



A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

**Investigation into the death of a man in March  
2014 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 was found hanged in his cell at HMP Wandsworth in March 2014. He was 51 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Wandsworth was undertaken. The prison cooperated with the investigation, but delayed providing some important information. The investigation was also suspended for some time because of the need to ensure our investigation did not impede ongoing police enquires. I am sorry for the consequent delay in issuing this report.

In the months leading to the man's death, he made numerous transfers of money which intelligence suggested were going indirectly to at least one other prisoner at Wandsworth. He told staff that he was being bullied for money, but there was no adequate investigation of this allegation and little was done to challenge the alleged perpetrators or protect him. He had a history of self-harm and, for some of his time at Wandsworth, he was monitored under Prison Service suicide and self-harm prevention procedures, although these took too little account of his vulnerability as a potential victim of bullying.

The investigation has identified a number of deficiencies in the operation of suicide and self-harm prevention and in anti-bullying procedures at Wandsworth, which the prison will need to address. I am particularly concerned that despite significant security information indicating that he was at risk, not enough was done to investigate this or challenge the alleged perpetrators.

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**

**May 2015**

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## SUMMARY

1. The man had a history of self-harm and mental health problems. In 2006, he was diagnosed with Munchausen's syndrome. In November 2008, he was remanded to HMP Pentonville charged with sexual offences. He was convicted in June 2009 and sentenced to four years in prison. In January 2012, while he was still in prison, he was sentenced to 14 years for further offences. He often harmed himself and said this was triggered by lack of external support, issues about money and to prevent being transferred to other prisons. Prison staff frequently monitored him under Prison Service suicide and self-harm prevention procedures known as ACCT, but regarded his behaviour as manipulative.
2. In 2011, security intelligence indicated that the man had received several payments of £500 into his prison account. The possibility that he was being bullied and was holding drugs for other prisoners was noted. In January 2013, a payment of £6,000 from his community bank account was made to his prison account.
3. In July 2013, the man transferred to the vulnerable prisoners' wing at HMP Wandsworth. At the time of his transfer, he had £4,254 in his prison account, so over £1,700 had left his account in the previous six months.
4. The man received some support from the mental health team at Wandsworth, particularly to help him control his impulsive behaviour. The mental health team did not have significant concerns about his mental health but referred him for counselling.
5. From August 2013 onward, the man made a number of large purchases from a mail-order company and made payments of £500 each to three people in the community. In October, an officer informed the prison's security department about the unusual transactions on his account. They linked the information to previous intelligence about drugs and bullying on the wing. Further intelligence reports were submitted over the following months, but no one investigated the matter.
6. On 9 January 2014, the man said he had swallowed a razor blade and nail clippers. He was admitted to hospital and monitored under ACCT procedures. He later said this was to prevent a transfer to another prison. He said he was lonely and being bullied, but would not give further details. Later that day, an officer reported that another prisoner had said he had been asked if his wife would accept a payment of £1,000 from the man's account to go to another prisoner's bank account. The prisoner said that the man had been bullied for money for a long time. The officer noted that £4,000 had left his account in the previous five months and that when he returned from hospital he should be asked if he was prepared to make a statement. No one spoke to him about the allegations.
7. On 19 February, the man told an officer that another prisoner was pressurising him to transfer £1,000 to him. The prisoner had threatened

that if he did not comply, he would destroy his property as he could get an officer he knew to unlock his cell. The officer submitted an intelligence report and a wing manager took some administrative action against the alleged bully. He was not monitored under the prison's procedures designed to protect victims of bullying.

8. At the beginning of March, an officer found the man hanged in the toilet area of his double cell. Although his cellmate had been in the cell with him during the lunch period, he said he had not noticed anything unusual as the man often spent a long time in the toilet area. Staff responded quickly to an emergency call but were unable to resuscitate him. Paramedics pronounced him dead at 2.45pm, shortly after they arrived.
9. The clinical reviewer concluded that the man's standard of healthcare was not comparable to that which he would have expected in the community. Although she recognised that he did not have a severe or enduring mental illness, she believed he would have benefited from more input from mental health clinicians. She was also concerned about some aspects of medicines management and record keeping.
10. The investigation found that prison staff at Wandsworth processed a number of intelligence reports indicating concern about unusual transactions on the man's accounts, but little was done with the information. Prison staff and the police did not communicate effectively, share information or fully investigate what was happening.
11. We were also concerned that the ACCT suicide prevention procedures were not effectively managed or coordinated. The process did not adequately address the man's two main risk factors: his fear that he would be transferred to another prison and the possibility that he was being bullied. We make six recommendations.

