Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammad Aghareda, a prisoner at HMP Wandsworth on 31 May 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Mohammad Aghareda was found hanged in his cell at HMP Wandsworth on 31 May 2016. He was 26 years old. I offer my condolences to Mr Aghareda's family and friends.

Mr Aghareda was a young man with a history of mental illness, suicide attempts and self-harm. The investigation found a number of weaknesses in the management of suicide and self-harm procedures and in risk management at Wandsworth. There were also deficiencies in the prison's emergency response. We also encountered unacceptable difficulties in accessing records and information in the case. It is hugely concerning that, as a result of this poor record keeping, I cannot come to an overall judgment as to whether the prison appropriately identified and managed Mr Aghareda's risk of suicide.

This parlous state of affairs comes against a background of repeated concerns I have raised about the management of suicide and self-harm prevention procedures at Wandsworth.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2017**

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Summary

Events

1. Mr Mohammad Aghareda had been diagnosed with paranoid schizophrenia in 2013, and had a history of suicidal thoughts, attempted suicide and self-harm. On 16 November 2015, he appeared in court charged with attempted robbery and was remanded to HMP Wandsworth. It was not his first time in prison.

2. A court liaison and diversion service alerted Wandsworth that Mr Aghareda was vulnerable and staff began Prison Service suicide and self-harm monitoring procedures (known as ACCT) when he arrived. Mr Aghareda was allocated a community psychiatric nurse from the mental health in-reach team. He was prescribed fortnightly injections of anti-psychotic medication, as he had been in the community, and medication to combat the side effects.

3. On 19 November, Mr Aghareda cut his arm because he did not want to share a cell. On 18 December, staff concluded that he no longer needed to be supported by ACCT procedures. Mr Aghareda had regular contact with his community psychiatric nurse, was assessed by prison psychiatrists and continued to receive his anti-psychotic medication as prescribed.

4. According to Mr Aghareda's prison record, on 7 January 2016, he threatened to kill himself if he had to share a cell. A named member of staff who appears not to be known at Wandsworth recorded that ACCT procedures had started again. Wandsworth was unable to provide any further material to confirm whether this actually happened. No ACCT documentation could be found. On 23 March, Mr Aghareda was sentenced to two years imprisonment.

5. On 15 May, Mr Aghareda moved to a single cell on a different wing. His prison record contains no entries by officers on that wing. He continued to have frequent contact with mental health nurses who had no concerns about his risk of suicide or self-harm.

6. On 31 May, the night patrol officer checked Mr Aghareda at about 6.00am but could not see him or get a response from him. The night patrol officer thought Mr Aghareda was using the toilet and that he had seen the privacy curtain move, so he did not raise the alarm. At about 8.40am, two officers went into Mr Aghareda's cell to carry out routine checks and found Mr Aghareda hanged behind the privacy curtain. Staff radioed for help and an ambulance and although it was apparent that Mr Aghareda was dead, nurses began cardiopulmonary resuscitation. Paramedics arrived, examined Mr Aghareda and at 9.02am, recorded that he had died.

Findings

7. The lack of entries in Mr Aghareda's prison file, absence of evidence that any staff on his wing knew him and the prison's lamentable inability to confirm whether Mr Aghareda was identified as at risk of suicide for a second time mean we are unable to come to any sort of view about whether staff did enough to predict Mr Aghareda's actions or prevent his death. However, we recognise that he received consistent and appropriate support from the mental health in-reach team, who did not have any concerns about his risk in the weeks leading to his death.

8. We consider that the absence of an up-to-date cell sharing risk assessment for Mr Aghareda and the failure to review it after Mr Aghareda's cell mate told officers he was trying to kill him and after Mr Aghareda reported voices telling him to kill his cell mate, is a significant failing. We consider these should have triggered reviews of his cell sharing risk assessment.

