Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Sean McKeown, a prisoner at HMP Wandsworth, on 4 June 2019

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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 Sean McKeown died on 4 June 2019 after he was found hanged in his cell at HMP Wandsworth. Mr McKeown was 51 years old. I offer my condolences to those who knew him.

Mr McKeown had a long history of substance misuse and serious mental health problems. He had not, however, self-harmed in the last 16 months of his life and I accept that prison staff had no reason to believe he was at imminent risk before he died.

I am, however, concerned that the mental health inreach team did not create a care plan for Mr McKeown when they discharged him from their caseload and that there was, therefore, no clear plan on what do if his mental health deteriorated again. The mental health team also failed to follow up on concerns prison staff raised about Mr McKeown's mental health in the days leading to his death.

I am also concerned that when Mr McKeown was found intoxicated, staff did not refer him to the healthcare or substance misuse team for support.

There was a delay in entering Mr McKeown's cell because staff were unable to open the sealed key pouch. I cannot say whether this might have affected the outcome for Mr McKeown.

Mr McKeown's post-mortem report found that he had used psychoactive substances (PS) before his death. HM Inspectorate of Prisons and the Independent Monitoring Board concluded that it was very easy to access illicit drugs at Wandsworth, and the prison will need to reassess their approach in line with the Prison Service's Prison Drugs Strategy.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2020**

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Summary

Events

1. On 11 September 2018, Mr Sean McKeown was remanded to HMP Wandsworth. It was not his first time in prison. He had been diagnosed with a schizotypal personality disorder and a history of depression and substance misuse. He was prescribed antipsychotic medication and completed a drug detoxification programme when he arrived.

2. In December 2018, Mr McKeown refused to take his antipsychotic medication. He wanted to be prescribed clozapine (a stronger antipsychotic). The prison psychiatrist noted that clozapine was not appropriate for Mr McKeown but prescribed another antipsychotic medication instead. However, when Mr McKeown did not consistently take his antipsychotic, his medication was changed to an antidepressant. Mr McKeown later stopped taking this medication too. Wing staff noted that Mr McKeown's hygiene was often poor. He continued to see the mental health inreach team until March 2019.

3. On 31 May, prisoners and wing staff raised concerns about Mr McKeown's mental health. Mr McKeown said that he had been waiting to see a member of the mental health team and a psychiatrist for some time. A wing officer passed this information to a member of the mental health team but no one saw him before he died.

4. At 5.02am on 4 June, while conducting a roll check, an officer found Mr McKeown hanged from a ligature made from a bed sheet. The officer radioed a medical emergency code and the control room called an ambulance immediately. There was a delay of around a minute and a half before staff could get into his cell because they were unable to open the sealed key pouch. When they did, healthcare and prison staff tried to resuscitate Mr McKeown. When the paramedics arrived, they took over his care but pronounced at 6.12am that he had died. The post-mortem toxicology results indicated that Mr McKeown had taken a psychoactive substance before his death.

Findings

Assessment of risk

5. We are satisfied that staff at Wandsworth properly assessed Mr McKeown when he arrived. Although concerns were raised about his mental health in the days before he died, he had not harmed himself during his time at Wandsworth and staff could not reasonably have predicted that Mr McKeown intended to take his life imminently.

Emergency response

6. When Mr McKeown was found hanged, there was a short delay entering his cell because the night duty officer was unable to open her sealed key pouch.

Clinical care

7. The clinical reviewer found that, overall, the care that Mr McKeown received at Wandsworth was equivalent to that which he could have expected to receive in the community.

8. However, there are concerns about his mental healthcare. The mental health in-reach team did not create a care plan to support him when they discharged him from their care. Although wing staff raised concerns about Mr McKeown's mental health four days before he died, no one from the mental health team noted this or assessed him.

9. When Mr McKeown was found under the influence of a substance, staff did not refer him to the healthcare or substance misuse team for support. The toxicology report also found that Mr McKeown had used PS at some point before his death.

