

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ross Springham, a prisoner at HMP Wandsworth, on 20 March 2021

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

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

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

Our 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 Ross Springham died in hospital on 20 March 2021, after being found with a ligature around his neck four days earlier at HMP Wandsworth. He was 29 years old. I offer my condolences to Mr Springham's family and friends.

Mr Springham arrived at Wandsworth on 22 February 2021. Staff started suicide and self-harm monitoring (known as ACCT) the same day, as they were concerned about Mr Springham's odd behaviour and unkempt appearance. He was monitored under ACCT throughout his three weeks at Wandsworth.

Mr Springham's behaviour was bizarre, including his refusal to wear clothes for most of the time. Healthcare staff assessed him for signs of psychosis, but it was unclear whether this was the cause of his behaviour. Staff referred him to a Psychiatric Intensive Care Unit (a secure mental health unit) for assessment.

The clinical reviewer was satisfied that the mental health care Mr Springham received at Wandsworth was equivalent to that he could have expected to receive in the community.

We recognise that Mr Springham was a very challenging prisoner to manage safely. We found some deficiencies in the prison's management of the ACCT procedures, and we consider that staff under-estimated the risk posed by Mr Springham's unpredictable behaviour. However, he was being observed at least hourly at the time he hanged himself and we consider this was reasonable in the circumstances.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

December 2021

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	11

Summary

Events

1. On 22 February 2021, Mr Ross Springham was remanded in prison custody, charged with indecent exposure, and sent to HMP Wandsworth.
2. A prison GP in reception started suicide and self-harm prevention procedures (known as ACCT), as he was concerned about Mr Springham's odd behaviour and unkempt appearance. Mr Springham remained on an ACCT until his death.
3. Mr Springham refused to wear clothes for most of the time. On 28 February, after being asked to put a shirt on before leaving his cell, he stripped and jumped naked onto the netting of the landing below.
4. On 1 March, Mr Springham was moved to the prison's Addison Unit for assessment of possible psychosis. However, healthcare staff were unable to reach a diagnosis. On 15 March, they referred him for a transfer to a Psychiatric Intensive Care Unit (PICU), a secure mental health unit, for assessment.
5. On 16 March, Mr Springham was unlocked for a shower, and grabbed a member of staff around the neck. It was decided he would not be unlocked again without three prison officers being present. Mr Springham had several interactions with staff during the morning and was last seen at 11.30am when he declined lunch.
6. Just over half an hour later, during a roll check, a nurse saw Mr Springham lying naked on his cell floor. This was not unusual but, as she was not sure if she could see movement, she fetched another nurse and they asked officers to let them into the cell. They realised that Mr Springham had a ligature around his neck and was unresponsive.
7. Staff began cardiopulmonary resuscitation (CPR) which they continued until paramedics arrived. Paramedics were able to restore Mr Springham's circulation and took him to hospital. He did not regain consciousness and died in hospital at 7.19pm on 20 March.

Findings

8. Mr Springham was a very challenging prisoner to manage safely.
9. He was appropriately managed under ACCT procedures, but we found some deficiencies in the prison's management of Mr Springham's ACCT. These included not holding an assessment interview within the prescribed timescale, not setting caremap actions designed to keep a prisoner safe, and not involving healthcare staff in all case reviews. We also consider that staff underestimated the risk posed by Mr Springham's unpredictability.
10. However, Mr Springham was being observed at least hourly at the time of his hanging and we consider that this was reasonable and appropriate for the level of risk he had shown.
11. The clinical reviewer found that Mr Springham's mental health care was equivalent to that he could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that:
 - A trained ACCT assessor completes an assessment within 24 hours of the ACCT being opened and attends the first case review.
 - Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate.
 - Staff set specific and meaningful ACCT caremap actions that are aimed at reducing prisoners' risks to themselves and review them at each case review.
 - Staff consider holding an ACCT review following a restraint.