## THE INVESTIGATION PROCESS

12. The investigator issued notices to staff and prisoners at HMP Wandsworth, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator obtained relevant documents about the man's time in prison. He interviewed a number of staff at Wandsworth and the man's cellmate. An assistant ombudsman attended some of the interviews. The investigator informed the prison about the initial findings of the investigation.
14. A clinical reviewer reviewed the clinical care that the man received at Wandsworth on behalf of NHS England, London Region.
15. We informed HM Coroner for Inner West London of the investigation and have sent the Coroner a copy of this report.
16. During the course of the investigation, Wandsworth advised the investigator that the police were investigating some allegations involving staff and prisoners who lived and worked on C wing at the prison and there were potential links with the circumstances of the man's death. The prison was also investigating some professional standards issues involving staff on the wing. We therefore suspended our investigation until the outcome of those investigations. The man's cellmate subsequently killed himself at Wandsworth on 29 July 2014. As there were also links to his case, we held up publication of both reports. We are sorry for the consequent delay.
17. One of our family liaison officers contacted the man's sister to inform her of the investigation and to invite her to identify any relevant issues she wanted the investigation to consider. She had no specific matters for the investigation to take into account but wanted to know more about what had happened to her brother during his time in prison.
18. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

## **HMP WANDSWORTH**

19. HMP Wandsworth is a local prison in south west London which 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**

20. 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**

21. 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 healthcare continued to improve. A victim support process had been introduced to support those suffering from violence or threats of violence. The IMB noted that, 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.

### **Previous deaths**

22. The man's death was the third self-inflicted death at Wandsworth since 2010. There have been three further apparently self-inflicted deaths at the prison since his.
23. Sadly, one of the subsequent self-inflicted deaths was of the man's former cellmate in July 2014. The cellmate had assisted this office in the investigation into the man's death and we had similar concerns in both investigations about issues of bullying.

### **Assessment, Care in Custody and Teamwork (ACCT)**

24. 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**

25. 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.
26. At Wandsworth, prisoners identified as bullies, or who are thought to be involved in anti-social behaviour, are expected to be monitored under tackling anti-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.

### **Prisoner accounts and money**

27. Prisoners have three different types of accounts for their money: spending, private and savings. (The savings account is used by prisoners to save money and is often opened in the months before a prisoner's release.)
28. The spending account is an everyday account, similar to a current account, and is used to receive payments from prison work, money sent in by relatives and transfers from private bank accounts. Prisoners use their spending accounts to buy items from the canteen (prison shop). There is a limit to how much money can be held in a spending account.
29. The private account is a prison account for money that exceeds the amount that a prisoner is allowed to have in their spending account. Prisoners cannot use money in their private account to buy canteen, but can transfer money out of the account to pay bills in the community or to make payments to other people. Prisoners are allowed to arrange for money in their private bank accounts to be transferred into this account.
30. Prisoners can ask the prison accounts clerk to transfer money between the various prison accounts and their personal bank accounts but cannot make transactions themselves. Transfers between accounts are monitored and any unusual or suspicious activity should be brought to the attention of the prison's security department. The security department should then investigate (where necessary) to satisfy themselves that the payments being made are appropriate and not the result of illegal activity, such as money laundering, extortion or to buy drugs.

## KEY EVENTS

31. The man had been under the care of community mental health services since 2003 and had a history of self-harm. In 2006, he had been diagnosed with Munchausen's syndrome. This is a condition known as a factitious disorder which causes the person to fake or induce symptoms of illness in themselves. (This condition appears to have continued until his death and he reported symptoms of illness, including diabetes and heart disease, which were not supported by any clinical findings.) He had also been diagnosed as having a personality disorder, characterised by a tendency to act impulsively and without consideration to the consequences.

## HMP Pentonville

32. In November 2008, the man was remanded to HMP Pentonville, charged with sexual offences. There was no evidence that he was suffering from a depressive illness at the time and he was fit to stand trial. In March 2009, he swallowed a number of sharp objects, which were removed in hospital. A month later, he made cuts to his wrists. Prison staff monitored him under ACCT procedures at the time. On 11 June 2009, he was convicted and, in July, was sentenced to four years imprisonment.
33. The man moved between prisons during his first two years in prison and staff often managed him using ACCT procedures. In June 2010, he was charged with further offences. Throughout 2011 and 2012, he complained of various symptoms including chest pains, asthma, fits and the symptoms of diabetes. Tests found no clinical cause for these symptoms.
34. In June, October and December 2011, the man's solicitors sent him postal orders to the value of £1,500. A security intelligence report at the time raised concerns about the transfer of money and the possibility that he was being bullied and was holding drugs for other prisoners. In November 2011, he tested positive for benzodiazepine.
35. In January 2012, the man was convicted of further serious sexual offences and sentenced to 14 years imprisonment. On 17 February 2012, he tried to kill himself by taking an overdose and hanging. He said he had felt low, as he did not have any external support.
36. In September 2012, the man swallowed razor blades and nail clippers, which were removed in hospital. He said he had swallowed the items as he had had difficulty in getting money from his post office account because it was in a name he had previously used. He said he needed to get this sorted quickly as he owed his cellmate £100. An intelligence report was made about the debt. At an ACCT review on 3 October, he said he had harmed himself because he did not want to move from Pentonville. Later, he said the reason was because he was in debt.

