

**Investigation into the circumstances surrounding the
death of a man shortly after leaving
HMP Wandsworth on 11 August 2006**

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

July 2007

This is the report of an investigation into the death of a man on Friday 11 August 2006. The man, a Czech national, was found on the trackside near Clapham Junction railway station, some 30 minutes after he had been released from HMP Wandsworth. He had been arrested on the Monday of that week but released hurriedly after the charge against him was discontinued by the Crown Prosecution Service.

The investigation was conducted by one of my investigators. I would like to extend my thanks to the Governor and his staff at Wandsworth for their help and co-operation during this investigation.

A clinical review of the medical care that the man received was carried out by the Wandsworth Primary Care Trust.

The circumstances surrounding the man's death were unusual. Nevertheless, my investigation identified a number of areas where performance could be improved and I make five recommendations. I also identify one example of very good practice.

This version of the report has been amended to remove the name of the man who died and those of the staff and prisoners involved in my investigation.

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Prisons and Probation Ombudsman

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SUMMARY

The subject of this report, a national of the Czech Republic, came to the United Kingdom at the end of July 2006 to work as a tour guide. After spending a short time in the Cambridge area, he came to London.

On 7 August 2006, he was arrested in the City of London on suspicion of burglary after trying to gain entry to an apartment building. The man was charged with the offence and remanded into custody by the City of London Magistrates' Court.

During the reception process at HMP Wandsworth on 8 August, the man told a nurse that he had not been treated for any mental illness, nor been prescribed any anti-psychotic medication. It was later discovered that he had twice been in hospital in his home city during the previous year, suffering from schizophrenia.

When the man's cell door was opened on 9 August, he ran past an officer and along the landing. He was restrained and returned to his cell. Later that afternoon, two nurses from the prison in-reach team assessed the man in his cell. They judged that he was psychotic but not at risk from self harm. The prison doctor prescribed zopiclone to calm him down.

A short while later, the man was transferred to the Care and Separation Unit (CSU) because of his previous disruptive behaviour. During a routine visit to the CSU the following morning, a member of the Independent Monitoring Board (IMB) noticed that the man had cuts to his arm and neck. A nurse was called and his wounds were dressed. An ACCT document (Assessment, Care in Custody and Teamwork) was opened and arrangements were made for the man to be assessed again by the in-reach team.

The following day (11 August), he was seen by a psychiatric nurse who decided not to complete his assessment until his medical records were obtained from his doctor. However, that afternoon the Crown Prosecution Service sent a fax to the prison saying that the case against the man had been discontinued. Consequently, he was to be released immediately.

The man was released at 6.00pm. Staff did not have access to the property store at that time of the day and he left the prison without his valuable items, including his passport.

By 6.30 pm, the man had jumped from a railway bridge about a quarter of a mile from the prison. He died as a result.

THE INVESTIGATION PROCESS

1. I am most grateful to the Governor of Wandsworth, who notified me personally of the man's death by telephone. The man was no longer a prisoner when he died but, given the circumstances, I exercised the discretionary power under my Terms of Reference to open a post-release investigation.
2. The investigation was undertaken by one of my investigators. The Governor and his staff provided the man's medical record and other documentation for examination. Notices were distributed around the establishment notifying staff and prisoners of the investigation, and a number of prison staff were interviewed.
3. My investigator arranged a meeting with the police detectives who investigated the attempted burglary charge against the man to ascertain the circumstances of the arrest and charging decision.
4. One of my Family liaison Officers (FLO) contacted the man's brother to inform him of my investigation. Later, my FLO and investigator travelled to the Czech Republic to meet with the man's brother and father. They were able to explain the purpose of my investigation and to answer some questions the family had. They also noted further questions the family wanted answered.
5. The Wandsworth Primary Care Trust (PCT) was notified of the man's death and asked to carry out a clinical review into the medical care that he had received whilst in custody. The PCT kindly agreed despite the death occurring after release. The subsequent report concluded that the man's condition was being actively managed and the reporting doctor could find no fault with the way his care was handled. He made one recommendation, similar to my fifth, regarding continuity of care for discharged prisoners.