Recommendations

- The Head of Healthcare and the Lead for the Mental Health Inreach Team should ensure that a clear discharge plan is recorded on SystmOne for those discharged from their care.

- The Head of Healthcare should ensure that:

    - all healthcare and prison staff have up-to-date contact details for the mental health team; and

    - a clear process is implemented for the mental health team to acknowledge, record and address promptly concerns raised about prisoners with mental health issues.

- The Governor should ensure that staff report and record all instances when prisoners are found under the influence of substances and refer them promptly to appropriate prison support services.

- The Governor should ensure that the key drug issues at Wandsworth are identified and that the prison's local drugs strategy is reviewed regularly to ensure that it meets the objectives of the Prison Service strategy to reduce the supply of and demand for drugs in prisons.

- The Governor should ensure that night staff are practised and confident in opening emergency cell key pouches in a timely manner to avoid delay in entering a cell.

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 him. No one responded.

11. The investigator visited Wandsworth on 10 June. He obtained copies of relevant extracts from Mr McKeown's prison and medical records.

12. NHS England commissioned an independent clinical reviewer to review Mr McKeown's clinical care at the prison. The clinical reviewer carried out the clinical review on their behalf. They jointly interviewed 13 members of staff at Wandsworth on 11 July and 16 August 2019.

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

14. Mr McKeown had not identified a next of kin before he died.

Background Information

HMP Wandsworth

15. HMP Wandsworth is a local Category B prison in London, with a Category C unit. It holds up to 1,452 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health services are provided by South London and Maudsley NHS Foundation Trust. There is an inpatient unit for up to six prisoners (the Jones Unit) which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Wandsworth was conducted in March 2018. Inspectors noted that a third of prisoners were receiving psychosocial help for substance misuse problems and prisoners reported it was easy to obtain illicit drugs. They found that around 450 prisoners were referred to the mental health team each month. They found that healthcare was a reasonably good and developing service, although the prison regime continued to affect the effective delivery of some services. Waiting times for some primary care services were too long and exacerbated by high rates of prisoners not attending appointments.

Independent Monitoring Board

17. 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 2018, the IMB reported that drug use, particularly of psychoactive substances (PS), commonly known as 'spice', had increased. They noted that waiting times for prison clinics were still very high - two weeks for a GP clinic and a week for a nurse-led clinic.

Previous deaths at HMP Wandsworth

18. Mr McKeown was the third prisoner at Wandsworth to take his own life since January 2016. In the previous investigations, we made recommendations about mental healthcare provision and the management of suicide and self-harm procedures, known as ACCT, which Wandsworth agreed to implement. However, the detail of these recommendations was not the same as the issues identified in this case.

Psychoactive substances (PS)

19. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence.

Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

20. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

21. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

22. On 11 September 2018, Mr Sean McKeown was remanded to HMP Wandsworth, charged with burglary and assault. This was not his first time in prison and he had last been released in July 2018. He had a long history of substance misuse.

23. During his reception interview, Mr McKeown did not name a next of kin. Mr McKeown told staff that he had no thoughts of suicide or self-harm. He had last been monitored under suicide and self-harm procedures, known as ACCT, in April 2018 and had last harmed himself in November 2017.

24. At an initial health screen, Mr McKeown told a nurse that he had been diagnosed with a schizotypal personality disorder and had withdrawal symptoms from heroin and cocaine which he had used in the last two days. The nurse referred Mr McKeown to the prison GP and the substance misuse team. Another nurse assessed that Mr McKeown had moderate withdrawal symptoms.

25. Mr McKeown was assessed by the substance misuse team and tested positive for opiate, cocaine and cannabinoids. A prison GP examined Mr McKeown and noted in his medical record that he appeared stable, and had a history of paranoid schizophrenia, for which he was prescribed amisulpride (an antipsychotic medication). However, he had not taken any medication since July 2018. Mr McKeown said that he used cannabis, crack cocaine and heroin daily. He denied thoughts of suicide or self-harm. The prison GP started Mr McKeown on a methadone detoxification programme and referred him to the mental health team to reassess restarting his amisulpride prescription.

