

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF A MAN IN SEPTEMBER 2005
WHILST IN THE CUSTODY OF HMP WANDSWORTH**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES**

SEPTEMBER 2006

This is the report of an investigation into the death of a man found hanging in his cell at HMP Wandsworth on 29 August 2005. He was resuscitated by staff and taken to St George's Hospital, Tooting, but he did not regain consciousness and died on 3 September 2005. He was 38 years old.

The loss of a loved one is always distressing. I would like to add my personal condolences to those already expressed to his family by my family liaison officer.

The investigation has been undertaken by two of my colleagues. I would like to thank the Governor of HMP Wandsworth, and his staff for their help and co-operation during this investigation.

Wandsworth Primary Care Trust (PCT) was notified of this man's death and a clinical review of his healthcare whilst in custody was conducted by one of the PCT's Joint Medical Directors.

This report reveals failures in the application of the Assessment, Care in Custody and Teamwork (ACCT) procedures at Wandsworth prison. The reader will also note the number of times the man was punished with cellular confinement or was otherwise held in segregation.

I have made a number of recommendations concerning the arrangements for monitoring prisoners at risk of self-harm at Wandsworth and regarding family liaison. Following comments made at draft stage of this investigation, I have concluded that there is at least some possibility that staff shortages on the day in question may have had an influence on the outcome of this tragedy.

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Prisons and Probation Ombudsman

September 2006

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Summary

1. The man who died was remanded in custody on 23 December 2004 for an offence of indecent assault. He was initially taken to HMP Elmley. It was not his first time in custody.
2. According to his family, he had a history of mental health problems since his early twenties. He had been an in-patient in 1988 following a paranoid illness and had intermittent contact with psychiatric services since then. He took an overdose in 2002.
3. On arrival at Elmley, his mood was described as flat and he appeared confused at times. He said that he had been using Procyclidine and Prozac medication. Despite being referred for a mental health assessment, he did not have a mental health assessment or receive any medication until 25 January. He began behaving in a disruptive fashion from the day of his arrival at Elmley. He urinated on the floor regularly and smashed the fittings in his cell. He was punished under the prison disciplinary system with cellular confinement.
4. The man was transferred to HMP High Down on 20 January after a court appearance. On 21 January, he put his arm around a teacher and attempted to kiss her. As a result, it was noted that he was a danger to female staff. On 22 January, he was found with a loose ligature around his neck.
5. He returned to Elmley on 27 January. He began a dirty protest that day and remained under regular review in the Segregation Unit at Elmley, under Good Order Or Discipline, until 11 March. His Cell Sharing Risk Assessment was high (CSRA) due to his behaviour.
6. He was transferred to HMP High Down on 11 March 2005. On 15 March, an F2052SH document was opened because he was deemed to be at risk of self-harm after he smashed his cell washbasin. Due to his difficult behaviour, which included banging his cell door, shouting, ringing his cell bell and flooding his cell with water, he spent most of the next two and half months under segregation. He continued to be thought of as a high risk in terms of cell sharing. The F2052SH was closed on 28 April after he appeared more settled.
7. On 17 May, a psychiatric report was prepared for Guildford Crown Court on his mental condition. It concluded that the man was not suffering from enduring mental illness requiring hospital treatment.
8. On 3 June, he was transferred to HMP Wandsworth. He was initially assessed as low risk in terms of cell sharing, based only on the answers he gave to staff who assessed him.
9. On 6 June, his case was discussed by the prison mental health in-reach team. They decided that he did not meet their criteria, as he was not

suffering from severe and enduring mental illness, but might have had a learning disability.

10. On 7 June, his previous CSRAs were reviewed. It was decided that he in fact posed a high risk to others. A further review of his CSRA was set for 7 July, but it did not take place nor did any subsequent reviews.
11. On 29 July, the man set fire to his cell after learning that his youngest two children had been put up for adoption. An ACCT Plan was opened to support him as he was considered at risk of self harm. He was later taken to the Care and Separation Unit and given four days cellular confinement as a punishment. There were a number of omissions in the way that the ACCT Plan was handled.
12. On 2 August, he was seen by a psychiatrist and a community psychiatric nurse (CPN). They concluded that the man did not show signs of psychotic illness and did not appear to want to harm himself.
13. On 22 August, a ligature was found in his cell. He told the officer who opened an ACCT Plan that he was concerned about not having the correct medication. He cut his wrist that evening and told the officer who found him that he had done it because his medication had been changed. He told a nurse who attended to his wound that he would hang himself that evening.
14. The man continued to be observed by landing staff. He told them that he was okay and did not express any feelings of wanting to harm himself. He did not like his cell door to be closed, however, and asked staff to be left unlocked. This was facilitated by some staff.
15. At lunch time on 29 August, the man was found in his cell, hanging from his cell window. A nurse and a doctor attempted to resuscitate him. Although he was revived, he never regained consciousness and died in hospital on 3 September.
16. The clinical review carried out by the PCT concluded that there was no evidence that the man was suffering from mental illness.

The investigation process

17. My investigators visited Wandsworth on several occasions and were given access to all the relevant prison records relating to the man who died. These included his main prison record, his medical record and statements from staff. My investigators interviewed staff and prisoners and met representatives of the Independent Monitoring Board and the Prison Officers' Association to offer them the opportunity to raise relevant issues.
18. The man's family were offered, and accepted, the opportunity to contribute towards the investigation process. One of my family liaison officers visited his mother with one of my investigators, to discuss issues the man's mother wished to raise.
19. A clinical review was requested from Wandsworth Primary Care Trust. I am grateful to the doctor for undertaking this review in a timely manner.
20. My investigators informed Her Majesty's Coroner of the nature and scope of the investigation and to request a copy of the Post Mortem report. My report has been sent to the Deputy Coroner at Battersea Coroners Court to assist her with her enquiries into this man's death.
21. My report was disclosed to the man's family and the Prison Service at draft stage for comment. I have incorporated their observations, where relevant, into my final report.

HMP Wandsworth - Background

22. Wandsworth was built in 1851 and has been refurbished in recent years. Many of its prisoners have problems with substance misuse and mental health. Wandsworth has a Certified Normal Accommodation for 1,173 prisoners, with a current Operational Capacity (maximum crowded capacity) of 1,416. The prison always functions at or near the Operational Capacity figure.
23. The prison's healthcare is commissioned by Wandsworth Primary Care Trust. Nurses work with a Medical Officer (a General Practitioner) providing primary health services for those prisoners in their care.
24. The Onslow Centre, a unit within Wandsworth for vulnerable prisoners, comprises three of Wandsworth's eight wings (G, H and K). It holds almost a quarter of Wandsworth's prisoners and is largely self contained within the prison, as it holds prisoners who have been segregated for their own protection (mostly, but not exclusively, sex offenders). According to the prison's Independent Monitoring Board, there is good interaction between prisoners and staff and an open door policy is run for much of the day. The Unit Manager for the Onslow Centre was on sick leave at the time of the man's death. His post was not covered until several months later when each Onslow unit senior officer was temporarily promoted in rotation.

Suicide and Self Harm prevention at Wandsworth

25. In January 2004, Wandsworth was part of a pilot group of five prisons to test and implement the new Assessment, Care in Custody and Teamwork (ACCT) system for caring for prisoners at risk of self-harm or suicide. ACCT is the replacement for the F2052SH system which is being phased out. All prisons should be using ACCT by March 2007.
26. According to training records, 42 staff were trained in ACCT awareness from December 2004 to August 2005. Forty-five case managers and a similar number of ACCT assessors have been trained since the system was introduced.
27. The suicide prevention co-ordinator (SPC) produces a monthly report outlining ACCT issues for the previous month. The August 2005 SPC's monthly report said of ACCT compliance in July:

“Residential managers need to continue to manage and monitor ACCT. Although the weekly ACCT review process has tightened up our processes somewhat we are still failing to meet basic targets: this is partly due to ignorance on the part of some staff and a failure by managers to effectively monitor the process.”

28. Under action points, the report says:
- “Wing Managers must monitor F213sh, ACCTs and Observation Books to ensure these are completed.
- “It is important that all ACCT documents are checked regularly for quality and that assessment, Caremaps and case reviews are carried out within the approved time frames.”
29. As part of the prison’s strategy to alleviate distress which may lead to a prisoner taking their life, a Listener scheme operates on a 24 hour basis for prisoners in need of support. The scheme is a prisoner peer group support system, with each Listener receiving training from the Samaritans. Listeners wear badges to identify themselves and a prisoner should be able to talk to a Listener whenever they feel the need. Onslow Centre had seven Listeners at the time of the man’s death. Prisoners can also telephone the Samaritans on a specially designated telephone.
30. Her Majesty’s Chief Inspector of Prisons (HMCIP) inspected Wandsworth in May 2004. She noted that staff/ prisoner relationships appeared to be positive in the vulnerable prisoner wings. Her report also noted that there was a continuing shortfall in staff while prisoner numbers remained high. She expressed serious concern that overall, Wandsworth was not meeting the standards required of a healthy prison. Having seen the draft of this investigation report, the Prison Service commented that the data of the HMCIP report was historic and not relevant. I shall return to this point later in my report.
31. There were four apparently self-inflicted deaths in 2005 at Wandsworth, including the death of this man. My investigation into the circumstances of the death on 18 February of one of those prisoners noted that the ACCT was closed without a 24 hour assessment interview taking place. My report into the other prisoner’s death recommended that the governor should review ACCT training so that as many staff as possible were fully familiar with the system. I also recommended that prisoners who self-harm and attempt suicide should be regularly monitored by the Mental Health In Reach Team.