HMP WANDSWORTH

6. HMP Wandsworth is a category B local prison for adult male prisoners and the largest prison in the United Kingdom. It has a Certified Normal Accommodation of 1,173, with an Operational Capacity (maximum crowded capacity) of 1,416. The prison always functions at or near the Operational Capacity figure. Prisoners work on their living unit or in the laundry. There are also education classes available.
7. Commissioning responsibility for the delivery of healthcare in Wandsworth transferred to the local Primary Care Trust (PCT) on 1 April 2005. A full time doctor is available each weekday. Medical cover is provided during the weekends and evenings by two PCT GPs. Appointments to see a doctor are triggered by wing application.
8. Prisoners' mental health problems are initially assessed by healthcare staff, who may then refer patients to the in-reach team. Arrangements can then be made for the prisoner to be seen by a psychiatrist and there are beds in the Addison Unit, a section of the prison's healthcare centre specially designated for the care of people with mental disorders.
9. Her Majesty's Chief Inspector of Prisons (HMCIP) recently published a report of a follow-up inspection of HMP Wandsworth in July 2006. The Chief Inspector noted that Wandsworth was an improving prison. However, she reiterated a number of recommendations made in her initial inspection report which had not been fully achieved. Recommendations on ACCT training, completion of the ACCT documentation, and better communication between healthcare staff, are especially significant in this case.
10. ACCT (Assessment, Care in Custody and Teamwork) is a system for supporting and monitoring prisoners thought to be at risk of self harm or suicide. ACCT is the replacement for the former F2052SH system and is designed to be more flexible. The intention is to encourage staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis, or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their anxiety.
11. There have been five apparently self-inflicted deaths at Wandsworth, and three from natural causes, since I was given the responsibility for investigating all deaths in prisons in April 2004. I have previously made recommendations relating to the lack of a 24 hour ACCT review and the lateness of another.

KEY FINDINGS

12. During 2005, the man who is the subject of this report spent two periods in hospital in the Czech Republic. He was diagnosed as suffering from schizophrenia. According to his brother, he responded well to treatment.
13. In June or July 2006, the man went to Austria to work for a tour guide company. He was there for ten days before returning home. At the end of July 2006, he came to the United Kingdom to work as a tour guide for three weeks. He had not previously visited this country.
14. When his brother telephoned him a few days later, the man said that he was in Cambridge and that he had been robbed. His brother said he sounded scared and told him he was being followed. His brother now believes that the man may have had a schizophrenic episode around that time, and that the alleged robbery may not have actually happened. (My investigator has made enquiries with the Cambridge Police and they have no record of the man reporting a crime.)
15. After another few days, the man rang his brother to say that he was spending the night with another tour guide. The family had no further contact.
16. At 00.20 am on Monday 7 August 2006, the man went into the reception area of a private apartment building in the City of London. He asked the security guard for somewhere to stay. Unsurprisingly, the man was asked to leave. He was then seen to climb a drainpipe and throw his jacket over the CCTV camera. Police were called and the man was arrested on suspicion of attempted burglary.
17. During the early hours of the morning, the man asked for the Czech Embassy to be notified, and he spoke with embassy staff at 9.20 am. At 11.57 am, he was seen by the police doctor who then informed the Custody Officer that the man would need an appropriate adult present as he was schizophrenic. (An appropriate adult is a responsible person over the age of 18 who safeguards the rights and welfare of young people and vulnerable adults in custody.)
18. The man was interviewed by the police in the presence of his legal representative, an interpreter and an appropriate adult. On the advice of his legal representative, he made no comment to a number of questions. Subsequently, he was charged. Police bail (release pending a court appearance) was refused on the grounds that he had no fixed address and was likely to abscond and commit further offences.
19. Just after midnight on Tuesday 8 August, the man asked the police custody officer for a knife. When asked why, he said, 'I want to cut myself. It would be best for everybody.' The man was kept under constant CCTV watch and on 30 minute checks.
20. The man appeared at the City of London Magistrates' Court later that morning. His Prisoner Escort Risk form had ticks in the 'no known risk'

medical section, 'no known risk' in the security section and a tick in the suicide/self harm box, although the form provided no further information on that perceived risk.