The Investigation Process

12. The investigator issued notices to staff and residents at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Springham's prison and medical records.
14. NHS England commissioned an independent clinical reviewer to review Mr Springham's clinical care at the prison. The investigator interviewed nine members of staff. Some interviews were conducted jointly with the clinical reviewer, and the clinical reviewer interviewed one nurse on her own. The interviews were completed by video and telephone due to the restrictions imposed by the COVID-19 pandemic.
15. We informed HM Coroner for Inner West London of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Springham's family to explain the investigation and ask if they wanted to raise any issues. They asked:
 - What psychological assessments did Mr Springham have in prison and what was the outcome?
 - Why was the family not contacted by the prison between 22 February and 16 March?
 - Why was his heart not donated?

These questions are covered in this report and the clinical review.

17. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies.
18. We provided Mr Springham's next of kin with a copy of our initial report. They raised some inaccuracies and issues which have been addressed in separate correspondence.

Background Information

HMP Wandsworth

19. 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. Oxleas Foundation Trust provides physical healthcare services at the prison. There is an inpatient unit for up to six prisoners. Mental health services are provided by South London and Maudsley NHS Foundation Trust. The Addison Unit is a 12-bed mental health unit, staffed by prison officers and a multi-professional team of medical, nursing and occupational therapy staff, with 24-hour nursing cover.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wandsworth was in March 2018. Inspectors found the demand for mental health beds in the prison remained high and there was a waiting list for admission to the Addison Unit. Delays occurred in transferring patients to mental health beds in the community. Assessment and care planning was good, and inspectors saw some positive care in the unit. The environment was adequate. Patients had satisfactory access to showers and exercise. Weekly art therapy and a hearing voices group were positive initiatives, but there were still too few therapeutic activities and many patients spent too long locked in their cells.
21. 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. They found that the prison had adopted clear plans to manage the pandemic at the start of the lockdown, identifying those who were most vulnerable so they could protect them and limit the spread of the virus. Health and safety protocols were in place and the prison remained calm, well ordered and safe. Most healthcare clinics had been suspended, but managers had implemented a triage system to ensure that urgent cases were dealt with appropriately.

Independent Monitoring Board

22. 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 said they remained very concerned that the Addison Unit was unfit for purpose. The Unit had insufficient beds and cells were frequently out of use awaiting repair. The waiting time for beds was up to seven days. The Board was also concerned about the poor condition of the Unit's showers and toilets, one toilet having an obvious ligature point.
23. Delays in transfers to secure psychiatric accommodation remained a problem, which the Board had reported on since 2009.

Previous deaths at HMP Wandsworth

24. Mr Springham was the tenth prisoner to die at Wandsworth since March 2019. Of the previous deaths, four were from natural causes, one was drug related and four

were self-inflicted. There were no notable similarities in these cases to the death of Mr Springham, although we have not yet completed our investigation into one of the self-inflicted deaths.

25. Since Mr Springham's death, there have been a further four self-inflicted deaths at Wandsworth, all of which are currently being investigated by the Ombudsman.

Assessment, Care in Custody and Teamwork

26. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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.
27. 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. 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.

Key Events

28. On 22 February 2021, Mr Ross Springham was remanded in prison custody, charged with indecent exposure, and sent to HMP Wandsworth. Police had arrested him wandering the streets naked the day before. This was Mr Springham's first time in prison. (Mr Springham had previously been found naked in a public place before, in January 2021. On that occasion, he was assessed in hospital and they found evidence of paranoia and psychosis, possibly due to drug or alcohol use.)
29. A nurse completed Mr Springham's initial health screen in reception. He told her he had no mental health issues and no thoughts of suicide or self-harm. He said he had no history of taking drugs (this was untrue) but that he drank around 85 units of alcohol a week. He showed no alcohol withdrawal symptoms. She referred him to a GP.
30. A prison GP saw Mr Springham in reception shortly afterwards. He noted that Mr Springham was unkempt, with messy hair, dirty nails and no shoes. Mr Springham told him that he had been detained under the Mental Health Act for ten days in 2020 and that he sometimes heard voices "saying bad things", but that he had no mental health problems and no thoughts of suicide or self-harm.
31. The prison GP noted that Mr Springham's behaviour was strange, and his mood was flat. He recorded that Mr Springham needed to be assessed in the prison's Addison Unit (a 12-bed mental health unit) but thought there was no space for him at that time. He told Mr Springham he would refer him to see a psychiatrist. He noted that in response Mr Springham said repetitively six times, "I will not see a psychiatrist". He noted that Mr Springham showed no signs of alcohol withdrawal.
32. The prison GP made a mental health referral and started suicide and self-harm monitoring (known as ACCT) due to Mr Springham's vulnerability and poor mental health. Staff put him on hourly observations.
33. An officer tried to carry out an ACCT assessment interview with Mr Springham the next day, but he refused to engage and said he did not need it. Another officer noted that Mr Springham also refused to take part in the first ACCT case review.
34. On 24 February, Westminster Magistrates Court Liaison and Diversion Team sent the Healthcare Department at Wandsworth an email asking for further information about Mr Springham before they decided whether he could be bailed. They asked the prison to assess Mr Springham's mental health before his next court appearance on 15 March.
35. The same day, a nurse went to see Mr Springham in his cell as part of the in-reach mental health team's triage. Mr Springham was sitting on his bed, naked, but then put on his trousers. Mr Springham said he felt fine, had no mental health issues and refused to discuss it further.
36. Shortly afterwards, a psychiatrist met Mr Springham. He was naked again and initially refused to engage but spoke briefly about how he liked being naked and had intended to go for a swim in the canal when he was arrested. The psychiatrist noted that Mr Springham should be assessed in the Addison Unit to identify

