

**Investigation into the circumstances surrounding the
death of a man
at HMP Wandsworth in January 2007**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

February 2008

This is the report of an investigation into the circumstances of the death of a man who was found hanging in his cell in B wing at HMP Wandsworth in January 2007. The man was 40 years old.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by two of my colleagues. Wandsworth Teaching Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Wandsworth.

I would like to thank the Governor of Wandsworth, and his staff for their help.

The man had a long history of mental health problems. His treatment included both hospital care and care in the community. On one occasion, the man was detained in a psychiatric unit for almost four years. One of the man's consultant psychiatrists reported that his compliance with medication when in the community was variable.

The man had been arrested in June 2006, when clearly mentally unwell. He was remanded initially into HMP Belmarsh before being transferred to Wandsworth. By the time of his transfer, the man's mental health condition had stabilised.

Although the man spent a lot of time talking to prisoner Listeners in the final weeks of his life, neither they nor anyone else who had contact with him anticipated that he was at risk. After the man's death a letter was found in his cell saying that he would attempt to take his life.

I have made five recommendations. Three of the recommendations are about arrangements relating to contact between prisoners and Listeners. The other two recommendations are about adherence to national guidance when dealing with deaths in custody.

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Prisons and Probation Ombudsman

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SUMMARY

The man was born in London in 1966. He had a number of jobs after leaving college but in 1995 was diagnosed as mentally ill and admitted informally to a psychiatric in-patient unit. The man had cut both wrists saying that he did so as a result of hearing voices telling him to harm himself. From that time he received treatment both in the community and as a mental health in-patient, once following a previous conviction. One of the man's psychiatrists who had treated him for many years reported that he was warm, sympathetic and intelligent when well but could become aggressive and violent when unwell. The psychiatrist also reported that the man's compliance with oral medication when in the community was variable.

On 24 June 2006, the man was arrested for carrying an offensive weapon in a public place and for two linked offences. The man spent two days in police custody before being taken to court where he was remanded into prison custody at HMP Belmarsh. It is clear from the man's clinical records and the clinical review that he was mentally ill at this time. But not, it seems, to the extent that it was unusual for him to have been initially placed into prison custody rather than into a psychiatric in-patient unit.

The man spent the first three months of his time at Belmarsh in the healthcare unit. For a good part of this period the man was assessed as requiring the presence of three Officers when unlocked. However, the man had agreed to restart his medication and even by 15 July, Belmarsh's consultant psychiatrist noted that he was gradually settling. On 19 September, the man was judged well enough to move to a standard prison wing. On 23 November, he was transferred to Wandsworth.

Upon his arrival at Wandsworth, the man was assessed by a doctor who noted that he was mentally stable with no thoughts of self-harm. The man's records at Wandsworth contain only one entry referring to him acting strangely, although the evidence of one of the Officers and one of the prisoners was that the man was an unusual person.

On 20 December, the man was convicted for the offences with which he had been charged. He was remanded back into Wandsworth to await sentencing. By this time, the man had been on remand for six months but this is not an unusually long period for a prisoner to have remained on remand.

During the final five weeks of his life, starting from just before Christmas 2006, the man saw Listeners almost every day (Listeners are prisoners trained by the Samaritans to give support to other prisoners). The Listener service is founded on the principle of complete confidentiality. Despite this, the Listeners agreed to speak to my investigators. They were not able to disclose what the man spoke about in their contacts with him but all described him as calm by the end of their meetings and none of them thought that he was at risk of self-harm.

Officers were unaware of the level of contact that the man was having with Listeners. This is understandable for contacts during association time in the day as the man could simply walk into a Listeners' cell. However, at night time when the man and the Listeners would have to be unlocked, not all these episodes were recorded in the

wing observation book as should have been the case. And no entries had ever been made in the man's personal records to say that he had seen a Listener.

At just after 6.00am on a day in January 2007, the night Officer began his morning role count. When he looked through the observation panel in the man's door he saw him at the cell window facing outwards. The Officer saw a cord running from the man's neck to the window but the Officer was not certain if he was hanging as his feet were on the floor. The Officer ran to the landing below and called to another Officer (a principal Officer) for help as well as calling the emergency nurse. The Officers ran to the man's cell, entered it and cut the ligature. The principle Officer and nurse examined the man and found that he had no pulse, he was not breathing and his body was cold to the touch. The staff concluded that the man was dead and decided, entirely reasonably, that it was not appropriate to attempt resuscitation.

When staff searched the man's cell they found a letter he had written to his solicitor, dated 17 January, in which he said he would attempt suicide. Among other things in the letter, the man said that he anticipated being put on intra-muscular tranquilising medication and he did not consider that to be a life.

As with the prisoner Listeners, none of the Officers interviewed thought that the man was at risk. Nor did the man's solicitor who had visited him in prison many times.

THE INVESTIGATION PROCESS

The investigation was opened on 31 January 2007 when two of my colleagues visited Wandsworth and met a number of prison staff, including the deputy governor, the prison's family liaison officer and a representative from the Prison Officers' Association. My investigators also met a member of the Independent Monitoring Board (IMB). My investigators informed the staff of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation.

