Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen O'Rourke, a prisoner at HMP Wandsworth, on 16 December 2020

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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 Stephen O'Rourke died in the early hours of 16 December 2020, having been found hanging in his cell late on 15 December at HMP Wandsworth. Mr O'Rourke was 48 years old. I offer my condolences to Mr O'Rourke's family and friends.

Mr O'Rourke repeatedly talked about killing himself after his court hearing. For this reason, he had been managed under Prison Service procedures to support those at risk of self-harm (known as ACCT) while he was at HMP High Down. When he was due to appear in court, he transferred to Wandsworth because it was closer. He was convicted on 15 December and was found hanging later that night.

I am very concerned about the adequacy of arrangements to manage those at risk of suicide or self-harm in Wandsworth. No individual took overall responsibility for managing Mr O'Rourke's risk as a case manager. It was well documented that the culmination of his trial was a potential trigger point for Mr O'Rourke's safety. Despite this, his risk to himself was not reviewed when he returned to prison after being convicted and prison staff did not consider whether he might need to be observed more frequently or require additional support.

There were also communication difficulties between the two healthcare departments when Mr O'Rourke transferred from High Down to Wandsworth.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **November 2022**

Contents

Summary 1

The Investigation Process.....4

Background Information.....5

Key Events.....7

Findings 15

Summary

Events

1. Mr Stephen O'Rourke was charged with murder in November 2018. He had a history of mental health problems. He often spoke of taking his life and was managed under Prison Service procedures to support those at risk of self-harm (known as ACCT).

2. In 2019, Mr O'Rourke's brother took his own life in HMP Belmarsh, and Mr O'Rourke was transferred to a secure psychiatric hospital.

3. In September 2020, Mr O'Rourke transferred from hospital to HMP High Down. He told staff that he might take his own life, particularly after he had appeared in court, and he was again managed under ACCT procedures.

4. In November, HMP Wandsworth agreed to accommodate Mr O'Rourke for the duration of his trial. He transferred on 23 November, the first day of his trial.

5. Healthcare staff at High Down had said that Mr O'Rourke needed to be accommodated in the healthcare unit at Wandsworth. However, Wandsworth had no space in their healthcare unit and, when he arrived, he was located in a constant supervision cell on a standard wing.

6. Staff at Wandsworth held ACCT reviews after Mr O'Rourke attended court on 24, 25 and 26 November. On 25 November, they assessed that he no longer needed constant supervision and his level of observations varied from that point. When a member of staff went to hold an ACCT review with him on 27 November, Mr O'Rourke was asleep, so no review was held. The next ACCT review was not held until 5 December.

7. On 12 December, Mr O'Rourke's sister told the prison that he had said that he might take his own life after court. At a subsequent ACCT review, Mr O'Rourke denied having said that. (A recording of the call confirmed that he did not.) The next ACCT review was scheduled for when Mr O'Rourke returned from court on 14 December, but this did not take place.

8. On 15 December, Mr O'Rourke was convicted of murder. When he got back from court, he saw a nurse and a doctor, both of whom told the reception manager that he needed to have an ACCT review and that constant supervision should be considered. The reception manager contacted Mr O'Rourke's wing manager, who said that he was about to go off duty. She then contacted the incoming wing manager, who said that he was not trained to carry out ACCT reviews. She then passed a message on to the central office. There was miscommunication between staff and, ultimately, no ACCT review was held.

9. When an ACCT check was conducted at 11.17pm, Mr O'Rourke had blocked his observation panel. Staff went into his cell and found him hanging. They provided emergency first aid until ambulance paramedics arrived, but, at 12.18am on 16 December, it was agreed that Mr O'Rourke had died.

Findings

Mr O'Rourke's transfer from High Down to Wandsworth

10. When the court expressed concern about potential delays in his trial, Wandsworth agreed to accept Mr O'Rourke at short notice. This was the decent thing to do. However, we share the clinical reviewer's concerns about poor communication between officers and healthcare staff, as well as between healthcare departments in the two prisons, about Mr O'Rourke's needs and the management of his risk.

Assessment Care in Custody and Teamwork (ACCT)

11. Mr O'Rourke was appropriately managed under ACCT procedures when he arrived at Wandsworth. However, after the first few days, the gaps between reviews grew longer. He was scheduled to have a review on 14 December, but this was not held, and the oversight was not picked up. For the seven case reviews held at Wandsworth, there were six different case managers. We consider that this lack of consistent oversight undermined the management of Mr O'Rourke's risk.

