

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wesley Rowlands a prisoner at HMP Garth on 14 October 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Wesley Rowlands was found hanged in his cell on 14 October 2016 at HMP Garth. He was 33 years old. I offer my condolences to Mr Rowlands' family and friends.

Mr Rowlands was serving a life sentence for murder. He had paranoid schizophrenia and appeared to be well supported in the therapeutic community at Garth.

Staff appropriately began suicide and self-harm prevention arrangements in September 2016, but the investigation found some failings in the standard of risk assessment and monitoring. In addition, the prison's violence reduction policy was not followed and Mr Rowlands was not adequately supported when he said he was being bullied. Nevertheless, I recognise that there was little to indicate that Mr Rowlands was at an imminent risk of suicide.

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

June 2017

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	10

Summary

Events

1. Mr Wesley Rowlands was convicted of murder in 2012 and was serving a life sentence with a minimum tariff of 15 years. He arrived at HMP Garth on 18 November 2015, having spent a period of seven months at a mental health secure hospital.
2. Mr Rowlands had paranoid schizophrenia and a history of self-harm. During his time at Garth, he was prescribed anti-psychotic and antidepressant medication and he received appropriate support from the mental health team.
3. On 13 April, Mr Rowlands told a prison officer that a prisoner was bullying him. On 14 April, Mr Rowlands told staff that he had been play fighting when he sustained a broken nose and swelling to his face on the wing. Staff suspected he had been assaulted by another prisoner. The prison's violence reduction co-ordinator investigated the incident but, as Mr Rowlands did not want to speak to the investigator, the investigation was inconclusive.
4. On 31 May, Mr Rowlands told his personal officer that another prisoner was threatening him because his previous cellmate was in debt. He said that this was affecting his mental health and asked to move wing. The officer noted Mr Rowlands' concerns in his prison record and submitted a security report. Mr Rowlands moved to E Wing, Garth's therapeutic community. No one investigated further or took any action to address the alleged bullying.
5. On 5 September, another prisoner told staff that Mr Rowlands had taken an overdose and had collapsed. Staff began suicide and self-harm monitoring (ACCT) procedures. Mr Rowlands said he had been drowsy because of his medication and he had no thoughts of harming himself, so ACCT monitoring was stopped on 7 September.
6. On 14 October at 6.05am, staff found Mr Rowlands hanging from the television bracket in his cell. He used a nylon bootlace as a ligature. Staff called an ambulance immediately and started resuscitation, despite signs of rigor mortis. Ambulance staff arrived at 6.39am and Mr Rowlands was pronounced dead at 6.53am.

Findings

7. We are concerned that officers did not adequately explore Mr Rowlands' risk factors after he took an overdose the month before he died. We have also identified some frailties in ACCT monitoring.
8. Despite Mr Rowlands reporting that he was intimidated by a prisoner, we found that he was not adequately supported, the alleged perpetrator was not appropriately challenged and the incident was not investigated as it should have been according to the prison's violence reduction strategy.
9. We are concerned that staff attempted to resuscitate Mr Rowlands, despite signs of rigor mortis.

Recommendations

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

- assessing the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and recording the reasons for the decision;
- completing the relevant paperwork, fully and accurately, at all stages of the ACCT process.

The Governor should ensure that staff understand that all information about bullying, threats and potential violence is recorded, fully considered and acted on through a robust and responsive violence reduction policy which appropriately supports the victim and challenges the perpetrator.

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
11. NHS England commissioned a clinical reviewer to review Mr Rowlands' clinical care at the prison.
12. The investigator visited Garth on 20 October 2016. She obtained copies of relevant extracts from Mr Rowlands' prison and medical records.
13. The investigator interviewed six members of staff and one prisoner at Garth in November. The clinical reviewer conducted a further telephone interview with one member of healthcare staff.
14. We informed HM Coroner for Preston and West Lancashire of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Rowlands' brother to explain the investigation. Mr Rowlands' family wanted to know if his mental health needs, including appropriate medication, were adequately addressed in prison.
16. Mr Rowlands' family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

Background Information

HMP Garth

17. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services. Nurses are on duty between 7.00am and 9.00pm every day. Chorley Medics provide a service outside these times. GP clinics are held every day, normally from 9.00am to 1.00pm but occasionally from 1.00pm to 5.00pm. There is no inpatient unit.