Eight members of staff and four prisoners were interviewed. All four prisoners are Listeners who spent a considerable amount of time with the man. No additional prisoners came forward to give evidence directly in response to the published notices.

Wandsworth Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Wandsworth.

One of my Family Liaison Officers (FLOs) spoke to the man's sister. She said that she had not seen or spoken to her brother for many years. She believed that he had suffered mental health problems from a young age, but a diagnosis of mental illness was only formally made within the last ten years. She said that her only concern about her brother's treatment was the seemingly contradictory information given by health care professionals regarding his mental health around the time of his death. The man's sister spoke very positively about the help and support she received from the FLO at Wandsworth, who, she said, had shown genuine interest and understanding of what the family was going through after her brother's death.

My FLO and one of my investigators visited the man's ex-partner who had had a child by the man. The man's half-brother was also at the meeting. The man's ex-partner raised a number of concerns. She could not understand why the man had remained on remand in prison custody for such a long time for what was a comparatively minor offence. She said that he had received treatment at a psychiatric clinic both as an outpatient and as an inpatient. One of the times as an inpatient was after he was arrested following a previous disturbance. She therefore wondered why the man was taken to prison this time rather than to a secure psychiatric unit, such as the one where he had been before.

The man's ex-partner said that he had written a suicide letter ten days before his death, so she could not understand why staff did not notice that he was depressed. Both she and the man's half-brother were distressed about the way in which they found out about the man's death. The man's half-brother said that he heard the news from his father when visiting him about a fortnight after the man's death. He then passed the news to the man's ex-partner. The man's ex-partner and his half brother were both named in the man's suicide letter and so they both thought they should have heard the news directly from the prison. The man's ex-partner felt the prison should be more sensitive to the fact that many families are fragmented and should not assume that information is passed on within the extended family as a matter of course.

HMP WANDSWORTH

HMP Wandsworth was built in 1851. It is a local prison that holds just over 1,400 prisoners. Wandsworth is the largest prison in London. The main prison has five wings leading out from a central hub. Each wing has four landings.

Although Wandsworth's residential areas remain in the original buildings, extensive refurbishment and modernisation of the wings has taken place. All cells have in-cell sanitation and in-cell electricity is presently being installed throughout the prison.

The last inspection of Wandsworth by Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, was a full inspection in July 2006 following up a previous inspection in May 2004. In her introduction to the report Ms Owers wrote:

"Wandsworth ... has had a difficult and troubled history, much of it recorded in the inspection reports of myself and my predecessor ...

"This inspection found an effective and united management team that was taking steps to move the prison forward. They had inherited a prison that was performing even less well than it had been at the time of the last inspection ... Since then, the prison had clearly improved: with greater confidence among staff and managers, more time out of cell and more activities for prisoners, and an improved focus on safer custody ...

"However, this inspection also revealed the distance still to travel, and the residual problems that remained ...

"This is therefore an inspection of an improving prison, but one which has a significant way to go before it is a good and well-performing prison on any of our four tests of safety, respect, purposeful activity and resettlement ..."

KEY EVENTS

The man's time at Belmarsh

On 24 June 2006, the man was arrested for carrying an offensive weapon in a public place. The weapon he was carrying was a wooden practice sword (a piece of equipment used for practising martial arts). After spending two days in police custody, the man appeared at Woolwich Magistrates' Court where he was charged with being in possession of an offensive weapon and with two further linked offences. He was remanded into HMP Belmarsh.

On arrival at Belmarsh on 26 June, the man received a First Reception Health Screen assessment. This is a standard part of the reception process when a person first arrives in prison. In answer to questions about his mental health, the man said that he had never received treatment from a psychiatrist outside prison and that he did not have a psychiatric nurse or care worker in the community. He also said that he had never received medication for mental health problems. In answer to questions about self-harm, the man said that he had never harmed himself in the past and that he did not feel like doing so at present. The health screening form includes a section where the person completing it is required to record their impression of the prisoner's behaviour and mental state man. In this section the healthcare worker wrote: *'Would not engage in questions, poor eye contact, appears agitated and, observed to be talking to himself and can be aggressive in his response to questions'*. The man was admitted to healthcare for a period of observation.

On 28 June, the man was made subject to 'controlled unlock status' (that is, that he should be unlocked only with the presence of three Officers). The reasons were recorded as: *'Mental state is very unpredictable. Has a history of assaults. Made threats to staff [and threw his plastic] knife at [an Officer]'*. The incidents reported had occurred in the days leading up to 28 June. The man's records at around this time show that he would have 'good' days and 'bad' days. For instance, an entry on 28 June, the day he was made subject to controlled unlock status, status: *'Had cell clean and shower [this morning]. Co-operated and was no problem to staff'*.

On 15 July, the consultant psychiatrist at Belmarsh wrote to the psychiatric clinic that had been involved in the man's mental health treatment since 1996 to request that the man be admitted there:

'... [the man] arrived in HMP Belmarsh on [27 June] and was admitted to the health care centre ... [a doctor] assessed him ... on [28 June] and found that he was labile (unstable), irritable and volatile. In his mood he appeared suspicious and angry, his thoughts were tangential and circumstantial expressing persecutory beliefs ...