12. When Mr O'Rourke got back from court on 15 December after being convicted of murder, escort and reception staff recognised that his risk had increased and that he should have an ACCT review. Despite the well-documented risk associated with his trial, and a reception nurse and doctor's concern that he was at high risk of suicide, no review was held that night. The message was passed on to several managers, but no one took responsibility for ensuring that a case review took place. As a result, no one considered whether Mr O'Rourke needed to be observed more frequently or to have additional support in place. This was unacceptable.

13. The OSG responsible for conducting ACCT checks that night was not told that Mr O'Rourke had been sentenced that day.

Mr O'Rourke's healthcare

14. The clinical reviewer found that the standard of healthcare provided by High Down and Wandsworth was not equivalent. She was concerned about the lack of meaningful handover between the two prisons.

15. The clinical reviewer was also concerned that the ACCT process was not properly reflected in Mr O'Rourke's medical records, which meant that healthcare staff might not have appreciated the extent of his risk.

16. The clinical reviewer was concerned that, although the mental health team intended that the primary care team should take over Mr O'Rourke's mental health care, there was no clear plan or handover to ensure this happened.

Recommendations

- The Governor and the Head of Healthcare should ensure that, when a prisoner transfers to Wandsworth from another prison's healthcare unit:
    - clinicians at Wandsworth speak directly to clinicians at the sending prison to establish the prisoner's care needs; and
    - information is shared with other relevant staff at Wandsworth.
- The Governor should ensure that prison staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including that:
    - a case manager is appointed at the first case review, who should lead all subsequent case reviews, wherever possible;
    - staff are aware of the potential risk factors and triggers that might increase a prisoner's risk, including conviction;
    - a multidisciplinary review is held when there is evidence of a significant change in risk; and
    - staff adhere to the frequency of observations as specified in the ACCT document and record those observations contemporaneously.
- The Governor should commission an investigation into the actions of SO A, SO D, CM A, CM B, SO B and SO C in relation to the failure to hold an ACCT review when Mr O'Rourke returned from court on 15 December, with a view to considering whether disciplinary action is appropriate.
- The Head of Healthcare should ensure that:
    - medical records clearly indicate when a prisoner is subject to ACCT monitoring; and
    - healthcare staff should record information from ACCT reviews in a prisoner's medical record.
    - there is a clear protocol for discharging a prisoner from the mental health team to the primary care team for ongoing mental health support.
- The Governor should contact the Ombudsman to arrange a meeting to discuss recent self-inflicted deaths at Wandsworth.

The Investigation Process

17. 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. One prisoner responded and was interviewed.

18. The investigator obtained copies of relevant extracts from Mr O'Rourke's prison and medical records.

19. The investigator interviewed 18 members of staff and one prisoner at Wandsworth. All the interviews took place remotely because of the COVID-19 restrictions. NHS England commissioned a clinical reviewer to review Mr O'Rourke's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

20. 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.

21. One of the Ombudsman's family liaison officers contacted solicitors acting for Mr O'Rourke's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider.

22. Mr O'Rourke's family asked about his care and consideration of his safety in HMP Wandsworth. They specifically raised the issue of his care after he was convicted.

Background Information

HMP Wandsworth

23. 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

24. The most recent full inspection of HMP Wandsworth was in February and March 2018. Inspectors reported concerns about staff going into cells in emergencies and delays in answering cell bells. Most ACCT case reviews were multidisciplinary and the three inspectors observed were good. However, overall, ACCT procedures were poor. Assessment interviews and first case reviews were regularly late, undermining effective risk management and care. Assessments, care maps and observational entries lacked detail, and post-closure interviews rarely took place.

25. HMIP also conducted a Short Scrutiny Visit of Wandsworth in April 2020 to report on the treatment and conditions of prisoners during the COVID-19 pandemic. Inspectors noted that Wandsworth had responded well, with good communication to prisoners and swift testing. Health and safety protocols were in place and the prison remained calm, well ordered, and safe.

Independent Monitoring Board

26. 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 2020, the IMB reported that the prison had responded well to the coronavirus pandemic. Healthcare services were good, but mental healthcare was a major issue.

Previous deaths at HMP Wandsworth

27. Mr O'Rourke was the third prisoner to take his own life at Wandsworth since 2018. There have since been a further six deaths, all apparently self-inflicted. In previous investigations, we made recommendations about mental healthcare provision and the management of suicide and self-harm procedures, known as ACCT.

Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

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

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

Key Events

31. Mr O'Rourke was remanded to prison on 19 November 2018, charged with murder, and sent to HMP High Down. His brother was also charged in connection with the same incident.

32. Mr O'Rourke had a history of mental health issues, including post-traumatic stress disorder, anxiety and depression, and a mixed personality disorder.