21. The man was remanded into custody and sent to HMP Wandsworth. During the prison's reception process, a First Reception Health Screen was completed. He told the nurse that he had not had any treatment for mental illness, nor received any antidepressant or antipsychotic medication. He told the nurse that he was fit and well, although he said he had previously self harmed by cutting his arms. He denied any current thoughts of suicide or self harm.
22. At about 1.00 pm on Wednesday 9 August, the man pressed his cell call bell. An officer answered the call. He was unable to hear what the man was saying so he opened the cell door. The man ran straight past the officer, along the landing and down the stairs. The officer blew his whistle and the man was stopped by a number of officers. He did not offer any violence but continued to try to pass by. He was returned to his cell under restraint.
23. A wing officer contacted the healthcare centre that afternoon and asked for the man to be seen as a matter of urgency. Two Registered Mental Health Nurses saw him in his cell at about 4.30 pm. The cell was in disarray. The man's bed was on end and there was water on the floor. There was also a set of drawers and a chair up against the window. The nurses noticed that the man had small superficial scratches on his arm which he said had occurred from moving the furniture. After about ten minutes, the nurses decided that the man was psychotic and was not in touch with reality. However, they did not believe that he was at risk from self harm at that time.
24. The man's medical record was not updated with the result of the two nurses' assessment. One of the nurses completed an in-reach referral form as the result of the telephone call from the wing officer. That form would eventually be attached to the medical record.
25. The nurse returned to the healthcare centre and spoke with the doctor. As a result, the man was prescribed zopiclone to calm him down and help him sleep.
26. At about 5.00 pm, as the result of his earlier behaviour on the wing, the man was transferred to the Care and Separation Unit (CSU). He was taken there in handcuffs for his own protection and to avoid any further disruption. A healthcare nurse was called to complete the initial segregation safety algorithm. (The algorithm is a flow chart completed by a nurse or doctor designed to ascertain any health reasons why the prisoner should not be segregated.) The nurse read the information in the man's medical record and saw him in his cell. She said during interview with my investigator that she was not aware that he had been seen by the in-reach team that afternoon (information that had not been entered in the medical record). She based her decisions on what was written on the reception health screen form from the previous day, and from her own impression of how he presented. She

decided that there were no healthcare reasons that meant he should not be segregated.

27. During the night of 9/10 August, the man broke up a cupboard in his cell. When the morning shift staff came on duty, he declined to take hot water and attempted to get out of his cell when the door was opened. He was moved back into the cell and the door was re-locked. At 9.50 am on Thursday 10 August, when his cell was unlocked again for him to see the doctor, the man struggled with staff and tried to get past them. The staff managed to hold him but, as he continued to struggle, he was fully restrained. He was placed onto the floor of his cell and the officers performed a full cell extraction (a way for the officers to leave the cell safely whilst keeping the prisoner safe and restrained).
28. One of the prison doctors was present during the restraint and afterwards wrote his assessment in the medical record. He wrote that the man appeared low in mood and that he had felt depressed for a few days before coming to Wandsworth. The doctor found no evidence of thought disorder or paranoid delusions. He noted that the man had had fleeting suicidal thoughts in the past, but not at that time. The doctor ended his entry by saying that the man needed a full assessment.
29. There is an administration officer at Wandsworth who is Slovakian by origin and thought that she would be able to converse with the man. She obtained permission to see him and arrived in the CSU while he was being restrained. She found it difficult to communicate with the man, but managed to find out that he had been on medication in the Czech Republic for schizophrenia.
30. At about 12.10 pm, a member of the Independent Monitoring Board (IMB) was visiting the CSU. When she looked into the man's cell, she saw that he had made cuts to his left wrist and the left side of his neck. A nurse was called and treated the cuts on the man's wrist by applying steri-strips, and cleaned the cuts on his neck with antiseptic. It was thought that he had used a screw to cut himself, retained from his broken cupboard. An ACCT document was opened.
31. The IMB member said during interview that the man's bedding was piled on his bed and was soaking wet. As there was no water on the floor of the cell, she wondered whether he had brought the wet bedding with him from his wing cell. When the wet bedding was noticed it was replaced with clean and dry items. My investigator spoke with the senior officer (SO) from the CSU. He said that, as the man had been relocated there under restraint, he would not have brought anything with him. He added that prisoners who bring bedding with them are always given fresh bedding upon arrival at the CSU.
32. The SO set out the immediate action plan for the man's care. It was decided that he should be seen as soon as possible by the in-reach team, be observed hourly, and have access to both a telephone and/or a Listener when requested. (A Listener is a prisoner who has volunteered to be trained by the

Samaritans to perform a similar role in prison as the Samaritans do in the community.)