'... I first saw him on [30 June] and he remained volatile and expressed persecutory beliefs ... his speech was increased in rate and he was elated in a way that I had not previously seen.

'[The man] is gradually settling ...'

Despite the consultant psychiatrist writing on 15 July that the man was gradually settling, he was again made subject to controlled unlock status that very day. The reason for this was recorded as: *Mental state has become unstable. Has a history of violence when unwell.* The man remained subject to controlled unlock status until 31 August.

The man remained in the healthcare centre until 19 September. Upon his discharge an 'Inpatient Unit Exit Plan' was completed stating the reason for his transfer to standard location as: *Currently settled.* In answer to a question on the form about clinical risk factors it was noted: *Stops taking medication then becomes unwell.*

On 23 November, the man was transferred to Wandsworth. The reason for his transfer seems to have been overcrowding at Belmarsh.

The man's time at Wandsworth

On the man's arrival at Wandsworth on 23 November a reception nurse referred him to the prison doctor due to his history of mental health problems and need for medication. The prison doctor saw the man and noted that he was: *'... mentally stable, co-operative and relaxed, no self-harm thoughts ...'*

The first Officer told my investigators that he has worked at Wandsworth for almost 16 years. He said that when the man first arrived on the landing he was placed in a single cell as he was considered a danger to other prisoners. The first Officer noticed that there were a lot of entries in the man's records from Belmarsh suggesting that he was a difficult prisoner and that three Officers should be present whenever he was unlocked. The first Officer said that he and the other Officers in B wing try to treat all prisoners the same way. He explained to the man that coming to Wandsworth was a new start for him. That no matter what was in his records from Belmarsh the Officers in B wing would make their own assessment to see how he got on. The first Officer told my investigators that the man was surprised, but also contented to be told that.

The first Officer said that the man did not associate with other prisoners, instead he tended to keep himself to himself. The first Officer said that the man mentioned to him once that he was schizophrenic and also paranoid. The first Officer described the man as an unusual person who would be a bit vague at times. The first Officer attributed this to the man's prescribed medication. The first Officer said, however, that he never had any problems with the man, always finding him to be polite. The first Officer found it hard to believe this was the same person who had caused so much trouble in Belmarsh.

The first Officer was aware that the man had some contact with Listeners, including a few times when he unlocked the man for this contact to take place. The first Officer said that when a prisoner has been with Listeners he will ask them if everything has been sorted out. If he has any concerns about the prisoner, he will

open an ACCT document¹ for the prisoner to be monitored. The first Officer could not recall ever noticing anything about the man indicating he might be worried so he never considered opening an ACCT form.

On 1 December, the man was seen by a mental health nurse who noted that the man was stable in mood and happy with his current medication.

On 4 December, the psychiatrist from the psychiatric clinic visited the man at Wandsworth to assess his suitability to return to the clinic if convicted. The psychiatrist subsequently wrote a report for the court recommending that the man be admitted to the clinic. The psychiatrist could not specifically recall discussing his report with the man's probation Officer but he thought that he might well have made such contact because he considered his psychiatric report to be very important for the man's future care and treatment. With reference to the referral letter of 15 July from the consultant psychiatrist at Belmarsh, the psychiatrist from the clinic said that the two of them would have met at case conferences to discuss the man. Availability of beds at the clinic meant that the man could not be admitted immediately. He then began to settle which diminished the urgency of his admission. The man's referral to the clinic then remained on hold pending his court case.

The man's trial started on 18 December. It continued through 19 December and on 20 December he was convicted. He was remanded back into prison custody to await sentencing. By then, he had been moved from C wing to B wing.

An entry by the second Officer in the wing observation book made at 6.00pm on 24 December shows that the man was unlocked that evening as he wanted to speak to a Listener. The second Officer told my investigator that he did not know the man and had no recollection of him. The second Officer said that he normally worked in A wing but in December he had covered a few shifts in B wing due to staff shortages. The second Officer said that when a prisoner has been with Listeners he always asks them afterwards if they are okay. If he has any concerns about the prisoner he will either open an ACCT form or speak to a more senior Officer. He said that the fact that he had taken no such action in the man's case meant that there must have been nothing about his demeanour to cause him concern.

On 30 December, the third Officer made an entry in the man's records: *'Constantly on [emergency cell bell], also claims he was not unlocked for meals which is incorrect, has very strange behaviour patterns, staff should be aware'*. The third Officer told my investigators that from what he could remember of that time the man kept raising the same point. This was that he had not been unlocked for his meals. The third Officer would reply to the man that he had been, saying how many times have I explained this to you. The man would giggle in response. The third Officer thought initially that the man was deliberately trying to get a reaction. The third Officer said though that when he spoke to another member of staff he was told that the man had been a problem at his previous prison. The third Officer told my investigators that after 30 December the man settled down. He understood what he was told about the correct use of emergency cell bell (that it is for emergencies only)

¹ ACCT (Assessment, Care in Custody and Teamwork) is the new procedure for monitoring those prisoners judged to be at risk of self-harm or suicide. ACCT has replaced the F2052SH procedure.

and he became quite a pleasant prisoner on the landing. He was never a problem again.