26. Mr McKeown was sent to E Wing, the induction unit, where healthcare staff checked on him regularly.

27. On 12 September, the court mental health liaison officer emailed the prison mental health team with concerns about Mr McKeown's mental health and substance misuse history.

28. On 13 September, a nurse completed a secondary health screen for Mr McKeown.

29. That day, a mental health nurse reviewed Mr McKeown in light of the court mental health team's concerns. Mr McKeown wanted to be prescribed clozapine (used for schizophrenia) as this was stronger than amisulpride. The mental health nurse noted that Mr McKeown appeared dishevelled, tired and fed up. He noted that he displayed no paranoid or delusional ideas and said he had no thoughts of suicide or self-harm. However, Mr McKeown said that he was hearing voices inside and outside his head. He said that he had used heroin for over 35 years and smoked cannabis, but denied drinking alcohol. The mental health nurse referred Mr McKeown for a psychiatric review. (We saw no evidence that this appointment took place.)

30. On 17 September, a prison GP completed a five-day treatment review with Mr McKeown. A member from the substance misuse team attended. Mr McKeown said that he was hearing voices and had difficulty sleeping but had no thoughts of suicide or self-harm. The prison GP noted that Mr McKeown did not know if his

substance misuse caused his mental state to deteriorate and agreed to increase his methadone dose.

31. On 20 September, Mr McKeown moved to D Wing.

32. On 9 October, Mr McKeown attended court and was sentenced to two years and four months in prison.

33. On 11 October, a prison GP saw Mr McKeown again who reported having no withdrawal symptoms. He said that he was taking amisulpride but was still hearing voices. The prison GP noted that Mr McKeown appeared mildly depressed but was not acutely psychotic and had no thoughts of suicide or self-harm. He diagnosed Mr McKeown as having an opioid-type drug dependence and paranoid schizophrenia. He referred him to the mental health team.

34. The mental health nurse reviewed Mr McKeown on 16 October. He noted that Mr McKeown's cell was dirty. He asked prison staff to arrange some support to help Mr McKeown clean his cell. Mr McKeown said that he smoked teabags and was not eating or sleeping well. He had a slight swelling under his right eye which he said that he had sustained when he got up from bed and hit his face. He noted that the mental health team would continue to monitor Mr McKeown and he was placed in the "amber zone", which meant that the mental health team would review him at least monthly. He noted that Mr McKeown said that he was being bullied. There is no record to say what the nurse did about this.

35. Mr McKeown started work in the prison's textile workshop on 23 October.

36. On 25 October, a nurse dressed a wound on Mr McKeown's right wrist. Mr McKeown told the nurse that he had spilled coffee on it three days earlier. The wound was redressed the next day and again on 29 October.

37. Mr McKeown told the mental health nurse, that he wanted to have clozapine prescribed, that the voices in his head were causing him distress and had led him to burn his right forearm.

38. The mental health nurse reviewed Mr McKeown on 30 October and noted that staff had asked other prisoners to help him with his cell. He observed that Mr McKeown was preoccupied with smoking tea bags, despite receiving nicotine replacement treatment. He noted that staff planned to monitor Mr McKeown's mental state for a few days and refer him to a psychiatrist if there was no improvement.

39. The mental health nurse told the investigator that he had assessed Mr McKeown's risk of suicide and self-harm and had no concerns, but he did not record this at the time. He said that if he had considered that Mr McKeown was at risk of suicide or self-harm, he would have recorded it.

40. On 30 October, a wing officer visited Mr McKeown to ask him to clean his cell and noted that he had discovered hooch (illicitly brewed alcohol) in Mr McKeown's cell. No other information was recorded about this incident.

41. A consultant psychiatrist reviewed Mr McKeown on 6 November. Mr McKeown said that he was hearing voices and wanted clozapine again. A prison GP noted that Mr

McKeown appeared settled and planned to review his medication records to assess the impact of clozapine.