33. As soon as he got to High Down, Mr O'Rourke talked about suicide. Staff assessed that he was at risk and started suicide and self-harm monitoring procedures, known as ACCT. Mr O'Rourke remained under ACCT management, sometimes under constant supervision, throughout his time in prison. He was often admitted to the prison's healthcare unit for monitoring of his mental health.

34. On 2 April 2019, Mr O'Rourke's brother took his own life in HMP Belmarsh. Mr O'Rourke was again placed under constant supervision. That month, he was transferred from prison to a secure psychiatric hospital. He remained there for 17 months.

HMP High Down

35. On 9 September 2020, Mr O'Rourke transferred back to High Down. He told staff that he had no thoughts of harming himself but did feel "a bit mentally unstable". On 10 September, staff started ACCT procedures because Mr O'Rourke said that his brother had taken his own life and that, if he got the chance to do so, he probably would do the same. A note on Mr O'Rourke's electronic prison record noted that his court date was a potential trigger for self-harm. At an ACCT review the following day, Mr O'Rourke said that he intended to take his own life after his court appearance in November.

36. At an ACCT review on 23 September, it was suggested that his medication could be reduced to make him more alert. Mr O'Rourke became agitated and threatened staff, so he was taken back to his cell. In the early hours of 24 September, Mr O'Rourke tied a ligature made from a bed sheet around his neck and rang his cell bell. He had written a suicide note. At an interim ACCT review, Mr O'Rourke said that he was angry about the suggestion of altering his medication. Later that day, staff held a further review. Mr O'Rourke was angry about being returned to prison and wanted to be given the level of medication that he had taken in hospital. He said that he did not want to be in prison and would kill himself. The note of the review said that appearing in court could be a trigger.

37. At an ACCT review on 27 September, Mr O'Rourke handed over a ligature. He was unkempt and had not been eating well. Staff arranged for him to speak to his partner and noted the improvement in his mood and behaviour afterwards. They agreed that he should move to a cell with a telephone. At an ACCT review on 29 September, it was agreed that his level of observation could be lowered to a minimum of once an hour.

38. A psychiatrist led an ACCT review on 12 October, when Mr O'Rourke said that he knew that staff were talking about moving him to Broadmoor Hospital, but he did not

want to go. He said that he intended to take his own life but wanted his time in court before doing so. The record of the review again noted that court attendance could be a trigger for self-harm. Those at the review, including Mr O'Rourke, agreed that he no longer needed to be in the healthcare centre and could move to a houseblock. (He did not actually transfer to a houseblock.)

39. On 19 October, Mr O'Rourke's sister telephoned the prison and said that he had told her that he had been hitting his head against the wall in frustration. She was concerned that his medication had been altered. This information was passed on to the healthcare department. At an ACCT review the next day, Mr O'Rourke said that he was concerned about his medication. He and medical staff present, including the lead psychiatrist, agreed to change his prescription. A note was entered on Mr O'Rourke's electronic prison record that he was at risk of taking his own life, with his court appearance noted as a potential trigger.

40. On 26 October, Mr O'Rourke's partner emailed the prison doctor to say that changes to his medication were causing him serious problems. At an ACCT review the following day, Mr O'Rourke admitted to the psychiatrist that he had hit his head against the wall. The meeting discussed his location during his pending trial. Normally prisoners attending the Central Criminal Court would stay at Belmarsh. As Mr O'Rourke's brother had taken his own life there, this was not considered appropriate, so it was agreed that he would remain at High Down.

41. At an ACCT review on 3 November, Mr O'Rourke said that he had no current thoughts of taking his own life, though the thought of dying was always present. At an ACCT review on 5 November, he said he was a little concerned about his forthcoming trial, but that he was 'okay'. At an ACCT review on 11 November, Mr O'Rourke said that he felt settled in the healthcare centre. He did not want to make any changes until after his court appearance, which would have a big impact on his future.

42. On 16 November, Broadmoor assessors reported that Mr O'Rourke did not meet the criteria for admission. The next day, he had a mental health assessment and risk review. Mr O'Rourke said that he was ready to face trial but felt anxious, and staff were aware that his risk would escalate during and after court. He said he had frequent thoughts of taking his own life but was able to access help and had support from his family and partner. The psychiatrist recommended that Mr O'Rourke should stay in the healthcare department of whatever prison he was in during his trial and noted that the risk of suicide would increase dramatically during trial and in the event of Mr O'Rourke being convicted.

43. At an ACCT review on 18 November, Mr O'Rourke talked about long-term plans, including accessing treatment. The note of the review recorded that Mr O'Rourke and his brother had had a suicide pact, but there is no further information about where the suggestion came from. Staff explained that he might not return to High Down after court, and they discussed how he could access support if things felt difficult.