9. We consider that the night patrol officer should have raised the alarm when he could not see or hear Mr Aghareda on the morning of 31 May. We do not think that staff should have attempted to resuscitate Mr Aghareda when there were clear signs that he was dead.

Recommendations

- The Executive Governor should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary during the course of any investigation.
- The Executive Governor should ensure that staff manage prisoners at risk of self-harm or suicide in line with national guidelines. In particular:
    - ACCT assessment interviews and first case reviews are completed within 24 hours of ACCT procedures beginning.
    - ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.
    - Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.
    - A post closure review should be held within seven days of closure of the ACCT.
- The Executive Governor should ensure that cell sharing risk assessments are reviewed whenever there is information that a prisoner is at increased risk of violence towards a cellmate.
- The Executive Governor should ensure that staff satisfy themselves of a prisoner's safety at routine checks if they cannot see or hear them properly and alert the relevant manager if there are any concerns.
- The Head of Healthcare should ensure that all staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wandsworth, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator visited Wandsworth on 9 June 2016. She managed to obtain copies of some relevant extracts from Mr Aghareda's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Aghareda's clinical care at the prison.

13. The investigator interviewed seven members of staff at Wandsworth in July and August. In September, she interviewed one member of staff who no longer works at Wandsworth. The clinical reviewer joined her for six of the interviews.

14. We informed HM Coroner for Inner West London of the investigation who gave us the results of the post-mortem examination. We have sent her a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Aghareda's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know whether Mr Aghareda had received appropriate mental and physical care at Wandsworth, whether he had attempted suicide previously at Wandsworth and how staff had responded, and whether he should have been transferred to a secure hospital. Mr Aghareda's sister was provided with a copy of the initial report. She did not identify any factual inaccuracies.

Background Information

HMP Wandsworth

16. HMP Wandsworth is a local prison in south west London that holds up to 1,658 male prisoners and primarily serves the courts of south London. St George's University Hospitals NHS Foundation Trust provides physical healthcare services at the prison. South London and Maudsley NHS Foundation Trust provides mental health care. In May 2016, Wandsworth was designated as one of six proposed reform prisons where Governors would be given more autonomy to develop innovative practices. In March 2017, it was announced that Wandsworth would no longer be part of the reform prison programme.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wandsworth was in February and March 2015. Inspectors reported the quality of ACCT documents was variable and many of those examined were poor. They described inconsistently applied safety processes and inadequate management checks. Case reviews were often late, with minimal attendance. Mental health services were good and there were mostly courteous relationships between staff and prisoners but staff shortages had severely reduced the capacity of staff to interact with prisoners.

Independent Monitoring Board

18. 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 latest annual report, for the year to 31 May 2016, the IMB reported that the overall shortage of staff affected almost every aspect of prison life and the lack of officer continuity meant providing any pastoral care was extremely difficult. However, it found that significant improvements had been made to the regime on the Trinity Unit, which held low security category prisoners, which had a relaxed atmosphere and a predictable regime.

Previous deaths at HMP Wandsworth

19. PPO investigation reports into the three previous apparently self-inflicted deaths at Wandsworth in 2015 were critical of the management of ACCT procedures and the lack of supportive interaction through an effective personal officer scheme for prisoners who were quiet and compliant. In two other cases in 2014 and 2015, we found that staff had attempted resuscitation when it was inappropriate as it was evident that the prisoner had died.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

21. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary case reviews involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions of the caremap have been completed.

22. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Cell Sharing Risk Assessment

23. PSI 9/2011, the instruction that covers cell sharing risk assessment procedures, states that prisons must ensure that there is an up-to-date cell sharing risk assessment for all prisoners. It requires that standard risk assessments should be reviewed where new or additional information becomes known which indicates increased risk, and reviews must be carried out or approved by a multi-disciplinary team.