42. The mental health nurse created a care plan for Mr McKeown on 29 November and noted who wing staff should contact if Mr McKeown had paranoid ideation, reported hallucinations or became agitated. It was noted that Mr McKeown had missed some doses of amisulpride and was due to have his medication reviewed on 5 December.

43. On 5 December, Mr McKeown failed to attend an appointment in the addiction clinic with a psychiatrist and a member of the substance misuse team. The appointment was rescheduled for 10 December.

44. The mental health nurse reviewed Mr McKeown on 10 December. Mr McKeown complained of insomnia and having auditory hallucinations, mainly at night. He again asked for clozapine as amisulpride was not working. The mental health nurse noted that there had been some improvement in Mr McKeown's hygiene and his cell was a little cleaner. He noted that he would discuss Mr McKeown at the next mental health team meeting. There is no record of a discussion in Mr McKeown's medical record.

45. On 12 December, staff noted that Mr McKeown had completed the two-week Stepping Stones course (which offered psychosocial intervention support for individuals with drug and alcohol problems).

Events from January 2019

46. On 7 January, a substance misuse worker discussed treatment with Mr McKeown. He told her that he was not happy taking methadone and wanted to reduce his dose. He said that he had not been taking amisulpride appropriately which resulted in him hearing voices and becoming paranoid about those around him. He said that his personal hygiene had also suffered. Mr McKeown wanted to be prescribed clozapine but said that healthcare staff had refused to do this. He asked her to attend a meeting with his psychiatrist to discuss medication. She referred him to the mental health team and noted that Mr McKeown had refused to take his medication.

47. The mental health nurse reviewed Mr McKeown on 14 January and noted that Mr McKeown's cell was still dirty. Mr McKeown was lying down, appeared angry and told him that he had stopped taking amisulpride as it did not work. He asked for medication as he had insomnia. The mental health nurse made an appointment for Mr McKeown to see a psychiatrist the next day.

48. A consultant forensic psychiatrist assessed Mr McKeown on 15 January. He noted that Mr McKeown presented as anxious and wanted clozapine. He tried to establish why Mr McKeown wanted it. However, Mr McKeown became irritable and angry at having to talk about his situation and left the room. He noted that he had not reviewed Mr McKeown's records before this assessment but that he would book another appointment once he had done so. He said that Mr McKeown displayed no signs of psychosis at this review.

49. A prison doctor from the substance misuse team saw Mr McKeown on 23 January. He wanted to start a methadone detoxification programme and she agreed to start a weekly reduction programme.

50. On 30 January, a pharmacist reviewed Mr McKeown's medication and noted that he had continued to refuse his amisulpride and that a different antipsychotic should be considered.

51. On 5 February, a prison GP assessed Mr McKeown and talked about clozapine. Mr McKeown described his mood as low and said that he had intermittent thoughts of ending his life, although he had not made any plans to do so. He was still hearing voices and had insomnia. He noted that Mr McKeown had poor hygiene but he displayed no evidence of thought disorder or psychotic features. He had reviewed Mr McKeown's history which did not explain why he had been prescribed clozapine many years earlier. At this stage he noted that the risks did not justify re-prescribing clozapine to Mr McKeown. He noted instead that Mr McKeown would be monitored for a period without any antipsychotics. He prescribed mirtazapine (an antidepressant) and agreed to review Mr McKeown in a few weeks. He noted that staff should be made aware that Mr McKeown should be urgently reassessed if he displayed suicidal ideations.

52. A prison doctor saw Mr McKeown in the substance misuse clinic on 13 February. She further reduced Mr McKeown's methadone intake and noted that his detoxification was going well.

53. On 18 February, wing staff reported Mr McKeown to the mental health team after he had complained of hearing voices and wanted medication. The mental health nurse saw Mr McKeown in his cell the next day. He was now sharing a cell with another prisoner. His cellmate said that Mr McKeown had been screaming at night and needed help. The mental health nurse noted that Mr McKeown was sitting with his head down and their conversation was limited. He noted that Mr McKeown had no thoughts of suicide or self-harm and planned to discuss him with the psychiatric team. (Shortly afterwards, Mr McKeown's cellmate was relocated.)