Transfer to HMP Wandsworth

44. Mr O'Rourke's trial was due to start at the Central Criminal Court on 23 November. In the light of the decision not to transfer Mr O'Rourke to Belmarsh, court officials

contacted Belmarsh on 19 November to inform them that the judge was concerned about possible delays if Mr O'Rourke had to travel from High Down to court every day. Belmarsh contacted HMP Thameside to ask if Mr O'Rourke could transfer there for the duration of his court case. Thameside declined, so, on Saturday 21 November, Belmarsh contacted HMP Wandsworth.

45. After discussion between High Down, Belmarsh and Wandsworth, the duty governor at Wandsworth agreed that they would accept Mr O'Rourke after he left court on Monday 23 November.

46. The duty governor included a nurse from Wandsworth's mental health team in the email exchange. The nurse telephoned High Down's healthcare centre to discuss the care Mr O'Rourke would need. The calls were unanswered. The nurse spoke to the service manager for the mental health team in Wandsworth. The service manager and the duty governor exchanged emails. Although High Down had wanted Mr O'Rourke to be held in the healthcare unit during his trial, the service manager said that there was a waiting list for admission to the healthcare unit at Wandsworth. She and the duty governor agreed that staff would assess Mr O'Rourke in reception when he arrived at Wandsworth and decide on the most appropriate location based on circumstances at the time.

47. At an ACCT review at High Down on 22 November, it was noted that Mr O'Rourke's trial would begin the following day, and this was a significant potential trigger as he had repeatedly said he would take his own life after trial. Staff explained to him that he would stay at Wandsworth during his trial. Mr O'Rourke said that he was anxious about attending court, but was pleased to be staying at Wandsworth, which would reduce his stress while travelling to and from court. He said that he was focussing on his trial and had no current thoughts of harming himself. Staff raised his observation levels to at least five an hour. Mr O'Rourke asked if someone could telephone his partner to inform her of the arrangements. The case manager did so. He then made an entry on Mr O'Rourke's electronic prison record noting that his court appearance could be a significant trigger for self-harm.

48. A nurse telephoned the healthcare department at Wandsworth to discuss Mr O'Rourke's care, as it was recommended that he should be accommodated in the healthcare unit. The medical record, prison record and ACCT document do not show who she spoke to, but they told her that they were not expecting Mr O'Rourke and had no beds in the healthcare unit. The nurse emailed managers at High Down involved in Mr O'Rourke's care.

49. At Wandsworth's senior management meeting on the morning of 23 November, staff discussed Mr O'Rourke's pending arrival. The service manager reiterated that there were no beds available in the healthcare unit and that there was a waiting list. The meeting agreed that Mr O'Rourke would be assessed in reception and an ongoing plan for his care would be made at that point. No information, however, was conveyed to the doctor who would be working in reception that evening.

50. Mr O'Rourke's medical record contains an email handover from a nurse to Wandsworth's healthcare department. The entry was made on 24 November, but the email refers to Mr O'Rourke leaving High Down that day so is likely to have been sent on 23 November. The email said that it was believed that Mr O'Rourke

had made a suicide pact with his brother and noted that Mr O'Rourke had maintained that he intended to end his life at the time of his trial.

HMP Wandsworth

51. On 23 November, Mr O'Rourke went to court and was then taken to Wandsworth. In reception, a nurse noted that he was tearful and agitated and said he had very strong urges to take his own life. She recorded that Mr O'Rourke was supposed to go to the healthcare unit but there were no beds available. She assessed him as at very high risk of suicide or self-harm. Mr O'Rourke than saw a prison GP, who noted his mental health history. Mr O'Rourke said that he was stressed and worried about his trial and had not slept for 24 hours. He admitted to current thoughts of self-harm, saying he would hang himself. The GP and nurse discussed this and, as there were no available beds in the healthcare unit, they recommended that he be placed under constant supervision. He was located in a constant supervision cell on a standard wing, and this was noted on his electronic record. There is no record of this on his ACCT document, and no indication that an ACCT review was held.

52. On 24 November, Mr O'Rourke went to court and staff held an ACCT case review when he got back to Wandsworth. A Supervising Officer (SO) was the case manager, and attendees included the duty governor, a member of chaplaincy, a psychiatrist and a Community Psychiatric Nurse (CPN) from the mental health team. Mr O'Rourke said that he felt better than he had the previous day and had slept in the night. Staff asked him whether he had had a suicide pact with his brother. Mr O'Rourke said that he had not and did not want to discuss such things. He did not appear to be in crisis and said that he had no thoughts of harming himself. Because of his anxiety levels, it was agreed that he should remain on constant supervision. The end of his trial was noted to be a time of heightened risk.

