

**Investigation into the death of
a man at HMP Wandsworth in
February 2005**

**Prisons and Probation Ombudsman for England and Wales
September 2005**

This is the report of an investigation into the circumstances surrounding the death of a man at HM Prison Wandsworth in February 2005. The man was found dead in his cell at 11.55 am that day.

A post mortem examination was performed in hospital on 15 February and it was found that there were no signs of restraint or injury. The ligature marks found on his neck were consistent with hanging.

I offer my sincere condolences to the family of the man who have suffered the tragic loss of a loved one. Prisoners and staff at Wandsworth who knew the man expressed their sense of shock and sadness at his death.

The investigation was carried out on my behalf by my investigators. The local Primary Care Trust were invited to undertake a review of the clinical care the man received. However, they declined as they had no direct commissioning responsibility at that time. My Deputy Ombudsman who is BSc RGN qualified has reviewed the medical record and found nothing of note.

My thanks also go to the Governor and all Wandsworth staff. I appreciate their willing cooperation which has enabled the investigation to be thorough, and to be completed in a timely fashion.

I make four recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman
September 2005

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Summary

This is the report of an investigation by the Prisons and Probation Ombudsman into the tragic death on 14 February 2005 at Wandsworth Prison of the man who was in prison serving a sentence under a different name.

The investigators reviewed the man's records and spoke to a number of staff and prisoners.

The man had been in custody since 20 January and at Wandsworth prison since 21 January. He was not considered to have been a suicide risk at any time during this period. He was found hanging from the window of his cell at approximately 11.55 am on 14 February by his cellmate. The prison staff who gave immediate help, and paramedic staff later called to the scene, were unable to revive him and he was pronounced dead at 12.40 pm.

This report reviews the care that the man received while in prison custody and the events leading to his death.

A letter written by the man gave an insight into the man's situation at that time and his state of mind prior to his death.

On 23 December 2003, the man entered the United Kingdom illegally using a false identity. It is understood that he had used a number of aliases of which the name he used in prison was one. The name he used in prison was the one that he used to gain employment in this country.

On the morning of 13 February 2005, after a number of attempts made while at Wandsworth, the man finally made contact by telephone with his girlfriend who knew him by the name he was using in prison. He had made it clear in earlier correspondence that he wanted to marry her, and two telephone calls to her included attempts by the man to try to persuade her to do so. He also spoke with someone in Ghana. This conversation included a discussion of arrangements to be made to accommodate his return there at the end of his sentence.

The report describes in detail the actions taken by staff following the man being found hanging. I note that the duty doctor was delayed in attending the scene. I also comment on the fact that there was no hot debrief following the incident. We have also investigated an allegation that a C wing cell call alarm was ignored on the morning of the incident, and that a spoof notice was put up on the wing about a memorial service for the man. No evidence was found during the investigation to substantiate these allegations.

The man's next of kin is his cousin. It is understood that he reported that both his parents were deceased. It is possible to route communications to his other family members in Ghana through his cousin. The prison has been in contact with her and

funeral arrangements were made. A memorial service for Vincent was held at Wandsworth prison on 18 February.

I conclude that, on the basis of the evidence I have seen, the man's death could not have been predicted or prevented.

Wandsworth Prison

7. Wandsworth Prison was built in 1851 and has been extensively refurbished in recent years to include integral sanitation for prisoners. It houses a large number of drug users and prisoners with mental health problems. It is leaving behind an image of being a jail where staff despite a somewhat forbidding reputation have little interaction with prisoners. This death and a similar incident four days earlier were the first in over a year and came as a huge disappointment to the Governor and his staff. A subsequent safer custody audit resulted in a score of 85%.
8. The prison was last visited by the HM Inspectorate of Prisons approximately nine months ago and it was noted that there was a continuing shortfall in staff numbers. The Chief Inspector also recorded her "serious concern" that Wandsworth was not meeting the standards required of a healthy prison.
9. Wandsworth has a CNA of 1,173 was with an operational capacity of 1,462. It is understood that the prison always functions at or near this figure which is the maximum population level.
10. Wandsworth is one of the first prisons to be using the new ACCT system for caring for those prisoners thought to at risk of suicide. Information received from senior managers at Wandsworth indicate that only 63 staff had suicide prevention or awareness training and eight staff were trained in ACCT awareness from December 2004 to February 2005 and 15 to March 2005. There have been 11 case managers and a similar number of ACCT assessors trained since the system was introduced.
11. There is currently an extensive building programme underway to provide in cell electricity to the cellular accommodation, thus enabling prisoners to have access to televisions and mains operated radios. I commend this project as a positive step to improving the environment.