33. Two important parts of the ACCT plan are the assessment interview and the first case review, both of which should be completed within 24 hours of the concern being raised. However, apart from the routine observations being noted in the daily record section and the immediate action plan, nothing else was completed in the man's plan.
34. The prison responded to my draft report by saying, *'The man's ACCT was opened on the 10th of August and he was released on the 11th - by the strict letter of the ACCT procedure, we exceeded this time by 2 hours. If the investigator had interviewed the Senior Officer in charge of getting this review done, he would have heard that the reason why this 2 hour delay had occurred was because he felt it was necessary to wait for an appropriate, professional interpreter rather than rely on the slovakian speaking administrator. Before this could be arranged, the man had received orders to be discharged.* I would have expected a written note on the ACCT to explain the reasons for delaying the review which would have been due by 12.15 pm on Friday. Also Language Line (a translation service via telephone) is available 24 hours a day.
35. An official at the Embassy of the Czech Republic sent a fax to the prison at 2.48 pm, informing staff that the man had a mental disorder, information obtained from the man's father. His solicitor also faxed the prison with the information that the man suffered from schizophrenia.
36. The remainder of the day passed without incident. At 6.20 am on Friday 11 August, the night officer heard a noise from the man's cell. He found him lying on the floor. The man said he had fallen over and hit the toilet, but that he was not injured. The officer saw that the toilet seat was broken.
37. At 9.30 am, the man again tried to get past staff when his cell door was opened for an IMB visit.
38. A governor attended the CSU with the intention of conducting an adjudication (disciplinary hearing) following the man's actions on the wing. However, at 10.00 am, a wing officer saw the man in his cell and thought he could see fresh cuts. Concerned that the man might have something either on him or in his cell with which to harm himself, the governor ordered a full search of both the cell and the man's person. Nothing was found. The governor decided to postpone the adjudication as he felt that, given the man's current behaviour and state of mind, he would be unable to present a defence.
39. The man was seen at 10.30 am by an in-reach nurse. The nurse recorded that the man's relatives were coming to visit at the weekend and would be bringing his Czech medical records. The man signed a consent form for his medical information to be released by his doctor. That was faxed to the Czech Embassy to be forwarded to the relevant doctor.

40. It was decided that the psychiatric assessment would be concluded after the medical information was received from the man's doctor. In the meantime, the decision was made to continue him on the zopiclone and for the man to be transferred to the Addison psychiatric unit as soon as a bed became available. (The Addison Unit is the mental health facility within the prison.)
41. The administrator's number had been passed on by the Czech Embassy and she had two messages from the man's brother waiting for her that afternoon. When she returned the calls, he told her that he was arriving in the UK on Sunday and had arranged to visit the man that afternoon and on the Monday. The administrator said that she would arrange a double visit for Monday. She gave the man's brother details of local hotels and directions to get to the prison. He asked for and was given her personal mobile phone number.
42. At 3.31 pm on Friday 11 August, the Crown Prosecution Service sent a fax to the prison stating that the charge against the man had been discontinued and he was to be released. It has not been possible to ascertain exactly when that fax was brought to the attention of relevant staff. Once the staff were aware of the fax, they had to make a number of checks and enquiries to verify that the man could indeed be released from custody.
43. He was informed that he was to be released and was taken to the reception area to be processed. It was then shortly after 5.00 pm. Prisoners' valuables are kept safe and secure in the Administration Office. However, the office had closed for the day by the time the man was taken to reception, and this meant that reception staff were unable to give him his mobile phone, visa card, driving licence, two SIM cards, his identity card and his passport. It was explained that he would have to return to the prison on Monday to collect his property.
44. The duty governor shared the concerns of other staff about releasing the man into the community. He tried to contact the in-reach team, but they had also finished work for the day. The duty governor sat down with the man and tried to explain what was happening. The man just said, 'I need to get out.'
45. Once the release paperwork was completed, the man was given £1.50 for travel expenses and released at 6.00 pm.
46. At 6.30 pm, he was seen to climb onto the parapet of a railway bridge about a quarter of a mile from the prison and close to Clapham Junction. He jumped from the bridge and died on the electrified rail line. The man was 28 years old. His body was not readily identified as he had no documentation on him.
47. The man's brother arrived at the prison on Sunday 13 August to visit him. At that time, the prison was not aware that the man had died and simply told his brother that he was not there. He did not understand and eventually telephoned the administrator. Initially, she was also confused as the man had still been in custody when she left the prison on Friday evening. However, she went to the prison to meet the man's brother and tried to find out where his missing brother was.