53. The psychiatrist considered that Mr O'Rourke was not likely to benefit from treatment from the mental health team because he would be at court when mental health services were available. He recorded on Mr O'Rourke's medical record that he should be discussed at a future mental health team meeting, with a view to adding him to the primary care caseload. He did not discuss his plan with anyone from the mental health team or the primary care team.

54. When Mr O'Rourke got back from court on 25 November, the duty governor chaired an ACCT review with a nurse from the mental health team. Mr O'Rourke engaged well and discussed his future. He denied a suicide pact with his brother and said he had no current plans to take his own life, though he believed he would one day. He did not like being watched at night, as he said he had trouble sleeping. It was agreed that, while his risk might increase at the end of his trial, he was not currently in crisis and did not require constant supervision. Observations were reduced to a minimum of three an hour.

55. When he got back from court on 26 November, Mr O'Rourke attended an ACCT review with a custodial manager (CM) and a nurse, neither of whom had been at the previous reviews. He discussed his trial and said that he had no current thoughts of dying. He said he was relieved to no longer be under constant supervision.

56. On Friday 27 November, Mr O'Rourke appeared at court via video link. After he got back to his cell, a SO tried to hold an interim ACCT review, but Mr O'Rourke was asleep and would not wake up. No review was held until 5 December.

57. There are no entries on Mr O'Rourke's electronic record until 5 December, although there were regular entries in his ACCT ongoing record during this time. When he got back from court on 5 December, a SO held an ACCT review with a nurse and Mr O'Rourke. Mr O'Rourke engaged quite well and did not appear to be in distress. He was mixing with staff and prisoners on the wing, was in touch with his family and his partner, and said that he had no thoughts of taking his own life. The SO noted that there was no recent evidence of self-harm, and so reduced his observation levels to at least once an hour.

58. On 9 December, Mr O'Rourke said he had a stomach upset, so could not go to court. The same day, a prisoner told prison officers that there was tension between Mr O'Rourke and a prisoner in the neighbouring cell. Staff asked if there was anything they could do to resolve the issue, but Mr O'Rourke said not. Notes in the wing observation book alerted staff to be aware.

59. On 10 December, Mr O'Rourke went to court. When he got back, a SO held an ACCT review with a nurse and Mr O'Rourke. He appeared to be in good spirits. He said that the trial could be over soon and, although he could be facing a sentence in excess of 25 years, he hoped he might be convicted of manslaughter with a sentence in the region of 10 years. He accepted that he was facing a long sentence. He said he had no thoughts of self-harm and had a good relationship with his partner and his sister. It was agreed that he would remain subject to ACCT management, with at least five quality interactions during the day and irregular hourly checks at night.

60. Mr O'Rourke attended court on 11 December. A note on his ACCT ongoing record showed that at one point in the court cell he appeared to be very distressed and was hitting his head against the wall, talking about killing himself. Medical staff went to his cell, but he refused to see them. This was not recorded in Mr O'Rourke's medical record, electronic prison record or in his ACCT ongoing record.

61. On Saturday 12 December, Mr O'Rourke's sister telephoned the prison. She said that he had told her that he might take his own life after attending court. A SO held an ACCT review and Mr O'Rourke denied having said that. (Security staff listened to a recording of the call and confirmed that he did not.) He said that he was going to refuse to take his medication as he wanted a clear head. He was facing a long prison sentence if convicted and did not have lunch because he was fasting as he thought this would help with his anxiety.

62. A healthcare support worker (HCA) and a community psychiatric nurse from the mental health team went to speak to Mr O'Rourke, and he talked to them about the afterlife. It was agreed to increase Mr O'Rourke's observation levels to at least once an hour, and the next ACCT review was scheduled for when Mr O'Rourke returned from court on 14 December. This was noted on the front of the ACCT document. The HCA noted on the ACCT ongoing record that increased observations should be considered if Mr O'Rourke was sentenced.

63. When Mr O'Rourke returned from court on 14 December, no ACCT review was held.

15/16 December

64. On 15 December, Mr O'Rourke attended court and was convicted of murder. He was scheduled to attend court in January for sentencing. He arrived back at Wandsworth at 4.30pm.

65. An alert on Mr O'Rourke's Person Escort Record (PER) on 15 December noted that he had previously made statements to end his life, with court attendance as a trigger and that the Safer Custody department should be advised when he was attending court. The risk indicator page was not completed.