Investigation

12. The investigation was opened on 18 February 2005 when my investigators met with the Governor and the head of safer custody at Wandsworth. They were given a comprehensive and helpful briefing on the events leading up to and after the man's death. Ombudsman's notices were issued to staff and prisoners, identifying the scope of the investigation and inviting anyone who wished to see the investigators to make themselves known. Staff and prisoners in key positions or locations were identified and were invited for interview. All responded willingly and fully. The local branch of the Prison Officers' Association was briefed. They were helpful and offered constructive comment and advice.
13. Local police were contacted and provided all the information at their disposal, as did the coroner's officer.
14. A member of the Independent Monitoring Board was interviewed, as was one other member of the Board.
15. The investigator requested an independent clinical review from the local PCT. However, the PCT declined to undertake this as they had no direct commissioning responsibility at that time.
16. My investigator, together with one of my family liaison officers, met with the man's cousin, at her home. They were made to feel welcome and the man's cousin was able to add to their knowledge and understanding of the events leading to the man's death.

Prison history

Number	Prison Number	Name
DOB	26 April 1972	
Sentence	six months imprisonment / detention order	
Release date	20 April 2005	
Sentenced	21 January 2005	
At	South Western Magistrates Court	
Offence 1	deception	
Offence 2	illegal immigration	

17. The man was received into Wandsworth on 21 January and underwent the First Night process that is designed to assess new prisoners, needs. He was seen while in reception by staff who established that, among a number of other things, he was fluent in English and that he had not been identified as being at risk of self harm. He was also seen by the chaplain who gave his name to the foreign national orderly and Listener. The Listener spoke to the man and they immediately realised that they were fellow Ghanaians and therefore had much in common. They discussed the man's situation and the Listener offered himself as a friend and as counsel. Later, after he had been put onto C wing, the man asked to see him in his capacity as a Listener. This was at about 9.50 pm and the conversation lasted until approximately 10.30 pm. This was the only time that the man asked for a Listener during his time at Wandsworth and his motive for doing so on this occasion may have been to speak again to a man with whom he had formed a rapport, rather than to express thoughts of self harm. As he had seen him in his capacity as a Listener could not reveal the content of the discussion that night. But after the man's death he expressed his surprise that the man may have taken his own life as he was not aware that he had had any intentions of self harm.
18. After his cell sharing risk assessment was completed, the man was allocated to shared double accommodation cell number 30 on the fourth level on C wing. He was well behaved and had no disciplinary issues at Wandsworth. He had a polite manner and he made friends with other African prisoners on the wing. He seemed to settle in over the following week, being described as "a gentleman" by a fellow prisoner. He saw Listener every day and when they spoke it was as friends not as Listener to client. In these conversations, the man revealed that he had a sense of anger and betrayal about the circumstances that had led to his situation. He had said to a cell mate on 8 or 9 February that he had a good job and a girlfriend in London and that he did not really wish to go back to Ghana. But to others he appeared to be reconciled to returning home at the end of his sentence. On 10 February, he requested a phone card so that he could call someone in Ghana to make arrangements for his return.

19. The man had three cell mates in C4/30 all of whom found him to be a quiet man. One noted that he sometimes cried at night. One of his cellmates mentioned that he had spoken of his girlfriend.
20. The man corresponded with his girlfriend and it is clear from the content that he had a very strong wish to marry her. He attempted to phone her quite often but experienced difficulties in getting a reply.
21. His girlfriend did not express a clear wish to marry the man and this appears to have played on the man's mind. The last letter that he sent to her included expressions of how at times he felt despairing. He mentioned the prison conditions he was experiencing that he associated with suicidal feelings
22. Although three visiting orders were issued to him during his time at Wandsworth, the man did not send them out and therefore did not receive any visits. He spoke on the telephone to his girlfriend about the possibility of a visit from her but no arrangement was made.
23. During this time, the man gave no indication to anyone other than his girlfriend of the feelings expressed in his letters.
24. At Wandsworth, prisoners choose in advance from a menu for their evening meals, and on 12 February the man completed an order form for sandwiches for the following ten days. His cell mate at that time, found him to be quiet and said that he sat on the bed not saying much. The man did however mention his girlfriend and said that he loved her.
25. On 13 February at 11.01 am, The man made a telephone call to Ghana. It is understood that it included discussion of arrangements for his return to Ghana. After the call the man mentioned to another prisoner, that there were financial difficulties in this regard but that he would be alright. At 11.30 am the same morning, the man called his girlfriend. He spoke of marriage to her and, while she did not appear to flatly turn him down at any point, the impression given was that they should not do anything soon and that they should talk about it when he was released. Another call at 11.48 am had the same result. The man was seen replacing the telephone receiver in an angry fashion after one of these calls. It is not known which one but a reasonable conclusion is that it was at the end of one of the calls to his girlfriend.
26. At around 12.15 pm, the man spoke to an officer. The officer explained that he had little time at that moment as he was engaged in lunchtime duty but would be happy to speak to him another time. The man seemed happy with this, was smiling and said that he "...will be looking forward to speak with you."