Key Events

24. On 16 November 2015, Mr Mohammad Aghareda was remanded to HMP Wandsworth, charged with attempted robbery. It was not his first time in prison. The court liaison and diversion service contacted Wandsworth before Mr Aghareda arrived to alert them to his history of suicide attempts and self-harm, which included tying something around his neck while in a secure hospital in September 2015. The liaison and diversion service did not complete a suicide and self-harm warning form. However, the police had earlier completed a Prisoner Exceptional Risk form (used to identify individuals who might be at special risk) and had ticked the box ‘mental disturbance’.

25. When Mr Aghareda arrived at Wandsworth, a reception custodial manager began Prison Service suicide and self-harm prevention procedures (known as ACCT). Healthcare staff accessed Mr Aghareda’s community mental health records which confirmed that he had been diagnosed with paranoid schizophrenia in 2013 and was managed by community mental health services under the Care Programme Approach (an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness). He was prescribed anti-psychotic medication in the form of an injection every two weeks and had been admitted to a psychiatric hospital four times between July 2013 and September 2015.

26. At an initial health assessment, Mr Aghareda told a nurse that he had no intention of harming himself but said he felt better when supported by ACCT procedures. The nurse referred him to the doctor and to the mental health in-reach team as a priority. He was placed in a shared cell on the First Night Centre, for new prisoners.

27. On 17 November, the mental health in-reach team discussed Mr Aghareda at their referral meeting and decided that Nurse A would manage his care. Mr Aghareda did not attend his appointment with the GP (the reasons why were not recorded). A psychiatrist prescribed fortnightly injections of zuclopenthixol decanoate, a slow-release anti-psychotic medication for treating schizophrenia. He also prescribed procyclidine, a medication to counter the unwanted side effects of anti-psychotic medication such as restlessness and tremors. This was in line with the medication he was prescribed in the community.

28. An officer checked Mr Aghareda at lunchtime on 19 November and saw that he had made a superficial cut to his left forearm. A nurse dressed his wound. Mr Aghareda told the officer he had cut himself to get some tobacco, but realised it was a stupid idea. No member of staff appeared to have noticed that Mr Aghareda had not yet had an ACCT assessment, which should have taken place within 24 hours of the ACCT procedures starting. No one reviewed his level of risk in light of his self-harm.

29. Later that day, another prisoner on the First Night Centre was found hanged in his cell. In line with national instructions, a supervising officer checked Mr Aghareda after the other prisoner’s death. Mr Aghareda said that he was okay and asked for some tobacco. The supervising officer assessed Mr Aghareda’s risk of suicide and self-harm as low. He did not notice that Mr Aghareda had not yet had his ACCT assessment and set the next review for 24 November. It is not clear how often staff were supposed to check Mr Aghareda.

30. On 20 November, a prison manager spoke to Mr Aghareda about the death. Mr Aghareda said he felt bad for the prisoner, but had no plans to harm himself. The manager assessed Mr Aghareda as at a raised risk of suicide and self-harm. At 12.30pm, an officer carried out the ACCT assessment. Mr Aghareda told her that he had harmed himself the day before because he wanted a different cellmate. He said that he had self-harmed in prison before in order to get what he wanted. He said that he had schizophrenia and heard voices but was taking medication for his condition. She noted that he seemed strangely upbeat and distracted. A case review did not take place after the assessment as required by Prison Service Instruction (PSI) 64/2011. An unknown member of staff wrote on the front cover of the ACCT plan that staff should record three 'quality interactions' with Mr Aghareda during the day and check him once an hour at night.

31. Also that day, Nurse A met Mr Aghareda for the first time. Mr Aghareda told her he had harmed himself the day before because he was not getting on well with his cellmate, but that he was now sharing with a different prisoner. He said he was sleeping a lot and had no current thoughts of suicide and self-harm. She concluded that Mr Aghareda was well, and displayed no psychotic symptoms. She gave him his scheduled anti-psychotic medication injection and noted that she would see him again in two weeks.