66. When Mr O'Rourke got back to Wandsworth, a member of escorting staff told SO A that he had been convicted. A note in his ACCT record on arrival back at Wandsworth showed that Mr O'Rourke was upset but "in the same mood as usual". He spoke to the SO in reception, who told the healthcare staff present that Mr O'Rourke had been convicted. Mr O'Rourke then saw a nurse and a prison GP. The GP agreed to give him medication to help him sleep. Mr O'Rourke said he had no thoughts of taking his own life.

67. The GP and nurse spoke to CM A, who was working in reception. The GP said that they were concerned about Mr O'Rourke following his conviction and that he needed an ACCT review. The CM told SO A that Mr O'Rourke needed an ACCT review. He then went to the centre office where the orderly officers (responsible for the day to day running of the prison) were based and told CM B that Mr O'Rourke had arrived back from court and needed an ACCT review.

68. SO A telephoned Mr O'Rourke's wing and told SO B, the wing manager, that Mr O'Rourke needed an ACCT review. SO B said he was about to go off duty. SO A then contacted SO C, who was taking over as the wing manager. SO C said he was not trained to carry out ACCT reviews. SO A then telephoned the centre office and spoke to someone who she thought was CM A, and said that Mr O'Rourke needed an ACCT review but she had been unable to arrange one. She said the person she spoke to thanked her for letting him know. She said she took that to mean that he would arrange a review.

69. In interview, CM A said that it was not him that SO A spoke to. He said SO D and another SO were on duty in the centre office with CM B at the time. SO D said in interview that he was not detailed to work in the centre office, but happened to be in there and answered the telephone. The call was from someone he thought was a member of the healthcare team in reception, he did not know who, saying that they were concerned about Mr O'Rourke. He said that he advised them to speak to the manager in reception, and passed these concerns on to CM B, who said that he would arrange a review. CM B said SO D did not pass this message on to him personally, though he was in the room at the time.

70. CM B said that he recalled CM A telling him that Mr O'Rourke needed an ACCT review. He said he telephoned the reception area and said that Mr O'Rourke needed an ACCT review. He did not know who he spoke to. He said he then dealt with two incidents in the prison, and after that went to Mr O'Rourke's wing and

asked SO C if everything was alright. SO C told him it was. He said he then went to the reception area and asked staff if everything that was required had been done and was told that it had. He said he assumed that Mr O'Rourke's ACCT review had taken place, but it had not.

71. Although he was supposed to be checked at least hourly, Mr O'Rourke's ACCT record contains no entries from 4.57pm until 7.07pm, when he was noted to be asleep in his bed. He was still asleep at the next check at 7.52pm. When an officer checked him at 8.40pm, he recorded on the ACCT document that he asked Mr O'Rourke if he was 'okay' and that he stood up and replied with a thumbs-up gesture. At 9.00pm, he was again asleep in bed. The next check was noted in the ACCT document at 10.22pm, over an hour after the previous one, and Mr O'Rourke was still asleep in his bed.

72. At 11.17pm, an Operational Support Grade (OSG) went to Mr O'Rourke's cell to make an ACCT check. The observation panel was blocked, and the OSG could not get a response from Mr O'Rourke. He used his radio to report that he was unable to confirm the wellbeing of a prisoner on an ACCT and requested assistance. Two officers went to the cell. They could not see into the cell and received no response from Mr O'Rourke, so they opened the door. Mr O'Rourke was hanging by a ligature attached to the bed frame.

73. The officers radioed a code blue emergency (meaning a prisoner is unconscious or having difficulty breathing), cut the ligature, and lowered Mr O'Rourke to the floor. The code blue was called at 11.19pm, which prompted the control room to call an ambulance. One officer checked for signs of life and, unable to detect any, started cardiopulmonary resuscitation (CPR). Other staff responded to the code blue call. A nurse checked Mr O'Rourke for signs of life but found none, so asked for Mr O'Rourke to be moved from his cell to the landing (where there was more room) and advised staff to continue with CPR. She applied a defibrillator, but it did not detect a heartbeat, so staff continued with CPR until paramedics arrived at 11.25pm and took over. Mr O'Rourke did not regain consciousness, and at 12.18am on 16 December it was agreed that he had died.

Contact with Mr O'Rourke's family

74. The prison identified Mr O'Rourke's partner as his next of kin and travelled to her home to break the news of his death. She was not home but they made contact via telephone and informed her of Mr O'Rourke's death. In line with Prison Service guidance, Wandsworth offered to make a contribution to the costs of Mr O'Rourke's funeral.

Support for prisoners and staff

75. After Mr O'Rourke's death, the deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support, at the time and subsequently.

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

Post-mortem report

77. Post-mortem reports showed that Mr O'Rourke died as a result of ligature compression. The pathologist listed asthma, personality disorder, mixed anxiety, and depressive disorder as contributory factors.

