but was suspected of bullying and supplying drugs. Staff said they had taken no action, as they had no firm evidence against him. However, Wandsworth's TASA guidance makes it clear that staff can initiate measures on the basis of suspicion and observation.

111. Maintaining meaningful TASA procedures must involve keeping accurate information, taking a robust approach and invoking TASA procedures as necessary. Unless this is done, information that might show a developing pattern is lost. We are concerned that staff did not follow the procedures designed to protect the man, which would have allowed a clearer picture to emerge of the risks he faced.

112. In April, the man complained that he was being bullied for his cellmate's debts. No one submitted a security information report about this and no one investigated or began TASA, although there was significant evidence that his cellmate had been bullied, which would have lent credence to his claims. At the time he was being managed under ACCT procedures and we are concerned that staff did not make the link between him being threatened or bullied in relation to debt and the potential impact on his risk of suicide and self-harm. We have identified the importance of this in a recent thematic report into self-inflicted deaths in prison in 2013-14 and in previous learning lessons materials, including one published in July 2012, which found that 20% of 18-24 year olds in our sample of self-inflicted deaths had experienced bullying from other prisoners in the month before their death, compared to 13% of other prisoners. While we cannot draw a direct causal relationship with their deaths, this suggests that prisoners in his age group are particularly

vulnerable and underlines the need for effective violence reduction procedures.

113. As in our investigation into the man's death, staff told us that many of the prisoners on C Wing had committed offences that made it necessary for them to live on the vulnerable prisoners' wing but that they were not otherwise vulnerable. Although they had committed sexual offences, some were also involved in serious and organised crime. This meant that there were considerable problems in managing this group of prisoners in a unit, which also contained many men who were susceptible to bullying and intimidation. We consider that this made it all the more important for staff to be vigilant about any signs of potential bullying and actively challenge and promptly deal with anti-social and threatening behaviour. It also indicates a need to develop a strategy to manage these different groups of prisoners safely. We make the following recommendations:

The Governor should ensure that the Tackling Anti-Social Behaviour procedures are used actively, promptly and effectively to challenge prisoners suspected of bullying behaviour and to support their victims.

The Governor should develop a strategy to manage prisoners in the vulnerable prisoner unit who themselves are a risk to other vulnerable prisoners.

The ACCT process

114. Our investigation identified serious concerns about the management of ACCT procedures at Wandsworth. In our investigation into the death of the man, we identified a number of shortcomings in the way staff implemented ACCT and these are even more evident in his case. In particular we are concerned about:

- The number of different case managers;
- The lack of healthcare staff at first case reviews;
- The lack of multi-disciplinary representation at many case reviews;
- Information about triggers for self-harm not being recorded or acted upon;
- Poor caremap actions, which were often marked as "achieved" at the time the caremap was opened;
- ACCTs being closed shortly before an obvious potential trigger for self-harm.

115. The man was managed under ACCT procedures five times. Twelve different supervising officers acted as case managers, including four on the first ACCT and three on the final ACCT. No healthcare staff were present at any of the first reviews after assessment, which is a mandatory requirement of the national instruction, PSI 64/2011. The ACCT opened on 2 April had no first review or careplan at all. In two of the other four ACCTs, the assessor conducted the first case review alone. Of 19 case reviews, six took place with one other person and seven with only officers present. Of the six reviews with

representation from healthcare or other disciplines, two involved only one other person and one of those was a drug and alcohol recovery service worker with no apparent connection to him. There was no multi-disciplinary element at all for the ACCTs opened on 10 January and 2 April.

116. The first ACCT, opened on 26 October, does not mention the man's allegations of bullying against a prisoner of 28 and 29 October. On 2 April, he told a SO that his main concern was his upcoming court appearances. The ACCT was closed on 7 April, before he went to court between 11-16 April. On 24 April, he harmed himself, but there was no ACCT review. The last ACCT was closed before his trial, despite him saying on several occasions that he was worried about the outcome of his case. Caremaps mostly consisted of actions already achieved and were not updated or reviewed. ACCTs were also closed before all the objectives were met and apparently at his request.

117. Staff told us that all C Wing ACCT reviews take place every Monday in about an hour. A random pool of whoever is available from mental health, drug and alcohol services and the chaplaincy team, is asked to attend to satisfy the requirement under PSI 64/2011 that reviews should be multi-disciplinary. Often no one from healthcare or the chaplaincy is available. One of the wing SOs said that they give priority in this hour to ACCTs they consider can be closed. Otherwise, reviews are held ad hoc, at other times. We are concerned that the prison is not managing ACCT procedures in line with the requirements of PSI 64/2011. It was evident that some staff saw ACCT reviews as a chore to be got out of the way, rather than an opportunity to deal properly with the person's underlying distress. The allocated multi-disciplinary resources appear insufficient to make an effective impact on reducing the potential for suicide and self-harm. As we pointed out in our thematic review of self-inflicted deaths in prisons in 2013-14, this is a failure often repeated across the prison estate. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Multi-disciplinary ACCT reviews which ensure continuity of case management and include all relevant people involved in a prisoner's care;**
- **Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them;**
- **Ensuring that all caremap actions have been completed before an ACCT is closed;**
- **Healthcare staff attending all first case reviews;**
- **Recording all relevant information about the risk of suicide and self-harm in the ACCT record.**

Clinical care and the emergency response

118. The clinical reviewer noted the recommendations from the serious untoward incident review completed by St George's Healthcare NHS Trust. The report recommended that the counselling service from the psychotherapists should be integrated with the mental health care pathway. The report also noted there had been no referral to the GP for sexual health checks after the man made allegations of sexual assault in mid-April, which is against Trust policy. He also identified some areas for improvements in emergency response arrangements which the Head of Healthcare will need to address.

119. CCTV shows that the man's cell was left unattended with the door open after he was taken to hospital and this allowed another prisoner to spend over half a minute in his cell. There is no evidence that he tampered with anything but in these circumstances it is important that the cell is locked until the police attend. PSI 09/2014 (Incident Management) makes it clear that staff should preserve evidence whenever there is a serious incident

The Governor should ensure that cells are locked as soon as possible when a prisoner is removed after a serious incident.

RECOMMENDATIONS

1. The Governor should ensure that the Tackling Anti-Social Behaviour procedures are used actively, promptly and effectively to challenge prisoners suspected of bullying behaviour and to support their victims.

2. The Governor should develop a strategy to manage prisoners in the vulnerable prisoner unit who themselves are a risk to other vulnerable prisoners.

3. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - Multi-disciplinary ACCT reviews which ensure continuity of case management and include all relevant people involved in a prisoner's care;
    - Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them;
    - Ensuring that all caremap actions have been completed before an ACCT is closed;
    - Healthcare staff attending all first case reviews;
    - Recording all relevant information about the risk of suicide and self-harm in the ACCT record.

4. The Governor should ensure that cells are locked as soon as possible when a prisoner is removed after a serious incident.