The third Officer said that he tries to build a good rapport with the prisoners on his landing and he thought he had achieved that with the man. The third Officer is Australian and the man would ask him questions about his country. The man did not volunteer any information about his private life however, nor did he talk about his court case. But he did mention a few things about Belmarsh and also said that he quite liked Wandsworth. The third Officer said that the man was generally happy. He never drew attention to himself and never seemed to have any difficulties with other prisoners. The third Officer was unaware that the man had a high level of Listener contact. He said that a lot of prisoners ask to speak to Listeners. The third Officer said that he never saw anything in the man's behaviour to indicate that he was a person at risk of self-harm. The third Officer last saw the man on the day before his death when he seemed his usual self.

On 8 January 2007, the man was assessed by a doctor and a psychiatric nurse from the Prison Inreach team – he had been referred to the Inreach team because of his mental health history. The man was noted as denying having any present thoughts of self-harm or of suicidal ideation and they agreed that his risk of self-harm appeared low. The assessors recorded that the man had no gross abnormalities in his mental state.

A positive entry about the man's behaviour was made on 11 January. It reads: '*... was a good help today when [another prisoner] was very emotional and stressed. [The man] took him into his cell and spoke to him and managed to cheer him up and get him to calm down.*'

B wing's observation book shows that at 9.55pm on 26 January, the fourth Officer unlocked the man for him to talk to Listeners. The fourth Officer told my investigator that he works permanent night shifts in Wandsworth's Care and Separation Unit but on 26 January he had been asked to work in B wing. The fourth Officer said that he could not really recall the man. He said, though, that if he observes a prisoner looking upset after being with Listeners he will routinely record that in the wing observation book and in the prisoner's history sheet. He will also make Oscar 1² aware of the situation and open an ACCT form if he considers that to be appropriate. The fourth Officer said that given that he could barely recall the man and given that he had written so little about him, it suggests that he had been okay that evening. As far as the fourth Officer could recall, that night was the only occasion that he met the man. He said that a record is kept if a prisoner has been unlocked to see Listeners. The fourth Officer said that if he had unlocked the man at any other time to see Listeners he would have made a record (there is no such record by this Officer).

The entry in B wing's observation book on 26 January by the fourth Officer is one of only two entries about the man being unlocked for him to talk to Listeners. The first entry was made on 24 December 2006. But Listeners confirmed to my investigators that they had seen the man on many occasions.

² Oscar 1 is the radio call sign of the Officer in charge.

The fifth Officer said that the man was quiet and spent most of his time in his cell. He was also a friendly man who did not cause any problems for the Officers. The fifth Officer noticed the man spending time with Listeners. This would sometimes be when prisoners were being locked in after association periods and if the man was still talking to the Listener, the fifth Officer would leave the man's door unlocked. The fifth Officer said that nothing occurred to give him concern for the man's safety. If he had noticed anything amiss he would have asked the man if he was okay and if appropriate taken further action such as making a record of the conversation or speaking to a senior Officer. The fifth Officer said that none of the other Officers ever mentioned to him having any concern about the man's wellbeing.

Another Officer told my investigators that the man was a very reserved man who never spoke about personal matters. However he was always very polite in expressing his thanks whenever staff did anything for him. This Officer said that his practice is always to check with Listeners after a prisoner has been with them to check if everything is okay. In the man's case the Listeners always said that there were no problems. This Officer also said that all of the staff were very surprised when the man took his life.

Each of Wandsworth's wings has its own wing observation book. All significant events should be recorded in the observation book. Most such events relate to specific individual prisoners. In addition, a record of daily events is maintained at the central hub off which all of prison wings lead out. Although B wing's observation book contains only two entries about the man being unlocked at evening/night time to see Listeners, the record of daily events contains six such entries for the time the man was in B wing.

My investigator spoke to the man's solicitor. The solicitor estimated that he met the man about four times while he was at Belmarsh and many more times at Wandsworth. The first time they met was when the man was in healthcare and subject to special unlock procedure. By their second meeting the man had been transferred to normal location in Belmarsh and a psychiatrist had deemed him fit to plead.

The solicitor said that he last saw the man about 10 days before his death. The man was 'in good form'. The solicitor said that he was stunned when he heard that the man had taken his life. The solicitor's colleagues and Council were also seeing the man around this time and no one thought that he was at risk.

The discovery of the man's death

The fifth Officer told my investigators that he started a night shift on the evening of 28 January. He received a handover from the evening staff during which nothing was mentioned about any concerns with the man. The fifth Officer counted the prisoners, including the man. The fifth Officer said that he had had no need to speak to the man during the night and he did not ring his cell call bell. Just after 6.00am on 29 January, the fifth Officer began his morning role count. When he came to the man's cell on the 4's landing he looked through the observation panel and saw the man in an upright position by the cell window facing outwards. The fifth Officer

noticed a cord running from the window frame to the man's neck. The man's feet were on the floor so it was not clear to the fifth Officer whether he was suspended or was standing and looking out of the window. The fifth Officer called the man's name but he got no response. He kicked the door but again got no response. The fifth Officer ran down the stairs from the 4's landing to the 2's landing where he called to the Principal Officer (PO) for assistance. The fifth Officer ran back to the man's cell followed immediately by the PO. The PO unlocked the door and the fifth Officer used his cut-down knife to cut the ligature. The fifth Officer said that as they lowered the man to the floor it was obvious that he was dead as rigor mortis had set in. As a result, they made no attempts at resuscitation.

