



**Investigation into the circumstances surrounding the
death of a man
at HMP Wandsworth in February 2011**

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

August 2012

This is the report of an investigation into the circumstances of the death of a man in February 2011. He was transferred from HMP Belmarsh on 1 February to HMP Wandsworth to undertake a course as part of his sentence plan. He was found hanging four days later at 5.05am during a routine morning check and was pronounced dead at 5.30am. He was 28 years old.

I would like to offer my condolences to the man's family and friends for their loss. The investigation was carried out by my colleague. I am grateful to the clinical reviewer who carried out the clinical review. I would also like to thank staff at both HMP Belmarsh and Wandsworth for their co-operation with the investigation. I apologise that the report has been delayed.

The man had been in custody since August 2009. In June 2010, he received a life sentence and was required to serve a minimum of 18 years, before he would be considered for parole. He had a history of self-harm outside of prison and was on medication for depression before and during his custodial sentence. He gave differing accounts of this history. He was assessed as a potential risk to himself at one point in custody, but was not subject to suicide/self-harm monitoring or considered to be at risk at the time he died.

The man considered himself at risk from others. In December 2010, he asked to be placed in the vulnerable prisoners' wing at Belmarsh. When he moved to Wandsworth, he initially asked not to go to their vulnerable prisoners' wing but to be integrated into the general prison population. However, he quickly changed his mind and was placed on the vulnerable prisoners' wing after spending one night in the first night centre. Having been transferred to Wandsworth to undertake a course along with another vulnerable prisoner, the course manager did not realise he had arrived in the prison. Consequently, he was not allocated a place on the course he might reasonably have expected to start and was not offered any explanation. The other transferred prisoner was allocated a place. The day before he died, he wrote to the Criminal Case Review Commission declaring his innocence and asking for help in relation to his leave for appeal against conviction, which had been refused a few months earlier.

Despite the complex range of issues and vulnerabilities which the man presented, the investigation concludes that staff could not reasonably have foreseen his tragic actions. However, the investigation found a number of areas for improvement and makes six recommendations. These include the need for a clear system for informing staff when a prisoner arrives on transfer from another prison and better sharing of information about potential conflict between prisoners.

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

**Mr Nigel Newcomen CBE
Prisons and Probation Ombudsman**

August 2012

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1.

SUMMARY

1. The man was remanded to HMP Highdown on 1 August 2009. He was transferred to HMP Belmarsh on 17 August. He was sentenced to life imprisonment with a tariff (minimum period time in custody) of 18 years on 7 June 2010 for murder. As part of his sentence plan, he was required to complete a number of courses, including the Thinking Skills Programme (TSP). At his own request, he became a vulnerable prisoner (VP – prisoners who are housed away from the main population due to their offence, presentation or at risk for another reason) in Belmarsh on 12 December. The TSP course was not available on the vulnerable prisoners' wing at Belmarsh. Therefore, on 1 February 2011, he transferred to Wandsworth, with one other vulnerable prisoner, where TSP courses were run specifically for VPs by the psychology and interventions team.
2. Upon arrival at Wandsworth, the man asked to go on normal location but changed his mind later that afternoon. He told staff that someone related to his offence had travelled to Wandsworth with him and he did not feel safe. He asked for VP status and shared his cell that night with another vulnerable prisoner on the first night centre.
3. The next morning he rang his cell bell and told staff that another prisoner, a vulnerable prisoner, who had travelled from Belmarsh with him was telling prisoners he was a "grass". He was told that he would either be in a single cell once he moved to the VP wing or away from the other prisoner. Later that afternoon, he told staff that he was a high risk, which he was not, and asked staff to "take me to the block". However, he remained on the wing until that evening, when he was one of a number of prisoners who moved to the Onslow centre, Wandsworth's VP wing. He was located in a single cell.
4. The next day, 3 February, he made three telephone calls to family members but only managed to speak to his aunt. He said Wandsworth was "horrible" but he was pleased to have a single cell. He also wrote to his mother and asked her to continue pursuing his appeal. He said he would ring her the next week. He requested, and saw, a Listener that evening. (Listeners are Samaritan trained prisoners who offer a confidential service to prisoners who may be in distress.)
5. On 4 February, the man spent time talking with the prisoner who he had travelled from Belmarsh with. The prisoner told the investigator that there was no ill feeling between them and he perceived him to be a friend. He said they had even spoken about sharing a cell. The other prisoner had been seen by staff from the Psychology and Interventions team at Wandsworth who were organising the TSP course for which both he and the man had been transferred. The course was due to start the following Monday. The man had mistakenly not been registered by the team as having arrived at Wandsworth and was not seen by staff. Therefore, he was not allocated to start the course, but also had not been told what was going on.

6. On 5 February, the man wrote to the Criminal Case Review Commission asking them to review his case. He continued to deny any involvement in the offence for which he was convicted. He saw an officer for a resettlement interview that day, who said he gave him no cause for concern. He asked an officer on the Onslow centre about the TSP course he had been transferred for, but staff from the relevant department were not available until the following Monday so the matter could not be followed up. Again, he was thought to be fine. He spoke to a number of prisoners during the day. He was last seen by staff at 8.30pm during a routine evening check.
7. He was found at 5.05am on 6 February during a routine check of all prisoners at the end of a night shift. Cardiopulmonary Resuscitation (CPR) was not undertaken as rigor mortis had already set in. He was pronounced dead at 5.30am.
8. I make six recommendations regarding the sharing of information both within Wandsworth and between Wandsworth and Belmarsh, medical assessments on arrival, adequate recording forms and family liaison.

THE INVESTIGATION PROCESS

9. The investigator visited HMP Wandsworth on 16 February to open the investigation and to collect documents relating to the man. She visited the cell where he died and spoke informally to three prisoners, as well as staff working on the vulnerable prisoners' wing. She met the Governor and the Chair of the Prison Officers' Association (POA). (The POA is the trade union for prison officers.) Notices of the investigation were emailed to Wandsworth inviting staff and prisoners to contact the investigator with relevant information. No-one came forward in response.
10. The investigator wrote to the local Primary Care Trust (PCT) on 9 February to request a clinical reviewer and a clinical reviewer was appointed. The clinical reviewer was sent the man's medical records directly by the healthcare team at Wandsworth. A number of these records had not been sent to the investigator and were eventually received in early May. His review was received on 19 April.
11. The investigator telephoned an officer at Belmarsh on 10 February and notified her of the man's death. Notices about the investigation were emailed to her that day to be displayed around Belmarsh, again inviting staff and prisoners to contact the investigator. No prisoners or staff came forward as a result of the notices. She interviewed three officers at Belmarsh on 4 April and also emailed the Head of Interventions and Psychology at Belmarsh.
12. On 10 February, the investigator spoke to the coroner's officer and asked for contact details for the investigating police officers. She was given a number of contacts, none of whom responded to her telephone messages. She eventually made contact on 11 May and spoke to one of the investigating officers. In response to her request, she received copies of the documents on 20 June which had been removed from the man's cell by the police after his death.
13. The Head of Safer Custody and the Suicide Prevention Officer acted as the liaison for the investigation at Wandsworth and the investigator fed back her findings to them during the course of the investigation. Thirteen members of staff and two prisoners were formally interviewed. One officer was unable to attend interview for the investigation, despite several attempts by the investigator. Instead, he responded to the investigator's questions by email. One prisoner who had spoken to the man in his capacity as a Listener was unable to disclose what had been discussed due to the confidential nature of the Listeners scheme. He had also been told by his Samaritan co-ordinator that he was also unable to discuss a general discussion he had had with him, even though it had been public since it is not known whether the man believed the conversation to be confidential.
14. The man's mother wrote to the Sponsorship and Performance Team at the Ministry of Justice who forwarded the letter to Offender Safety Rights and Responsibilities Group (OSRRG), the department at the National Offender