48. The man's body was identified by his brother on Tuesday 15 August 2006.

ISSUES

49. Following his arrest, the man had been identified at the police station as having schizophrenia. That information was not passed on to the Prison Service via the PER form, as it should have been.
50. The man did not tell the reception nurse about his schizophrenia when he came into Wandsworth prison. Moreover, when he was seen by the prison's in-reach team late in the afternoon on Wednesday 9 August, no proper record of that assessment was placed in his medical record. Consequently, when the nurse checked the medical record prior to completing the segregation safety algorithm, she did not know that there were concerns about his mental health. When the ACCT document was opened around midday on 10 August, as part of the immediate action plan the CSU SO wrote that the man was to be seen by the in-reach team as soon as possible. He was not aware of their involvement prior to the man's transfer to the CSU.
51. A nurse from the in-reach team saw the man on the morning of 11 August. He had not been told that an ACCT had been opened the previous day, although during his interview he said he assumed one had been after he noticed the evidence of self harm.
52. This was all evidence of poor communication both within the healthcare team and between them and discipline staff.

The Governor and the Healthcare Manager should remind staff of the importance of making proper records of interactions with prisoners.

The Governor and the Healthcare Manager should establish protocols to ensure effective communication both amongst healthcare staff and between healthcare and other prison staff.

53. An ACCT document was opened following the routine visit to the CSU by an IMB member on 10 August. ACCT protocols require an assessment interview and a case review within 24 hours of the concern being raised, but these actions were not taken. My investigations into self-inflicted deaths at Wandsworth in February and September 2005 also highlighted the lack of a 24 hour ACCT review; although in one of those cases the review was carried out three days later. I made recommendations in both of those reports in respect of the ACCT reviews and I am disappointed that they do not appear to have been implemented. I would urge the Governor to address this as a matter of urgency.
54. The man was seen by a psychiatric nurse during the morning of 11 August, but that was part of a follow-up from the in-reach team, not as the result of the ACCT being opened. In any case, that consultation does not appear in the ACCT daily supervision and support record.

The Governor should ensure that all staff are fully aware of their responsibilities regarding the use of an ACCT document and address any training needs.

55. A number of staff interviewed expressed concern about the man's release. It was accepted that there was an obligation to release him from custody as soon as the legality of his confinement ceased. However, they were worried that there was no onward care plan that could be implemented. I share those concerns and recommend that contingency plans are drawn up to cover circumstances when a prisoner about whom there are health concerns is released at short notice into the community. In this particular case, the man's poor English and his lack of knowledge of London added to the danger of releasing him with no onward care plan in place.

56. There is an obligation placed on the Prison Service to try and ensure continuity of care of prisoners who have identified medical needs. This is set out in Prison Service Order 3050. No efforts were made in this case.

The Governor should ensure that all staff are aware of their responsibilities regarding the continuity of healthcare for prisoners about to be released.

The Governor should explore links with the Primary Care Trust and other agencies to seek a way to provide onward care for vulnerable prisoners upon release.

57. The final issue in this case was the fact that the man was released without his valuable items, especially as these included his mobile phone, credit card and passport. Valuable property is kept securely within the Administration Office and, at the time, could not be retrieved after the staff went home or at weekends. Subsequent to the man's death, a new procedure has been implemented by the Governor. It sets out how either the duty governor or the orderly officer may gain access to property out of hours. I welcome the Governor's action.

58. The administrator's assistance to the man's brother and to the Czech Embassy, much of it in her own time, is to be commended. Her actions demonstrated courtesy, understanding and a willingness to help. I highlight her work as an example of good practice.

RECOMMENDATIONS

- **The Governor and the Healthcare Manager should remind staff of the importance of making proper records of interactions with prisoners.**
- **The Governor and the Healthcare Manager should establish protocols to ensure effective communication both amongst healthcare staff and between healthcare and other prison staff.**
- **The Governor should ensure that all staff are fully aware of their responsibilities regarding the implementation of an ACCT document and address any training needs.**
- **The Governor should ensure that all staff are aware of their responsibilities regarding the continuity of healthcare for prisoners about to be released.**
- **The Governor should explore links with the Primary Care Trust and other agencies to seek a way to provide onward care for vulnerable prisoners upon release.**

Good Practice

- **The administrator' assistance to the man's brother and to the Czech Embassy, much of it in her own time, demonstrated courtesy, understanding and a willingness to help. The Governor should formally commend her for her actions.**