Findings

Mr O'Rourke's transfer from High Down to Wandsworth

78. Wandsworth exceptionally agreed to accommodate Mr O'Rourke during his trial, which we consider was the decent thing to do. However, Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, says that prisoners with complex care needs may require more detailed planning in advance of transfer.

79. The clinical reviewer noted that the decision to accept Mr O'Rourke at Wandsworth was made at very short notice, without clinician to clinician discussion. Staff at High Down had recommended that he be located in the healthcare unit, but there were no beds available. Senior managers in Wandsworth discussed Mr O'Rourke and agreed that his location should be assessed on arrival. A prison GP was working in reception on 23 November but was given no notification that Mr O'Rourke was due to arrive in Wandsworth that evening. There was no apparent plan for continuity of care.

80. The prison GP did see Mr O'Rourke when he arrived and concluded that he did not need 24-hour healthcare. The clinical reviewer considered that from a clinical perspective there was no need for him to be admitted to the healthcare unit in Wandsworth. Nevertheless, we make the following recommendation:

    The Governor and the Head of Healthcare should ensure that, when a prisoner transfers to Wandsworth from another prison's healthcare unit:

    - **clinicians at Wandsworth speak directly to clinicians at the sending prison to establish the prisoner's care needs; and**
    - **information is shared with other relevant staff at Wandsworth.**

Assessment Care in Custody and Teamwork (ACCT)

81. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action.

HMP High Down

82. Mr O'Rourke had been managed under ACCT procedures for a long time, before and after his spell in hospital. At High Down, reviews were regular and included staff who knew Mr O'Rourke, both officers and healthcare staff. When he was due in court and was to be held in Wandsworth, staff contacted his partner to let her know of the arrangements. When he was to transfer to Wandsworth, healthcare staff contacted their counterparts there to try to ensure a smooth handover bearing in mind Mr O'Rourke's mental health issues and risk of self-harm. We consider that Mr O'Rourke was given a good level of support in High Down, and we commend staff for involving his family to help inform his care.

HMP Wandsworth

83. Mr O'Rourke had ACCT reviews on 24, 25 and 26 November. The planned review on 27 November was not held because he was asleep, and he was not reviewed again until 5 December. At the review on 10 December, the next review was set for 17 December, but when an interim ACCT review was held on 12 December, the next review was reset for 14 December. This did not happen.

84. In all Mr O'Rourke had seven ACCT reviews at Wandsworth. These seven reviews were chaired by six different case managers. No individual case manager was given responsibility for ensuring that reviews were held. As a result, when the scheduled review for 14 December was missed, nobody noted this or followed it up. There was no system of management checks to ensure scheduled reviews were held.

85. Mr O'Rourke's ACCT documents, his medical record, and his prison record contain numerous warnings that he had threatened to take his own life after appearing in court and that this was a key risk point. On 15 December, he was convicted of murder and was therefore facing a life sentence. We are satisfied that Mr O'Rourke was seen and assessed by healthcare staff after being convicted and they recognised that his risk was likely to be raised. It is clear that escort staff, reception staff and healthcare staff were all aware that Mr O'Rourke needed an ACCT review that evening. However, prison staff failed to ensure that a review took place.

86. SO A, SO D, CM A, CM B, SO B and SO C, all management grades, all knew that Mr O'Rourke should be reviewed. Despite this, no one took responsibility for ensuring that a review was held.

87. SO C had only been in a supervising role for a matter of weeks and was not trained to conduct an ACCT review. Even so, having been told that Mr O'Rourke needed an ACCT review, he did not inform officers on the wing or make a note on the wing observation book. Nor did he check on Mr O'Rourke himself.

88. Although we understand that wing managers might not have had the opportunity to be trained to conduct ACCT reviews during the COVID-19 pandemic, we are concerned that there was no system in place to cover managers who were not trained to chair reviews. In addition, even though healthcare staff had raised the possibility of Mr O'Rourke needing constant supervision, nobody informed the orderly officer (responsible for the day to day running of the prison) or the duty governor that a review was needed.

89. There was a catalogue of miscommunication and missed opportunities. Given all the previous warnings that court and conviction was a potential trigger point for self-harm, we consider this was an unacceptable oversight.

90. Although Wandsworth carried out an internal investigation into the events of 15 December, we do not consider that this was adequate as it did not address the key issue of why none of the managers involved took responsibility for ensuring that Mr O'Rourke had an ACCT review after he was sentenced.

91. We are also concerned that the hourly ACCT checks already in place did not happen as frequently as they should have done, despite the fact that Mr O'Rourke

had just been convicted of a very serious offence and might well have needed extra support. There are no entries on the ACCT record between 4.57pm and 7.07pm. There was then a gap longer than an hour between the checks noted at 9.00pm and 10.22pm.