Management Service responsible for co-ordinating the response to deaths in custody. This letter was forwarded to our office.

15. She also contacted her local Member of Parliament (MP), who wrote to the Governor of Wandsworth. The Governor passed a copy of the letter to the investigator, which contained the following questions from her:
 - Why was he moved to Wandsworth Prison to do a course he did not want to do?
 - Was he being monitored by the Vulnerable Person Unit?
 - What happened between 4 and 6 February 2011 for him to commit suicide?
 - Did he have any one-to-one sessions and are there any records of these?
 - What time was he last seen alive?
 - Who was the last person to see him alive?
 - What was his mood like on the day leading up to his death?
16. One of our family liaison officers spoke with the man's mother on 3 March. He outlined the purpose of our investigation and offered to meet with her and the investigator. On 5 October, the investigator and the family liaison officer met with the man's mother and aunt at the offices of solicitors. The investigator was able to outline the circumstances of the man's death and the findings of the investigation at that meeting. Following this meeting, the solicitor wrote to the investigator with further questions. It is hoped the investigation addresses all their concerns.
17. Having had a number of email exchanges with the Interventions and Psychology team at Wandsworth, the investigator returned there to interview the TSP treatment manager on 2 November. She was also able to interview an officer with whom she had previously only had telephone contact.
18. This report has been delayed due to a protracted investigation and workload pressures in the office.
19. A copy of the draft report was sent to the National Management Service (NOMS). They accepted all the recommendations and their responses repeated verbatim in the recommendations section. NOMS made a number of observations and in the main these have been responded to by letter. Additional information has been made to paragraph 13 and 90 in response to further information provided by NOMS.
20. A copy of the draft report was sent to the man's mother's solicitor. The solicitor made a number of comments and these have been addressed in a letter. No changes have been made as a result.

HMP WANDSWORTH

21. HMP Wandsworth is the largest prison in the United Kingdom, holding up to 1,665 adult male prisoners. It is a local category B prison, accepting prisoners on remand, convicted and sentenced from courts within the catchment area. The prison is formed of five residential wings and two specialist units. The Onslow centre caters for vulnerable prisoners. There are four floors on the unit and three wings (each holding approximately 120 prisoners). The original prison buildings date from 1951, but since 1989, the prison has been undergoing extensive refurbishment and modernisation.

Vulnerable prisoners

22. The term vulnerable prisoner (VP) is used to describe someone whose offence or presentation means they will not necessarily be safe within the general prison population, or individuals who asked for vulnerable prisoner status because they are poor copers, in debt or feel at risk. The former are likely to remain as VPs throughout their sentence whereas the latter may be able to reintegrate back into the general prison population, but often only after they have moved prisons. Prisoners may ask for VP status and it is often referred to as “the rule”, relating to Rule 45 of the Prison Rules 2003:

“Where it appears desirable, for the maintenance of good order or discipline or in his own interests, that a prisoner should not associate with other prisoners, either generally or for particular purposes, the Governor may arrange for the prisoner's removal from association accordingly.”

Previous deaths on the Onslow centre

23. Two previous self-inflicted deaths (2007 and 2009) on the Onslow centre at Wandsworth have involved prisoners recently transferred into Wandsworth from other prisons. We have previously made a recommendation about ensuring that their transfer register is completed.

Life sentenced prisoners

24. An offender supervisor is allocated to any prisoner sentenced to life. They are prison officers working in a specialised role. Within seven days of the sentence, they are required to make contact with the prisoner to explain about the lifer process and to answer their questions. They liaise with the prisoner's offender managers (probation officers) in the community and contribute towards risk assessments and sentence planning documents. They are required to see each prisoner once a week when first sentenced although this may extend to fortnightly as their sentence progresses.

Prison Service policy on resuscitation

25. Prison Service policy on resuscitation of prisoners is contained in the Prison Service Order (PSO) 2700. This PSO, which relates primarily to suicide prevention and self-harm management, states:

“If not breathing and/ or no pulse is present, clear airway and attempt resuscitation . . . unless rigor mortis of the limbs has clearly set in.”

HMP Belmarsh

26. HMP Belmarsh is predominantly a remand local prison servicing the Central Criminal Court and surrounding courts. It also holds category A prisoners and within its walls has a high secure unit holding high and exceptional risk category A prisoners. According to the last HM Inspectorate of Prisons report in April 2009, Belmarsh is a complex prison given the mix of category As and low risk prisoners.

KEY EVENTS

27. The man was arrested on 28 July 2009 on a charge of murder. He spent three days in police custody and saw a number of Forensic Medical Examiners (FMEs) who recorded his history of depression and self-harm. He was prescribed mirtazapine (used primarily in the treatment of depression). On the police national computer print out, there were self-harm warnings from March and April 1999 and January 2004. However, he was not assessed as at risk of self-harm while he was in police custody.
28. When he arrived at HMP Highdown on 1 August, a first reception health screen (a document completed in discussion with a nurse looking at physical and mental health issues) was completed. When asked about his mental health, he said that he overdosed in June 2008 and that he had previously spent two weeks in a psychiatric hospital. He said that he did not have any thoughts of self-harm at the time of the health screen. At a follow-up appointment, the doctor continued his prescription of antidepressants. He was transferred to HMP Belmarsh on 17 August.
29. On 18 August, the man was referred to the mental health team, although there was no reason recorded. At a mental health team referral meeting on 25 August it was concluded that his mental health needs could be met by the primary care mental health team rather than more specialist care, as he was not assessed as having a severe mental health condition. He received ongoing treatment from nursing staff for facial dermatitis (a skin rash) and was referred for outside hospital appointments for the condition throughout his time in custody.
30. According to the man's records at Belmarsh, he did not often come to staff's attention for negative behaviour. However, he could be disruptive and was subject to anti-social attitude monitoring on two occasions. An officer knew him well from his time in Belmarsh. He described him as someone who "blew hot and cold" and recalled that he might react badly to something before apologising the next day. Occasionally he received warnings for displaying a poor attitude to staff. He described him as:

"quite young in his outlook, and if he listened to somebody then he would take it as verbatim. One prisoner said to him you are never going to get out and he went sort of, he believed it hook, link and sinker".
31. On 30 March 2010, it is recorded in his medical records (MR) that he was discussed at a Mental Health In-Reach Team Meeting and decided that he should be referred to the "Cass Unit" (Belmarsh's mental health occupational therapist department).
32. The man was convicted on 10 May of murder along with two co-defendants. On 2 June, he was placed on an ACCT (Assessment, Care in Custody and Teamwork document – the system for monitoring and supporting prisoners at risk of suicide and self-harm), following the apparent suicide of a prisoner he had shared a cell with for five weeks. He had moved out of the cell ten days

before the man's death. A Senior Officer told the investigator that the man did not think he needed support and did not want to be on an ACCT. During the ACCT assessment, he told the assessor that he had "never tried any acts of self harm". On 7 June, he was sentenced to life imprisonment with an 18 year minimum tariff. His ACCT remained open as a precaution. A review took place on 10 June and it is recorded that he wanted to come off the ACCT and that he had no thoughts of self-harm. Despite his request, the ACCT was kept open as a result of his recent sentence. It was eventually closed on 17 June. (On 27 July, he was interviewed by staff from this office in relation to the death of his former cellmate and gave no cause for concern.)

33. An officer was allocated as the man's offender supervisor after he received his life sentence. The officer described their relationship as "cordial", but "demanding" and said that he spent a lot of time working with him. He said he was "somebody you will tell something but he will listen to what other prisoners tell him which is contrary and come back with some agitation that this is what I've heard and I always tell him that don't listen to what other people say, what I tell you is right".

34. In his MR, it is recorded that the man did not attend an appointment with an occupational therapist (mental health worker) on 22 June. According to his MR on 25 June:

"Staff are becoming concerned about this young man's behaviour. He has become very paranoid about staff as he focused on one person at a time. He reacts to little things that people do and it's usually aggressive yet it could be a very simple thing the other person had done. The staff on the house block are becoming concerned as they have noticed his behaviour changing since his co-offender hanged himself on houseblock 3, and he was given a life sentence a short time ago. Referral to the mental health team".

(It is not clear quite what is meant by 'co offender'. The prisoner who died had shared a cell with him but was not his co-defendant.)

35. At a mental health referral meeting on 29 June, the man was discussed and it was acknowledged that he had already been offered two appointments (22 and 29 June) with occupational health (mental health), but had not attended either appointment. Nevertheless, the mental health team agreed to offer him one further appointment. He was offered an appointment on 6 July which he again failed to attend as he "stated he decided to go to football and that he would rearrange the appointment at his convenience". It was decided that he would not be offered any further appointments at that time.

36. On 27 July, his first annual sentence planning and review meeting took place. It was attended by his offender supervisor, offender manager (probation officer from the community) and a representative from healthcare. One of his long term objectives was to assess his suitability to undertake the Thinking Skills Programme (TSP). Another objective was to have a psychological assessment, in light of his risk of self-harm. The sentence plan identified:

“the possibility that when the seriousness of the killing of his victim dawns on him in the future, he may resort to possible self-harm. If that were to be the case, it may influence how he copes with his incarceration and general behaviour”.

37. According to a medication review on 13 August, the man was:

“on Mirtazapine and wonders if can come off as getting weird dreams and shakes. Accepts that these s/e [side effects] are not very troublesome and since mood wise not there yet – happy to stay on same dose for a few more weeks then review”.

38. On 8 September, he saw a doctor to collect his prescription and it is recorded that he reported “no self-harm in past five years and had never overdosed”. In August, he successfully completed the COVAID (Control of Violence for Angry Impulsive Drinkers) course which was another of his long term sentence planning objectives.

39. On 9 November, the offender supervisor wrote:

“Seen today in response to a general application made. He informed me that the relationship between him and his co-defendant has suffered a deterioration after he –the man – lost his appeal against sentence and conviction. He was directed to avoid any unpleasant confrontation and promised that the issues between both will be resolved in the most appropriate and amicable way”.

40. In interview, the offender supervisor said that the man and his co-defendant were never on the same house block together and that his co-defendant was transferred out of Belmarsh around that time. (Not only was he the man’s offender supervisor, he was also the offender supervisor of the co-defendant.) He said that the man believed that the co-defendant had told others that he was a ‘grass’ (a colloquial term for informant). He told the investigator that he was not aware of any direct threat being made to the man.

41. An occupational therapist wrote an entry in the man’s medical record on 15 November that he took part in a yoga session which he said he had enjoyed. Another entry on 23 November recorded that he “feels paranoid with Mirtazapine -stop it very gradually”.

42. According to his history sheet on 5 December, “he had settled down recently and had no concerns at the moment”. On 8 December, the offender supervisor recorded that having told him that he was listed to start the TSP course in January he was “appreciative and delighted by the news”.

43. On 11 December at 7.40pm, the following entry was made in the man’s history sheet:

“He declared to me today that he was worried about his safety and would like to be relocated to the VP [vulnerable prisoners] wing. According to him, this is about an earlier disclosure he made to the SO.”

44. There was an undated handwritten note in the man’s file which read:

“(Gov-please don’t speak through door because people listening.)
I need to go on the numbers [VP wing] as everyone has found out what I was talking about with [assumed to be the SO] on Tuesday night that I am a grass and gona get it if I don’t move, so please can somefing be done in the morning before soca as it’s not safe for on normal location, many thanks. (I’m very worried and scared gov).”

45. Someone else has written “Do you want to go to HB [house block] 4? You don’t feel like doing anything to yourself do you?”

46. In interview, the SO said he had spoken to the man about his co-defendant. He said that the man did not want to go to the same prison as him and that people were talking about him. The SO told the investigator that he was not the author of the question written on his note referred to above. (It is not known who wrote the comment.)

47. At 10.36am, the following day, 12 December, an entry reads “placed on rule 45 and located on spur 1 HB4. Resolved to the fact that this was the only option to reduce risk of assault on him”. The reason for his application was recorded, as follows:

“received threats on HB1 that he would be ‘done’ on association on 12/12/10 for going Q.E. (Queen’s Evidence – evidence given by one defendant against another) against his co-defendant on their trial this year. He feels this threat to be genuine and believes it to be jail wide now. He has been spoken to about the implications of going on R45 and told about the alternatives, still fearful so placed on VP unit”.