The man's time in prison

HMP Elmley - 23 December 2004 to 20 January 2005

32. On 21 December 2004, the man was arrested for indecent assault. On arrest it was noted that he had failed to answer bail for other unrelated charges. He was charged and appeared at the local magistrates' court on 23 December. He was remanded in custody and arrived at HMP Elmley that day.
33. On arrival at Elmley, he was seen in Reception by a health care worker who completed a First Reception Health Screen form. The man said that he was using Procyclidine and Prozac medication and that he had a long history of psychiatric problems. His mood was described as flat and he appeared to be confused at times during the interview. The form shows that the answer "yes (in prison)" is circled for the question "Have you ever tried to harm yourself?". No further details are recorded. The man was asked if he felt like harming himself and the answer "no" is circled. He wanted to see a doctor concerning his medication. A referral was made for him to see a doctor and for a mental health assessment. A note in his medical record states "nil self harm issues expressed." However, he does not appear to have received a mental health assessment, nor was he prescribed any medication at that time.
34. A Cell Sharing Risk Assessment form (CSRA) was completed on reception. The man asked to be segregated for his own protection due to the nature of his offence. He also expressed concerns about sharing a cell. In section 2 of the form, the assessing officer recommended a single cell as, according to the man, he had caused problems with cellmates on a previous sentence. The man was assessed as posing a high risk to others. "High" is defined as "clear indication of high level of risk that prisoner might assault cellmate".
35. In section 3 of the form completed by a member of the Healthcare Team, his risk of harm to others was assessed as high due to his previous behaviour and a feeling that there was something wrong. It was not the first time that the man had been to Elmley and he was well known to staff and prisoners. A Pre Sentence Report dated 1 April 2004 relating to a previous period of custody was faxed to Elmley on 23 December. It stated:

"Whilst in custody at HM Prison Elmley, the man's behaviour has given cause for concern. He was engaged in episodes of self-harm, cutting himself with razors and burning himself with cigarettes. Staff have been unable to allow him much time out of his cell as he had urinated himself on a number of occasions ... His behaviour and refusal to co-operate with Psychiatric Services suggests that he is high risk in terms of risk to the public and self-harm ... He is a risk to himself and others."

36. On the evening of 23 December, the man flooded his cell with water and, according to his medical record, he kept ringing his cell buzzer and banging on his door. He was moved to the Healthcare Centre the next day. There, he blocked the washbasin and toilet in his cell and urinated over the floor. He was described in his Record of Events as “very disruptive”.
37. He was placed on report on 27 December for contravening prison disciplinary rules by urinating against his cell door. He was seen by a doctor on 28 December, prior to the adjudication, but was not considered depressed or suicidal. He was assessed as suitable for segregation and was given a punishment of five days cellular confinement and loss of privileges.
38. On 31 December, his Record of Events noted that he was bathing in his own urine in his cell and behaving bizarrely. He again blocked his toilet and washbasin.
39. On 1 January 2005, the man smashed his cell and sustained a cut finger. On 7 January, he flooded his cell with water and was placed on report. He was given four days cellular confinement and seven days stoppage of earnings at 20 per cent.
40. On 6 January, he was charged under the Prison Rule 51 with damaging his television. He was seen by a doctor on 7 January who assessed him as fit for adjudication and cellular confinement. According to the records, the adjudication hearing on 7 January was conducted in his absence as he was covered in urine. He was found guilty and given a further seven days cellular confinement. As part of the punishment, he also had to forfeit seven days loss of cash, tobacco, radio, occupations in cell and possessions in his cell.
41. On 12 January, the man was given a mop to clean out his cell as he had flooded it. According to documentation, he broke the mop handle into three pieces and threatened staff. He was restrained by staff using approved Control and Restraint techniques and the handle was removed from his cell. He was segregated for reasons of Good Order or Discipline (GOOD) under Prison Rule 45 until 15 January. He was told to stop flooding his cell, urinating on the floor and showing aggressive outbursts.
42. The man’s segregation under GOOD was reviewed on 17 January, two days after the segregation had officially expired. It was felt that his behaviour was still unpredictable and that it would not be safe for him to return to a normal houseblock. His segregation was extended to 24 January.
43. On 19 January, he removed his clothing whilst on the exercise yard and swung from the perimeter razor wire. He dressed and returned to his cell.
44. On 20 January, he was transferred to HMP High Down.

HMP High Down – 20 January to 27 January

45. The man's CSRA was reviewed. It was noted that he seemed to have a mental problem and that he could become aggressive quickly. He was assessed as posing a medium risk.
46. After an education class on 21 January, he put his arm around a teacher and attempted to kiss her. His security record was subsequently updated to record that he was a danger to women and should not be left alone with female staff.
47. On 22 January, he was found by a nurse with a noose made from a sheet tied loosely around his neck. He was given tear-proof fabric bedding.
48. On 25 January, he was seen by a staff grade psychiatrist who concluded that he was not suffering from psychosis but was agitated. The man was prescribed Haloperidol, an anti-psychotic drug used in the short term to reduce anxiety and violent, aggressive manifestations of mental illness, and Lorazepam, for anxiety.

HMP Elmley – 27 January to 11 March

49. The man was returned to Elmley after a court appearance on 27 January. His CSRA was again reviewed. It was concluded that due to his previous behaviour, he was still high risk and was to remain in a single cell on House Block 4, an ordinary unit. The next day, he threatened staff and prisoners with a pool cue. He was locked in his cell and later set fire to papers and his blankets. He was then taken to the Segregation Unit.
50. The man was placed on report for the cell fire and for banging and shouting continuously in his cell for four hours. A Segregation Safety Algorithm, to assess whether he was fit for cellular confinement, was completed. The adjudication hearings took place on 31 January. The charges were found proved and he was given a total of seven days cellular confinement and forfeiture of all privileges. On 2 February, he was given five days cellular confinement (for waving a book in a sock as he came out of his cell) to run consecutively from the punishments he was already serving.
51. On 4 February, he was seen in the Segregation Unit by a member of the prison mental health in-reach team. However, the assessment was postponed as he was lying on a mattress on the floor saying repetitively "put me in hospital".
52. On 14 February, the man was returned to an ordinary houseblock. His Record of Events states that prisoners complained to staff about his noisy and disruptive behaviour. On 20 February, he suffered an injury to his nose. He told an officer that he had been involved in a fight but would not identify

who had assaulted him. He told a nurse, however, that he “fell over” and had an accident.

53. The man smashed his television and flooded his cell on 21 February. He was taken to the Segregation Unit pending the outcome of his adjudication hearing.
54. On 22 February, he was seen in the Segregation Unit by a doctor, before having an adjudication for damage to prison property. The doctor wrote in his medical record that he was not depressed or suicidal. His behaviour deteriorated and included aggressive behaviour towards staff, removing his clothes, shouting and banging in his cell for days on end, putting excrement on cell walls and smashing his furniture. The man pleaded not guilty at the adjudication hearing, but the case was found proven and he was given seven days cellular confinement and loss of privileges.
55. On 27 February, he began a dirty protest and smeared excrement on his cell walls. He was again kept in the Segregation Unit under GOOD until 1 March. He was seen by the mental health in-reach team for review but was agitated, kept demanding medication and kept hitting himself in the face. Arrangements were made for him to see a doctor the next day to review his medication. The doctor noted that he was very dishevelled and had said he was hearing voices at times. He was prescribed Seroquel, an anti-psychotic drug.
56. On 1 March, his segregation under GOOD was reviewed. It was decided that while he was still smearing his cell with excrement, his behaviour was unsuitable for the ordinary houseblocks. His segregation was extended until 7 March.
57. On 7 March, his mental health was again reviewed by the in-reach team. He was seen by a psychiatrist, who concluded that he was possibly psychotic. The man’s segregation was also reviewed on 7 March. It was noted that he was still shouting and banging, and was aggressive towards staff and behaving bizarrely. A further segregation review was set for 21 March.

HMP High Down – 11 March to 3 June

58. On 11 March, the man appeared at Guildford Crown Court and was remanded in custody for psychiatric reports. He was transferred back to HMP High Down and his CSRA was reviewed. He was described as being extremely aggressive and posed a high risk to female staff. His cell sharing risk level was assessed as high. The man was admitted to the Healthcare Centre for observation as he appeared agitated.
59. On 15 March at about 9:25pm, he smashed his cell washbasin and toilet seat. An (unidentified) member of staff opened an F2052SH because of his risk of self harm, and wrote on page 1 that when they entered the cell the man had placed a ligature around his neck. He was asked why he had

smashed his washbasin and he said he could not remember why. He said his ligature was a “necklace.” He was moved to a Crisis Intervention Room (an unfurnished cell) at 9:35pm and remained there until 2:30pm the next day.