HM Inspectorate of Prisons

18. An unannounced inspection took place at HMP Garth in September 2016 but the report has not yet been published. The latest published report relates to an unannounced visit in August 2014. The report identified weaknesses in some critical areas – safety, equalities, activities and offender management. The inspectorate found that there was an ineffective system for challenging antisocial behaviour and was concerned by a sharp rise in violent incidents, with frightened prisoners seeking refuge in the segregation and drug recovery units. The inspectorate said that there was very good mental health provision with excellent therapeutic resources, but there was varied support for those at risk of suicide and self-harm. There was also a good drug treatment service, but this was undermined by readily available drugs and alcohol. The report was critical of staff shortages, which resulted in restricted regimes and undermined the staff/prisoner relationship.

Independent Monitoring Board

19. 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 last annual report for the year to November 2015, the IMB reported concerns about the education and training provision. They were also concerned about the waiting times to see a GP and the increased pressures on the mental health team.

Previous deaths at HMP Garth

20. Mr Rowlands' death is the third self-inflicted death at Garth since August 2015. In the previous two cases, there were also concerns about suicide and self-harm monitoring procedures and the prison's violence reduction policy.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan

should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. Mr Wesley Rowlands was serving a life sentence for murder, imposed in 2012, with a minimum tariff of 15 years. He had paranoid schizophrenia and had spent seven months at a mental health secure unit between April and November 2015, before being transferred to HMP Garth on 18 November 2015.
23. Mr Rowlands had a history of self-harm but he was not subject to suicide and self-harm prevention measures (known as ACCT) when he arrived at Garth. A mental health nurse saw him in reception and reported no concerns about his mental health, assessing him as stable in mood. He was prescribed quetiapine (anti-psychotic), fluoxetine (antidepressant) and gabapentin (pain relief).
24. From January 2016, Mr Rowlands was unhappy about his anti-psychotic medication dosages, which resulted in him being aggressive towards healthcare staff for a number of weeks. He said that he wanted to be returned to the mental health secure unit as he did not feel he was being supported by the prison. He threatened to stop complying with his medication.
25. Mr Rowlands' offender supervisor wrote to the Head of Healthcare on 23 February to ask that the problems with his medication be resolved urgently due to the risk to staff. The issues with his medication were resolved shortly afterwards. Mr Rowlands was assessed as suitable to have his medication in his possession and took his medication as prescribed.
26. Mr Rowlands moved to C Wing on 30 March after telling staff that he did not feel safe on A Wing. He said he was in debt and was being threatened by other prisoners. Security reports were submitted but no further action was taken, as Mr Rowlands did not say who was threatening him.
27. On 7 April, Mr Rowlands was in a one to one session with his mental health keyworker when he became aggressive. She wrote in his medical records that he presented as agitated, paranoid and delusional, and that he made minimal eye contact. She told the Head of Healthcare that she felt threatened by Mr Rowlands and was concerned about continuing to work with him. He agreed to contact doctors at the mental health secure unit. She submitted a security report and Mr Rowlands was moved to D Wing the next day.
28. The Head of Healthcare told the clinical reviewer that healthcare staff carry out spot checks to ensure medication compliance and he did not believe there were any concerns that Mr Rowlands was not taking his medication. On 12 April, a prison GP stopped Mr Rowlands' prescription of gabapentin after he was unable to produce it to the pharmacy service when asked to do so as part of a medication check. (Gabapentin is a highly tradable drug in prison and therefore its use, particularly when given in possession, is carefully monitored.)
29. On 13 April, Mr Rowlands told an officer that he was being bullied by another prisoner so he could not go to the prison workshop. He named a specific prisoner and the officer added this information to his prison record but did not submit a security report or investigate the matter any further.