92. In interview, the OSG said that he was not told that Mr O'Rourke had been convicted that day. He said he would normally take time to read about each of the prisoners on an ACCT, but there was an unusually high number of ACCT checks to be conducted that night, so he had not had the time.

93. The OSG also said that he did not necessarily make and time the entries in the ACCT document at the time he made the checks. He said, for example, that he started the roll check at about 9.00pm that evening, so by the time he reached Mr O'Rourke's cell for the combined roll check and ACCT check, it may have been 9.30pm, but he recorded it as 9.00pm because that is when he started doing the checks. It is therefore difficult for us to know whether ACCT checks were made as frequently as they were supposed to be. ACCT guidance says that entries should be made immediately after the observations or as soon as is practicable thereafter.

94. We have commented on the poor management of prisoners' risk of suicide and self-harm at Wandsworth in previous fatal incident investigations.

95. We make the following recommendations:

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

- **a case manager is appointed at the first case review, who should lead all subsequent case reviews, wherever possible;**
- **staff are aware of the potential risk factors and triggers that might increase a prisoner's risk, including conviction;**
- **a multidisciplinary review is held when there is evidence of a significant change in risk; and**
- **staff adhere to the frequency of observations as specified in the ACCT document, and record those observations contemporaneously.**
- **The Governor should commission an investigation into the actions of SO A, SO D, CM A, CM B, SO B and SO C in relation to the failure to hold an ACCT review when Mr O'Rourke returned from court on 15 December, with a view to considering whether disciplinary action is appropriate.**

Emergency response

96. When the OSG found Mr O'Rourke's observation panel blocked and could not get a response, he called for assistance. Wandsworth's local night instruction says that "where there is, or appears to be, an immediate danger to life, cells may be unlocked … and an individual member of staff may enter the cell on their own by breaking their sealed pouch and using their cell key". It goes on to say that "night staff should not take action that they feel would put themselves or others in unnecessary danger".

97. The OSG told the investigator that when he realised Mr O'Rourke's observation panel was blocked, he did not consider going into the cell. We consider that it was reasonable for him to ask for help before he went into Mr O'Rourke's cell, given that he did not know Mr O'Rourke and could not see where he was in the cell or what he was doing.

98. Once other staff arrived, they quickly entered Mr O'Rourke's cell and provided first aid. They used the correct emergency code, ensuring that medical staff attended immediately, and prompting the control room to call for an ambulance.

99. The clinical reviewer noted that the emergency response by medical staff was clear and well-led.

Mr O'Rourke's clinical care

100. The reviewer concluded that as Mr O'Rourke went from a healthcare unit in High Down to a non-healthcare unit in Wandsworth, his care was not equivalent between the two prisons.

101. When the decision was taken that Mr O'Rourke was not to be added to the mental health team's caseload at Wandsworth, the psychiatrist suggested that his care should eventually pass to the primary care team. There was no documented discussion of this decision and no handover to the primary care mental health team. The clinical reviewer noted that the entry in the medical record was not correctly recorded and was unlikely to have been picked up.

102. The clinical reviewer was concerned that no specific healthcare service or individual had oversight of Mr O'Rourke's care, which meant that, despite the known risk, there was no pre-arranged plan to assess Mr O'Rourke's mental health on his return from court. The clinical reviewer noted that the ACCT process was not properly reflected in the medical records, nor was there a patient alert to allow any staff accessing his record to recognise the risk Mr O'Rourke presented to himself.

103. We make the following recommendation:

The Head of Healthcare should ensure that:

- **medical records clearly indicate when a prisoner is subject to ACCT monitoring; and**
- **healthcare staff should record information from ACCT reviews in a prisoner's medical record.**
- **there is a clear protocol for discharging a prisoner from the mental health team to the primary care team for ongoing mental health support.**

Self-inflicted deaths at Wandsworth

104. We have now investigated four self-inflicted deaths, including Mr O'Rourke's, that occurred at Wandsworth between March 2020 and March 2021. We are still investigating a further four self-inflicted deaths that occurred in May and June 2021. We have identified a range of concerns in the deaths we have investigated so far,

and we consider it would be beneficial for the Ombudsman to discuss our findings with the Governor. We therefore recommend:

The Governor should contact the Ombudsman to arrange a meeting to discuss recent self-inflicted deaths at Wandsworth.

Inquest

105. The inquest into Mr O'Rourke's death was held in May 2023. The conclusion was that Mr O'Rourke's death was due to suicide, following failings by HMP Wandsworth in the management of Mr O'Rourke's heightened risks following conviction.

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