37. At an ACCT review on 2 January 2013, the man said he still felt low as he had asked to have money transferred from his bank to his prison account but this had not been done. He asked to move to HMP Dovegate. Two days later, he said that if his ACCT monitoring ended he would harm himself to try to prevent transferring to HMP Isle of Wight. Staff noted that he was manipulating his situation to avoid having to participate in the sex offender treatment programme. On 9 January, staff closed the ACCT, when he said that he had changed his mind and wanted to move to do the programme.
38. On 24 January, the man transferred £6,000 from his community bank account into his prison private account.
39. In May, a mental health meeting, which included a consultant psychiatrist, discussed the man and noted that he was a prolific self-harmer and had a factitious disorder. Staff agreed a care plan to manage him.
40. In early July, the man learnt that he had been unsuccessful in his applications to move to a therapeutic community at either HMP Dovegate or HMP Grendon and there were no places on the sex offender treatment programme at HMP Rye Hill. He objected to a possible transfer to Wandsworth and said he did not like the prison and that he would refuse to go. HMP Isle of Wight was the only likely alternative, but he did not want to go there either. Staff identified that he might self-harm because of his situation, but they did not open an ACCT.
41. On 10 July, the man transferred to Wandsworth. When he arrived, he said he had no thoughts of self-harm and was happy to share a cell. Because of his offence, staff allocated him to a cell in the prison's vulnerable prisoners unit (VPU) on C Wing. At the time he transferred, he had £4,254 in his prison account.
42. A nurse carried out a reception health screen and noted the man's previous self-harm. Based on what he told her, she recorded that he had a history of asthma and epilepsy, but he had neither of these conditions. A GP saw him the next day and noted that he took medication for diabetes and hypertension. The GP recorded that he did not have any history of mental health problems. He prescribed a number of medications and continued his existing prescriptions. A nurse later noted that he suffered from angina, although there was no evidence to support this diagnosis.
43. A mental health nurse at Pentonville gave another nurse a handover about the man but this nurse did not record the detail of their conversation. On 18 July, the mental health in-reach team discussed him, but no one from the team saw him in person. Based on his records, the team noted that there was no evidence that he had any severe or enduring mental illness and had had a long period of stability. The team decided that he did not meet the criteria for the in-reach team and that he should be referred to the prison's primary care mental health team. A nurse made that referral.

44. Over the next week, the man met his offender supervisor and his personal officer. They did not note any concerns about him.
45. On 5 August, the primary mental health care lead saw the man and noted his history of self-harm and that he was, "communicative and appropriate". He acknowledged that he had acted impulsively during the previous year, but said he was now more settled. He said that he had found counselling at Pentonville helpful. They agreed that there was little that the mental health team at the prison could offer him, but she referred him to the prison's voluntary counselling team, which had a waiting list of three to four months.
46. On 9 August, the man bought £174 of goods from a mail-order company which prisoners were able to use to buy a range of goods. On 16 August, he authorised a payment of £500 from his private prison account to a member of the public. On 12 September, he made two payments of £500 to two other members of the public. It is not clear how or whether he knew these people, but prison intelligence suggested they were associates or relatives of other prisoners.
47. On 4 October, an offender supervisor working in the prison's public protection unit (PPU) submitted an intelligence report noting that the man had made large payments to various recipients in August and September and that he had applied to make further payments. He noted that he was not happy to authorise the payments until there was an investigation.
48. On 8 October, a security and intelligence analyst sent details of the information received from the offender supervisor four days earlier, to two officers and a custodial manager, who was the manager of the public protection unit at the time. He copied the report to the police liaison officer and to the finance business manager. Supporting intelligence indicated that the man was being bullied and had drug debts. It noted his propensity to harm himself and named another prisoner on C Wing as under suspicion because of previous intelligence connected with drugs.
49. On 8 October, the offender supervisor submitted two further intelligence reports noting that the man had authorised money to be sent to the home address of another serving prisoner and that he had made payments to other recipients. That day, a payment of £500 went from his prison private account to another member of the public.
50. On 10 October, a C wing officer submitted an intelligence report noting that the man had asked for a statement of his accounts. Two days earlier, the officer had confirmed the payment of £500 with him. The officer noted in the intelligence report, that he had not recorded anything about this in the wing observation book, as there was no evidence of any bullying. It was not until 3 December, that the intelligence report was forwarded to the Head of the PPU, the PPU Clerk and security collators.

51. On 16 October, the police liaison officer submitted an intelligence information report to the Metropolitan Police about the officer's intelligence report of 8 October.
52. On 1 November, the man bought a further £385 of goods, including a PlayStation.
53. Towards the end of November, the man's offender supervisor informed him that a proposed move to HMP Hull had been rejected. The offender supervisor said the man was keen to move to another prison to undertake the sex offender treatment programme. He tried to arrange a transfer to HMP Rye Hill but the man had to complete an application form, which the offender supervisor said the man deliberately avoided doing.
54. On 29 November, a payment of £150 went from the man's private prison account to another person.
55. On 3 January 2014, an officer submitted an intelligence report noting that the man had asked him to stop a cash payment for £1,000, which he had made to another prisoner's wife, but was intended for another prisoner. He told the officer that the prisoner had pressurised him to make the payment, but asked the officer not to say anything, as he was afraid of reprisals. On 8 January, the intelligence report was forwarded to staff and was copied to the prison's Head of Security.
56. On 8 January, a nurse from the prison's mental health team saw the man. He had referred himself, but told the nurse he was not sure why. He said that he had previously been in hospital for nine months after he had had a nervous breakdown. The nurse noted that he was ambivalent about what sort of help he wanted, but said he would like emotional support from time to time. The nurse planned to follow him up four weeks later and took no other action.
57. At 8.30am on 9 January, the man told a nurse that he had swallowed a razor blade and nail clippers during the night. The nurse noted that he complained of pain in his abdomen, but was alert and orientated. He was taken hospital. Doctors decided he did not need surgery but should remain in hospital for observation.
58. An officer opened an ACCT. The man told the officer he had swallowed the razor blade and nail clippers because he had been very stressed out that he might be moving to the Isle of Wight. He believed that he should be on a "medical hold" (when prisoners are not moved to other prisons because of outstanding health conditions which need ongoing treatment.)
59. That day, an officer submitted an intelligence report noting that a prisoner had told her that another prisoner had asked him if his wife would accept a £1,000 postal order from the man to pay into a prisoner's bank account. She noted that the man had paid large amounts of money to other prisoners' families and associates. The prisoner said that the man was