60. On 16 March, he was seen by a consultant psychiatrist, who described him as disruptive, destructive, demanding and racially abusive. The doctor prescribed some Olanzapine, an anti-psychotic, to make him calmer, and advised him to stop behaving in an unruly manner. It was noted in his Record of Events that he had a personality disorder and was known to be very violent. It was thought that it was only a matter of time before he seriously harmed himself or another individual. Staff were warned to be “extra vigilant” with him.
61. A case review was held on 17 March. It concluded that there was no evidence of mental illness and that “his disruptive behaviour is more related to his personality and should be managed as such.” He was moved to the Segregation Unit.
62. At a F2052SH case review two days later. He shook throughout the interview and was described as seeming confused and distant. He stated that he did not wish to harm himself but was hearing voices.
63. On 18 March, his segregation under GOOD was authorised due to his poor behaviour and damaging prison property. He remained in the Segregation Unit, but on 21 March the duty governor expressed concerns to the doctor that he was not fit for cellular confinement or adjudication yet was still being held in segregation. The doctor agreed that he should be moved to Healthcare. Later that day he was declared fit for adjudication and cellular confinement and moved back to the Segregation Unit.
64. On 24 March, his segregation under GOOD was reviewed. The Independent Monitoring Board and the governor chairing the review both expressed their concerns about him being in the Segregation Unit, but it was also accepted that he was not suitable to be on a houseblock. The Healthcare Centre had refused to admit him as there was no clinical reason for him to be there. It was agreed that he would remain in the Segregation Unit until his next review on 29 March, but healthcare staff would devise a programme to manage his behaviour.
65. At his next F2052SH review on 26 March, he said he was no longer hearing voices and felt much better. He asked to leave the Segregation Unit and go back to an ordinary landing. However, his behaviour continued to be disruptive – banging on his door, shouting and ringing his bell.
66. The man was referred to the Learning Disability Team and was seen on 31 March. The psychiatrist explicitly excluded the possibility of him suffering from a learning disability and concluded he might have some personality problem.

67. On 4 April, his segregation under GOOD was reviewed and, although he said he felt he was progressing and was feeling more settled, he appeared tearful at times but was unable to explain why. His behaviour was noted to have improved and he was noticeably more polite to staff. He was allowed to have a radio. He was reviewed on 7 April after he appeared to have regressed and was admitted to the Healthcare Centre.
68. The man was segregated again on 14 April under GOOD. A review on 17 April found that his behaviour had shown some improvement but that he still behaved bizarrely at times. He had not displayed self harming behaviour but was kept on the F2052SH. It was decided that he should remain segregated due to concerns about his behaviour and safety if he were to be placed on an ordinary landing.
69. On 28 April, his F2052SH and his continued segregation were reviewed. He seemed more coherent than hitherto and said that his girlfriend had recently had a baby and he wanted to leave custody. It was decided to close the F2052SH but to monitor him closely for seven days. He remained under segregation with regular reviews on 5 May, 19 May and 26 May when his segregation was further authorised until 9 June.
70. On 17 May, a psychiatric report was prepared for Guildford Crown Court by the consultant psychiatrist. Based on three interviews with him, his medical notes and information from other practitioners in contact with him, it concluded that :
- “[The man] was unable to understand the reasons for his imprisonment and he appeared dismissive about the events leading to his arrest and remand in prison ... continued assessments have not established that he suffers from an enduring mental illness for which he requires treatment in hospital. He also has an anti-social personality, lacks impulse control, acts in an aggressive manner and origins of this may be from his learning disability or perhaps are due to repeated injuries to his head during his boxing career.”
71. On 31 May, an entry in his medical record read:
- “Asked to speak to the man this evening. He was on the phone to the Samaritans, crying. Stating he could not cope anymore. Asking to go to HCC. Admitted for overnight obs.”
72. A mental health review was conducted the following day. A CPN noted in his record “no mental illness detected – suffering from nicotine withdrawal.”

HMP Wandsworth - 3 June to 28 August

3 June

73. The man arrived at Wandsworth on 3 June. In response to questions from the reception officer who was completing a reception Cell Sharing Risk Assessment on him, he said that the offence for which he had been remanded in custody was not a sex offence. He said that he had not ever displayed anti-social behaviour (defined by the categories on the CSRA form as including damage to property, unpredictable/unexplained aggression, assault on staff or others). He was asked whether he had abused drugs or alcohol in the past, whether he was dependent on drugs and whether he had previously or was currently on a F2052SH monitoring for self harm or suicidal behaviour. He answered "No" to all the questions. He had no concerns about sharing a cell and said he would not describe himself as a person who got angry/frustrated quickly. The officer, who only had a copy of his court warrant and Prisoner Escort Form, noted that the man was the source of this information rather than documentary evidence and assessed him as posing minimum risk to others, based on the available evidence.
74. On a Cell Location Certificate for the man, the section to be completed by a doctor or healthcare staff asks "Is there a requirement for the prisoner to share a cell on medical grounds? If yes, please enter any information of assistance to residential staff on the history sheet." The box for "yes" is ticked, though no details have been written in the Record of Events (history sheet). The reception officer completed the section by the First Night in Custody Officer. He ticked that there was no requirement for the man to share a cell on the grounds of self harm or suicide prevention and the man did not need to be placed in a shared cell on any other grounds.
75. The man was seen in reception by a healthcare worker who, in the absence of evidence to the contrary, assessed him as presenting a low risk of cell sharing. It is not clear where his core prison record, which contained details of his past history, was at this time. However, his medical record was available. The entry in his medical record for 3 June reads "Tx [transfer] in from HMP High Down, on medication ref M.O."

6 June

76. The man's case was discussed by the Prison Mental Health In-reach Team (PIT), who had access to his medical record. They concluded that, as there was no evidence of severe and enduring mental illness, they had no plans to assess him. PIT only cares for prisoners with severe and enduring mental illness. They did query whether there was a gap in healthcare provision regarding prisoners with a learning disability. However, there is no evidence of this being followed up.

77. The consultant psychiatrist, who had written an earlier psychiatric report dated 17 May on him, produced an addendum report stating that he considered him fit to plead in court on any further charges laid against him.

7 June

78. The man saw a doctor. According to his medical record, he demanded medication for epilepsy and diabetes although his record showed no evidence of him being on the medication he was requesting. He also asked for anti-depressants. Arrangements were made for his blood glucose to be tested.
79. Following a review of his CSRA, he was re-assessed to “high” by the assessment officer due to the information in previous CSRAs and his Records of Events that he was deemed a high risk to female staff and possibly cell mates “due to his unpredictable and aggressive behaviour”. The officer advised him that he would be re-assessed once staff had got to know him better, but should be given a single cell. A review date of 7 July was given, but my investigators were unable to find evidence that a further CSRA took place.

18 – 25 July

80. The man had an appointment with the prison doctor on 18 July and asked him for medication to deal with “fits and shakes.” The doctor noted in the man’s record that he did not need such medication and that the Olanzapine he was already taking should act as a mood stabiliser.
81. On 19 July, he was scheduled to have a legal visit from his solicitor. The visit did not take place as the man was said to be unable to attend as he had been crying all day and was being seen by the Samaritans when his legal visitor arrived.
82. On 25 July, a court order was made allowing his two youngest children to be freed for adoption.

29 July

83. During lunch break, the senior officer (SO) noticed that smoke was coming from the man’s cell on the Onslow Centre. The man had set fire to his bed. The SO and other staff opened his cell and called for him to come out as, the SO said, he could not actually see him because of the amount of smoke. As he became visible, the SO pulled him out of the cell. The fire brigade were called and the man was taken to the Care and Separation Unit (CSU). The SO told my investigators that the man was taken to the CSU because there were no other available cells in the Onslow Centre, and he had to be in a cell by himself.
84. The SO initiated an ACCT Plan on the man at 1:50pm that day. The plan takes the form of an A4-sized booklet divided into sections. The frequency

of observation was not stated on the cover, nor the date of his subsequent case reviews. There were no triggers or warning signs to prompt immediate review flagged up. On page 3 of the Plan, the Concern and Keep Safe form, the SO wrote that his behaviour had caused concern because he had set fire to his cell and stated that he was hearing voices. The Immediate Action Plan on page 4 was completed by a second SO. He noted that the man should be “made a single cell high risk” by the Unit Manager, that the frequency of staff support should be interaction during the day and observation at night. He added that he explained to the man how to gain access to a Listener and that he could use the Samaritans telephone.

85. The Immediate Action Plan lists four tasks that should be completed before its author goes off duty. Only one of them, obtaining a log number for the ACCT Plan cover, is ticked.
86. A trained ACCT assessor must carry out an ACCT assessment interview within 24 hours of the ACCT being opened. The man’s assessment should have taken place by 30 July. It was not in fact done until 2 August.
87. Whilst in the CSU, the man was charged with contravening prison discipline by “intentionally or recklessly” setting fire to his cell and given a Notice of Report.
88. Although the CSU Daily Occurrence Sheets covering the period the man was in the CSU show that it was known he had an open ACCT Plan, entries were only made in the on-going record section of the plan from 4:00am on 31 July.
89. Wandsworth’s Suicide Prevention and Strategy Document states:

“On no account should a prisoner subject to a ACCT be located in the Care & Separation Unit without a case conference being attended by the duty governor and/or head of residence (if on duty). If the head of residence is not on duty, the residential manager i/c should attend.”

My investigators found no evidence that a case conference had taken place in relation to his stay in the CSU.
90. A newly arrived prisoner in the Care and Separation Unit should be assessed by a doctor or registered nurse within two hours of being placed there, using a Segregation Safety Algorithm. Prisoners on an open ACCT Plan should be monitored at least five times an hour until a safety algorithm is completed. Wandsworth could not provide my investigators with evidence that a safety algorithm had been completed to ascertain whether the CSU was an appropriate place for the man to be. Whilst the man was in the CSU, there were up to three other prisoners also on open ACCT Plans. The man was not placed in a Safer Cell, designed to eliminate possible ligature points, as there were only two in the CSU out of 23 cells and both were occupied.