In a written statement made on the day the PO wrote that he was on the 2's landing when the fifth Officer called for his assistance. The PO used his radio to send an alert that there was a Code One³ incident on B4 landing and he followed the fifth Officer to the man's cell. In his statement, the PO explained that the man's body was cold and stiff. His arms were in front of his chest and the PO could not move them away to allow him to attempt CPR (cardio pulmonary resuscitation). The nurse then arrived and checked the man for a pulse but he had none. The PO wrote that in consultation with the nurse and a senior Officer it was decided that resuscitation should not be attempted.

The nurse made the following entry in the man's medical record:

'Called to B4 landing ... [the man] was cold to touch and his face was blue/purple in colour. He had no pulse ... Unable to open his mouth. Placed [defibrillator pads] on his chest – just a straight line [on read-out]. Gave [oxygen] via mask. Ambulance ... paramedics came, they checked the man and said he was dead.'

A debrief was held with the staff who responded when the man was found hanging. Staff were also offered the opportunity to see the care team.

After the man's death

When the man's records were checked it was found that no information had been recorded about his next-of-kin. Wandsworth telephoned the firm of solicitors from whom the man had received legal visits. They had no information about the man's next-of-kin but gave Wandsworth contact details of the psychiatric clinic where the man had previously been treated. The clinic was able to supply the name, address and telephone number of the man's mother. Two of Wandsworth's FLOs together with one of the chaplains visited the man's mother to break the news in person. While there one of the FLOs telephoned the man's sister. The man's mother told the prison FLO that her son had had a child with an ex-partner. The man's mother said that she did not have contact details for the ex-partner but she thought her son's father, from whom she is divorced, did. The man's mother also mentioned her son had a half-brother. The man's mother told the prison FLO that she would contact her ex-husband to tell him about their son's death.

³ A Code One alerts staff about an emergency or life threatening incident.

The prison FLO offered the man's mother the opportunity to visit Wandsworth. The prison FLO also advised her to approach the benefits agency about funding for her son's funeral and told her that Wandsworth would contribute as necessary.

On the day of the man's death, police Officers visited Wandsworth, searched his cell and spoke to staff. In keeping with standard practice following a death in prison custody the cell was then sealed. Two days later the police gave authorisation for the cell to be entered by prison staff. Staff collected the man's belongings among which they found a letter to his solicitor dated 17 January.

The man started the letter by declaring: *'Didn't do the crime – won't do any more time anywhere!'* The man then wrote about an incident that occurred while he was in police custody adding that he was: *'... severely ill at the time ...'* The man went on: *'It is almost certain that I'll be back on major tranquilising intra-muscular injections. That is no life. In protest at my fix-up I shall attempt to commit suicide. This is my last and only suicide note ...'*

The man asked in the letter that his half-brother be informed of his death.

A diary was also found in the man's cell but this only contains a number of routine entries. The man made no entries about his thoughts on his court case, any thoughts he might have had about his future or any plans to take his own life.

CONSIDERATION OF THE ISSUES

The man's psychiatric history, his arrest and detention in prison

The man was first diagnosed with a mental health illness in 1995 when he was admitted informally to a mental health unit. In June 1996, the man was convicted on counts of threats to kill and affray arising from a neighbour dispute. After again being diagnosed as mentally ill, the man was admitted to the psychiatric clinic (a mental health secure unit). The man remained in the clinic from August 1996 to February 2000. After his discharge, the man continued to receive intermittent care and treatment through the psychiatric clinic both as an in-patient and via community care.

On 24 June 2006, the man was arrested following a disturbance that commenced with him walking in the street carrying a wooden martial arts practice sword. He spent two days in police custody before being remanded into custody in HMP Belmarsh. He was diagnosed as suffering a relapse of his schizoaffective illness.

The man spent his first three months at Belmarsh under observation in healthcare. There are quite a number of entries in the man's records indicating that his mental health state was not good. For a lot of the time the man was designated as a prisoner to be unlocked only with the presence of three Officers. The man was discharged from healthcare on 19 September when his mental health was assessed as 'settled'.

On 23 November, the man was transferred to Wandsworth. It seems that the reason for the move was overcrowding at Belmarsh. On arrival at Wandsworth, the man was seen by a doctor who found him to be mentally stable with no thoughts of self-harm.

On 30 December, the third Officer made an entry in the man's records that he was acting strangely that day. Apart from that entry, it seems that the man largely remained well while at Wandsworth. Having said that, the first Officer described the man as unusual and at least one of the Listeners thought the same.

The man was assessed by a doctor and a nurse from the Prison Inreach team on 8 January 2007. The clinical review from Wandsworth PCT found that the Inreach team's assessment and management plan appears detailed, thorough and appropriate.