being bullied and that money had been being extorted from him for some time. She noted that he had recently spent £500 but did not have any of the items he had bought. She noted that, when he came back from hospital, staff should ask him if he was prepared to make a statement. She noted that he had sent out £4,000 from his prison accounts in only five months.

60. The security department sent the officer's intelligence report to two officers and the police liaison officer the next day. (At the time, the police liaison officer was temporarily covering his colleague's post and was not working in the prison full-time.) No one sent the information to the Metropolitan Police and no one asked the man if he would make a statement about this.
61. On 10 January, the daily safer custody complex case meeting discussed the man briefly. A custodial manager chaired the meeting, which was attended by representatives from offender safety, the mental health teams and the prison chaplaincy team. The manager noted that the man had swallowed razor blades and was in hospital. The meeting concluded that no further action was needed and they did not discuss the man again at any further complex case meetings.
62. On 11 January, Supervising Officer (SO) completed an ACCT Immediate Action Plan and another SO interviewed the man for an ACCT assessment, while he was in hospital. He told the SO that he had harmed himself because he had been distressed about moving to the Isle of Wight. He said that he was lonely, had no family or friends and found it difficult serving a long sentence. He said that his self-harm had been more a protest than a suicide attempt. Although his actions had prevented his transfer, it had caused him pain. He said he was being bullied, but would not say who the perpetrator was or give any other details. The officers noted that, when he returned to Wandsworth, the man should be monitored under anti-bullying procedures and referred to the prison's mental health team.
63. A SO completed an ACCT caremap. He noted that when the man returned to Wandsworth, wing staff should contact his community probation officer and staff should refer him to the prison's mental health team. The SO did not include any caremap action about anti-bullying measures.
64. On the evening of 12 January, the man returned to the prison. A nurse referred him to that the prison GP but could not recall if she had seen him when he arrived back. No one referred the man to the mental health team.
65. On 13 January, a SO chaired the man's first ACCT case review with two members of the prison's substance misuse service and a worker from the offender safety team. The man said he had harmed himself, as he did not want to be sent to the Isle of Wight, but had no current thoughts of harming himself. The review assessed the man as being at low risk of suicide and self-harm. The record indicates that the staff reviewed the man's caremap

but there were no changes or updates. The caremap actions had not been completed but the review team decided to close the ACCT and scheduled a post-closure review for 20 January. The staff did not begin anti-bullying procedures.

66. On the morning of 17 January, an officer was checking the man's account when she noticed that he had made a payment of £100 to another prisoner. The officer asked the man about the payment. The man said he had made the payment so the prisoner could buy some trainers. He told the officer that he had also made payments to some prisoners' wives and to a former cellmate. She noted that the man was quite distressed about this. That evening the officer completed an intelligence report about the payment. (The intelligence report was sent, by the prison's security analysts, to the wing manager, safer custody manager and the Head of Residence on 31 January, two weeks later.)
67. At 12.30pm on 17 January, a nurse saw the man at the request of an officer. The nurse recorded that the man was in bed, appeared lethargic and reluctant to move. She noted that it was possible he was being bullied. Because of his history of swallowing objects, the nurse considered that the man should be admitted to hospital for tests and that he might need mental health input when he came back to the prison. The man refused to go to hospital and said that he wanted to die and things should just take their course.
68. The nurse saw the man again later that afternoon. He told her that he had passed the nail clippers he had previously swallowed but had recently swallowed some additional items. She was concerned that the man and his cellmate might have some kind of pact with each other, and both were low in mood. She told a SO and a custodial manager about her concerns and noted that both prisoners should have an ACCT review. (The SO told the investigator that the "pact" referred to was for both the man and his cellmate to be taken to hospital together and did not refer to a suicide pact.)
69. The man's ACCT was re-opened. A SO chaired an ACCT review at 3.15pm. An officer and the man also attended. The SO noted that the man was tearful during the review, mainly because he was in pain and realised that this was his own fault. He said he wanted to go to hospital and then get back to his normal self. The SO scheduled a further ACCT review for 24 January. He made no changes to the previous caremap.
70. Two nurses from the prison's mental health team assessed the man's mental capacity. He told one nurse he not want to go to hospital and he wanted to die slowly. He said that he had had enough and he had the right to refuse treatment. He said that no one listened to him or cared about him. He said he was being bullied, but would not give any further details. The nurse concluded that the man had the mental capacity to decide whether to go to hospital. After some persuasion from staff and his cellmate, he agreed to go to hospital. The man went to hospital later that

afternoon. X-rays showed that he had swallowed a number of items but, as before, doctors decided he should not have invasive surgery but should stay in hospital for observation.