32. On 4 December, Mr Aghareda attended an ACCT case review with a supervising officer and a custodial manager. Nurse A was not present, and no one recorded whether she had been invited. Mr Aghareda said he wanted a single cell. The review group made two entries on the ACCT caremap: that staff should review Mr Aghareda's Cell Sharing Risk Assessment as he wanted a cell by himself, and that he should be seen by a member of the mental health in-reach team (although he was already under their care). The staff assessed Mr Aghareda as at a raised risk of suicide and self-harm and left the frequency of recorded observations unchanged at three times during the day and once an hour at night. Mr Aghareda had three case reviews after this, however, none were multidisciplinary, no healthcare staff attended and there was no record of whether they were invited. We do not know whether Mr Aghareda's Cell Sharing Risk Assessment was reviewed.

33. On 11 December, Mr Aghareda moved from the First Night Centre to a shared cell on A Wing, a standard prison wing. On 18 December, staff and Mr Aghareda agreed that he no longer needed the support of ACCT procedures.

34. On 4 January 2016, Mr Aghareda was convicted and remanded to Wandsworth until March, when he would be sentenced. On 6 January, Mr Aghareda's cellmate told officers that Mr Aghareda was trying to kill him, so he was moved out of the cell. Mr Aghareda said that if he was not left on his own, he would kill the next prisoner put into the cell. Wandsworth did not review his Cell Sharing Risk Assessment as they should have done. Mr Aghareda continued to share a cell.

35. On 7 January, Mr Aghareda threatened to kill himself if he was forced to share a cell and it seems that staff began ACCT monitoring again. A manager noted in his prison record that she had conducted his ACCT assessment and he had told her that he had no intention of taking his life or harming himself. She wrote that he seemed happier. Wandsworth was unable to find the ACCT document opened on 7 January, or provide any confirmation that Mr Aghareda was monitored under ACCT procedures for a second time, and no one could identify the manager.

36. On 11 January, Mr Aghareda told Nurse A that he had heard a voice two days previously telling him to kill his cellmate, and asked for a single cell. She made an appointment for him to see a psychiatrist but warned him not to use his mental health symptoms as an excuse to get a single cell. She wrote in his clinical record that he was not normally someone who was distressed by or responded to voices.

37. On 26 January, an officer told Nurse A that Mr Aghareda was again refusing to share a cell. Mr Aghareda told her that he would not share a cell as voices were telling him to kill his cellmate. She placed him on the list for a mental health review.

38. On 22 February, a prison psychiatrist assessed Mr Aghareda following Nurse A's referral. He noted that Mr Aghareda had talked about feeling threatened and harming others, and had appeared distracted by voices he was hearing. Nurse A recommended increasing his fortnightly dose of anti-psychotic medication from 200mg to 300mg.

39. On 23 March, Mr Aghareda was sentenced to two years imprisonment. A psychiatrist, instructed by Mr Aghareda's solicitor, prepared a report for the court. He concluded that Mr Aghareda's schizophrenia was not severe enough to merit his transfer to a psychiatric hospital.

40. Nurse A reviewed Mr Aghareda on 30 March, after his sentencing, and had no concerns about him. On 4 April, the psychiatrist saw him again and noted that he appeared relaxed, warm and polite. She found him to be positive and thought he seemed better than when she had last assessed him. Mr Aghareda told the psychiatrist that he was hearing muffled sounds rather than voices, but that he was able to distract himself by watching television and telling himself the sounds were not real. However, he said that he felt bored during the day. Although Mr Aghareda seemed confused about why he had not been recommended for transfer to a secure hospital, the psychiatrist wrote that he seemed to have accepted his sentence and was looking to the future. She decided to maintain the same dose of medication.

41. Nurse A told the investigator that as Mr Aghareda was stable she agreed that Nurse B, a new mental health nurse, would take over his care. On 20 April, Mr Aghareda asked Nurse B if his dose of anti-psychotic medication could be reduced as he was feeling tired and over-sedated and she referred him to the psychiatrist for a medication review. She told the investigator that each time she saw Mr Aghareda, she asked him how he was feeling and whether he had any thoughts of suicide and self-harm and he said he did not.