48. At 10.57am, on 13 December, the offender supervisor wrote:

“I will be liaising with OCA [the Observation, Classification and Allocation department, who co-ordinate prisoner transfers] to effect his immediate transfer to any establishment that will take him as a VP lifer offender (non sexual offender). He is currently on medical hold for an outstanding medical appointment, this HCC [healthcare centre] will be asked to cancel and appointment can be re-arranged by his receiving establishment.

The implication for this is that he will no longer be in a position to commence the TSP programme scheduled to start in January 2011. Having spoken to him this morning he intends to remain on the rule for the foreseeable future even in the event of a progressive move.’

49. On 24 December, the offender supervisor wrote:

“Seen today with the sole purpose of returning his original certificates. Wing staff informed me of his disruptive behaviour after an earlier DST (dedicated search team) target search. Nil was recovered from him but he complained about the way he was dealt. He packed up his property and stated that he was relocating to the Segregation unit. I spoke to him and was able to defuse the situation reminding him to make his grievances known through officially approved means.”

50. The offender supervisor said that he managed to calm the man down, by reassuring him that the search was routine and nothing was found. In interview, he said that he encouraged him to come off the rule. He said:

“there was a time I told him to come off the rule even if he’s at the point of departure, that is at reception, because I said if he remains on the rule it will impede his progress here or anywhere he goes because there’s limited establishments that take sex offenders and because he is not from his index offence a sex offender so it might be advisable that he comes off the rule. ... he told me that throughout his sentence he was going to remain on the rule.”

51. An officer introduced himself to the man as his personal officer (a named officer to whom prisoner can go to for advice or to resolve complaints) on 28 December. He recorded that there were no problems with his behaviour and that he had asked about moving to another establishment.
52. On 8 January 2011, an entry in the wing’s observation book recorded that the man “stated he could not hack it on the HB anymore and was packing his kit to go down the block. I stated he did not dictate where he went. He then stated he would refuse to bang up for lunch”. His personal officer spoke to him on 11 January about his intention to go to the segregation unit. The officer recorded that he was now more settled and was speaking about getting a transfer. The officer spoke to him again on 23 January, and recorded that he remained “settled” and was “civil and polite”.
53. Towards the end of 2010, the psychology and interventions department at Wandsworth sent an email to their counterparts in London prisons, asking if they had any suitable prisoners to complete a TSP course on the vulnerable prisoners’ wing. Belmarsh psychology department responded to the email. On 20 January, the TSP treatment manager at Wandsworth spoke to her counterpart, Mr Lewis, at Belmarsh and explained that they had two places on their next course due to start on 7 February.
54. Her counterpart identified two prisoners as suitable to complete the TSP on the VP wing and requested their transfer. (Requests for transfers of this nature are usually not date-specific but requested for “as soon as feasible”.)
55. On 31 January 2011, the offender supervisor wrote in the man’s history sheet:
- ”He was informed last week of his impending possible transfer to HMP Wandsworth to facilitate his TSP course. This morning he expressed

certain reservations on the move. On further exploration he was satisfied with the plan. He also asked if he could relocate on normal location on his arrival at Wandsworth. I made it clear to him that being a non sex offender, it's in his interest to come off the rule when ever and as soon as possible."

56. In interview, the offender supervisor explained that he thought that the man was changing his mind about staying on the rule throughout his sentence. He explained that him had indicated that he did not want to move again, but the offender supervisor explained that he could not stay on the VP wing at Belmarsh as he needed to attend courses in order to progress through his sentence. He was also concerned about his family being able to visit, but the offender supervisor reassured him that Wandsworth was not far from Belmarsh.
57. The man transferred to Wandsworth on 1 February with another prisoner. According to his Person Escort Record (known as the PER which is used to share information between the police, escort services, courts and the prison service), the nature of his offence was identified as a risk and he had a medical condition (thought to be his skin rash). He arrived at Wandsworth at 1.20pm and was taken to the first night centre (known as E wing) at 4.45pm.
58. A nurse completed the first reception health screen. In interview, he was not able to recall the man in any detail. According to the nurse's entry on his MR, he "transferred in HMP Wandsworth. States fit and well. Get a doctor to prescribe his medication. Is not willing to see the doctor". He completed an in-possession medication sheet for his prescription of Mirtazapine.
59. A first night officer explained to the investigator that once prisoners have been through the reception process they come onto the First Night Centre (FNC), also known as E wing, and sit and wait to be interviewed by a prison officer. He was the officer completing first night interviews on 1 February. Prisoners who are deemed to be vulnerable are placed together in a holding cell separated from the other prisoners on E wing.
60. The officer completed the man's cell sharing risk assessment (CSRA) and wrote "tx [transfer] in belmarsh lifer, off rule but then applied for it during fnc [first night centre]." (A CSRA is used to determine whether a prisoner can safely share a cell with another prisoner.) He assessed him as low risk. The nurse completed section 3 of the CSRA. He wrote "fit and well" and classed him as low risk to others.
61. During his interview for this investigation, the first night officer was vaguely able to recall the man. He said that he was a bit concerned about why he was there and another officer was called over from the Occupation, Category and Allocations department (OCA) to talk to him. The first night officer remembered the man telling him that he had 'come off the rule' to do the course at Wandsworth. The officer did not have any concerns about him. He thought that he had seen someone whilst sitting waiting on E wing who he knew from Belmarsh.

62. The investigator spoke to the other officer over the telephone and she recalled seeing the man when he first arrived. She said that he wanted to talk about going on the rule as he said that someone had travelled in the bus with him who was something to do with his case and felt he was not safe. She explained that he would not be able to stay at Wandsworth if he did not want to go on the rule as they could not guarantee his safety if he thought he was at risk. He told her that he would think about it. She said that she told the SO on the first night centre about her conversation with him.
63. Although only the man and the other prisoner travelled from Belmarsh, it is possible that one of the prisoners on the bus coming from another prison may have spent some time at Belmarsh and seen him there.
64. Having taken the rule again, the man was placed in cell E2022, one of a group of cells used for VPs. The prisoners are separated from the rest of those on the FNC who were to be accommodated within the general prison population. Later that evening, at about 8.00pm, another prisoner (who was a VP) moved in to the cell with him. In interview, he said that they got on fine for the night they shared a cell. However, the man wanted to be in a cell on his own and became quite agitated. In interview, the cellmate said the man was said to have complained about the amount of time they spent locked in their cell on 2 February, especially in comparison to his experience at Belmarsh. The other prisoner said that they had seen the Roman Catholic priest that morning as he did the wing rounds. Apparently, the man had asked about attending the service but there was not one that day.
65. An officer wrote the following entry in the FNC observation book: "The man rang his cell bell this morning stating that another prisoner has been telling other prisoners that he was a grass. I informed the SO". His cell bell was rung at 9.37am.
66. In interview, the officer recalled the man saying that he did not want to share a cell with the other prisoner on the VP wing because he had been telling people he was a grass. The officer said he reported this to all the senior officers present in the office. He also said that he spoke to the movements officer (officer responsible for co-ordinating wing transfers) on the FNC to tell him that they should not share a cell and that Onslow centre should be made aware of their history.
67. The officer said that he went back to tell the man that he would either be in a single cell or away from the other prisoner on the VP wing. He said that he thought that he seemed "uptight" and that he offered him some time on his own or with a Listener. He declined and said that he just wanted to be on his own or away from the other prisoner on the VP wing.
68. The officer said he asked him if he felt like doing anything to himself and explained about opening an ACCT. The man said he did not want an ACCT opened as it would mean having his light switched on and off overnight for

observations. The officer said that he did check him later, and saw that he seemed to be asleep on the bed.