30 July

91. According to the Record of Hearing and Adjudication, the man was seen by a medical officer who found him fit to be adjudicated on and to serve a punishment of cellular confinement if necessary. The adjudication hearing was conducted by a governor. It began at 10:25am. The man indicated that he understood the charge, had sufficient time to prepare an answer and would not be calling any witnesses. He pleaded not guilty. He told the adjudicator that he had fits and was smoking at the time so he set fire to a blanket by accident. The adjudicator found that he was reckless in setting fire to his bedding. The man agreed and apologised. The adjudicator found the charge proved. The adjudication report presented to the adjudicator, once the man had been found guilty, lists his occupation as working in the laundry earning £6.00 a week. I understand, however, that whilst he had initially worked in the laundry when he arrived at Wandsworth, he was stopped due to his health problems. His computerised work allocation was not changed, however, and he was not paid.
92. The adjudication report indicated that the man was on an open ACCT. The adjudicator was also given a conduct report on him. Instructions on the conduct report for its completion state that the report should be about the prisoner's behaviour during his/her current sentence including comments on any vulnerabilities such as an open 2052SH. The man's conduct report does not mention his open ACCT.
93. The adjudicator gave him a punishment of three days cellular confinement, 14 days exclusion from work and stoppage of earnings for 14 days at 50%. There is no evidence that the adjudicator completed the required section of the Segregation Safety Algorithm before deciding on the man's punishment.
94. Once the punishment was given, he should have had a full case review within 24 hours (which should have taken place on 31 July). However, no case review took place.

1 August

95. The man returned to the Onslow Centre after serving his punishment in the CSU. He returned to his previous cell, H2-04. He told an officer that he was okay and that he would not set a fire again. The officer commented that the man was in good spirits.

2 August

96. Although ACCT reviews should take place according to the individual needs of each person, the Onslow Centre generally carries out reviews on Tuesdays at 10:00am. A trained ACCT assessor initiated an assessment interview with the man on 2 August (a Tuesday). The interview should

have taken place 24 hours after the ACCT was opened. It is not clear why this did not happen. Asked why he thought the assessment had not occurred at the proper time, the officer speculated that perhaps there were no ACCT assessors on duty over the preceding weekend.

97. The man told the assessor that he was not well and was hearing voices telling him to start a fire. It was not a pre-planned act. He said that he felt isolated in prison and wanted to share a cell with someone. At interview with my investigators, the assessor said that the risk of placing him in a shared cell, given that he might have been a danger to other prisoners, was too high. He said he explained this to him, who was not happy about it because he wanted a cellmate. The man added that he had tried to contact his family by writing letters, but had not received a reply. The man was asked if he had tried to harm himself before, but he replied that he had not and that he had no thoughts of self-harm. The assessor noted that, although the man said he was okay, he appeared unsure of himself, anxious, and was rocking back and forth in his seat.
98. Following the assessment interview, the man met with the SO and the assessor later that day. The man said that he was not suicidal and that he had not heard the voices which told him to start a fire before or after the event. The man's risk was assessed as raised and he was referred to see a CPN. No date was set for the next ACCT case review.
99. A Care and Management Plan (CAREMAP) for the man was devised by the SO. He made a referral to the CPN and explained to the man that he could contact the Samaritans or a Listener to deal with his feelings of isolation. He was given a telephone call to a member of his family, but there was no answer. The SO said that he would look into the issue of the man sharing a cell.

3 August

100. The man was seen by a Psychiatrist, and a CPN of the Prison In-Reach Team, as an emergency referral. The man told the doctor that he was sorry for starting the fire, and promised he would not do it again, but he had received a letter from social services to inform him that his two youngest children had been taken into care and this had upset him. The doctor noted that he showed good eye contact and did not appear distracted or show signs of psychotic symptoms. He denied wanting to harm himself and said that he hoped to be released at his next court appearance. The doctor concluded that the man did not need to be seen by the Prison In-Reach Team as he was suffering from poor impulse control due to personality and learning difficulties. He did not feel he needed to be on an ACCT and that the closure of the ACCT should be considered after his next case review. The man asked to speak to a Listener at 2pm. He did so and returned to his own cell at 2:30pm.

4 August

101. The clinical director of Kent Forensic Psychiatry Service interviewed the man on 4 August in order to prepare a psychiatric report for his defence lawyer. She concluded that he did not present with any evidence of mental illness but presented “as somebody who is trying to manipulate the prescription of medication, which he feels meets his needs ...” She noted that he had a long history of contact with mental health services but that, although he may have suffered from acute and transient psychotic episodes which could be related to illicit drugs, his principal problem was an antisocial personality disorder and that if he had a learning disability, it was very mild.
102. As he was on an ACCT, he was seen by an assistant chaplain who commented in the Chaplaincy handover book that the man seemed better but was wary of other prisoners. The man mentioned to two officers that he did not think he was getting the right medication.
103. The man asked to speak to a Listener at 2:20pm. He went to the care suite on his landing with two Listeners and returned to his cell at 3:15pm.

5 August

104. The man submitted a written complaint. It was written out by his friend and a fellow prisoner, who was also his tutor on the Toe-to-Toe literacy programme. He wrote that when he went to see the doctor earlier that day, he was sent away without being able to explain why he had wanted to see the doctor. The man added that the psychiatrist he had seen the previous day had said she felt he was on the wrong medication.
105. On 9 August, health care principal officer (HCPO) rejected the man’s complaint responding:

“I have checked your medical file and spoken to both doctors, who agree there is no clinical indication to warrant prescribing the medication you’ve requested.” The man did not take the complaint any further.

12 August

106. An officer noted in his ACCT Plan that he seemed quite cheerful and, on being given some tobacco by another officer, was extremely happy. The man asked to speak to a Listener at 2:20pm and again at 9:30pm. Both requests were facilitated.

August

107. The man's ACCT Plan contained the following entries - "He is coping quite well. His bigger problems are centred around getting something to smoke, but does not have self harm concerns ... States he is fine, would like to move to a double cell. Explained that on medical grounds he cannot share a cell ... Has been loaned a 'spare' radio and this has pleased him somewhat. No thoughts of self harm."

16 August

108. A review of his ACCT Plan took place. Attending the case review were the SO, a wing officer, the suicide prevention co-ordinator, a member of the chaplaincy and the man. The summary of the review states that the man denied having thoughts of harming himself. He was concerned about his medication and asked again for a cellmate. It was explained to him that it was not yet possible for him to share a cell. It was decided that the Prison In-reach Team would be informed of his concerns about his medication and that his ACCT Plan would be closed, but he would have a post closure interview on 23 August. In the event, another ACCT document was opened on 22 August.

18 August

109. A nurse was called by an officer to see the man in his cell after he was found lying on the floor. His medical record said that he kept hearing voices, that people were against him and would kill him. In the afternoon, healthcare were again called to attend to him as he was on the floor in the recovery position with his body twitching. No medical problem was diagnosed and, when he was asked to sit on his bed, he did so.

22 August

110. The ACCT assessor initiated a Report of Injury to Prisoner form, F213 on the man who died. In completing it, he wrote that he was passing the man's cell when he noticed him with a ligature around his neck. The ligature was removed and he had a conversation with the man, during which he banged his head on the table as the officer spoke. The officer opened an ACCT Plan. On the front cover of the ACCT Plan, there is no indication of the frequency that the man should be observed or the date of his next case review. The officer completed the Concern and Keep Safe form on page three of the document at 11:45am saying: "Found with ligature around his neck, had a long chat, his main problem is with his medication." The box indicating self injury or statement of intent to self harm was ticked. The officer then completed the Immediate Action Plan on page four, indicating that he had to be in a single cell "as is a danger to others". He wrote that the frequency of staff support should be "at least once every period" and access to Listeners and Samaritans should be as required.

111. At interview with my investigators, the ACCT assessor said that he had not actually seen the man with the ligature, but that a prisoner had told him about it. He explained that once every period meant "at least one proper interaction as in a proper conversation morning, afternoon and evening duty". He added that, although the Prison Service Instruction on ACCT states an Immediate Action Plan is usually completed by a Unit Manager, because he was an assessor, he dealt with ACCTs more frequently than most line managers so he felt competent to complete it. In the box marked "Other immediate interventions" he wrote that the CPN should be telephoned.
112. According to the Immediate Action Plan, the ACCT assessor referred the man's case for an assessment and case review, briefed staff and made an entry in the Observation Book, obtained a log number for the ACCT plan and completed an F213SH. The officer in fact completed a F213 Report of Injury to Prisoner form, rather than an F213SH for prisoners who have self-harmed, which he took to the Treatment Room.
113. The man was then seen by the prison doctor on an emergency appointment. The doctor wrote in his medical record "when seen as usual demanding more and more drugs ... he is at the treatment hatch every day demanding drugs. Has been s/b the psychiatrist on 2/8/05 and had full assessment. Opinion: no mental illness personality disorder. Not for any further psychiatric review".
114. The prison doctor wrote a plan in the man's medical record and ACCT Plan:
" - to remain in ordinary location shared cell
keep ACCT open and regular intermittent close watch
to speak to Listeners/Samaritans
arrange priest to speak to the inmate and counsel
arrange psychologist to see inmate for counselling"
115. There is no record of the man seeing a psychologist. At interview, the prison doctor said that his recommendation for a shared cell was overruled and he was not aware at that time that the man's CSRA had stipulated that the man be located in a single cell. The doctor explained in a telephone conversation with my lead investigator in May 2006 that, when he wrote "regular intermittent close watch", prison staff would understand that to mean that the man should be observed every half an hour. He did not think that the man needed more frequent observation as his previous attempts at self harm had been superficial cuts. In reference to his entry in the man's ACCT "arrange psychologist to see inmate for counselling", the prison doctor said that he would expect the ACCT case manager or someone from the team to make and follow-up the referral to a psychologist. It currently takes between two and three months to arrange counselling through a psychologist.
116. At 11:50am, the man saw a Listener. Staff observation entries were written in his ACCT Plan at 2:45pm and 5:00pm. At about 5:30pm, he cut his left

wrist then rang his cell bell. When a wing officer answered, the man told him that he had cut himself because his daily medication had been changed by the doctor. The officer completed an F213 form although he should have completed an F213SH instead. A nurse saw him at about 5:45pm, cleaned and dressed his cut and arranged for him to see the doctor the next day. The man told the nurse that he intended to hang himself that evening. At 5:50pm, he spoke to two Listeners in the wing's Care Suite until 8:40pm. The wing observation book states that the night staff were warned about him expressing the intention to kill himself and a close watch would be kept on him. The ACCT Plan shows that he was observed at hourly intervals throughout the night.