42. On 6 May, Mr Aghareda refused his anti-psychotic medication and, on 9 May, the psychiatrist agreed to reduce the dose to 200mg provided that Nurse B, as his named nurse, regularly monitored Mr Aghareda's mental health. Mr Aghareda agreed with this and resumed his medication.

43. On 15 May, Mr Aghareda moved to a single cell on G Wing of Trinity Unit, which holds prisoners for whom a lower level of security is appropriate. No officers made entries in his prison file after he moved to G Wing.

44. On 18 May, Mr Aghareda saw Nurse A passing through G Wing and they chatted. Mr Aghareda told her that he had committed his offence to get away from someone in the community who wanted to kill him. She told the investigator that she was concerned that he had developed paranoid beliefs as he had previously said that he had committed offences for money. Mr Aghareda asked her to refer him to a hospital. She did not think that Mr Aghareda was delusional but asked him whether he was in debt, which he denied. He said he was not hearing voices as frequently and they talked about sorting out his housing issues before he was released. She placed him on the clinic list to see the psychiatrist. This was the last time she saw him. She described him as cheerful and talkative, as he always was with her.

45. On 26 May, Nurse B saw Mr Aghareda for the last time in his cell. He said he was experiencing some side effects from his anti-psychotic medication and they discussed changing the times he received procyclidine to combat this. Mr Aghareda said he was worried about his accommodation on release in November and she assured him that he would get help with arrangements before he left. He said he had no thoughts of suicide or self-harm.

46. According to CCTV footage, Mr Aghareda was locked his cell at 5.36pm on 30 May. An officer carrying out routine checks of all prisoners on the wing checked him at 5.40pm, and again at 7.11pm and recorded no concerns.

Evening of 30 May and morning of 31 May

47. A night patrol officer checked Mr Aghareda at 8.54pm. He told the investigator that he thought Mr Aghareda made a thumbs up gesture. Mr Aghareda did not press his emergency cell bell during the night, and he had no reason to check him again until the next morning.

48. According to CCTV footage, the night patrol officer looked into Mr Aghareda's cell at 6.09am as part of a routine check. He said the cell light was on but he could not see Mr Aghareda in bed or in the cell. He called Mr Aghareda's name through the door and rattled the door handle but there was no response. He noticed Mr Aghareda's prayer mat, Qu'ran and slippers on the floor so thought he might be preparing himself for prayer and using the toilet behind the privacy curtain. He shouted Mr Aghareda's name again and thought he saw the privacy curtain move. He said that he wanted to respect Mr Aghareda's religious beliefs and thought this might be why Mr Aghareda had not responded. However, he was not completely satisfied so he waited, called to him again, and thought he saw the curtain move again. CCTV footage showed him looking through the observation panel into Mr Aghareda's cell from 6.09am to 6.12am, before moving on and checking other prisoners.

49. At 8.00am, officers unlocked those G Wing prisoners with jobs, taking education classes or prescribed morning medication. The rest, including Mr Aghareda, remained in their cells. At 8.41am, two officers went into Mr Aghareda's cell to carry out a routine cell check. An officer pulled back Mr Aghareda's privacy curtain and saw him hanging from a piece of sheet which was attached to the cell window. He shouted for other staff to help and an officer, who was checking the cell next door, ran into Mr Aghareda's cell immediately followed by another officer. An officer cut the sheet while another radioed an emergency code blue message (indicating a prisoner is unconscious, not breathing or is having breathing difficulties). The London Ambulance Service records show that the prison called for an ambulance at 8.43am.