54. On 23 and 26 February, an officer saw Mr McKeown for key worker sessions. They discussed his concerns about his medication and his wish to move to C Wing after he completed his methadone detoxification. Mr McKeown said that he wanted to get a job (having previously lost his job for not attending). The officer said she would discuss his medication at his next psychiatric appointment.

55. When the officer saw Mr McKeown for a key worker session on 11 March, she discussed his behaviour the previous weekend when she had seen Mr McKeown throwing items around his cell out of frustration. (She had asked Mr McKeown what was wrong at the time but he had said that he wanted to be left alone.) Mr McKeown told her that prison was "doing his head in" but did not elaborate. He talked about his intention to complete his methadone reduction programme so that he could be moved to the Trinity Unit. He reiterated that he wanted his clozapine reinstated as otherwise, his only choice was to be hospitalised. The officer said that she would try to get more information about his medication from the mental health team. She noted that Mr McKeown had been assigned a workshop job and would benefit from more time out of his cell.

56. A prison GP reviewed Mr McKeown on 12 March. Mr McKeown told him that his sleep pattern had improved but his mood was still low. He increased Mr McKeown's mirtazapine dose. Mr McKeown agreed but remained dissatisfied that he had not been prescribed clozapine.

57. On 13 March, a prison GP saw Mr McKeown as his methadone treatment was coming to an end. She noted the increase in antidepressants and that overall, Mr McKeown was doing well. At Mr McKeown's request, the prison GP prescribed him zopiclone to help him sleep.

58. Mr McKeown moved to G Wing on 14 March. (G Wing is part of the Trinity Unit which holds Category C prisoners.)

59. That day, a prison GP discussed Mr McKeown in the mental health team meeting. It was noted that Mr McKeown did not need further input from the mental health team because his medication issues were resolved.

60. On 19 March, healthcare staff assessed Mr McKeown as suitable to keep and administer his own medication in his cell. (However, on 23 March, Mr McKeown was found trying to conceal medication and this decision was reversed on 4 April.)

61. On 25 March, an officer introduced himself to Mr McKeown as his new key worker. Mr McKeown was polite and asked to be transferred to a prison closer to his home in Liverpool. The officer told him that he would have to apply for a transfer.

62. During their key worker session on 12 April, Mr McKeown told his key worker that his only concern was not having clozapine, and the keyworker passed this on to a nurse from the mental health team. She briefly spoke to Mr McKeown and agreed to look into his concerns. She told us that she would have looked at Mr McKeown's medical records and taken action. However, there is no record that she did so.

63. The keyworker met Mr McKeown again on 22 April. Mr McKeown told him that he had still not seen the mental health team. The keyworker said that he would follow up his concerns again. He told the investigator that he had left a telephone message for the mental health team.

64. A pharmacy worker recorded on 25 April that when Mr McKeown attended the medication hatch, he said that he no longer wanted to take mirtazapine. There is no evidence to suggest that this information was passed to the healthcare or mental health team.

65. The next day, an officer noted that Mr McKeown appeared to have lost motivation to look after himself and that his cell was in an "awful state" despite staff prompting him to clean it.

66. Healthcare staff recorded on 30 April that Mr McKeown was still not attending the medication hatch to collect his medication and that a review should be completed.

67. On 1 May, staff recorded that they sent Mr McKeown back to his cell from the prison workshop because he was "intoxicated". There is no record of whether this information was shared with the healthcare or substance misuse team.

68. On the morning of 15 May, an officer arranged for Mr McKeown to speak to a Listener at his request. After their conversation, the Listener told the officer that Mr McKeown was beyond their help and took him to the healthcare clinic, where they raised concerns about his mental state and personal hygiene. The officer contacted a prison GP who told him that Mr McKeown had been added to his appointment list. The officer left a telephone message for the chaplaincy, asking them to support Mr McKeown. He told them that Mr McKeown's behaviour seemed on a downward spiral.