whether he had an underlying psychosis. In the meantime, Mr Springham remained on the wing, monitored by ACCT and by mental health staff.

37. On 26 February, staff tried again to complete an ACCT assessment interview with Mr Springham, but he refused to engage. He was sitting in bed naked and, when asked to get dressed so he could attend the ACCT meeting, he refused.
38. On 28 February, an officer unlocked Mr Springham and asked him to put on a shirt before he left his cell. In response, Mr Springham stripped, ran out of his cell and jumped from the landing onto the netting of the landing below. He refused to let a nurse carry out a thorough examination, told her he felt alright and denied it was a suicide attempt.
39. The same day, a prison manager held an ACCT review with Mr Springham. A nurse also attended. The manager noted that Mr Springham was quite despondent and disorientated, and that he had been like this since arriving at Wandsworth. He asked Mr Springham if he intended to take his own life and he said he did not. He noted that he had discussed Mr Springham with nurses who considered that the act of jumping onto the netting below was linked to his mental health condition rather than an attempted suicide. He noted that Mr Springham would be moved to a lower landing to limit the risk of him jumping again. He kept observations at one an hour. He did not complete a caremap.
40. On 1 March, staff moved Mr Springham to the Addison Unit. Just before, a Custodial Manager (CM) held Mr Springham's second case review. No other staff were present. Mr Springham was naked in his cell but got dressed when asked. Mr Springham said he did not believe he needed to move to the Addison Unit, but he walked there compliantly.
41. When Mr Springham arrived at the Addison Unit, staff set his observations at every 15 minutes for 72 hours, in line with the new patient admission protocol. After 72 hours, if there were no concerns regarding a new or increased risk, the observations would be reduced to hourly.
42. On 2 March, a psychiatrist met Mr Springham. Mr Springham was lying naked on the cell floor and mainly answered, "Leave me alone" in response to the psychiatrist's questions. He noted that Mr Springham should continue to be assessed in the unit.
43. Later that day, an officer held an ACCT review with Mr Springham. A nurse also attended. Mr Springham was naked in his cell. He said he liked to be naked but understood he should not be naked in public. He said he was not suicidal and did not self-harm. Mr Springham said he did not want his parents "told", although it is unclear whether he meant about his offence, that he was in prison, or that he was on ACCT. He did not give staff managing the ACCT any next of kin details. The officer did not add any caremap actions.
44. On 3 March, a consultant forensic psychiatrist saw Mr Springham. He spoke to him through his cell hatch. Mr Springham was naked and crouching on the floor. He later moved to his bed but remained naked. Mr Springham told the psychiatrist he was not mentally ill, did not feel depressed, was not hearing voices and said he just did not want to wear clothes. He said he was happier on the Addison Unit as it was quieter, and knew he was due to appear in court for sentencing on 15 March. The

psychiatrist asked Mr Springham if he was autistic, and he said that he had never been told he was and did not think so. He noted that Mr Springham's behaviour might be as a result of autism or he might have a psychotic illness and was trying to hide his psychotic symptoms.