50. A nursing manager and emergency response nurse responded to the code blue message and arrived at Mr Aghareda's cell, with the emergency bag, a few minutes later. The nurse said that when she arrived Mr Aghareda's body was rigid and he was on his knees, and there was no sign of breathing. She instructed the officers to lay Mr Aghareda onto his back and she began chest compressions. Paramedics arrived at the prison at 8.50am and reached Mr Aghareda's cell at 8.57am. They decided not pursue resuscitation and, at 9.02am, recorded that Mr Aghareda had died.

Contact with Mr Aghareda's family

51. At 1.45pm, a supervising officer and an officer arrived at Mr Aghareda's sister's home as he had named her as his next-of-kin and broke the news to her. The prison offered to contribute to the cost of Mr Aghareda's funeral, in line with national policy.

Support for prisoners and staff

52. After Mr Aghareda's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

53. The prison posted notices informing other prisoners of Mr Aghareda's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Aghareda's death.

Post-mortem report

54. The post-mortem examination concluded that Mr Aghareda died from asphyxia due to compression of the neck. The toxicology tests did not detect any illicit substances in his body.

Findings

Identifying and managing Mr Aghareda's risk

55. Prison Service Instruction 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Aghareda had some factors that increased his risk including previous suicidal thoughts and at least one previous suicide attempt, previous self-harm and a history of serious mental illness. His risk of suicide and self-harm was correctly identified when he arrived at Wandsworth and he was monitored under suicide and self-harm prevention procedures (known as ACCT) for one month. We have some concerns about the management of those procedures.

56. Although staff began ACCT procedures on 16 November, no one carried out an ACCT assessment interview for four days, despite the requirement that one should take place within 24 hours. No one from the healthcare department, or more appropriately the mental health in-reach team, attended the first ACCT review, which is a mandatory requirement. In fact, there was no evidence of any healthcare involvement in the later ACCT reviews despite Mr Aghareda's well documented history of schizophrenia.

57. On 19 November, while being supported by ACCT procedures, Mr Aghareda cut himself. Although his injury was noted in his medical record and in the on-going record of events in the ACCT plan, it did not trigger an ACCT review or a review of his level of risk or the frequency of observations. There is no evidence that staff completed a post-closure review interview after they ended ACCT monitoring on 17 December.

58. PSI 9/2011, the instruction that covers cell sharing risk assessment procedures, sets out the steps which should be taken to identify and address the risks which can be created by locating prisoners in the same cell.

59. However, we found no evidence that staff had reviewed Mr Aghareda's Cell Sharing Risk Assessment (CSRA), despite his cell mate reporting that Mr Aghareda was trying to kill him, despite Mr Aghareda saying he was hearing voices telling him to kill his cell mate and despite him threatening violence towards other prisoners if he was made to share a cell. Reviewing the CSRA was also an uncompleted action on his ACCT caremap.

60. Given these omissions in the ACCT procedures and risk management, we make the following recommendations:

The Executive Governor should ensure that staff manage prisoners at risk of self-harm or suicide in line with national guidelines. In particular:

- **ACCT assessment interviews and first case reviews are completed within 24 hours of ACCT procedures beginning.**
- **ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.**
- **Staff review risk and consider whether to hold a case review whenever an event occurs which indicates an increase in risk.**

- **ACCT monitoring continues until the risk posed by the prisoner has reduced and all caremap actions have been completed.**
- **A post closure review should be held within seven days of closure of the ACCT.**

The Executive Governor should ensure that cell sharing risk assessments are reviewed whenever there is information that a prisoner is at increased risk of violence towards a cellmate.

61. At the investigator's initial visit to the prison, she was told that Wandsworth had given all of Mr Aghareda's original documents to the police. The prison had not kept a copy for themselves and had not identified which individual had the records beyond "Wandsworth CID". Although, subsequently she was able to obtain some documentation, it is of great concern is that we have not been able to establish whether Mr Aghareda was monitored under ACCT procedures again in January 2016, after he threatened suicide, and if so for how long, because Wandsworth were unable to find a second ACCT plan, or any supporting evidence that staff began ACCT procedures then. They could not identify a manager who made the one entry about ACCT in Mr Aghareda's prison file in January 2016.