69. The investigator asked the officer if he considered writing a Security Information Report (SIR) in light of what the man had said. The officer said that he had not because he had reported to the SOs that he did not want to share a cell with the other prisoner and so he thought the matter would be dealt with. One of the SOs in the office said that what he was told was that two prisoners “were not getting on” which is very common and does not usually prompt a SIR.
70. The TSP manager went to the FNC during the morning of 2 February. Since her contact with Belmarsh on 20 January, the TSP course due to start on 7 February had become full so the prisoner and the man were to attend the course starting in April. However, unexpectedly one of the participants pulled out of the February course so she needed to fill the last place. She had seen an email exchange between the two prisons OCA departments indicating that they hoped to have them transferred some time that week (the email was dated 31 January).
71. However, in interview, the TSP manager explained that she received no formal notification that they had been transferred. She had searched PNOMIS (the computer system used to record information about prisoners and which replaced paper records across the prison estate) and read that the prisoner was on E wing but she did not see the man listed. Upon reflection, she was unclear whether, when she had looked at the computer system, it had not provided a cell location for him which led her to assume that he had not arrived.
72. The investigator established that there was an entry on PNOMIS from the day before to say that the man had arrived in the establishment. It is possible that because he had initially asked to go on normal location the system had not been updated at the same time as his location entry, and therefore the TSP manager could not see his location. However, this is speculation and it cannot be confirmed if this was the case. This was the first time that she had been involved in transferring prisoners in for a specific course.
73. The TSP manager said that she approached the movements officer on E wing as he was walking along the corridor on the FNC. She asked if the prisoner and the man were down on the list to be moved to the Onslow. He said that the prisoner was on the list but not the man. (When he spoke to the investigator, the movements officer was not able to recall anything in relation to the man.) From this, she assumed that he had not been transferred from Belmarsh. She said that it was not unusual for someone not to arrive as prisoners can change their mind or some other factor prevents transfer. She was then away from the prison for a few days and was going to check what had happened to him when she returned. In terms of the prisoner, she asked another member of the team to assess him for the course starting on the following Monday.

74. An entry on PNOMIS at 4.04pm on 2 February by an officer reads:
- “The man rang his cell bell [Records show he pressed his cell bell at 2.53pm] saying he should not be in shared cell as he was high risk. I explained that my staff would have checked his record last night when he came in. I also told him that the only person who could place him on high risk was a Governor. He then said ‘take me to the block’. I said that that would not be happening. I informed him that I would go and have a look at his record to see his previous CSRAs. Upon checking his record every CSRA states that he is low risk. I have informed the movements officer.”
75. The officer explained by email that when he spoke to the man he appeared calm and that he had no concerns about him. By the time he spoke to him at 4.00pm, he had been identified as being on Rule 45. He said that he told him that he was not a high risk prisoner and that the Governor was the only person who could make him high risk after a risk review.
76. A SO said that they had tried to get the VP prisoners over to the wing earlier in the day but the cells were not ready. The movement sheet shows that the man moved to the Onslow centre at 7.48pm and was placed in a single cell H4-027. The other prisoner moved at 7.29pm and was placed in a cell on a neighbouring wing which is still part of the Onslow Centre. The man’s cellmate also went over to the Onslow Centre and was in cell H26 which was the next one along from the man, although there was a recess between the two cells
77. In interview, the prisoner said he was very surprised to hear that the man had said that he was calling him a “grass”, as he considered them to be ‘friends’ and spoke fondly of him. The personal officer from Belmarsh recalled the prisoner as a quiet man who worked as a cleaner on the unit when he was there. There was no record from Belmarsh of any conflict between them. The prisoner had been on the VP wing with the man at Belmarsh and remembered him being very involved in the football team there. He said that he had told him that he wanted to come on the rule at Wandsworth because another prisoner on the bus had realised that he had been a VP at Belmarsh and had told other prisoners on E wing when they were waiting to see the first night centre officer. The prisoner said he had told him this whilst they were still on E wing. He also said the man had told him that the reason he had originally requested VP status at Belmarsh was because he had owed some tobacco and there was tension on the wing.
78. The prisoner also said that they had discussed sharing a cell together although the man explained that he had been assessed as high risk and would need to check if this was still the case. The man said he would ask staff, and subsequently told him he was told he was high risk. (This was not the case.)
79. Records show that the man pressed his cell bell at 8.45am on 3 February but there is nothing recorded in the observation book. It is not unusual for there to be no corresponding entry when a cell bell is rung, as only events of

significance are recorded. He made three phone calls at about 10.35am. The first call to his brother was unanswered, as was the second to his mother. He did speak to his aunt and they spoke for ten minutes. He said that Wandsworth was "horrible" but he was pleased to have a single cell. He talked about an article in the newspaper about an appeal and his aunt told him to "stay positive". He said that would not do anything stupid and that he would ring later in week.

80. The Onslow Centre observation book records that at 1.55pm, the man asked to see a Listener. An officer wrote this having responded him pressing his cell bell at 1.32pm. He said that he asked him if there was anything he could do to help but he said that he just wanted to speak to a Listener. The officer said that he was just about to go off shift so rather than sorting a Listener out himself he asked other staff to co-ordinate it.
81. It was not until 6.45pm that an officer wrote "The man asked to see the Listeners. Placed in care suite". The cell bell had been pressed by him at 6.27pm. In interview, the officer did not remember him in any detail. He was unable to recall if he took him to the care suite himself to see the Listener.
82. The prisoner recalled the man telling him he had seen a Listener. He said that he was aware that he used the Listener's scheme at Belmarsh as he had been a cleaner and was out of his cell a lot so tended to be more aware of what was going on. He did not tell him what they discussed.
83. The man wrote a letter to his mother on 3 February. (This was not received by her until after his death and is discussed in the issues section.) He spoke about her contacting his solicitor and asking about the appeal and the letters from JENGBA (a campaigning organisation called Joint Enterprise Not Guilty by Association which represents prisoners who say they are innocent). He said that he did not have any money as he was not working. He apologised that he had not rung for a week and a half and would ring again the next week.
84. The man's former cellmate from the FNC remembered speaking to him on Thursday when he saw him on the wing. The man asked him if he was okay. He complained about the prison saying there had been much more time out of the cell at Belmarsh. He said that the man presented the same as he had done before. He remembered him coming to his cell on one day for some tobacco but he was not sure which day this was.
85. One of the prisoners in the cell next door (H28) recalled speaking with the man on Thursday. He said he was asking him where the showers were and other questions about the prison. In answer to the prisoner's questions, he said he was in for 18 years and was not happy about that. He said that he had run out of tobacco and was trying to get some more by asking the officers.
86. According to cell bell records, the man's cell bell was rung at 9.07am on 4 February but again there is no corresponding entry in the observation book.