Two questions asked by the man's ex-partner was why he was sent to prison rather than to a psychiatric hospital and also about the length of time he spent in custody. It is clear that the man was mentally ill when he was arrested on 24 June 2006 and taken into police custody. Even so, when the man went to court two days later he was remanded from there into prison custody rather than a mental health unit. Among others, my investigator spoke to the man's solicitor and he spoke to the man's probation Officer who was asked to write a pre-sentence report on the man. My investigator also spoke to the psychiatrist from the psychiatric clinic.

The man's solicitor said that it is not unusual for a person like the man to be in a prison rather than in a psychiatric unit. Moreover, the man had said that he did not want to be in psychiatric hospital. The probation Officer said that he had spoken with the psychiatrist at the psychiatric clinic and so he was aware of the man's clinical history. The probation Officer said that with the lack of availability of psychiatric beds it is common for people such as the man to be initially remanded into prison. He said that he was not able to write his report before the man's death, but had he written it he would have recommended that the man be taken into a psychiatric unit. The probation Officer said that psychiatrist at the psychiatric clinic was very clear that this is what the man needed. The psychiatrist from the psychiatric clinic confirmed all that the probation Officer said. He also said that the man's health had clearly improved during his time in Belmarsh and this diminished the urgency of any admission to the psychiatric clinic.

The man's solicitor also told my investigator that it is not unusual for a prisoner to be on remand for six or more months.

Findings from the clinical review

The clinical reviewer's conclusions include that the man received significant psychiatric support at Belmarsh and that it seems his mental health was stabilising by the time of his transfer to Wandsworth. The reviewer points out that although the man's clinical records at Wandsworth are brief, his prescription chart confirms that he was continuing to take his medication regularly and that no concerns were noted by the nursing staff. The reviewer goes on to say that it appears that the man's care at Wandsworth was reasonable.

Contact with Listeners

In common with the majority of prisons in England and Wales Wandsworth has a Samaritan supported 'Listener' scheme. The Listener service is not about resolving practical problems, instead it is to do with listening to prisoners without judging them or telling them what to do. The support Listeners give is emotional and is intended to empower the 'caller' to do what they need to do or to find the practical help they need. The whole scheme is founded on the principle of complete confidentiality between the Listeners and the 'caller'. A Listener might speak to prison staff about a particular situation, but only if the 'caller' gives permission.

To become a Listener, a prisoner must apply to both the prison and the Samaritans. The prisoner attends a course in the prison that is run by the Samaritans and which is of the same duration and the same content as the course that Samaritan volunteers undertake. At the end of the course the Samaritans will only accept as Listeners those whom they have assessed as being suited to the work.

If a prisoner needs to talk to a Listener, the contact might be made through a prison Officer but sometimes Listeners are approached directly. They can meet in the Listener's cell or in the caller's cell. Wandsworth has a Listeners' suite so meetings

can also take place there. This contact can be at any time, day or night. At night time, meetings at Wandsworth will always be in the Listeners' suite.

My investigators discovered that the man spent a great deal of time with Listeners during the final five weeks of his life. My investigators spoke to four of Wandsworth's Listeners who had had contact with the man. A Samaritan volunteer sat in on the interviews. The principle of complete confidentiality under which the Listener scheme operates continues even after the death of a prisoner (the fear is that without such a guarantee, some prisoners will be deterred from accessing the service). Consequently, the Listeners could give only limited information to my investigators about their contact with the man. They were able to say however that the man spoke to Listeners almost every day during the final five weeks of his life. Most of these contacts were during the day time and not recorded by the Listeners as at that time only night time contacts were recorded. Since the man's death, Listeners have made a record of all contacts with prisoners.

The Listener who had the greatest contact said that the man came to his cell most days in the final weeks of his life. The Listener described the man as mentally unstable and a person whose manner caused other prisoners to feel uncomfortable in his presence – some prisoners would chat to him, but many would try to avoid him. The Listener said that there were times when the man could be very agitated, but he usually calmed down as they spoke. The Listener was very surprised that the man took his own life.

The other three Listeners had much less contact with the man. All said that on the occasions they saw him he would talk until ready to leave and was always calm by the time he had finished.

The Listeners mentioned two things to my investigators that would help them in their role. They said that after spending time with a prisoner they try to see him again the following morning to check that he is alright. However, if the prisoner is in a different wing it can be difficult gaining access. The Listeners would therefore welcome freer access across the prison. Two of the Listeners said that some Officers do not seem to have respect for the work the Listeners do. My investigators were told that there was a time when Listeners were invited to talk on induction courses to explain their role to new staff. This no longer happens.

After speaking with the Listeners my investigators spoke with Wandsworth's Head of Safer Prisons. She told my investigators that her responsibilities include suicide prevention and deaths in custody. The Head of Safer Prisons said that she chairs the monthly suicide prevention meeting which both Listeners and the Samaritans attend.