45. On 5 March, staff put Mr Springham on hourly observations.
46. The psychiatrist saw Mr Springham again on 8 March. Mr Springham declined to leave his cell and speak privately, so they spoke through the hatch. Mr Springham was naked, but a blanket covered his genitals. The psychiatrist noted that Mr Springham was polite, but his responses were vague and brief. The psychiatrist said that prison did not seem to be the right place for him, and Mr Springham shrugged his shoulders. The psychiatrist asked if he could visit him again later, but Mr Springham did not respond.
47. Another psychiatrist also reviewed Mr Springham on 8 March. He recorded that Mr Springham was naked, appeared perplexed and distracted, and did not make much eye contact. Mr Springham said he was worried that he posed a risk to other people. When the psychiatrist asked for details, Mr Springham refused to engage further. The psychiatrist noted that Mr Springham had a probable underlying psychosis and planned to refer him to a Psychiatric Intensive Care Unit (PICU – a secure mental health unit for people experiencing an acute period of mental illness). (This was discussed further at a meeting on 11 March, and the psychiatrist made the referral on 15 March.)
48. A Supervising Officer (SO) held an ACCT review on 9 March. An officer also attended, but Mr Springham declined to attend. He told staff he did not want to kill himself and then went back to sleep. The SO noted that Mr Springham had not shown any thoughts of self-harm and she assessed his risk of self-harm as low. They reduced his ACCT observations to five observations during the night. They did not add any caremap actions.
49. A psychiatrist wrote to Westminster Magistrates Court on 10 March. He said that Mr Springham could be suffering from a psychosis and was being referred to a PICU in his home area of Nottingham. He said Mr Springham was not fit to attend his court hearing on 15 March and that a report from the PICU was needed before sentencing. He requested a minimum two-week adjournment.
50. The next day, 11 March, Mr Springham seemed more settled, but still did not engage with staff.
51. On 13 March, Mr Springham asked a nurse for some hot water, but when he passed it to him through the hatch, he lunged and tried to grab his chest. The nurse noted that this was the second time this had happened and that an officer should be present before opening the hatch in view of Mr Springham's unpredictability. Mr Springham later tried to grab a chaplain's arm.
52. A SO held an ACCT review with Mr Springham on 15 March. A mental health nurse, a clinical support worker and an ACCT assessor attended. She noted that Mr Springham refused to engage with her. She said that every time she tried to engage with him, Mr Springham kept trying to grab her and when she asked why, Mr Springham did not respond. She noted that Mr Springham would not say whether he had any concerns or how staff could help him. Staff assessed his risk

of self-harm remained low, and his ACCT observations were altered to once during the morning, afternoon and evening (although healthcare staff continued to observe him hourly in line with the standard policy in the Addison Unit). She noted that a psychiatrist would be invited to attend the next review on 18 March. She did not add any caremap actions.

53. On 15 March, a psychiatrist tried to review Mr Springham, but Mr Springham suddenly pushed both his hands through the hatch and tried to grab him. Mr Springham could not explain why. The psychiatrist told Mr Springham he had referred him to Northampton Hospital PICU. He noted that Mr Springham did not understand the reason for the referral.