27. At approximately 6.30 pm, another prisoner, who was responsible for bringing hot water to each cell on the fourth landing on the wing. He went to cell 30 and saw the man whom he thought seemed fine.
28. At the 7.30 am roll check on 14 February nothing unusual was noticed in cell 30. Hot water was taken to the cell at approximately 7.45 am. This requires the door flap to be opened. Again nothing unusual was noticed.
29. At approximately 9.00 am the man's cell mate, was taken from the cell so that he could attend a number of appointments relating to his induction into Wandsworth. This left the man alone in the locked cell.
30. At approximately 11.00 am, an officer opened the cell door for the wing social and domestic session. He saw the man who was either sitting or lying on his bed. They did not speak but the officer saw nothing unusual in the cell and nothing to cause him to discontinue unlocking the rest of the prisoners on the landing.

Discovery of the death

31. At approximately 11.55 am on 14 February, the man's cell mate returned to cell 30. He had completed the programme of appointments that he had for that morning and was waiting for the cell to be opened. He looked through the spy hole and saw the man's legs protruding from the gap between the head of the bunk bed and the window. He alerted an officer who looked through the spy hole and shouted to another officer to blow his whistle. The officer became aware that an incident requiring the emergency cut down equipment might be needed and ran to get it from the wing office. The officer unlocked the door and observed the apparently lifeless body of the man hanging by the neck from the top bunk. When the officer opened the cell door and upon entry he took a prison issue plastic cutlery knife that happened to be to hand and cut through the strip of bed sheet hem from which the noose had been made. Assisted by two other officers who had responded to the whistle, he lowered the man to the floor of the cell. The officer cut the ligature from the man's neck with the same plastic knife, and he checked the man for a pulse. He also tried to ascertain if he was breathing but these vital signs were not detected. Cardio pulmonary resuscitation was begun by the SO and the officer who had unlocked the door.
32. The alarm was raised by the prison control room calling for a nurse to attend C wing and for an ambulance at 12.03 pm. Attempts were also made to contact the duty prison doctor but this was not possible. The prison control room confirmed that there would be a doctor in the ambulance that had been despatched by the emergency service as well as paramedic nurses.
33. Using the face mask from the cut down kit, the SO was giving mouth to mouth resuscitation to the man while the officer who had opened the cell door was maintaining chest compressions. Prison Nurse arrived at the cell at approximately 12.10 pm and with the help of another Prison Nurse deployed the oxygen equipment that she had brought with her. The man showed no signs of life throughout the resuscitation attempts and there was some frustration on the part of the staff attending to the man that the prison doctor had not yet arrived.
34. CPR continued and at approximately 12.15 pm the paramedic team including the doctor arrived and took over the care of the man. Attempts continued to be made to revive the man for a further 20 minutes before it became apparent that they were not going to be successful and a collective decision was made to cease attempts. Death was subsequently pronounced by the doctor at 12.36 pm.