71. The man remained in hospital. On 19 January, at 7.50am, the escorting officers held an ACCT review at the hospital. The officers noted that the man was having tests to locate the objects he had swallowed and they were keeping him under constant observation. They arranged a further case review for 26 January, but did not update the caremap. At 8.30pm, the man told one of the escorting officers that other prisoners had bullied him for thousands of pounds. The officer noted that he would complete an intelligence report about this when he got back to the prison, but he did not do so.
72. On 20 January, the man returned to Wandsworth from hospital. He refused to go to the prison's healthcare unit, where nurses could monitor him more closely. However, staff noted that the man appeared in good spirits and said that he had no thoughts of self-harm. A nurse noted that no follow up was required unless he did not pass the objects that he had swallowed. Another nurse saw him in his cell the next day and recorded that he was fit and well. He did not mention any concerns.
73. A SO chaired an ACCT review at 3.20pm on 23 January, which another SO also attended. No healthcare staff were present. The man said he was more upbeat and felt fine. He said that if he felt depressed or down he would let staff know before he did anything rash. The lead SO noted that the man's risk of suicide and self-harm was low. Although the record indicated that staff had reviewed the care map, no changes were made. The SO told the investigator that he had asked him about bullying during the review, but he had not mentioned any concerns. There is no evidence of this in the written record of the ACCT review. The SOs closed the ACCT and scheduled a post-closure review for 30 January.
74. On 24 January, the man's offender supervisor went to see how he was coping. He said that he had been stupid to swallow razor blades but was desperate not to leave Wandsworth, as it took him a long time to settle anywhere. However, the offender supervisor noted that the man was aware that he was due to transfer to either Rye Hill or the Isle of Wight within the next two weeks.
75. On 26 January, an officer noted in the man's prison record that concerns about suspicious activity in his prison account were being looked into.
76. On 2 February, the offender supervisor saw the man again and emailed the offender manager about plans for him to transfer to either the Isle of Wight or Rye Hill. He noted that the man had still not completed the form to transfer to Rye Hill and that he had said he was in too much pain to sit and write at the time. He considered that the man was deliberately avoiding completing the form, as he wanted to stay at Wandsworth.

77. The man missed several healthcare appointments at the end of January and the beginning of February. On 19 February, a nurse saw him after he reported feeling shaky. The nurse encouraged him to drink tea with sugar, as his blood sugar levels were low. The nurse stayed with him until he felt better. This was his last recorded contact with healthcare staff.
78. On 19 February, the man told an officer that a prisoner was bullying him to send money to other prisoners. He said that the previous day, the prisoner had told him to transfer £1,000 to his account and had threatened to break his play-station and other items in his cell if he did not. The prisoner had added that he could get an officer to unlock his cell to do so. The officer submitted an intelligence report about this and noted the previous reports about the man sending money out to other prisoners. She emailed her line manager about her concerns and her line manager forwarded the email to an officer in the prison's security department. On 24 February, the officer acknowledged the line manager's email. He said that he was aware of the issues about the prisoner and would get back to her. (Staff in the security department did not forward the officer's intelligence report of 19 February to the security officer and the police liaison officer, until 4 March, a day after the man's death. The police liaison officer submitted a report to Wandsworth Police on 5 March, two days after the man's death.)
79. On 25 February, the line manager spoke to the prisoner about the allegations of bullying and taxing of other prisoners, as she had not received any more information from the prison's security department in response to her email. She arranged for the prisoner to be monitored under the prison's tackling anti-social attitudes procedures (TASA). He was put on the basic regime of the Incentives and Earned Privileges scheme and suspended from his work as a wing cleaner. She told the investigator that she later spoke to the man, who said that there was nothing that he wanted to talk about and that he was fine. There is no note of this conversation in his record or elsewhere and she did not begin TASA procedures designed to protect and support victims of bullying.
80. On 3 March, a doctor reviewed the man's medical records when he did not attend a neurology appointment that day. The review was in response to a drive to reduce non-attendance of appointments. The doctor did not see the man.

### **Events leading up to the incident**

81. The man's cellmate told the investigator that at lunchtime he left their cell to collect his food, but the man stayed behind and did not go to collect his lunch. He said that they later argued in their cell about cigarettes because the man felt that he was taking advantage of him by using his tobacco. He said that the man 'got nasty' but after they had argued, he (the cellmate) had fallen asleep.
82. At 12.45pm, Officer A saw the man in the cell when she made a lunchtime count of prisoners and did not have any concerns about him. At 2.00pm,

she and her colleague began unlocking prisoners on C wing for work. At 2.05pm, she opened his cell and the cellmate left the cell, leaving the door ajar. The man and his cellmate worked together and the officer said she thought it was strange that only the cellmate had come out of the cell. When she asked him, he said he did not know where the man was.