30. Mr Rowlands was involved in an incident on 14 April, which resulted in a broken nose and swelling to his face. He told staff that he had been play fighting, but officers suspected he had been assaulted by another prisoner. No one completed a security report. He initially refused any healthcare assistance but during the early hours of the following morning a nurse attended his cell to offer him treatment. The incident was investigated by the prison's violence reduction co-ordinator. Her findings were inconclusive as Mr Rowlands said he did not want to take any further action and insisted that he had been involved in a play fight.
31. On 13 May, a family friend of Mr Rowlands called the prison expressing concerns about Mr Rowlands' mental health and how it was being supported within the prison. He told the investigator that he contacted the prison because Mr Rowlands had been writing letters to him which he described as "bizarre". The prison asked him to write in with his concerns, which he did. He said that a prison manager rang him and he was reassured that the prison was trying to support Mr Rowlands.
32. On 31 May, Mr Rowlands again told an officer that he was being threatened due to a debt left by his former cellmate. He said that he was being asked to carry out assaults on staff and prisoners in order to clear the debt and the pressure was affecting his mental health. He asked for a move to B Wing, which is seen by prisoners as a safe place for them to go when being targeted due to debt, but the officer explained he needed to complete an application to transfer to B Wing. He was moved to E Wing in the meantime. The officer explained in interview that he inadvertently noted in the security records that he had opened a CAB (challenging anti-social behaviour) support document but he did not in fact do this. He said that this was due to him being unexpectedly off work for personal reasons. (The CAB document is intended to offer support to victims of bullying and challenge the behaviour of the perpetrator.)
33. On 15 July, Mr Rowlands moved onto the therapeutic community on E Wing and started the therapeutic programme. The programme comprises group work and one to one sessions and aims to challenge drug-seeking and offending behaviour. Mr Rowlands' keyworker said that he found it difficult to open up to others in group work but he seemed motivated to address negative behaviour.
34. On 5 September, Mr Rowlands collapsed and another prisoner said that he thought he had taken an overdose. Staff called a code blue over the radio (which means that a prisoner is not breathing or unresponsive and an ambulance should be called). When healthcare staff arrived, Mr Rowlands became abusive towards them and refused any assessment or treatment. An officer started suicide and self-harm monitoring (ACCT) procedures. She completed the Concern and Keep Safe form, recording that Mr Rowlands was suspected of taking an overdose of his prescribed medication, was in a very low mood, and was displaying unusual behaviour. She recorded that other prisoners had told her he had taken an overdose and had been making comments to them about "leaving soon". He was observed by officers regularly during the night.
35. A SO assessed Mr Rowlands as part of ACCT procedures on 6 September. Mr Rowlands repeated to him that his medication made him drowsy and he had no

intention of harming himself. She told the investigator that Mr Rowlands was “happy and chirpy” when he came into the interview and he was making jokes with staff and prisoners. She said she had no concerns about him. She completed the record of her ACCT assessment interview with very limited information. She told the investigator that, when she reviewed it after Mr Rowlands’ death, she realised that the quality of the assessment was not acceptable.

36. Another SO chaired an ACCT review on 7 September, which was attended by mental health key worker and Mr Rowlands. The previous SO could not attend the ACCT review, but she said she spoke to the SO saying that she felt Mr Rowlands did not need to be subject to ACCT monitoring. At the review meeting, the SO recorded that Mr Rowlands said he had no intention of harming himself and he did not need to be monitored. The review concluded that Mr Rowlands would continue to work closely with his keyworker and therefore the ACCT could be closed. They did not discuss Mr Rowlands being bullied or the reason for his overdose. Mr Rowlands did not sign the ACCT closure paperwork. The SO told the investigator that he did not recall looking at the previous SO’s assessment during the review. When he looked at it during the interview with the investigator, he acknowledged that the assessment was not sufficiently detailed. He explained his decision to close the ACCT after only two days was based on Mr Rowlands’ presentation and because he said he had no thoughts of suicide or self-harm, as well as the fact that he would continue to be supported by the mental health team.
37. The post-closure review was held on 21 September and chaired by a SO. The SO recorded that Mr Rowlands had good support and regular activities in place. Mr Rowlands refused to complete or sign the ACCT questionnaire but the ACCT remained closed.
38. On the evening of 13 October at around 8.40pm, Mr Rowlands pressed his cell bell and an operational support grade (OSG) went to his cell door. He said that Mr Rowlands seemed in good spirits and asked him if he could get him some cigarette papers and tobacco from the prisoner next door and some toilet paper. When he went back with these items, he said that Mr Rowlands was chatty and told a couple of jokes. He said he had no concerns about Mr Rowlands when he left his cell door.
39. On 14 October at 6.05am, the OSG was conducting the morning roll check when he looked into Mr Rowlands’ cell and saw him on the floor with a bootlace around his neck which was tied to the television bracket. He called code blue on his radio and an ambulance was called immediately. Officers responded to the code blue and opened the cell door. By this time, a prison manager had also arrived at the cell and he cut the ligature.
40. A healthcare assistant arrived around five minutes after the code blue was called. The officers moved Mr Rowlands into the corridor for resuscitation. She told the investigator that she knew that Mr Rowlands was dead and rigor mortis was present, but she began chest compressions and used life saving equipment in an attempt to restart his heart. She said she thought she should continue until the paramedics arrived.

41. The ambulance was called at 6.09am, but the prison received a call from the ambulance service to say they would be delayed. In the event, the ambulance did not get to the prison gate until 6.39am. The healthcare assistant continued resuscitation for more than 30 minutes. The paramedics pronounced Mr Rowlands dead at 6.53am.
42. Mr Rowlands left two notes in his cell. He wrote that he was having difficulty coming to terms with the offences he had committed and asked for forgiveness from his friends and family. He also thanked prison and healthcare staff for the support they had given him. After his death, officers found a number of handwritten notes, including names and prison numbers of other prisoners with various amounts of money written against each name.