Examination of the issues

35. The man arrived at Wandsworth prison and went through the normal procedures for new receptions. The chaplain saw him and was able to introduce him to another prisoner, who was able to help the man settle in. The man was made aware of the support available to prisoners who may feel suicidal, and took advantage of the opportunity to speak to a Listener after lock up on his first night. He did not do this again after that and it is possible that he did so on this occasion because the duty Listener was the prisoner who had helped him to settle in and with whom he had struck up a friendship. Certainly, the Listener was as surprised as everyone else at the news of the man's death.
36. The prisoner was a quiet man and gave no indication to prisoners or prison staff of the inner turmoil that was reflected in correspondence with his girlfriend. All who had known him were shocked by his death and found it difficult to believe that he would take his own life.
37. The elements in his behaviour that might have triggered the initiation of ACCT procedures were not obvious as he seems to have ensured that those around him in prison did not realise how he felt. He came across as someone who was not too happy about his return to Ghana at the end of his sentence, but was reconciled to it and was making arrangements for his return. On Sunday 13 February he spoke with prisoners and staff but gave no clue to any other feelings. He seemed relaxed and cheerful on that day.
38. It appears that the man was desperate to marry his girlfriend and expressed despair over his perception that she would not agree to it. His language in letters and phone calls is that of love and it seems that marriage to his girlfriend meant a lot to him at that time. In his letter to her of 8 February he writes at length about St Valentines Day and the date 14 February seems to have been significant to him. He also writes that he wants forgiveness from her for an event that day and that he could not "...stand that day where I am."
39. What is also clear from the correspondence with his girlfriend is that the man felt oppressed by the long periods that he was locked in his cell with nothing to do. He describes it as "hell" and then writes of ending his life.
40. On inspecting the man's cell, which had been preserved in its post incident state, it was noted by the investigator that on top of a fairly large pile of papers and other items on the table in the man's was a letter from his solicitor dated 21 January 2005. It advises the man that he has no realistic avenue of appeal against conviction.

41. On the morning of 14 February, his cell mate left the cell and the man was alone for the rest of the morning. The Ombudsman's office has received allegations that a cell bell rang in C wing office unanswered by staff that morning. It was also said that a spoof notice was put up by persons unknown on the wing notice board about a memorial service for the man. My investigator could find no evidence to support the first allegation, although it was noted that the system in use did not have a mechanism for recording when a cell alarm was activated.
42. It was correct that a notice was put up by the Governor to publicise the memorial service that was held in the prison chapel on 18 February. There was nothing amusing about the notice that was seen by my investigator. We have uncovered no evidence of a different notice.
43. The man's cell door was opened at about 11.00 am but when the incident was discovered it was locked. It should not have been possible for him to have closed his door himself as the procedure for this type of unlock requires the officer to leave the locking bolt in lock position on the open door. This is known as 'shooting the bolt' and one officer believes that he would definitely have done this. My investigator could not identify anyone who locked the door, but if it had been open it is possible that a number of staff of various disciplines and duties could have done so at the man's request. This is normal procedure. If a prisoner does not want to come out of his cell during an association period, he can request his door be closed by a member of staff.
44. It is also practice at Wandsworth to lock any empty cell to prevent theft, and a passing prison officer might do this as a matter of course. If it was not obvious that the cell was occupied then this too could have happened.
45. On discovering the man hanging from the bunk bed, the staff response was prompt and professional, providing care to the man very soon after the alarm was raised. It was soon clear as the staff worked to revive the man that it was probably too late to save him. Nevertheless, they continued to make the utmost effort.
46. Although there is a system of daytime attendance for the duty doctor, he was not available and therefore not able to assess the situation, manage or direct the team's first aid efforts. The duty doctor was contacted, but it is understood that he was not in the prison as by then as he was having a meal break and unavailable. His colleague who was in the establishment was not immediately contacted, but when attempts were made to do so they failed because his mobile phone was engaged. It is understood that the only method of contacting the duty prison doctor is by mobile phone, and that there are no formal arrangements for the doctor's meal breaks.

47. As the incident progressed some staff became quite upset that the doctor was not there. It was expressed afterwards that staff felt unsupported in this difficult situation. The officer who had found the man was particularly badly affected and took sick leave as a direct result of his experience.
48. Following the incident, some staff were seen by senior managers and the staff care team but no immediate post incident debrief was arranged. This was a lost opportunity to go through events while all the participants were available and the experience fresh in their minds. A debrief that took place some days later was able to find critical points for discussion. The later session allows a more considered view of events that have been established earlier, but can be less effective in identifying all the issues. It is understood that there is currently an on-going review of the critical incident debrief process, in order to establish best practice.
49. There was a delay in contacting the next of kin. This was due to difficulties concerning the man's aliases and police advice that the matter would take a little time to resolve. Once established it is understood that relations with the family on the part of the prison were good. A senior manager was tasked with ensuring that all possible assistance was offered.