69. A nurse saw Mr McKeown when the Listeners brought him to the healthcare clinic. She noted that Mr McKeown presented as agitated, said that he was hearing voices and demanded to be seen by the mental health team. Mr McKeown said that he wanted clozapine. The nurse told the investigator that Mr McKeown was engaged until she explained to him that she could not prescribe him clozapine. Mr McKeown then walked out of the clinic. The nurse discussed Mr McKeown with two nurse from the mental health team. They told her that he had a GP appointment the next day. She did not consider that Mr McKeown displayed any indication of deliberate self-harm or psychosis and therefore she did not consider that immediate action was necessary. There is no record of their conversation.

70. On 16 May, a prison GP saw Mr McKeown who said that he needed help sleeping. The prison GP discussed short and long-term therapies and agreed to prescribe zopiclone (a sleeping aid). The prison GP told the investigator that he had no concerns about Mr McKeown.

71. That day, Mr McKeown applied for a transfer to HMP Brixton so that he could complete a Rehabilitation for Addicted Prisoners Trust (RAPt) course. He was later told that he was not eligible for the course as the criteria included being from London.

72. On 21 May, Mr McKeown told his keyworker that he needed to leave Wandsworth. The keyworker saw Mr McKeown again on 26 May but he reported no concerns. There is no evidence of any requests for a mental health or healthcare appointment.

31 May

73. An officer worked in the Trinity Unit. He told the investigator that he had not had much contact with Mr McKeown but he was aware that he lived on the wing. He said that when he had contact with Mr McKeown, he had not given him cause for concern although he had heard Mr McKeown talking and shouting to himself in his cell on more than one occasion.

74. On the morning of 31 May, the officer responded to Mr McKeown's cell bell and heard him shouting inside his cell. When the officer opened the cell door observation panel, Mr McKeown immediately stopped shouting and asked to speak to a Listener urgently. The officer agreed and went to find one. Two Listeners agreed to speak to Mr McKeown and accompanied the officer to Mr McKeown's cell. The Listeners initially spoke to Mr McKeown through his observation panel. After around five minutes, the officer observed that Mr McKeown appeared calm. He therefore opened his cell door so that the Listeners could speak to him on the landing. They talked for around 15 minutes. Afterwards, the Listeners told the officer that they were concerned about Mr McKeown's mental health.

75. The officer spoke to Mr McKeown who said that he was concerned as he had not been able to see anyone from the mental health team, wanted his medication reinstated and had tried to see a psychiatrist for the last three months. The officer telephoned the mental health team but no one answered. (However, he had called a telephone in the doctor's office rather than the mental health team's contact number.) He left a voicemail message to explain why he was calling and giving Mr McKeown's details. He recorded what had happened in the Trinity Unit observation book. He then spoke to an unidentified female member of the mental health team about Mr McKeown in the wing office. She agreed to visit Mr McKeown. There are no medical records about this.

76. The officer returned to Mr McKeown and told him that he had left a voicemail message for the mental health team and had spoken to a nurse who would visit him shortly. He noted that Mr McKeown was pleased with this news and thanked him. At the time, Mr McKeown was helping to clean the wing with another prisoner. The officer returned Mr McKeown to his cell before lunchtime and had no concerns about him at the time. When he returned to the wing office, he saw the female nurse he had spoken to earlier. She was about to leave but told him that she would visit Mr McKeown before she did so. There is no evidence that she did so.

3 June

77. CCTV shows that at 4.49pm on 3 June, an officer completed a roll check and checked that all prisoners were in their cells and that the cell doors were locked. She raised no concerns about Mr McKeown. An officer completed a roll check at 6.54pm and again, did not raise concerns about Mr McKeown.

78. An Operational support grade (OSG) checked on Mr McKeown during a roll check at 10.00pm. She said that when she looked though his cell door observation panel, Mr McKeown was standing at the window at the bottom of the bed and told her that he was okay. Another OSG was also on night duty in Trinity Unit. (The OSG was unavailable for interview due to sick leave.)