16 March

54. Between 7.00am and 12.09am on 16 March, prison and healthcare staff interacted with Mr Springham on 20 separate occasions.
55. At approximately 10.11am, staff unlocked Mr Springham so he could take a shower. As he left the cell, he lunged at a SO and grabbed her around the neck. Staff restrained Mr Springham and returned him to his cell. The unit's manager increased Mr Springham's unlock level to three officers due to the increased risk of assaulting staff. Healthcare staff did not assess Mr Springham for injuries following his restraint, due to his level of risk. However, they observed him through the spy hole in the cell door.
56. A healthcare assistant observed Mr Springham for his hourly check. At 11.31am, Mr Springham was offered lunch, but declined.
57. At 12.09pm, a nurse was completing the unit's roll check. She saw through the door's spy hole that Mr Springham was lying naked on the cell floor, which was not unusual. She called him but was unable to get a response. She asked an officer to unlock the hatch in the cell door so she could observe Mr Springham better. She could only see Mr Springham's back but thought she detected some movement to indicate he was breathing. Both staff members walked away from the cell, but she was concerned so asked the ward manager for advice.
58. At 12.12pm, the nurse and the ward manager returned to Mr Springham's cell. Mr Springham remained unresponsive, so the ward manager asked officers to unlock the cell door. Three officers, in full personal protection equipment (PPE), responded and unlocked Mr Springham's door at 12.15pm, and they went in.
59. The ward manager saw that Mr Springham had a ligature, made from a torn bedsheet, tied around his neck. An officer immediately radioed an emergency code blue call (indicating a life-threatening medical emergency). The nurse passed her anti-ligature knife to an officer who cut the ligature, while the ward manager checked Mr Springham and started chest compressions. The nurse collected emergency equipment, including a defibrillator. When she returned, she took over chest compressions. Two nurses attached the defibrillator and managed Mr Springham's airway. The defibrillator did not recommend Mr Springham was shocked.
60. At 12.22pm, ambulance paramedics arrived at the cell and Mr Springham was moved on to the landing. Paramedics took over Mr Springham's care and managed

to restore his circulation, although he remained deeply unconscious throughout. The paramedics took Mr Springham to St George's Hospital where he was taken to the Intensive Care Unit (ICU).

61. A psychiatrist spoke to hospital staff and then telephoned Mr Springham's mother at approximately 3.00pm to explain what had happened. He remained in contact with Mr Springham's family over the next few days. Staff telephoned St George's daily for updates on Mr Springham's condition. On 17 March, hospital staff said that Mr Springham had suffered irreversible brain damage. Further scans verified this and with the family's agreement, Mr Springham's life support was removed, and he died at 7.19pm on 20 March.

Contact with Mr Springham's family

62. An officer was appointed as the family liaison officer (FLO). Mr Springham had not provided any next of kin details and prison staff did not have access to Mr Springham's medical records (where a psychiatrist had found his mother's details), so police located and broke the news to his family. These details were passed to a SO, who telephoned Mr Springham's mother and kept in contact with her.
63. The prison contributed to the cost of Mr Springham's funeral, in line with national guidelines.

Support for prisoners and staff

64. After Mr Springham'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.
65. The prison posted notices informing other prisoners of Mr Springham'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 Springham's death.

Post-mortem report

66. The post-mortem report concluded that Mr Springham's cause of death was compression of the neck. The toxicology report noted that Mr Springham had tested positive only for the medication administered to him in hospital, although analysis of his hair suggested he had used cocaine in the six months before his death.

Findings

Management of Mr Springham's risk of suicide and self-harm

67. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that staff should follow when a prisoner is assessed as being at risk of suicide and self-harm.
68. A prison GP started ACCT procedures for Mr Springham on 22 February 2021, the day he arrived. He was concerned about Mr Springham's strange behaviour and his unkempt appearance. This was good practice. The ACCT remained open throughout Mr Springham's three weeks at Wandsworth. Although this was appropriate, we have some concerns about how the ACCT was managed.
69. PSI 64/2011 says that the ACCT assessment interview should take place within 24 hours of the ACCT being opened. We are aware that an officer noted in Mr Springham's prison record that he had tried to hold the ACCT assessment interview on 23 February, but Mr Springham refused to engage. The ACCT paperwork shows that staff tried to interview Mr Springham again on 24 and 25 February, but he still refused to engage. The ACCT assessment interview form was completed on 26 February, but Mr Springham still refused to engage. We do not understand why there was this delay. PSI 64/2011 says, '*...if the prisoner refuses to be interviewed or is unable to participate in the interview, the ACCT assessor must undertake the assessment based on all available information e.g., pre-sentence reports, OASys, health care information, NOMIS case notes and previous ACCT documents*'. Given this, the ACCT assessment should have been completed on 23 February.
70. PSI 64/2011 says that the first case review should be held within 24 hours of the ACCT being opened. Mr Springham refused to take part in the first ACCT review on 23 February, and it appears it did not go ahead until 28 February. PSI 64/2011 says that the first case review should be timely and not unduly delayed to ensure full attendance. It also says that the prisoner should attend but if they do not, their reasons for non-attendance should be recorded on the case review document. The first case review should not have been delayed by four days.
71. PSI 64/2011 says that at the first case review, the prisoner's most pressing needs in respect of their risk of suicide and self-harm should be identified and a caremap should be completed, giving detailed and time-bound actions aimed at reducing the risk posed by the prisoner. We are concerned that no caremap actions were identified at the first case review, nor indeed at any subsequent case review. The caremap of the ACCT document was left blank throughout.
72. We acknowledge that it was challenging trying to engage Mr Springham in the ACCT process. We also recognise that healthcare staff were frequently trying to engage with him and trying to understand his behaviour and concerns. Nevertheless, when an ACCT is opened, staff have a responsibility to manage those procedures correctly and to identify and record the actions that might reduce the prisoner's risk of suicide and self-harm.