Conclusions

50. The man was found guilty an offence that meant that he would be deported to his home country at the end of his sentence. It appears that he was not keen to return to Ghana, but when the issue arose in discussion with others he gave the impression that he was reconciled to doing so.
51. The man expressed a very strong desire to marry his girlfriend, the woman he had met at the hospital, and seemed to spend a lot of time thinking about her. She did not seem so keen to marry, neither was she aware of the man's true identity or situation. She had agreed to talk about his proposals of marriage upon his release from prison not realising, as he did, that they would not have the opportunity. The man would have been removed to Ghana.
52. The man was apparently emotional and increasingly despairing about his predicament. But this was not noticed by his fellow prisoners or staff, to whom he presented as a quiet man who had problems but who was dealing with them.
53. The man's letters to his partner demonstrate that he was low in mood and despairing of the situation he found himself in. He wrote, "It really is hell in here. The doors are banged almost 24 hours a day. No communication to the world whatsoever". In a later letter he wrote to his girlfriend, he wrote "I am more lonely. And I will be more lonely, I am in a small room where I live alone. And all that is my friends are table and chair, my bed and your letters". There was no in cell electricity in the man's cell, and he therefore had no access to a television or mains radio to help keep his mind away from his apparently depressing thoughts. It is clear that marriage to his girlfriend was very important to him and it was apparent that this was not going to happen before he was deported. This knowledge also seems to have affected the man's state of mind and he repeatedly refers to "killing himself" in his letters.
54. Valentine's Day features in the last letter that the man wrote to his girlfriend on 8 February in which what seems to be the depth of his feelings is expressed. It would appear the man had placed great significance on 14 February.
55. Despite a system of medical cover being in place for the day time period, the duty doctor did not arrive at the scene until the medical care had passed to the emergency doctor, who arrived as part of the paramedic team. While it must be stressed that the final outcome would not have been altered, the staff attending to the man, who continued with the CPR, would have had the additional clinical support and advice from the duty medical officer. The lack of which was clearly a frustration to them at the time.
56. In the aftermath of the incident the staff care team was alerted, but no immediate or "hot" debrief was arranged. This was a pity because it is an opportunity for all those involved to contribute to the post incident review and learning process.

57. The lack of occupation of prisoners at Wandsworth is an issue of general concern that may have impacted in this case. It is understood that in cell electricity is being installed throughout the prison thus enabling prisoners to have televisions and radios during the long hours of “bang up”.
58. The training figures for ACCT are low, as are the numbers trained in the related areas of suicide prevention and awareness. This will not assist in ensuring that staff awareness of potential suicidal prisoners is kept high. Neither will it contribute to the correct operation of ACCT.
59. The prison roll has been at or near Operational Capacity in recent times and is predicted to remain at this level for the foreseeable future (this is apart from temporary reductions in numbers related to refurbishment programmes). It is understood that the staff resources are used at the maximum to enable the prison to operate safely and efficiently.

Clinical Review

The man was in good health and had had no ongoing contact with the health care services at Wandsworth.

The PCT was requested to provide a clinical review but has stated that they are not responsible as the incident occurred before the transfer of commissioning responsibility on 1 April 2005.

The man was seen on reception by a healthcare worker and it was noted that he had no physical or mental health issues. The man did not use drugs or alcohol and was a non-smoker.

The next documented entry in the medical record is when healthcare staff attended the scene of the incident on 14 February 2005.

The use of the risk assessment for in-possession medication is seen as good practice and should be disseminated throughout prison healthcare centres.

Recommendations

That the duty doctor system be amended to ensure that if on site cover is to be provided then a doctor attends any medical emergency. Additionally the doctors should be issued with pagers or some other dedicated means of alert to ensure they can be summoned in the case of an emergency.

That management guidelines be issued reminding those responsible during and after operational emergencies of the importance of a hot debrief of all those involved.

Good practice

The use of the in-possession medication risk assessment is identified as an example of good practice for the care and management of prisoners and their prescribed medication.

Glossary of terms

ACCT	Self harm management system
CNA	Certified Normal Accommodation for prisoners
CPR	Cardio Pulmonary (heart and lung) resuscitation
F2050	Prisoner's main record
Fish knife	Ligature cutting tool
Governor	Senior manager graded A-F
IMB	Independent monitoring board
IMR	Prisoner's medical record
LIDS	Computer database of prisoner's details
Listener	Prisoner trained by Samaritans to support prisoners at risk of self harm
Operational Capacity	Maximum number of prisoners that can be accommodated
Oscar 1	Orderly Officer
POA	Prison Officers' Association
PO	Principal Officer
SO	Senior Officer
SAD	Social and Domestic session for prisoners
Standards Audit	Prison Service performance audit system