23 August

117. When he was seen by the prison doctor on 23 August, the man said he had cut himself because he had not been prescribed any medication. He then named five types of medication that he wanted. The doctor's notes say that he explained to him that the psychiatrist had said that he did not need any of the medication he was asking for. The doctor made a note for a CPN to review his case. He described the cut on his wrist as four centimetres long and cut through superficial skin.
118. The man was observed by staff and entries were written in his ACCT Plan regularly. His cell door was left unlocked all morning. An officer wrote at 4:30pm that she "locked him up last but he did not like it."
119. Although his ACCT plan had been opened the day before, no case manager was appointed to be responsible for monitoring his progress, and he did not have an assessment interview within 24 hours as set out in the relevant Prison Service Order. A trained ACCT assessor, who had been on duty on 23 August, said at interview that she had told a senior officer that she was unable to do the assessment interview with the man because he had been deemed high risk to female staff and she did not feel comfortable being in an office alone with him. The assessment interview was eventually carried out by the SO on 26 August, a trained ACCT assessor, three days after it should have been undertaken.
120. The suicide prevention co-ordinator was interviewed by my investigators concerning the ACCT process and the gaps in meeting its requirements. He said that he had spoken to the man at the review meeting on 16 August when the decision was taken to close the ACCT Plan and he did not believe that the man had any intention to kill himself.
121. When the suicide prevention co-ordinator went to the review meeting on 23 August, he was not at first aware that the man was on a new ACCT Plan. This transpired during the review meeting. They then decided not to do a post closure review for the previous ACCT because he assumed that the ACCT assessment in the new document would be done at some point that day. Asked by my investigators why he did not know that the man was on a new ACCT, he said that he checked the ACCT log once or twice a week. If

a form F213SH was completed on a prisoner, he would get a copy. If an F213 was completed rather than a F213SH, as happened in this case, he would not get a copy and therefore would not be aware of the injury. He acknowledged that there were shortcomings with the documentation being completed properly.

24 August

122. There are regular staff observation entries in the ACCT document during 24 August and a note to say that the man stated he was “ok”.

25 August

123. An entry in the man’s ACCT Plan at 12:25pm reads “collecting his meal, appeared to be unwell when he went on all fours encouraged to collect his meal.” At 2:45pm his behaviour was noted to be “normal”.
124. The team manager of the Prison In-reach Team reviewed the man’s medical record. He noted he had been seen on 2 August by a psychiatrist, and by a CPN and that there was no evidence of current psychotic illness. He suggested that the man should be managed through the ACCT process, liaising with the residential unit manager, and that someone should consider seeking advice from the psychology department, although it is not clear to whom the latter suggestion was made.

26 August

125. The man went for a visit in the morning, but when he returned he told the ACCT assessor that his visitor had not turned up. She recorded in his ACCT Plan that he did not express any thoughts of self-harm. He asked to speak to a Listener.
126. The man was interviewed by the SO ACCT Assessor in the afternoon. The man told him that that he had been diagnosed as a paranoid schizophrenic some time ago, but that he was “fine” when on medication. The man told the SO that he had not tried to harm himself until he had come into custody. Since then he had attempted to hang himself by making a ligature. He acknowledged this was a cry for help. He mentioned an aunt who hanged herself six years ago, to whom he was close. The man described his current mental state as good, although he heard voices now and again. He said he did not want to die and had no plans to end his life as his mother was waiting for him to be released from prison. The man made mention of his “seven children and their mother” waiting for him to come home.
127. The SO described his appearance as calm and oriented. The man said that when he was agitated, tobacco helped to calm him down and he was in dire need of some. His prison pay had been incorrect for several weeks. The SO asked the wing officer to resolve this so that he could buy some tobacco. The wing officer said at interview with my investigators that a prisoner had brought it to his attention that the man had not received his correct pay for

six weeks because he had been wrongly recorded as refusing to work when in fact he was unable to work because of his medical situation. The wing officer had eventually secured £18.00 back pay for him shortly before his death. This was used to buy tobacco as the man was a heavy smoker.

128. In addition, the SO wrote that the man should continue to take his medication regularly and that a friend should be “appointed”. Apart from ensuring that his canteen money was sorted out, the CAREMAP was unsigned and no case manager was allocated. No date for a case review was set. A case review should have taken place within 24 hours of the assessment but did not. Page 10 of the ACCT Plan, entitled Action following Assessment, was not completed.

27 August

129. According to his ACCT Plan, he was unlocked all morning, spending his time wandering about. When he was unlocked for lunch, he asked for his cell to be left open over lunch time but the senior officer on duty refused. His demeanour was described as okay.

28 August

130. An officer noted in the man’s ACCT Plan that he “seemed to be in much better spirits than he has been, this seemed to be because he now had his canteen and had a smoke, stated he was ok.” The officer recorded several times throughout the day that the man seemed in good spirits. The man said to him that he was okay because he had tobacco.

The events of 29 August

131. Monday 29 August was a Bank Holiday. There was an open-door policy on the Onslow Centre that morning. This meant that all the cell doors were left unlocked from about 8:00am until lunchtime. There were 363 prisoners of whom 14 were on ACCT Plans that day. The wing officer remembered seeing the man walking about. The man asked him about one of the new prisoners as he thought he recognised him. The officer remarked at interview that it was the most he had ever heard the man speak. He recalled seeing him about all morning.
132. A friend of the man, said he saw him at about 9:30am and that he:
- “seemed better than he had been for ages and he himself said that he was feeling quite positive. Because of that I didn’t feel the need to pop in and see him as much during that day. He actually did seem a lot better.”
133. Another prisoner on the Onslow Centre, told my investigators that he had spoken to the man some time between 10:30 and 11:00am. The man had seemed his usual self, a bit down. The man told him that he felt ill, but when he had gone to the Treatments Room a nurse had told him to go away. He

said that the man often said he felt ill and that nurses would tell him to stop wasting their time.

134. A officer wrote in the man's ACCT Plan at 11:00am, "out on association this morning, has seemed to be in good spirits. States he is ok. No issues raised."
135. At around 11:00am, the man approached the Church of England Chaplain, who was passing through the Onslow Centre, and asked him for a blessing. The Reverend asked him what he wanted him to pray for and the man replied that he felt unwell. The Reverend thought the man looked depressed and asked him whether he had mental health problems and he said that he did. The man spoke slowly and without any emotion. The man said that he wanted to go to church so the Reverend asked him to put his name down and he would be seen on Friday. He then said a prayer for healing and blessed him. At interview, the Reverend said that it was not unusual for a prisoner to stop him and ask for a blessing while he was on his way through a unit. The man did not show any indication that he intended to take his life.
136. An officer spoke to him in his cell after the social and domestic period had ended and prisoners were locked in their cells. He noted in his ACCT Plan at 11:40am, shortly after association ended, "No apparent concerns at end of social/domestic, says he was alright."
137. An unrelated prisoner on Onslow, told my investigators that the senior officer had unlocked the man, (however, my investigators have established that the named SO was not in the prison that day, another SO was on duty). The man had been brought to his cell by a second prisoner before lunch.
138. The man talked to the unrelated prisoner and said he felt like killing himself. At interview, the prisoner said that he had said to the man: "You do have family?" and he said "Yes". I said "How do you think they would feel or you would feel if they killed themselves?". He said "I'd feel pretty bad". So I said "Well, that's exactly how they are going to feel" and he said he wasn't going to do it. He had another cigarette and then he wanted to go back to his cell. The other prisoner said that he shouldn't be on his own so I walked back up to the centre ... I stayed there about five minutes ... His door was open. There were people around. And I thought I'd talked him out of it. He said he wasn't going to do it and then did it, which was a surprise."
139. The unrelated prisoner said that when he last saw the man's cell door, it was wide open. The second prisoner said that as the man's cell was near the servery, he would usually chat with him whilst helping staff serve lunch if the man was unlocked. However, on 29 August, although the second prisoner intended to go to the man's cell at lunch time, for some reason he did not as he said that the man's cell door appeared closed.