73. PSI 64/2011 says that case reviews should be multidisciplinary where possible. We identified two case reviews that did not have multidisciplinary input. One was attended only by the case manager and the other by the case manager and one officer. Given that Mr Springham was being assessed on the Addison Unit and there were serious concerns about his mental health, we would have expected healthcare involvement in every ACCT review.
74. We are also concerned that, at the second of these reviews, on 9 March, the case manager and the officer assessed Mr Springham's risk as low and reduced the frequency of his ACCT observations on the basis that he had not shown any thoughts of self-harm. We consider that this was premature. Although Mr Springham had not self-harmed and repeatedly denied that he had any thoughts of doing so, he did not share his thoughts with staff, his behaviour was bizarre and unpredictable, and his mental health issues were undiagnosed and untreated. In these circumstances we consider that Mr Springham's unpredictability should have been seen as a risk factor in itself, and that, by not doing so, staff under-estimated his risk. We therefore consider that the decision to reduce his observations, particularly without someone from mental health present, was unwise.
75. We recognise that Mr Springham was still being observed hourly by healthcare staff in line with the standard policy in the Addison Unit, but we are concerned that his risk to himself was underestimated by prison staff.
76. We also consider that an ACCT review should have been held on the morning of 16 March after Mr Springham was restrained. Although it is clear from the post-mortem examination that Mr Springham did not suffer any significant physical injuries, being restrained, even when all the correct procedures are followed, can be a distressing experience, and we are concerned that this was apparently not recognised even though Mr Springham was being managed under ACCT procedures at the time.
77. However, Mr Springham had not self-harmed before this, and therefore, even if an ACCT review had been held, we consider it unlikely that Mr Springham's risk to himself would have been assessed as so high as to require constant supervision. He was seen alive at 11.31am and was found unresponsive 38 minutes later. We think it is unlikely that an ACCT review would have resulted in more frequent observations and, therefore unlikely that the outcome for Mr Springham would have been different.
78. We make the following recommendation:

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

- **A trained ACCT assessor completes an assessment within 24 hours of the ACCT being opened and attends the first case review.**
- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate.**
- **Staff set specific and meaningful ACCT caremap actions that are aimed at reducing prisoners' risks to themselves and review them at each case review.**
- **Staff consider holding an ACCT review following a restraint.**

Clinical care

79. The clinical reviewer noted that in the last year of his life, Mr Springham was seen and assessed by a range of clinicians in a variety of environments, all of whom agreed that his behaviour was odd, but none were able to form a diagnosis. The clinical reviewer said that Mr Springham's presentation was perplexing and very unusual, and even with the experience of the prison healthcare team, it was not possible to form a clear diagnosis and thus develop a treatment plan.
80. The clinical reviewer was satisfied that the mental health care Mr Springham received while at Wandsworth was equivalent to that he could have expected to receive in the community. The clinical reviewer found that Mr Springham was assessed by a nurse when he arrived at Wandsworth, followed up with a detailed GP review shortly afterwards. He was referred to the prison's mental health in-reach team and was seen and assessed promptly. Once under the care of the team, he was assessed very regularly by psychiatrists. The proposed transfer to a secure mental health unit for further assessment was appropriate but could not be achieved immediately.

Inquest

81. The inquest, held from 11 to 18 March 2024, concluded that Mr Springham died by suicide.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100