4 June

79. Both OSG's started their roll check of G Wing at around 5.00am. At 5.02am, an OSG looked through Mr McKeown's cell door observation panel to check on him. (CCTV footage shows that this was at 4.49am as it was approximately 12 minutes slow.) The second OSG was checking the cell opposite when said she heard the OSG make a gasping sound. The OSG then said, "Man hanging" and radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties). The control room log notes that this happened at 5.02am and that staff called an ambulance at 5.03am. The second OSG said that she tried to help their colleague to break the seal on her key pouch but they were unable to do so.

80. An officer responded to the code blue and arrived at Mr McKeown's cell in approximately 45 seconds. He looked through Mr McKeown's cell door and saw Mr McKeown hanging from torn sheets, attached to the window bars. He did not hold cell keys so was unable to open the cell door. However, a second officer arrived approximately 30 seconds afterwards, opened the door and went in with the officer.

81. The officer cut the ligature while the second officer supported Mr McKeown's weight and they lowered him to the floor. The officers then moved Mr McKeown to the wing landing to create further space. Both OSG's remained on the wing landing.

82. The officer assessed Mr McKeown and found no signs of life and his body was cold. He started chest compressions to try to resuscitate Mr McKeown. Within 30 seconds, a nurse arrived with an emergency medical response bag and oxygen. He checked Mr McKeown but found no signs of life. An officer took over chest compressions, assisted by another officer.

83. A nurse and a healthcare assistant had arrived at the cell two minutes after another nurse. They assisted with cardiopulmonary resuscitation attempts and attached a defibrillator which found no shockable heart rhythm. They continued with chest compressions. The nurse noted that McKeown's lips were blue and that he was pale.

84. At 5.15am, paramedics arrived and took over resuscitation efforts. Another ambulance arrived minutes later but a paramedic confirmed at 5.55am that Mr McKeown had died.

Contact with Mr McKeown's family

85. When Mr McKeown arrived at Wandsworth, he had not provided any next of kin details. The prison, the police, the probation service and the NHS tried to contact members of Mr McKeown's family but did not succeed. They informed the Coroner.

Support for prisoners and staff

86. After Mr McKeown's death the Deputy Governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

88. In addition to the standard support procedures, an officer from the safer custody team, checked on the wellbeing of some of the prisoners who lived near Mr McKeown's cell.

Additional information

89. A security intelligence report after Mr McKeown's death noted that two prisoners had seen Mr McKeown the day before his death, walking around the wing asking other prisoners for 'spice' (PS). It noted that Mr McKeown was heard saying that if he did not get any, "he would kill himself".

Post-mortem report

90. The post-mortem examination established the cause of Mr McKeown's death as hanging. Toxicology test results confirmed the presence of synthetic cannabinoids

(PS), namely spice. The report noted that the use of PS may have altered Mr McKeown's mental state before he died.

Findings

Assessment of risk of Mr McKeown's risk

91. When he arrived at Wandsworth, staff appropriately identified and addressed Mr McKeown's physical and mental health issues. He had a long history of substance misuse and mental health issues, including paranoid schizophrenia and depression, for which he was taking medication. He had last harmed himself in November 2017, 16 months before his death.

92. Four days before Mr McKeown died, staff and Listeners raised concerns about Mr McKeown's mental health, although they did not consider that he was at risk of self-harm as he had not harmed himself since he arrived at Wandsworth. Mr McKeown complained about his antipsychotic medication and wanted to see a member of the mental health team and psychiatrist. However, no one from the mental health team saw him before he died. In the three days before he died, Mr McKeown had not expressed any thoughts of suicide or self-harm. We think that staff might have considered whether Mr McKeown's mental distress placed him at risk of suicide or self-harm, but we accept that, as he had no recent history of self-harm, they had no reason to believe that he was at imminent risk.

Clinical care

93. The clinical reviewer noted that overall, the mental and physical healthcare that Mr McKeown received in prison was equivalent to that which he could have expected to receive in the community.