The discovery of the man

140. In the Onslow Centre, lunch is normally served one wing at a time and landing by landing within each wing. The order is usually K wing, G wing and then H wing. The supervising officer was supervising the serving of lunch on the man's landing, H2. On 29 August, H2 was the last landing to be served lunch that day. At about 12:30 pm, he noticed that the man's name had not been ticked on his list as having collected his lunch. This was not unusual in itself as there had been previous occasions when the man had not collected his lunch.
141. The officer went to the man's cell. It was not locked and the door was slightly ajar. As he pushed open the cell door, he saw the man hanging from the window bars by his neck from a bed sheet. The man's feet were off the ground and he appeared unconscious. The supervising officer called for the landing officer, to assist him in getting the man down. He asked a wing officer to fetch medical assistance. The landing officer lifted the man up enabling the supervising officer to untie the ligature from the man's neck. With the assistance of another officer, they laid the man on his bed. The supervising officer said that he called the man's name a few times to try and get a response.
142. The wing officer went to the Treatments Room, a short distance away from the man's cell, and asked healthcare staff for immediate assistance. The staff nurse, who was in the Treatments Room, attended the man's cell immediately followed by the doctor who was also in the Treatments Room. The staff nurse arrived at the man's cell and checked for a pulse. She found a faint pulse in his carotid artery in his neck. She opened up his airway using a chin thrust and administered oxygen. The prison doctor described the man's appearance as having fixed and dilated pupils, cyanosed [blue in colour] and no perceptible pulse. The pulse that the nurse had detected had faded. The doctor asked for an ambulance to be called. He began Cardio Pulmonary Resuscitation (CPR) with the help of the staff nurse. He said that after about 10 minutes, the man's colour improved and he could hear a heartbeat although it was irregular. They continued for another five minutes or so and the man had regained a radial pulse and a pink colour. However, he remained unconscious and was not breathing spontaneously.
143. According to the communications room log, Wandsworth requested an ambulance at 12:40pm. An ambulance arrived at the prison gate at 12:44pm and paramedics got to the Onslow Centre at 12:47pm. Paramedics took over CPR from the prison doctor and the staff nurse.
144. The man was taken to St George's Hospital, Tooting, by ambulance at 1:21pm. Two prison officers who were to remain with him followed half an hour later.
145. The staff nurse commented in the man's medical record that they were unable to open the emergency bag at first due to a thick plastic seal which

had to be cut with ligature scissors. The ambu bag was also ineffective because there was no connection.

146. By 3pm, all prisoners in the Onslow Centre on an open ACCT had been reviewed in the light of the man's attempt to hang himself.

Contact with the man's family

147. The man was visited by the duty governor at 5pm on 29 August. He was moved to an intensive care unit within the hospital. He was not handcuffed, was sedated and on a ventilator. Later that evening, the officers were given permission by the duty governor to observe him from a side room rather than by his bedside, so as not to impede the nursing staff.
148. At about 2:30pm on 29 August, the chaplain of HMP Elmley, the nearest prison to the man's mother's address, was asked by a chaplain at Wandsworth to contact her. Unfortunately, she was not at home so he left a note asking her to telephone Wandsworth. The man's mother had in fact moved from that address, but the note was forwarded to her that evening by the new occupant. The man's mother told my investigator and my family liaison officer that she had tried to telephone the prison that evening on receiving the note but was unable to get through. The number she had been given was the direct line to the Chaplaincy Office which is only open during office hours. She went to her local police station for assistance, but found them unhelpful. She telephoned Wandsworth the next day and was told that the man had attempted to take his life and was in hospital.
149. The man's mother went to the hospital and met the governor on duty at Wandsworth when the man was found in his cell. The man's mother said that the duty governor had described the man's actions as "attention seeking", a remark she found insensitive and upsetting. His mother had noticed a scar on the man's wrist with a fresh scab which indicated that he had harmed himself recently, but the duty governor could not give her any information on how the man had come by this injury. She said that the governor told her that the man was on a "suicide watch" every 15 minutes, but due to staff shortages he was only observed every 25 minutes. The mother was concerned that the man had been in a single cell given that he was at risk of self-harm and said that she had been told by the hospital that his brain injury had been caused by being deprived of oxygen for 10 minutes. She felt that the delay in monitoring him might have been crucial to his survival.
150. At 1:00am on 3 September, the man was pronounced dead by hospital staff. After his death, his mother felt that the prison's invitation to visit her son's cell was inappropriate and added to her distress. The mother was certain that the duty governor had stated in front of other family members that Wandsworth would pay for the man's funeral, but in fact that the prison's contribution fell short of the actual cost. Nevertheless, she was appreciative of the chaplain and the duty governor's help in arranging transport for the man's family to visit him in hospital and for keeping in regular contact.

151. My investigators put the man's mother concerns to the duty governor. She said that she was sorry if she had caused offence to her and it had not been her intention to do so. Families often welcomed the opportunity to see where a loved one had lived and died. She could not recall having a conversation with the man's mother about his cut wrist or the frequency of him being observed. She was adamant that she had told the man's mother that Wandsworth would make a contribution towards the man's funeral, not pay for all of it. The eventual cost of the funeral had been twice the £2,000 the prison offered, but the duty governor regarded Wandsworth's contribution as a reasonable sum which was in line with Prison Service guidelines.
152. The man's mother told my investigators that her son had told her after his last custodial sentence that he had had enough of prison and was not prepared to return there. He had been concerned about his twins, his youngest children, and not being able to see his mother.
153. After seeing a draft version of this report, the Prison Service commented concerning its contact with the man's family that :
- “The comment made about “attention seeking” was not one made in isolation and was not made in direct reference to the man. The man's mother was told by the duty governor that the routine was slightly different that day due to staff shortages. There was a slight delay in unlocking the man for his meal and he might have expected to have been unlocked earlier.
- “The duty governor explained to the mother that her son was in a single cell because he presented a danger to other prisoners, given the nature of his previous violence.
- It is mandatory within PSO 2710, Follow up to deaths in custody, for the family to be invited to visit the establishment and to offer them the chance to see where their loved one died.
- The duty governor had numerous conversations with different members of the family about the funeral and advised them that we would contribute towards the costs in line with our policies and within our limits. She also discussed this with the funeral directors.”
154. The Prison Service's comment at draft stage that there was a slight delay in unlocking the man for his lunch due to staff shortages points not only to the relevance of the comments made by HM Chief Inspector of Prisons in her last report on Wandsworth which I alluded to earlier but also goes to the heart of the man's mother concerns namely the possibility that if the man had been found earlier, his life might have been saved.

The man's life in Wandsworth

155. In marked contrast to his behaviour at Elmley and High Down, he was very quiet at HMP Wandsworth and conformed to prison discipline. He made two close friends whilst at Wandsworth.
156. The first friend had helped him improve his literacy with one-to-one lessons and their friendship developed from there. The man spoke to him about how he was missing his mother and that he could not understand why he had not heard from her. (His mother's local authority had re-housed her on condition that she was not allowed to let the man know her address, due to him having caused a disturbance at her previous address. It is not clear if he was aware of this). He also discussed with his friend his problems with his medication, that the doctor would allegedly just send him away, and his relationship with the mother of his two youngest children who were going to be adopted. The man was upset and confused about his children being taken away.
157. The man had told his friend that he was afraid of being beaten up, and he wanted to be in a shared cell. He had said a few times that he was tired or sick of life and was feeling low or upset, but his friend felt that staff and prisoners were looking after the man and had purposely placed him in a cell near the staff office so that they could keep an eye on him. The man's friend did not think that other prisoners had threatened him and felt, in fact, that people on Onslow were protective towards him. The man's friend had seen bedding tied to the man's window grille a couple of times and had asked him about it, and he would acknowledge that suicide was pointless.
158. The man's second friend was a prisoner orderly with responsibility to support disabled prisoners. He came into contact with him as he was sometimes asked by staff to help the man. He said that the man had showed him a rope he had made [to hang himself] as he could not bear the loneliness. The friend had reported this to the ACCT assessor. The friend said that during the three days before the man had attempted to hang himself, the man asked for his door to be left open at lunchtime but staff had refused. The SO would allow him to sit with the man at lunchtime, as he would say that he felt lonely and did not want to be on his own. They would often talk about his family and the voices in his head. He was happy to talk with the man and felt that by allowing these chats, the SO had kept the man alive.
159. The supervising officer described the man as a quiet individual, and as "a committed smoker". It was difficult to engage him in conversation. He would reply "yes" or "no" and then refer to not having any tobacco or cigarette papers. The man would walk around the wing with the aim of trying to get something to smoke. When he had tobacco, he was happy.
160. Several staff mentioned that the man did not like to be locked in his cell and would ask for his door to be left open. They said it was not uncommon for

him to be left unlocked if staffing allowed. This could also apply to other prisoners, depending on their circumstances.

161. The SO told my investigators that he had come to know the man well after removing him from his cell following the fire. He told him that, if he was feeling distressed and did not want to be locked in his cell, he could ask the SO not to be locked in. The SO said this was an informal arrangement and he could not say what happened with other staff when he was not on duty.