The prisoner said on the Friday afternoon all cells were opened up, and he and the man were chatting. He said the man was sorting out a few things, like work applications. The prisoner had been told that morning that he was going to do the course starting on the Monday. He thought that the man had been told that he was going to start the next course after that one. He said that they both put their applications in for a smoker's pack and they both received them that afternoon.

87. Again, according to the cell bell records, the man rang his bell at 9.00am and 2.00pm on Saturday 5 February. One of the Listeners recalled seeing him that morning, spoke to him as part of a group, not in his formal role as Listener. He said the conversation was of no consequence. The prisoner recalled speaking to him on Saturday in the morning and he seemed fine. He said he went to his cell after dinner to have a quick chat through the door and he seemed "joyful, mucking about at the door".
88. At 3.11pm, an officer wrote in his records 'seen for R/BOARD [review board] Interview in VPU'. In interview, the officer could recall very little about the meeting with the man which took place in his cell. He said that he remembered him talking about a course he had attended in another prison but did not recall him saying anything about the course he was at Wandsworth for. The purpose of the interview was to cover a number of issues, such as his sentence plan. The officer said that he always asks prisoners about self-harm and would have opened an ACCT if he had had any concerns about his welfare. Although the meeting is recorded as 3.11pm, the officer said that he would have seen him in the morning and after he had seen all the prisoners he needed to see, he would have written up the records in the afternoon.
89. An officer on the Onslow Centre recalled speaking to the man at approximately 4.30pm. He said that he was asking about when he was going to be able to see someone about the TSP course and the officer explained that it would not be possible to find out anything until the Monday. The officer said he "seemed fine" and he did not have any concerns about him. (The psychology and interventions department is based on the Onslow Centre but staff only work on weekdays.)
90. A letter found in the man's cell following his death, dated 5 February, was to the Criminal Case Review Commission. It outlined his case and requested that someone from the organisation look into it for him. He explained that he had lodged an appeal but that it had been turned down in October. He wrote: "I have been told by my solicitors who represented me throughout my trial and appeal that there's not a lot more they can do for me". (A renewed application for appeal had been lodged by his solicitors in November 2010, at his request but it is not clear whether he fully understood the implications of this.) He went on to write:

"I would be very grateful if someone would let me know whether you can help me with my wrongful conviction as I'm sitting here today with an 18 year tariff for an incident I did not take part in what so ever, the way the courts with people like myself on this lazy law is an utter joke, so please

help me with this miscarriage of justice as I don't know how I can get to the bottom of this as I have tried an appeal and got nowhere."

Following the issuing of the draft report, the psychology and interventions team provided the following information:

"It is worth noting that one of the main criteria for suitability for TSP is that a prisoner should not be appealing against their conviction i.e. as it is an offending behaviour programme where the psychological intervention focuses on the offending behaviour. Therefore, the fact that he had attempted to appeal previously should have been raised with the Wandsworth interventions team. If he had of been assessed in Wandsworth there is a high possibility that if he was actively trying to appeal his conviction and was declaring his innocence that he would not be suitable for TSP at that point."

91. Officer A started her shift that night at about 8.30pm. She had worked the five previous nights, always on H wing and the man had not come to her attention during those nights. She recalled seeing him at about 8.30pm when she did the roll check at the start of the night shift. She did not recall seeing him in any detail, but remembered that his television was playing quite loudly but again nothing to cause concern.
92. One of the prisoners in the cell next door remembered hearing a sound like someone thumping the cell door coming from the man's cell at about 11.00pm. Officer A knew nothing about this and neither the man nor any other prisoners rang their cell bell. As part of their night duties, officers are required to patrol round the landing once an hour, but do not have to check in cells or speak to prisoners, unless they are subject to suicide monitoring procedures.
93. At about 5.00am, the night staff started the roll check in anticipation of handing over to the on-coming day staff at approximately 7.15am. This involves opening the cell door flap on each cell and physically counting all the prisoners. Each cell has either one or two beds. A privacy curtain can be pulled when a prisoner is sitting on the toilet which is at the far end of the cell by the window and furthest away from the cell door. This is ceiling to floor length, with two strips of mesh at head and toilet seat level so officers can see the shadow of a figure. It is also possible to see someone's feet at the bottom of the curtain. At night time, the limited light from outside (and sometimes the cell window will be covered to make the room even darker), even with the cell light turned on can make it very difficult to see the person clearly if they are behind the curtain.
94. At 5.05am, the officer opened the cell door flap. She could not see the man in his bed, which she recalled was fully made up. She remembered that the television was on and she put the night light on so she could see more clearly inside the cell. She called out his name. She could not initially see any sign of him but then saw his arm through the netting of the curtain.

95. She called to her colleague by name, who was checking cells on one of the other landings on the wing. Officer B ran immediately to where she had called from and because he was only on the landing below he reached her very quickly. Officer C was also working on the wing and heard her shouts and also reached the cell very quickly. Officer A explained that she could not see the prisoner in the cell. She tried to open her pouch (a leather pouch with a plastic seal which contains a cell key that can only be used in an emergency) but said she panicked and could not open it. (Staff do not carry keys at night.) Officer C helped her and undid the pouch. They all entered the cell and when they pulled the curtain they saw the man.
96. The man had wedged himself between the toilet bowl and the sink by putting a chair between them, and staff were unable to move him from that position. The ligature was cut from the window bars by Officer C. Officer B said they checked for vital signs but could not find any. They were unable to move him from his position due to rigor mortis.
97. Officer A radioed for Oscar 1 (the night orderly officer who is operationally in charge of the prison during a night shift) and Hotel 3 (the healthcare response officer). The control log recorded the call at 5.06am. She told the investigator that she could not recall using a code, as panic had taken over. (Code systems are used by staff to communicate the nature of an emergency.) The officer confirmed that she did not ask for an ambulance to be called.
98. The officer in the control room radioed and asked Officer A to telephone them, which she did from the office which was just nearby. She told the control room she thought the man was dead. The night orderly officer, a SO, received a call from the control room asking her to go directly to the Onslow Centre. She had not heard the message about an incident previous to this call and this was the first time she became aware of an incident.
99. Upon entering the centre, the SO heard Officer A calling her and she went up to the landing. She was briefed that the man had hung himself. She entered the cell and saw that he was being held up by staff although rigor mortis had set in. The orderly officer went to the office and called the control room to ask for an ambulance. She also asked for the police and the duty governor to be notified. When she subsequently spoke to the duty governor, she was told to cover him with a sheet. The control log recorded an ambulance was requested at 5.10am. The healthcare response arrived and confirmed that he had died. As rigor mortis had set in, staff could not move him. No cardio pulmonary resuscitation was attempted. He was pronounced dead by ambulance staff at 5.30am.
100. Officer C saw a letter by the television which he suspected might be a suicide note. However, the investigating police officer said it was not, although they did remove it from the cell as part of their investigation.
101. Following his death, the police found some correspondence which they made available to the investigator. Some were from an organisation by JENGBA including a general one to the man dated 11 January 2011, which included an