Contact with Mr Rowlands' family

43. Mr Rowlands' brother was listed as his next of kin. Two prison family liaison officers visited Mr Rowlands' brother at the address held on his record at approximately 11.30am, but his family no longer lived there. A neighbour contacted them and they came to the neighbour's house where they were informed of Mr Rowlands' death. The prison contributed to the cost of Mr Rowlands' funeral, in line with Prison Service instructions.

Support for prisoners and staff

44. After Mr Rowlands' death, a deputy governor debriefed staff involved in the emergency response to offer support and ensure they had the opportunity to discuss any issues arising. The staff care team also offered support. One member of staff said that they had not felt appropriately supported.
45. The governor posted a notice for prisoners on the therapeutic support community informing them of Mr Rowlands' 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 Rowlands' death.

Post-mortem report

46. The post-mortem report concluded that death was due to hanging. The toxicological report showed the presence of therapeutic levels of antidepressant medication. No alcohol or other drugs were detected.

Findings

Management of risk of suicide or self-harm

47. On 5 September, staff appropriately started suicide and self harm prevention (ACCT) procedures after they suspected Mr Rowlands had taken an overdose. A SO's assessment interview was extremely poor and this undermined the assessment of Mr Rowlands' possible level of risk and his issues. She said that Mr Rowlands came into the interview with a cup of tea and he was "laughing and joking" so, due to his presentation, she was not worried about him. He told her that he had not taken an overdose, that he had no thoughts of harming himself, and that he did not want to be subject to ACCT monitoring. There is no evidence that she discussed bullying with Mr Rowlands, nor that she explored possible reasons for his overdose. She acknowledged in interview that her written record of the assessment was unacceptable.
48. We are concerned that staff attached too much weight to Mr Rowlands' presentation at his case review on 7 September. Another SO said that he did not look at the previous SO's assessment and there is no evidence that the suspected overdose or previous allegation of bullying were explored before making the decision to stop ACCT monitoring. This was a missed opportunity to identify and manage Mr Rowlands' risks. We are concerned that staff involved in the ACCT process appeared too ready to accept Mr Rowlands' assurances that everything was fine and that he did not need to be monitored.

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

- **assessing the level of risk based on all available information and known risk factors and not on a prisoner's presentation, and recording the reasons for the decision;**
- **completing the relevant paperwork, fully and accurately, at all stages of the ACCT process.**

Violence reduction strategy

49. The PPO has published a range of publications identifying the links between bullying and suicide. In a review of self-inflicted deaths, published in June 2011, we found evidence of bullying and intimidation in 20 per cent of the cases we reviewed. In a follow-up report of October 2011, 'Violence reduction, bullying and safety', we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that individuals who have been the victim of bullying are potentially at greater risk of suicide and self-harm. We repeated similar messages in our review of all self-inflicted deaths in prisons in 2013/14 and pointed to the need for all reports or suspicions that a prisoner is being threatened or bullied to be recorded and thoroughly investigated and for the potential impact on the victim's risk of suicide to be considered.
50. Garth's local policy 'Violence Reduction Strategy: Creating a Community for Positive Change' states that all incidents of violence - including threats, bullying

and intimidation - will be investigated and managed accordingly. The last HMIP inspection report on Garth, published in 2015, said “the challenging antisocial behaviour system was not effective in challenging perpetrators of violence or bullying, or supporting victims adequately”. Mr Rowlands told staff that he was in debt and that he was being bullied. We found further evidence to support this from notes left in his cell after his death, interviews with other prisoners, and phone calls made to his family. He regularly called his brothers asking them to make payments to him and to other prisoners.

51. Mr Rowlands told an officer that a specific prisoner had been threatening him. The officer did not follow this up with the alleged perpetrator or put support measures in place for Mr Rowlands. When Mr Rowlands was found with a broken nose and bruising the following day, the matter was apparently investigated by a SO in her role as the prison’s violence reduction co-ordinator. Despite officers’ concerns, her findings were inconclusive as Mr Rowlands said it was just a play fight. Furthermore, when Mr Rowlands was later subject to ACCT monitoring and she completed his assessment, she did not discuss whether he was bullied and neither did those at the case review. We make the following recommendation:

The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.

Resuscitation

52. When staff found Mr Rowlands hanging in his cell, it was apparent that he had been dead for some time, as rigor mortis was present. Despite this, the healthcare assistant attempted to resuscitate him before ambulance staff pronounced him dead. We consider that it was not necessary to attempt to resuscitate Mr Rowlands.
53. European Resuscitation Council Guidelines 2010 say that, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” The guidelines give examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual’s situation. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

**Prisons &
Probation**

Ombudsman
Independent Investigations