62. It is remarkable that such documentation as exists appears to hold an entry by a named, but otherwise apparently unidentifiable, member of staff. It is wholly unsatisfactory to be unable to comment on whether Mr Aghareda received adequate support after this and we make the following recommendation:

The Executive Governor should ensure that all documentation relating to a prisoner is stored securely and able to be retrieved as necessary during the course of any investigation.

63. Mr Aghareda's prison file contains no entries by prison staff after 22 April, although he moved from A Wing to G Wing after that date. There is little evidence that wing staff knew Mr Aghareda or were able to offer him meaningful support. Nurse B last talked to Mr Aghareda on 26 May and said that he reported no thoughts of suicide. We found no other evidence to indicate that his risk of suicide had substantially increased in the days leading to his death, but the general paucity of information in Mr Aghareda's file makes it hard to be certain whether staff could have predicted or prevented his death.

Mental health care

64. Mr Aghareda had paranoid schizophrenia and had been under the care of community psychiatric services. Wandsworth sought and received his community mental health records and his care was managed by a named community psychiatric nurse. His prescription for fortnightly injections of anti-psychotic medication continued at Wandsworth and the dose was adjusted when he complained of the side effects. Community psychiatric nurses saw him regularly and monitored his condition and he was assessed by the same psychiatrist several times. His named nurses regularly asked him about thoughts of suicide and self-harm and he always said he had no such thoughts. In the period before his death, it seems his mental state was stable and there was good coordination between the mental health professionals responsible for assessing and monitoring his condition.

65. The clinical reviewer reviewed the clinical care Mr Aghareda received at Wandsworth and concluded that the mental health care he had received was equivalent to what he could have expected to receive if he had been in the community.

Emergency response

66. The night patrol officer carried out a routine check of all prisoners on G Wing on the morning of 31 May. When he checked Mr Aghareda's cell at shortly after 6.00am, he could not see Mr Aghareda but thought he might be using the toilet behind the privacy curtain. Although he called to Mr Aghareda, Mr Aghareda did not respond.

67. Wandsworth's local policy states that the occupants of a cell should be visible or audible when checked. The night patrol officer did not want to intrude into what he thought were Mr Aghareda's preparations before praying. He was certain that he saw the privacy curtain move twice in response to his attempts to get a response and he waited several minutes at Mr Aghareda's door before concluding that all was well. We conclude that his response was understandable, but mistaken. If he had had any doubts, he should have returned to Mr Aghareda's cell after allowing a reasonable period for him to use the toilet and should have alerted the duty manager if he continued not to be able to see or hear Mr Aghareda. It is likely that Mr Aghareda had already hanged himself when he checked him. We make the following recommendation:

The Executive Governor should ensure that staff satisfy themselves of a prisoner's safety at routine checks if they cannot see or hear them properly and alert the relevant manager if there are any concerns.

68. When the officers found Mr Aghareda hanged it was evident that rigor mortis was present and that in all likelihood he had been dead for some time. European Resuscitation Council Guidelines 2015 which support current national guidance from the British Medical Association, Royal College of Nursing and National Offender Management Service note that every decision should be made on the basis of a careful assessment of each individual's situation. However, they say that resuscitation should not be pursued when rigor mortis is present. We understand that the natural inclination of prison and healthcare staff is to begin emergency first aid by giving life support. However, attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.

69. In investigations into two deaths at Wandsworth in 2014 and one in 2015, we found that healthcare staff had attempted resuscitation when rigor mortis was present and it is apparent that there is still some confusion about the circumstances in which staff should attempt resuscitation. We repeat a previous recommendation:

The Head of Healthcare should ensure that all staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

Prisons & Probation Ombudsman
Independent Investigations

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