The Head of Safer Prisons was asked to comment on the recording of the man's contact with Listeners – the record of daily incidents held at the central hub contains six dates during the final five weeks of the man's life when he saw Listeners after evening lock-up; the wing observation book contains only two such dates; no dates had been entered in the man's personal records. The Head of Safer Prisons said that any time a prisoner has to be unlocked to see a Listener it should always be

recorded and she would therefore expect the number of entries in the daily record to match with the entries in the observation book.

The Head of Safer Prisons was asked to comment on what interaction she would expect between an Officer and a prisoner who has been with Listeners at night time. She said that at a minimum, she would expect the Officer to check that the prisoner is alright. She thought that it would be a matter of good practice for the Officer to make a brief record about that contact referring to the prisoner's state of mind. She said though that that is the ideal and it should be borne in mind that Officers are often under a lot of pressure at night when there is only one Officer on duty in each wing. She also pointed out that if the prisoner says that he is fine it is very difficult for the Officer to read between the lines or go beyond what the prisoner is actually prepared to disclose. The Head of Safer Prisons considers that the quality of care for prisoners at Wandsworth has improved drastically in recent times, but that the standard of record keeping has not improved at the same rate.

My investigators asked the Head of Safer Prisons to comment on the Listeners' complaint that they sometimes find it difficult to make a follow-up visit on the morning following time spent with a prisoner. She said that some of the Listeners are 'Red Bands' which means that they are the most trusted prisoners and have security clearance to access a lot of areas in the prison. However, other Listeners have a lesser level of clearance and that places restrictions on their movements.

In conclusion, the Head of Safer Prisons thought that the vast majority of staff would consider Listeners to be positive and useful. She said that without Listeners, Officers would find their own jobs so much harder. She agreed that it would be a good idea for Listeners to explain their role at induction courses for new staff.

Some of the Officers interviewed remembered the man having contact with Listeners. However, none of them were worried that the man might be at risk. All of the Officers said that they would have opened an ACCT form if they had been concerned.

I agree with the Head of Safer Prisons that it would benefit prisoner care and welfare if Officers were to check that prisoners are okay after seeing Listeners at night time. Of course the confidential nature of the Listener scheme means that Officers must be careful not to intrude on that relationship. Nor must they do or say anything that might deter prisoners from accessing Listeners.

The Governor should remind staff to always record in the wing observation book when a prisoner has been unlocked to see Listeners.

In the case that a prisoner has been unlocked to see a Listener, the Officer involved should speak to the prisoner following the contact and note in the prisoner's record that they have seen a Listener.

I was disappointed to learn that two Listeners felt that some Officers have little respect for the work they do. In my opinion, Listeners make a valuable and significant contribution to the welfare of prisoners. The Head of Safer Prisons quite

correctly pointed out that Officers would find their work much harder if there were no Listeners.

The Governor should consider inviting Listeners to induction courses for new staff to explain their role.

The discovery of the man's death

The man's death was discovered when the fifth Officer was carrying out his morning roll check at just after 6.00am. The fifth Officer said that when he looked through the observation hatch he saw the man in an upright position by the cell window facing outwards. His feet were touching the floor. The fifth Officer noticed a cord running from the window to the man's neck, but it was not clear to him whether the man was hanging or was standing and looking out of the window. The fifth Officer called the man's name and kicked the door but he got no response. The fifth Officer ran from the 4's landing down to the 2's where he summoned assistance from the PO. The two Officers went to the man's cell, cut the ligature and lowered the man to the floor. No attempts were made to try to resuscitate the man as rigor mortis was established and it was obvious that he was dead.

There are several matters connected with the response when the man was found on which I wish to comment. The first matter is the fifth Officer's decision to summon help rather than to enter the man's cell alone. The fifth Officer said that he considered going into the cell, but for security reasons judged that he needed the presence of another Officer. This was a matter upon which the fifth Officer was entitled to use his discretion and I accept that he exercised his discretion in a reasonable way on this occasion.

Having decided that he needed support, the fifth Officer ran two floors below where he called to the PO for help. At interview, the fifth Officer was quick to acknowledge that he should have used his radio to summon assistance.

As already mentioned staff made no efforts to try to resuscitate the man as it was obvious to them that he was dead. That decision contravened Wandsworth's local contingency plans that say if a prisoner is not breathing, resuscitation should always be attempted. However, Wandsworth's contingency plans do not reflect the national guidance contained in PSO 2700. The PSO does not require staff to attempt resuscitation where rigor mortis has clearly set in. The decision by staff not to attempt resuscitation in the man's case was therefore entirely appropriate even though it contravened local instructions.

The Governor should revise Wandsworth's contingency plan for dealing with deaths in custody to bring it in line with PSO 2700. Specifically, that where rigor mortis has clearly set in, it is unnecessary for staff to attempt resuscitation.

Should staff have recognised that the man was at risk?

The man's mental health condition had stabilised by the time he came to Wandsworth. Even so, those who came in contact with him described him as unusual or odd. Twelve days before his death the man wrote a letter addressed to his solicitor. The man wrote that he would almost certainly be put back on '*major tranquillising intra-muscular injections*'. He said that that would be 'no life'. The man described the letter as a suicide note.