apology about not being in touch recently. There was also a copy of a letter allegedly written by his co-defendant saying that he had nothing to do with the murder for which he was convicted, dated 22 July 2010. There was also a letter dated 25 October 2010 saying that his application for leave to appeal against conviction had been refused. Finally, there was the letter already referred to, that he had written to Criminal Case Review Commission dated 5 February.

Prisoner support

102. Prisoners were informed of the man's death by letter which was posted under their cell doors.

Staff support

103. A hot debrief was carried out and staff were all seen by the care team.

Family Liaison

104. The prison family liaison officer and Chaplain went to break the news to the man's mother at 11.00am that morning. The prison offered to pay for all of the funeral expenses. They also offered to send a representative from prison to his funeral, but she declined this. The man's brother, stepfather and two aunts went to the prison to visit the cell and meet staff.

ISSUES

Clinical care

105. The clinical review was carried out by a clinical reviewer. From the community GP records, he noted that the man was recorded as having a history of alcohol dependence syndrome in 2003, and, in May 2009, had a diagnosis of a 'dissocial and emotionally unstable personality disorder' from the South London and Maudsley psychiatric team. He also observed that he had taken overdoses on 25 June 2008 and 23 February and 18 June 2009.
106. The clinical reviewer does not comment on the actions taken by staff upon discovering the man. PSO 2700 contains guidance on the actions which should be taken on finding a prisoner hanging. The PSO states that resuscitation should not be attempted if rigor mortis has "clearly set in". Accounts given by attending staff indicate that some degree of rigor mortis had occurred and therefore any attempt at CPR would have been futile and undignified. In the absence of clinical opinion, policy appears to have been followed by the decision not to resuscitate him.
107. After considering the man's community and prison health records, the clinical reviewer concludes:

"it appears that the care he received during his time at Wandsworth was reasonable and appropriate. It is impossible to say whether there were signs of deteriorating mental health that were not picked up during the time leading up to his very sad death".

The man's self-harm history

108. The man had a history of self-harm prior to being in custody. However, from all the various records – police markers, GP records and his own changeable self-accounts – the picture is inconsistent. In custody, he was placed on an ACCT, as a precaution rather than because of any expressed thoughts of self-harm, following the suicide of his former cell mate in June 2010. During the same period, he received a life sentence and it was felt appropriate to keep the ACCT open. However, when asked directly about any history of self-harm during the assessment interview, he said that he had none. He was recorded as not wanting to be on an ACCT and this may have been why he denied any previous attempts.
109. Whilst in custody, the man did not carry out any acts of self-harm or give any indication that he would do so. Upon reception, he was seen by a nurse for the first reception health screen and FNC staff and no concerns were raised. Prisoners he spoke to did not note anything significant and from his conversation with his aunt there appears to have been no indication that he was contemplating suicide. Accordingly, there appears to have been nothing of note in his behaviour to suggest that staff at Wandsworth could have perceived that he was at risk at the time of his death.

The man's mental health

110. Upon reception into custody, it was noted that the man suffered from depression and anxiety and his prescription for Mirtazapine was continued throughout. (The post mortem reported that “the concentration of Mirtazapine detected in the basic drug screen is estimated to be within the therapeutic range”.) He was not thought to be in need of input from the mental health team but was offered appointments at Belmarsh with the occupational therapist. He declined to attend these although did attend a mental health review on 15 November 2010. On 23 November 2010, he spoke about coming off Mirtazapine and a discussion took place with the doctor that this should be done gradually. He remained on Mirtazapine at the time of his death.
111. Upon his arrival at Wandsworth, the man declined to see the doctor. The clinical reviewer does not comment on this in his report. However, as outlined in PSO 3500 - Continuity of Healthcare for Prisoners, reasonable steps should be taken when a prisoner is received into an establishment:
- “Whilst reception screening in primary care is not standardised it is expected that during the consultation the health care team ‘make such enquiries and undertake such examinations as appear to be appropriate in all the circumstances’ as set out in the General Medical Service contract.”
112. The man arrived with his medical record so medical staff were aware of his clinical needs and could see that he had not engaged with mental health services at Belmarsh and was on anti-depressants.

The Head of Healthcare should ensure that prisoners are seen by a doctor upon reception if they are being prescribed medication and have a history of mental health difficulties.

Managing the man's perceived risk from other prisoners

113. One of the man's sentence planning objectives was to complete the TSP course. Whilst on ordinary location at Belmarsh, he was assessed as suitable and due to start the course in January 2011, which his offender supervisor said he was “very pleased” about. However, on 12 December 2010, he requested to move to the VP wing making him ineligible for the course because Belmarsh was not able to offer the TSP course to those on the VP wing at that time.
114. The man's apparent reason for initially requesting to go to the VP wing at Belmarsh was that acquaintances of his co-defendant were making him feel unsafe. He did not name those he felt at risk from so it was not possible for Belmarsh staff to place any sanctions on them or take any action against them. His mother said that he had been threatened with “jugging” (the act of throwing a jug of hot water at someone) but there is no record of him reporting this to staff.