83. The cellmate 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 the man often spent a long time in the toilet and he had assumed that he was in there.
84. The officer went into the cell to see why the man had not left. She could not see him, but noticed that the door to the toilet was wedged shut with a crutch that had a cord wrapped around it. She knocked on the toilet door and called the man's name but got no response.
85. The officer went to get help and she and Officer B went back to the cell. They could still get no response from the man. Officer B tried to kick the crutch from under the door and to cut the cord attached to it with his anti-ligature knife, but was unable to. A maintenance officer, who was passing by the cell, gave him some pliers to cut the cord.
86. Officer B then went into the toilet area, found the man hanging from the window bars by some white material, which he cut. Officer A tried to use the maintenance officer's radio to make an emergency call, but was unable to as it was on a different radio frequency. She therefore went to the wing office and phoned the control room. She said there was an emergency code one and asked the emergency response nurse to attend. (A code one indicates a life-threatening medical emergency, such as when a person is hanging, unconscious or not breathing.) The London Ambulance Service records show that they received an emergency call from the prison at 2.12pm. An officer helped Officer B lay him on the cell floor.
87. The emergency response nurse arrived at 2.12pm with an emergency bag, which contained a defibrillator, oxygen and other equipment. Another nurse and a GP arrived shortly after. The emergency response nurse checked the man, but found no signs of life and began cardiopulmonary resuscitation. Both nurses said that he felt cold and they believed he was dead. They attached the defibrillator but this did not find any shockable heart rhythm. The nurses continued cardiopulmonary resuscitation until paramedics arrived, at 2.30pm, and took over. Paramedics were unable to resuscitate him and, at 2.45pm, the GP pronounced him dead.
88. The man left an unsigned note in his cell leaving his play-station and other possessions to his cellmate. At the time of his death, he had £247.97 in his prison account.
89. An intelligence report submitted after the man's death, on 5 March, noted that another prisoner had said that the man had been using cannabis before he died and was in debt to a "non-English" prisoner, which had

been causing him concern. Another intelligence report on 8 March, noted information from another prisoner that the man 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 a prisoner was upset at being owed money. On 10 March, a further intelligence report recorded similar information.

### **Family Liaison**

90. Wandsworth's Head of Operations acted as the family liaison officer. The man had not given any next of kin and the Head of Operations was unable to find any family. He asked the police for help and they identified one of the man's sisters. On 7 March, the police informed her of her brother's death.
91. He telephoned the man's sister on 13 March. She asked him to contact another sister. He told both sisters that the prison would meet the funeral expenses. He offered to visit them at their homes but they did not want him to visit.

### **Support for staff and prisoners**

92. The prison held a debrief for staff who had been involved in the emergency response and offered support. The staff said they found it helpful and that the prison's care and welfare team had given them good support.
93. Staff reviewed prisoners who had been identified as at risk of suicide and self-harm in case they had been adversely affected by the news of the man's death. The cellmate said that prison staff had given him good support after the death.

### **Evidence from the cellmate**

94. The man's cellmate killed himself at Wandsworth on 29 July 2014. The investigator and a colleague had interviewed him several days earlier as part of the investigation into the circumstances of the man's death.
95. The cellmate told the investigator that the man had been a friendly and cheerful person and he had been happy to share a cell with him. However, he alleged that the man had sexually assaulted him about a month before his death. He said he had reported the assault to staff but had been content to continue sharing a cell with him as staff had said there was no room for him elsewhere on the wing. In the investigation into the man's death, we found no evidence that he had reported this at the time.
96. The cellmate said many different prisoners used to come to their cell to see the man. He said that, when they did, he kept out of the way as he did not want to be involved, but said that he was aware that he was giving away large amounts of money. He said that, at around the time the man went to hospital in January, an officer had asked him if he knew anything

about this. He said he had told the officer that the man did not talk to him about the money and he did not know whom he was giving money to.

97. The cellmate said that the man smoked cannabis occasionally. In the days leading up to his death, he said that the man had become very withdrawn and stayed in their cell most of the time. He had become very possessive about their friendship and had followed him around. He said other people on the wing had noticed something was going on and some staff had asked him if everything was okay.
98. The cellmate thought that the man might have been bullied for money, but kept it quiet. He said that the man had said that his family were being threatened because of this. (Although the man had no contact with his family.) He thought that the bullying could have been linked to the fact that some prisoners were jealous of the man sending money to some prisoners and not others.