The man's ex-partner told my staff that the man must have been depressed to have written that letter and she could not understand why prison staff had not noticed. I can understand this sentiment, however no one seems to have considered the man at risk of self-harm. Although it is easier to identify risk with hindsight and the benefit of a letter that signifies the man's true feelings, no one knew of the letter until after his death. It was not only the staff who were surprised at what happened. The Listeners with whom the man had almost daily contact in the final weeks seem not to have had any suspicion that he would harm himself. It does not automatically follow that a prisoner who makes contact with Listeners for support might be at risk of self-harm or suicide. Listeners are a means of emotional support at a range of levels. In addition, the man's solicitor visited him frequently in Wandsworth. The last time was about 10 days before his death when he said that the man was '*in good form*'.

Contact with the man's family

The man's ex-partner is also the mother of the man's child. She and the man's half-brother told my staff that they were very upset that they did not hear about the man's death until a fortnight after it had happened. Both thought that they should have been told directly by the prison rather than via other family members.

The man had not given Wandsworth any details of his next-of-kin. Wandsworth obtained contact details for the man's mother through the psychiatric clinic having initially made contact with the man's legal team. Three of Wandsworth's staff, including the prison FLO then visited the man's mother to inform her of her son's death. The prison FLO also spoke by telephone with the man's sister. She told the prison FLO that she would pass the news to the man's father.

Two days later the police gave authority for the man's cell to be entered. Among other belongings, a letter was found that the man had written to his solicitor. In the letter he gave contact details for his ex-partner and his half-brother. Wandsworth did not contact either of these two family members as it was assumed that they would hear through other family members.

The instructions contained in Prison Service Order (PSO) 2710 say that following a death the prison must notify the next-of-kin and any other person the prisoner has reasonably requested should be informed.

Guidance supplementary to PSO 2710 about liaison with bereaved families includes:

'3.4 The family may be large, split geographically, at odds amongst themselves. Many modern families are split by divorce or separation and there may be several branches all with equal rights to information. The

Family Liaison Officer may be able to get the family to nominate a single point of contact who undertakes to keep other family members up to date. This may not always be possible, or may not work in practice, so the Family Liaison Officer should be prepared to deal with different sections of one family if necessary ...'

The man had not given any information directly to Wandsworth either about his next-of-kin nor anyone else he would want informed in the case of his death. However, in the letter to his solicitor the man made it clear that he wanted his half-brother to be told of his death. By the time the letter was found two days had passed by since the man's death. I do not think it unreasonable for Wandsworth to have assumed by then that the man's mother would have informed the man's father and that he would have told his younger son (the man's half-brother). The conclusion that Wandsworth did not do anything inappropriate is of course no consolation to the family for whom I have every sympathy.

PSO 2710 also gives guidance on funeral arrangements. It advises that prisons should offer to pay reasonable expenses and £3,000 is the figure that is considered reasonable. PSO 2710 goes on to say that this offer should be made irrespective of any entitlement the family may have from the Social Fund. When the prison FLO visited the man's mother she advised her to first seek funding from the Benefits Agency. The prison FLO told her that Wandsworth would then pay any further contributions needed. This was not in line with the guidance set out in PSO 2710.

The Governor should remind his family liaison Officers to follow the guidance contained in PSO 2710 about the offer of payment of funeral expenses.

RECOMMENDATIONS

I make the following recommendations (the Prison Service's responses to the recommendations following issue of the draft report are set out below each recommendation):

1. The Governor should remind staff to always record in the wing observation book when a prisoner has been unlocked to see Listeners.

Prison Service response: *Recommendation accepted. A Governor's Order had been issued to this effect.*

2. The Governor should issue an instruction that in the case that a prisoner has been unlocked to see a Listener, the Officer involved should speak to the prisoner following the contact and note in the prisoner's record that they have seen a Listener.

Prison Service response: *Recommendation accepted locally. However, recording the contact should be decided on a case by case basis. Many prisoners do not use Listeners to the same extent as Mr The man and it may not be necessary to record their contact with Listeners.*

3. The Governor should consider inviting Listeners to induction courses for new staff to explain their role.

Prison Service response: *Recommendation accepted. The Head of Safer Prisons is discussing the possibility of this with the training department. Incorporating a brief presentation in the ACCT awareness training of the role of Listeners will be introduced. However as induction training is usually conducted in a building outside the prison, the suggestion is to either use Samaritans Volunteers to speak about the role of Listeners or move the training venue. The target for completion is December 2007.*

4. The Governor should revise Wandsworth's contingency plan for dealing with deaths in custody to bring it in line with PSO 2700. Specifically, that where rigor mortis has clearly set in, it is unnecessary for staff to attempt resuscitation.

Prison Service response: *Recommendation accepted. The deaths in custody contingency plan has now been revised to bring this in line with PSO 2700.*

5. The Governor should remind his family liaison Officers to follow the guidance contained in PSO 2710 about the offer of payment of funeral expenses.

Prison Service response: *Recommendation accepted. The Head of Safer Custody has now undergone Family Liaison Officer and Family Liaison Co-ordinator training and will co-ordinate the response to bereaved families. This will ensure that the PSO 2710 guidelines on funeral expenses will be adhered to in a consistent manner.*