Record Keeping

162. I have mentioned elsewhere in this report the omissions in the man's ACCT Plans and the absence of case conference notes in recording the decision to keep him in the Segregation Unit. My investigators also noted that the Wing Diary for the Onslow Centre, which gives a snapshot of the activities of the unit on any given day was sometimes not completed at all by a senior officer or countersigned by the wing principal officer. There were various dates that were left blank. The front cover of the first wing diary stated that it started on 21 July and finished on 30 August. My investigators looked at the diary to learn of the wing activities on 29 August. However, the pages for 29 and 30 August were missing. My investigators asked a senior officer, who was on duty when the man was found, to account for their absence. He said that the diary pages had run out on 28 August and another one was not assembled until 31 August. Another SO, who created the Wing Diary, said that it was a pilot document which drew together information that would normally be written on different forms but, as it was new, it depended on the senior officer of the day making sure it was completed.
163. The prison's Local Inmate Data System (LIDS) printout on the man who died, stated that his self-harm monitoring was closed, when in fact he had an open ACCT when he died. The escort risk assessment for the officers monitoring his condition whilst in hospital, which was based on information from LIDS, stated that he+ was not on an open ACCT and that his last ACCT Plan had been closed on 16 August.

Post Mortem and Clinical Review

164. A post mortem was carried out on 8 September 2005. It concluded that the man's cause of death was hanging and that death "resulted from the effects of a hypoxic brain injury produced by an episode of hanging. He had developed severe pneumonia in hospital as a direct result of his brain injury."
165. A clinical review of the Healthcare the man received whilst in prison was conducted by a Joint Medical Director of Wandsworth NHS Primary Care Trust. He found that:

"[The man] did not have a formal psychiatric diagnosis, in that he suffered from a personality disorder and possibly some learning difficulties with poor impulse control, but not a 'treatable' psychiatric condition.

“It was therefore felt by psychiatrists who saw this man that there was no specific form of treatment that could be offered to him, other than medication such as Olanzapine to try to calm him down. Despite the regular psychiatric reviews the prisoner still, sadly, took his own life.

He concluded:

“ ...It would therefore appear from a psychiatric point of view that there is no disagreement as to his mental status. I would therefore consider that there is no evidence of any failure as such in the Mental Health Service and Medical Services provided to this man.”

166. The clinical reviewer commented that, whilst the medical management of the man seemed adequate, he felt it would be useful for Wandsworth’s psychiatric in-reach team to carry out a review of the man’s case to see whether any further actions could have been of benefit. He also expressed his concerns about him being moved to several prisons and having access to materials to make ligatures.

Conclusions and Recommendations

167. The man who died was a troubled man. He had a history of mental illness, having first been admitted to a psychiatric hospital in 1988 and having been diagnosed with paranoid schizophrenia in 1993. He had been in prison several times over the past 20 years. During his last period of imprisonment, his custodial behaviour could be problematic as evidenced at Elmley, where he engaged in dirty protests, constant shouting, banging, smashing furniture and fittings and urinating on the floor. His behaviour at High Down was just as challenging. Whilst ostensibly he had been exhibiting disturbing behaviour, the medical consensus seems to be that during his time in custody he was not suffering from a psychiatric illness, but rather had a personality disorder.
168. On his arrival at Elmley, after being examined on reception, he was referred for a mental health assessment. However, according to his medical record, this assessment does not appear to have taken place. He was seen by a doctor on 28 December and again on 7 January, but these consultations were to assess whether he was fit for adjudication and cellular confinement, rather than an in-depth health assessment. The man had said that he was on two types of medication but no checks appear to have been done to verify whether this was the case and he did not receive any medication for a month. If a mental health assessment had taken place at Elmley when requested, his medication needs could have been assessed more promptly.
169. The man spent most of his first six months in custody being isolated for extended periods in the Segregation Units of Elmley and High Down, either serving punishments or for reasons of Good Order or Discipline. His conduct was not only disruptive to others, but damaging to himself. Where prisoners end up spending significant lengths of time by themselves with little prospect of associating with other prisoners and nothing to distract them, it is all the more important to weigh up the value of adjudication punishments of cellular confinement with additional loss of "privileges". I can understand the desire to encourage him to conform to acceptable behaviour, but I have doubts about the decision to deprive him of all material comforts.
170. On arrival at Wandsworth on 3 June, due to the responses he gave when questioned, he was assessed as a low risk to himself or others on the Cell Sharing Risk Assessment. It does not appear that information from Elmley and High Down regarding his previous behaviour was used to make an informed assessment and his answers were taken at face value. A CSRA upgrading his risk to "high" was completed, in the light of previous CSRAs, on 7 June.
171. Prison Service Instruction 32/2005 on Cell Sharing Risk Assessments states:
- "In the case of a transferred prisoner, the sending prison must ensure an up-to-date ... cell sharing risk assessment form, and any risk management

plans, accompany the prisoner to the receiving prison as part of the transfer documentation. These must be read before location decisions are made in receiving closed prisons where there is the option of other than single cell occupancy.”

I recommend that the governor of Wandsworth reviews the system for drawing up CSRAs on reception to take into account previous CSRAs.

172. The man was considered by the Prison In-reach Team regarding his psychiatric care but, as he did not suffer from a severe and enduring mental illness, he fell outside their remit. They did query whether he had fallen through a gap in healthcare provision for prisoners with a learning disability. However, he was seen at High Down by a psychiatrist on 3 May who concluded that he was not suffering from a learning disability. The clinical director of psychiatric services, who saw the man on 4 August, also concluded that if there was such a disability, it was very mild. Of more concern is the fact that, despite the prison doctor writing in the man’s ACCT Plan and medical record that arrangements for the man to see a psychologist for counselling should be made, there is no evidence that this was done. It is unclear who was responsible for making any further referral for him to other healthcare services when he was not suitable for PIT involvement. I support the recommendation in the clinical review that the PIT “carry out a review and give a report, as to whether or not, they feel any further actions could have been of benefit in the management of the individual cases concerned.”

I recommend that the governor of Wandsworth, together with the head of healthcare, reviews the provision of services for prisoners at risk of self harm who fall outside the remit for the Prison In-reach Team.

173. The man’s prison employment record stated, wrongly, that he had refused to work. After initially receiving £6.00 a week for working in the laundry, he received nothing for almost eight weeks until a wing officer rectified the situation after being made aware of it by the man’s friend and by a SO. Yet staff on the Onslow Centre were aware that the man did not appear to have money for cigarettes and was frequently in search of cigarettes, papers or tobacco. Indeed, some staff and prisoners offered him their own. Prisoners’ pay is not an insignificant issue. For a prisoner already at a low ebb and at risk of self harm, the failure to pay him properly did not help his situation. It may be of some comfort to his family that, due to the officers’ efforts, in the days before attempting to hang himself, the man was able to buy sufficient tobacco for his needs.

I recommend that the governor takes steps to ensure that prisoners unable to work are properly paid and that, when prisoners employment changes, the systems are amended in a timely manner.

174. After receiving notification that his two youngest children had been put up for adoption, he man set fire to his bed. An ACCT Plan was initiated which was good practice. However, he was taken to the Care and Separation Unit (CSU). At the very least, in line with Prison Service Order 1700 on the Management of Segregation Units, arrangements should have been put in place to ascertain whether it was an appropriate place to care for him.
175. A prisoner newly located to the CSU should be assessed within two hours of arrival by completing a Segregation Safety Algorithm. There was no evidence that this was done. The Segregation Daily Memo, which should record the completion of the Segregation Safety Algorithm on a prisoner to ensure that they are fit to remain in the CSU, could not be located.
176. Given that he was on an open ACCT, in the absence of a Segregation Safety Algorithm, he should have been observed at least five times an hour at irregular intervals until the Segregation Safety Algorithm was completed.
177. The importance of completing a Segregation Safety Algorithm and having it readily available for reference should not be underestimated. It provides evidence that an adjudicator has considered a prisoner's circumstances, mental health and well-being before imposing a punishment. The man was given a punishment of three days cellular confinement, but there is no evidence that any particular measures were adopted to care for him as a prisoner who had just set fire to his cell. (The same applies to the three other prisoners were on open ACCT at the time the man was in the CSU). It is not acceptable to place potentially suicidal prisoners in the CSU without following the safeguards laid out in the Prison Service Orders on Management of Segregation Units and Suicide and Self Harm Prevention.

I recommend that the governor ensures that Segregation Safety Algorithms are completed within the required time frame on prisoners admitted to the CSU and are properly documented.

178. It is unclear why it took two days before CSU staff began to update the on-going record section of the man's ACCT Plan, when records held in the CSU show that they were aware that he was on an ACCT Plan from the time he arrived there. No frequency of observation had been noted on the cover and the man did not have an assessment interview until four days after the ACCT was opened, by which time he had already left the CSU.

I recommend that the governor reminds staff that assessment interviews on ACCT must take place within 24 hours.

I recommend that the governor provides training for all Care and Separation Unit staff on the specific requirements of caring for prisoners on ACCT.

179. The man was adamant that he was not receiving the correct medication for his mental problems and demanded medication for conditions such as diabetes and epilepsy, that he was not known to be suffering from, but

seemed to have convinced himself he was. He was treated with compassion by most of the staff he came into contact with, although he reportedly told others that health care staff had told him to go away when he tried to talk to them about his medication.