## ISSUES

### Management of security information

99. The man moved to Wandsworth in July 2013. Between August 2013, and February 2014, he transferred £2,250 from his prison account to other prisoners or their associates. In addition, he spent over £500 on goods. Intelligence reports dating back to 2011 noted concerns about him transferring money, and the possibility that he was being bullied to hold drugs for other prisoners. On 4 October 2013, the security department at Wandsworth received information about unusual activity on his prison account. The evidence suggested that he was a victim of bullying and had drug debts. A member of staff in the security department sent the information to the manager of the prison's public protection unit and the prison's police liaison officer, who sent a report about the unusual transfer of funds to Wandsworth Police. There were further intelligence reports about transfers of funds in October.
100. On 3 January 2014, an intelligence report noted that the man had asked the prison to stop a payment of £1,000 he had authorised to be sent to the wife of another prisoner. On 9 January, an officer repeated this information in another intelligence report and noted that there was evidence that he had been paying money to other prisoners, their families and associates, had been bullied, and had bought large quantities of goods, much of which he no longer had in his possession. (Which would indicate possible bullying.) He was in hospital at the time and the officer suggested that someone should speak to him about this when he got back to the prison. The security analyst sent the report to two security officers in the security department and the police liaison officer the next day. No one spoke to him about it when he came back to the prison and no action was taken.
101. There were further intelligence reports on 17 January and 19 February about payments from the man's account. Both reports noted that he had said he was being bullied by other prisoners to transfer money to them and that he was distressed about this. (On 19 January, while he was in hospital, he told a member of staff that other prisoners had bullied him out of thousands of pounds. No intelligence was submitted.) The security department did not send the 17 January report to his wing manager, the Head of Residence and the offender safety team manager, until two weeks later. No one had taken any action on the 19 February report by the time that he died in March.
102. In the intelligence report of 19 February, an officer recorded that the man had said another prisoner on C Wing had threatened him for money and would destroy some of his property if he did not pay. He said that the prisoner had told him that he could get access to his cell and his property by getting an officer to unlock it for him. The deputy governor told the investigator that they had received information from an unknown source that some officers on C wing had been letting this prisoner out of his cell at

times when he should have been locked up. The information suggested he had influence over the officers. She said that she had warned the officers about their conduct. The investigators spoke to the officers, who denied unlocking him at inappropriate times. The prison took no further action as there was no substantive evidence to support the allegation.

103. We are concerned that, despite a number of intelligence reports, which raised very serious issues with supporting evidence, no one at Wandsworth took any further action to establish the reliability or credibility of the information received or to initiate further investigations. The prison's police liaison officer made a report to the Metropolitan Police in October 2013, about the unusual activity on the man's prison account, but made no further reports when additional information was received. There is no record that any manager at Wandsworth discussed the matter with the police.
104. We have not been able to establish whether the police took any action in relation to the intelligence they received or whether they investigated further. There is no record of any additional exchange of information between the police and the prison's security department, but we understand that a specialist unit of the Metropolitan Police, the London prison anti-corruption team, was investigating some allegations about staff corruption at Wandsworth at the time, including on C Wing, where the man lived. (These investigations subsequently led to the prosecution and conviction of a member of staff at the prison but we are unaware of any direct link with the man.)
105. We accept that the prison's anti-corruption unit, professional standards unit and the police might have been conducting their own sensitive investigations about which they would have needed to be discrete. However, if this were the case, we are concerned about the lack of communication with senior managers at the prison to keep them informed and to allow them take a coordinated approach and prioritise protecting the man. The prison told the investigator that senior managers at the prison and the Metropolitan Police had monthly security tasking meetings at which they would discuss issues such his situation. Despite several requests, Wandsworth took two months to find and provide us with the minutes of those meetings. There is no reference to him in any of the minutes of the meetings held between July 2013 and April 2014
106. Seven intelligence reports noting unusual activity in the man's account, allegations of bullying or both, were submitted between the time he arrived at the prison in July 2013 and his death on 3 March 2014. We do not consider that the security department at Wandsworth handled this information appropriately or consistently. Although many of the intelligence reports contained similar information, they were not sent to the same people. There were references to bullying in a number of the intelligence reports, but the security department only sent one report to the offender safety team. They copied some, but not all to the public protection unit. Action in response to the intelligence reports was often

much too slow. For example, it was six weeks before an intelligence report, submitted on 19 February, was passed on appropriately, by which time the man had already died. The police liaison officer submitted only one report to Wandsworth Police while the man was alive. (He sent two more reports after the man's death.)

107. Little of the information noted in the intelligence reports is recorded elsewhere, even when it referred to the man being bullied. This information should have been recorded in the wing observation books and in his prison record to alert all staff to his vulnerability and to help protect him. None of the managers who were aware of the situation, commissioned any investigation and there is no evidence of anyone taking any action in response to the security information reports.
108. Many of the staff we spoke to at Wandsworth said they had believed that someone else was dealing with the issues in the intelligence reports. There was no clear leadership or direction from the security department and the absence of a permanent police liaison officer compounded the problems. Wing staff told the investigator that they had expected security staff to act on the information, yet security staff believed that responsibility for taking action rested with the wing staff. The lack of clear lines of responsibility and accountability meant that no one took appropriate action to protect the man. We make the following recommendations:

**The Governor should ensure that there is a coordinated approach to handling intelligence at the prison with clear lines of responsibility and a clear protocol about information sharing between the security department, residential staff and others, including the police. Information should be acted on quickly and investigated where necessary.**

**The Governor should ensure that, where appropriate, staff submitting security intelligence reports also record relevant information in prisoners' records, wing observation books and elsewhere as necessary.**

## **Bullying**

109. 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'.