Mental healthcare

94. The clinical reviewer found that throughout McKeown's stay at Wandsworth, he continued to request clozapine. The mental health team assessed and treated Mr McKeown and noted that it would not have been appropriate to start prescribing clozapine at Wandsworth. An alternative antipsychotic drug was prescribed, although Mr McKeown stopped taking it in February 2019 and was prescribed an antidepressant. Mr McKeown was discharged from the care of the mental health inreach team care on 14 March. The clinical reviewer noted that there was no recorded information or plan made to support primary mental healthcare staff in their continuing and future management of him.

95. In April 2019, when Mr McKeown stopped taking his antidepressants, healthcare staff failed to record any information or details about the reasons for his decision. Mr McKeown had apparently just stated that his medication "did not work" and there was no evidence to suggest that he was probed about his decision and whether a referral to the mental health team was considered. Staff also noted a deterioration in Mr McKeown's personal hygiene and he was found intoxicated on one occasion. If a mental health team discharge plan had been completed, it is likely that Mr McKeown would have received some mental health support if his behaviour changed or when he stopped taking his antidepressants. We make the following recommendation:

The Head of Healthcare and the Lead for the Mental Health Inreach Team should ensure that a clear discharge plan is recorded on SystmOne for those discharged from their care.

96. Although prison staff did not raise concerns about Mr McKeown's risk of suicide or self-harm, they did have some concerns about his mental state and a wing officer tried to contact the mental healthcare team by telephone four days before Mr McKeown's death. However, the officer left a message on an incorrect telephone number which he obtained from a list of healthcare contact numbers.

97. The officer also spoke in person to an unidentified nurse from the mental health team who agreed to check on Mr McKeown. However, no one from the mental health team saw Mr McKeown in the days before his death or recorded the concerns raised by wing staff about his mental health. This was a missed opportunity to assess and appropriately support Mr McKeown.

98. We also note that on 22 April, another officer had tried to contact the mental health team and left a voicemail message but again, no one followed up the concerns raised. We make the following recommendation:

The Head of Healthcare should ensure that:

- **all healthcare and prison staff have up-to-date contact details for the mental health team; and**
- **a clear process is implemented for the mental health team to acknowledge, record and address promptly concerns raised about prisoners with mental health issues.**

Responding to incidents of substance misuse

99. Mr McKeown had a history of substance misuse and had recently completed a methadone detoxification programme. However, there was no evidence that he was referred to the healthcare or substance misuse team after he was found apparently under the influence of a substance on 1 May. This was a missed opportunity to review his behaviour and offer support. We make the following recommendation:

The Governor should ensure that staff report and record all instances of prisoners who are found under the influence of substances and refer them promptly to appropriate prison support services.

Substance misuse

100. Although there was no intelligence to indicate that staff were aware that Mr McKeown took PS, the post-mortem toxicology test results showed that he had used PS sometime before his death and it is possible that this affected his mood and played a part in his decision to end his life.

101. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for

national guidance to prisons from HMPPS providing evidence-based advice on what works. We welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

102. In relation to reducing the supply of drugs, the new Prison Service strategy says:

"Every prison is different and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate."

We make the following recommendation:

The Governor should ensure that the key drug issues at Wandsworth are identified and that the prison's local drugs strategy is reviewed regularly to ensure that it meets the objectives of the Prison Service strategy to reduce the supply of and demand for drugs in prisons.

Emergency response

103. When the night patrol officer, an OSG, found Mr McKeown hanging, she correctly called a code blue emergency and control room staff called an ambulance immediately. Both OSG's tried to enter Mr McKeown's cell, but could not open the OSG's sealed key pouch. The second OSG said at interview that they tugged at the cable tie but were unable to open the pouch to release the key. An officer arrived after approximately 90 seconds, opened the door, and so there was little delay in entering the cell. We cannot say whether the short delay in entering the cell caused by the difficulty opening the sealed pouch, affected the outcome for Mr McKeown. However, such delays could be critical in other life-threatening situations. We make the following rfecommendation:

The Governor should ensure that night staff are practised and confident in opening emergency cell key pouches in a timely manner to avoid delay in entering a cell.

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