180. Landing Officers working in the Onslow Centre showed a good understanding of ACCT and the on-going record section of the ACCT Plan showed that, despite the man engaging in limited conversation, staff made efforts to observe and interact with him. The open-door policy and allowing prisoners to have their cell doors left ajar or to be able to speak to another prisoner over lunch, staff permitting, were good examples of staff showing commitment to prisoners in their care and trying to create a more humane approach.
181. When the man's second ACCT Plan was opened, one week before he attempted to hang himself, again the assessment interview did not take place for four days, the frequency of observation was not specified on the cover, he did not have a case review, nor was a case manager appointed. These incremental lapses should have been picked up by management checks, but were not. I note that due to illness, the Onslow Centre did not have a Unit Manager for some considerable time, including the period of the man's attempt to hang himself and his subsequent death. Although landing staff contact with the man was good, the monitoring of the ACCT Plan itself was poor.
182. The prison doctor specified that the man should be observed on a "regular intermittent close watch" which he took to mean every 30 minutes. He said that prison staff would understand what this meant, though it is by no means clear that they did. On the day that the man cut his wrist and then told the nurse who dressed his wound that he intended to kill himself that evening, the ACCT Plan shows he was observed hourly, at predictable times. The man was found hanging 50 minutes after the last entry in his ACCT Plan was made. The man's family have been distressed by this apparent lack of observation. It seems that staff were following the Immediate Action Plan in observing him "once every period" i.e three times a day rather than the prison doctor's plan in the on-going record, to observe him every thirty minutes.

I recommend that the governor ensures that the frequency of observation of a prisoner on ACCT is clearly stated on the front cover of the ACCT Plan and kept up to date.

183. The deficiencies in the documentation of the man's ACCT might have been more obvious if there was a named member of staff responsible for taking an overview of the man's monitoring. The importance of having a case manager, as stipulated in the Prison Service Instruction on ACCT, cannot be overstated. I am disappointed that there were fundamental failings with the working of ACCT at Wandsworth, all the more surprising in a prison that was part of the original pilot scheme.

I recommend that the governor devises an auditable system for ensuring that the mandatory requirements of the ACCT Prison Service Order are adhered to. Unit Managers in particular should make sure that incomplete ACCT Plans are rectified within the timescale set out in the Prison Service Order.

184. The suicide prevention co-ordinator, was not aware that the man had a new ACCT Plan opened on 22 August until he attended Onslow on 23 August for case reviews, intending to discuss the man's post-closure interview. The suicide prevention co-ordinator said that he checked the log for new ACCT Plans, which is kept in the communications room once or twice a week. Asked by my investigators why he was unaware that the man was on another ACCT Plan, he said that a copy of form F213SH should have been given to him when the ACCT Plan was opened, but this did not happen. However, an F213 was completed at the time by the ACCT assessor and another one, again the same day by a wing officer when the man cut his wrist. Indeed, the ACCT Plan had been given a log number, indicating that it had been officially noted. On the other hand, LIDS, the computerised system for retaining information on prisoners, had not been updated, even up to and beyond the man's death. Clearly the system for notifying the suicide prevention co-ordinator (SPC) and updating LIDS did not work as fluently as one would wish.

I recommend that the governor reviews the current system, so that the suicide prevention co-ordinator is notified daily of any new ACCT Plans and changes in circumstances.

185. It is an inescapable fact that the man died when there was no date set for a case review. While I am unable to say whether a review would have led to a different outcome, I am in no doubt that a review should have been arranged.

I recommend that the governor ensures that all prisoners with an open ACCT Plan should have a case review arranged within the recommended timescales.

186. The man's family are concerned that he was in a cell by himself, even though he was known to be at risk of self-harm. The man told staff and his friends at Wandsworth on several occasions that he wanted to share a cell. On arriving at Wandsworth he was assessed as low-risk to himself and others, but this was upgraded on 7 June following a review of his previous CSRAs. His previous history in Elmley and High Down showed that he was capable of sudden and intense violence, both in smashing his cell repeatedly and threatening officers. Nevertheless, there were three occasions – when he set fire to his cell and was placed on an ACCT Plan, when he was found with a ligature and an ACCT was opened, and again when he cut his wrist – when the CSRA could have been reviewed, although no further reviews were carried out.

187. The prison doctor, who was not aware that the man was in a single cell, had written in the on-going record on 22 August that the man should remain in a shared cell, but had been overruled. The decision not to place another prisoner in a cell with the man was finely balanced. Wandsworth was not unreasonable in erring on the side of caution, given that the consequences of getting it wrong could have been extremely serious. However, records do not show what consideration was given to the man sharing a cell, despite the prison's decision on 7 June 2005 that the CSRA should be reviewed, and the man's requests that this be done.

I recommend the governor ensures that all prisoners with a high risk CSRA are re-assessed if there is a significant event that triggers concern, and that this re-assessment is properly recorded.

188. I am concerned that the man's family was unable to find out until the next day that he had been taken to hospital, because the contact telephone number his mother had been given was only staffed during office hours. It was good practice for Wandsworth to ask a suitable member of staff from a prison nearer to the man's mother to make contact. But Wandsworth should have made sure that any contact telephone number was available over 24 hours. And when it turned out not to be possible to contact his mother directly, Wandsworth should have asked the local police for assistance. This was all the more important as the man was in the last few days of his life and time was of the essence.

I recommend that in future cases of death or serious harm, the governor ensures that the family is provided with a telephone number for the family liaison officer that can be reached out of office hours.

189. Whilst at St George's Hospital, the man's mother said that she had been told by the duty governor, that the man had been on a "15 minute watch" but when he died he had not been observed for 25 minutes. The duty governor does not recall discussing this with the man's mother, who felt that the outcome might have been different if her son had been found 10 minutes earlier. The confusion over how often the man should have been observed has only served to distress his family.
190. On the basis of the Prison Service's response to the draft of this report, which stated that there had been a slight delay in unlocking the man due to staff shortages, one cannot avoid the possibility that had there been a full complement of staff, the man could have received his lunch slightly earlier, he might have been discovered whilst attempting to hang himself and it is possible that he might have survived.
191. The man's mother told my investigators that, despite asking, she had not been given an explanation why her son's wrist was cut. The circumstances of his cut wrist were noted in his ACCT Plan and his family should have been told. Also, the mother believes that she had been told that the costs of the funeral would be borne by Wandsworth. The duty governor does not

remember being asked about the man's wrist. She is certain, however, she told the man's mother that the prison would make a contribution towards funeral expenses. I recognise that the immediate aftermath of a death in tragic circumstances has the potential lead to misunderstandings on both sides where information has been conveyed orally.

I recommend that members of staff dealing with bereaved families should be instructed to follow up, in writing, any important information given to avoid later misunderstandings.

192. The clinical reviewer conducted a review into the care that the man received whilst in custody. He concluded that he had received regular psychiatric reviews and the consensus was that the man did not show evidence of mental illness, psychosis or mood disorders. The reviewer recommended that the prison in-reach team carry out a review to see whether further actions could have been of benefit to the man. He also questioned the role of transfers from unit to unit and the availability of material to make a ligature.
193. I concur with the findings of the clinical review and its recommendations. The reviewer has made comments concerning ligature- making and the frequency of transfers that Wandsworth PCT and the Prison Service may wish to consider.

I recommend that the governor, in partnership with the Primary Care Trust considers the learning opportunities identified in the Clinical Review and develops an action plan to address them.

194. There is much to praise in the speed with which the man received medical assistance once he was found. The supervising officer and the landing officer acted swiftly to release the man from the ligature. The wing officer acted promptly to alert medical staff. The efforts of the prison doctor and the staff nurse in resuscitating the man were sterling. It is sad indeed that, despite the efforts of all involved, the man did not regain consciousness. At the end of his medical record, it was noted by the staff nurse that the emergency bag had contained a seal which had been difficult to cut and the ambu bag was missing a connector hose making it inoperable.

I recommend that the governor satisfies himself that the difficulties with access to emergency bags and the operation of the ambu bag have been rectified and sets up an auditable programme of regular equipment inspections.

List of Recommendations and Good Practice

I recommend that the governor of Wandsworth reviews the system for drawing up CSRAs on reception to take into account previous CSRAs.

I recommend that the governor of Wandsworth, together with the head of healthcare, reviews the provision of services for prisoners at risk of self harm who fall outside the remit for the Prison In-reach Team.

I recommend that the governor takes steps to ensure that prisoners unable to work are properly paid and that when prisoners' employment changes, the systems are amended in a timely manner.

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I recommend that the governor ensures that the frequency of observation of a prisoner on ACCT is clearly stated on the front cover of the ACCT Plan and kept up to date.

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I recommend that the governor reviews the current system, so that the suicide prevention co-ordinator is notified daily of any new ACCT Plans and changes in circumstances.

I recommend that the governor ensures that all prisoners with an open ACCT Plan should have a case review arranged within the recommended timescales.

I recommend the governor ensures that all prisoners with a high risk CSRA are re-assessed if there is a significant event that triggers concern, and that this re-assessment is properly documented.

I recommend that in future cases of death or serious harm, the governor ensures that the family has a telephone number for the family liaison officer that can be reached out of office hours.

I recommend that members of staff dealing with bereaved families should be instructed to follow up in writing any important information given, to avoid later misunderstandings.

I recommend that the governor, in partnership with the Primary Care Trust considers the learning opportunities identified in the Clinical Review and develops an action plan to address them.

I recommend that the governor satisfies himself that the difficulties with access to emergency bags and the operation of the ambu bag have been rectified and sets up an auditable programme of regular equipment inspections.

Good practice

Senior officer's actions in placing the man on an ACCT Plan after he set fire to his cell.

The encouragement of an open-door policy on Onslow Centre and creating a positive atmosphere amongst most staff and prisoners.

Allowing prisoners who feel particularly vulnerable to have their cell doors open or be able to talk to another prisoner, subject to sufficient staff on the unit, during non-association times.

Assistance to to the man once he had been discovered was swift. The prison doctor and the staff nurse's resuscitation efforts were commendable.