110. 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.
111. During his time at Wandsworth the man told staff a number of times that he was being bullied for money. He named at least one perpetrator, yet there is little evidence that staff made any early attempt to investigate this. It was not until 25 February that the line manager spoke to the prisoner, as she was concerned that she had received no response to an email from the security department seeking further information. This was less than a week before the man died and some months after the prisoner had first been identified as allegedly threatening the man.
112. The TASA scheme includes a requirement that victims of anti-social behaviour and bullying should be supported and monitored if appropriate. The victim support (VS) 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 VS booklet for observations and care plans and to record frequent reviews.
113. The man was never monitored using TASA victim support measures, despite the significant evidence of bullying. On 11 January, when he was in hospital, an officer noted that the man should be monitored under victim support procedures when he returned to the prison, but this never happened. Many of the staff we spoke to during our investigation said that they were not aware that he might have been the victim of bullying. In a relatively small unit such as the VPU at Wandsworth, which holds around 85 prisoners, it is difficult to understand how this could be the case unless officers were not vigilant. Nevertheless, even the staff who did know that the man was being victimised did not follow the procedures designed to protect him.
114. A SO told the investigator that, with the benefit of hindsight, he should have opened a victim support plan. However, he said that he knew that the security department was involved and thought that such an action might jeopardise their investigation. He did not check with staff in the security department whether this was the case. Although the line manager spoke to the man on 25 February, when she placed the prisoner on TASA procedures, she told the investigator that she did not initiate victim support procedures for the man as he had said he was fine and did want to talk

about the matter.

115. 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.
116. Whatever the reason for intimidation or bullying, safeguarding measures should be used to challenge threatening behaviour and protect prisoners from being targeted by others. We are concerned that anti-bullying procedures at the prison were not used effectively to protect the man. 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**

117. Staff at Wandsworth began to manage the man under ACCT procedures on 9 January, when he harmed himself by swallowing a razor blade and nail clippers. We have identified a number of deficiencies in the ACCT process, which meant that staff did not manage his risk effectively .
118. The man's assessment interview was of a good standard, but subsequent reviews were not. The reviews were perfunctory and there was no recorded discussion about his allegation that he was being bullied, or of his distress at his planned transfer – both of which were issues that affected his risk of suicide and self-harm. The reviews focused more on his presentation at the time rather than dealing with the underlying causes of his distress. A SO said he did not note bullying as an issue in the ACCT care plan, as the man had not given details about this, but agreed that this should have been done and would have been useful for wing staff to indicate they needed to monitor this.
119. We have identified a number of other shortcomings in the ACCT process. These include a poorly defined, vague and not updated caremap; closing of the ACCT before all the objectives were met; and ACCT observations

not being conducted at sufficiently unpredictable intervals. In addition, few reviews involved healthcare staff and two nurses said they had not received any formal ACCT training.

120. We do not consider that staff managed the man's ACCT procedures, in line with the requirements of PSI 64/2011. An internal review, in January 2014, highlighted the work needed to improve ACCTs at Wandsworth. Suicide and self-harm triggers were consistently listed incorrectly, reviews contained limited information and substantial work was needed to improve caremaps. The same issues were identified again during a review in February 2014. In light of these recognised failings, 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 set caremap objectives to address the underlying causes of a prisoner's distress.**
- **Ensuring that all caremap actions have been completed before an ACCT is closed.**
- **Carrying out ACCT observations at unpredictable intervals.**
- **That all staff receive ACCT training.**

### **Healthcare**

121. In her clinical review, the clinical reviewer concluded that the clinical care the man received at Wandsworth was not equivalent to that he could have expected to receive in the community. She made a number of recommendations, which the Head of Healthcare will need to address. As we do not consider that these healthcare issues were directly related to the circumstances of the man's death, we do not repeat the recommendations in this report.

### **Family liaison**

122. Prison Rule 22 requires prisons to inform the next of kin as soon as possible if a prisoner dies. PSI 64/2011 gives mandatory instruction that, wherever possible, this must be done in person by a family liaison officer and another member of staff.
123. Because the man left no next of kin details, the police were asked to assist the prison in identifying his next of kin. The police identified one of his sisters and, on 7 March, they informed her that her brother had died. No one from the prison established the police's contact until the investigator prompted the prison. It was not until the 13 March, that an officer telephoned her to introduce himself as the prison's family liaison officer. This was a day after the investigator had asked the officer about the prison's contact with the man's family.

124. Although we understand that there were initial difficulties, as the prison had no contact details for the man's next of kin, we consider that someone from the prison should have contacted them much earlier. We make the following recommendation:

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

## RECOMMENDATIONS

1. The Governor should ensure that there is a coordinated approach to handling intelligence at the prison with clear lines of responsibility and a clear protocol about information sharing between the security department, residential staff and others, including the police. Information should be acted on quickly and investigated where necessary.
2. The Governor should ensure that, where appropriate, staff submitting security intelligence reports also record relevant information in prisoners' records, wing observation books and elsewhere as necessary.
3. 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.
4. The Governor should develop a strategy to manage prisoners in the vulnerable prisoner unit who themselves are a risk to other vulnerable prisoners.
5. 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 set caremap objectives to address the underlying causes of a prisoner's distress.
  - Ensuring that all caremap actions have been completed before an ACCT is closed.
  - Carrying out ACCT observations at unpredictable intervals.
  - That all staff receive ACCT training.
6. The Governor should ensure that a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national guidance.