115. Having become a VP at Belmarsh, the man expressed the wish to return to ordinary location upon his arrival at Wandsworth. Whilst at Belmarsh, a return to ordinary location would have been difficult as once identified as a VP it can be risky to return to the general prison population. Consequently, if he hoped to achieve his sentence objectives, as well as reintegrate back onto ordinary location, he had little option but to move to another prison. If he had been reintegrated into the general population at Wandsworth, he could have progressed routinely and completed the TSP course there on ordinary location. However, when he spoke to the officer from OCA, she told him he would not be able to go to ordinary location if he had been identified by someone at risk from other prisoners during his escort.
116. After his arrival at Wandsworth, the man quickly changed his mind about being reintegrated into the general prison population. The account he gave to some staff was that the other prisoner who had travelled with him from Belmarsh had been telling other prisoners that he was a "grass". This contrasted with the account he gave to the prisoner, which was that he had been identified as a VP by another prisoner being taken to Wandsworth at the same time. The prisoner described his relationship with him as "friendly" and was surprised to hear what he had said about him. In interview, the prisoner said that once they had both been transferred to the VP wing at Wandsworth they frequently spoke to each other.
117. However, the man had expressed some potential conflict between himself and the prisoner. This information should have been shared with staff on the VP wing where both prisoners were ultimately located. Whilst it was recorded in the observation book on E wing, it was not passed onto the Onslow Centre either via a Security Information Report (SIR which records any incident which might compromise the security of staff or prisoners) or by any other means. The SO of E wing said it was relatively common for one prisoner to say that they did not get on with another prisoner and SIRs are not usually generated under such circumstances.
118. Information about potential risk between prisoners should be shared and we make the following recommendation to reflect the importance of this:
- The Governor should ensure all staff are aware of the importance of recording information about potential risk when prisoners move between wings.**
119. The man's requests to become a VP in both prisons were processed efficiently. However, the form used by Wandsworth for those requesting VP status does not include a section for the date and time of the request to be recorded. It would have been helpful to know exactly when he requested VP status after his arrival. Given the seriousness of the decision to become a VP, there should be a full auditable record of such a request:

The Governor should develop a form for prisoners requesting vulnerable prisoner status which includes all pertinent facts.

The man's transfer and the TSP course at Wandsworth

120. In December 2010, Wandsworth's interventions and psychology team sent out a London-wide request to other prisons for any VPs that needed to complete the TSP course as part of their sentence plan to fill course vacancies. Both the prisoner and the man fitted the suitability criteria and when Belmarsh staff spoke with them they were assessed as motivated. No start date was given but the Head of Psychology at Belmarsh assumed that once they were transferred the course would start imminently. Accordingly, this expectation could have been passed onto him.
121. However, the investigator discovered that courses are run regularly Wandsworth and pre-course motivation work is undertaken before prisoners start a course. This could mean that the course does not start until six weeks after transfer. After their transfer, the team aim to see all new arrivals within two weeks. The investigator was told that in exceptional circumstances, for example, if a place unexpectedly comes up on the forthcoming course, a prisoner could be fast-tracked to start soon after transfer. In the absence of documentary evidence from Wandsworth, this might explain why the prisoner was assigned to the TSP course two days after his arrival at the prison.
122. The expectations in the psychology department at Belmarsh were that the man was going to start the TSP course as soon as he had been transferred, but the reality was that he would have to wait after his arrival at Wandsworth. The investigator spoke with the psychology department at Wandsworth about this and the manager agreed to produce a leaflet which could be handed to prisoners transferring to Wandsworth to explain access to courses.

The Governor should ensure that an explanatory leaflet describing the arrangements for offending behaviour courses is produced, shared with sending prisons and issued to prisoners coming to Wandsworth to take part in their courses.

123. Once the two psychology departments had agreed the man and the prisoner's transfer, the arrangements were co-ordinated by the OCA departments at each prison. When the two prisoners arrived at Wandsworth, the psychology department were not notified. Without a formal system in place to be notified, the TSP treatment manager said she checked the computer system daily to see who had arrived to complete courses. She was unable to explain why she saw that the prisoner was in Wandsworth, but did not see that the man had arrived. She approached the movements officer on E wing and found out that the prisoner was down to be moved to the Onslow Centre but that the man was not on the list to be moved.
124. She was not unduly concerned as she said there are many reasons why someone might not be transferred at the last minute. Having seen no confirmation that he was in the establishment, she assumed he must not have been transferred. She asked her colleague to seek out the prisoner for the place which had come up on the course starting 7 February. She was not due

to return to work until the following Tuesday (8 February) when she intended to chase up why the man had not arrived at Wandsworth.

125. Two previous self-inflicted deaths on the Onslow Centre have involved individuals who have recently been transferred from other establishments, one of these, like the man, came for a specific reason. On that occasion, a recommendation in the investigation report was made for the Governor to remind staff of the importance of keeping the 'Singular Transfer Register', which records prisoners being transferred into the establishment, and the then Governor confirmed in his action plan that this has been completed by issuing a Governor's Order.
126. However, once again a prisoner has arrived for a specific purpose and the necessary department, the psychology and interventions department, were not informed. Accordingly, the man was not seen by staff to be told what was happening. He was aware that the prisoner who had travelled with him from Belmarsh for the same reason was starting the course the next day. Of course, there is no way of knowing what was going through his mind in the days leading to his death. His mother told the investigator that he had always been someone who needed to know exactly what was happening otherwise he would become very anxious. It is possible that the absence of knowing what was happening with the TSP course increased his vulnerability.

The Governor should ensure there is a robust system in place for the relevant departments to be informed when a prisoner arrives for a specific reason.

Family Liaison

127. The Governor wrote a letter of condolence to the man's family. This letter was sent to the man's mother inside an envelope which had been addressed by him and contained the letter he had written on 3 February. Understandably, this caused additional distress to his mother upon seeing her son's handwriting on an envelope after his death.

The Governor should ensure that family liaison at the time of a death is conducted sensitively.

CONCLUSION

128. The man was on medication for depression and had a history of self-harm in the community. However, he gave differing accounts of his self harm history, and was assessed as a risk when his cellmate died and he subsequently received a very long prison sentence for a conviction of murder. He continued to deny his offence and his appeal had been rejected, although he was continuing to fight this. After several assessments, he was no longer considered at risk of self harm.
129. It is possible that the uncertainty around the TSP course increased his vulnerability. He perceived himself to be at risk from others. He was also in the first year of serving a life sentence and had had his recent appeal rejected. That said, staff had recently assessed his risk of suicide and self harm, upon his transfer to Wandsworth and he gave no indications, either to staff or fellow prisoners, that he was feeling suicidal.

RECOMMENDATIONS

The Head of Healthcare should ensure that prisoners are seen by a doctor upon reception if they are being prescribed medication and have a history of mental health difficulties.

Accepted.

Should a prisoner present on certain medication during first night (reception) screening for the following conditions (eg. cardiac, diabetes, epilepsy and mental health/self harm issues) then the patient will be seen that night by the GP on duty. Prisoners who have been identified for Substitute Prescribing to minimise withdrawal syndrome from dependency on psychoactive substances (eg. alcohol, opiates, heroin, benzodiazepine etc) will also be referred to the Reception GP. Prisoners who have brought in their own medication or prescription chart will have an entry made giving details. All medication seized by Discipline officers will be presented on Reception GP then locked in the medicine cupboard, [central pharmacy], and will then be taken to pharmacy at the earliest opportunity. An IP risk assessment will be done at the earliest opportunity.

All prisoners are risk assessed for self harm ideation and mental health issues and if it is necessary then an ACCT form would be opened. If these issues are identified then a referral to PCMHT/Inreach will be made and the tick box on the 'outcome of screening page' marked on SystemOne.

These prisoners will be seen by the reception GP for further assessment and/or treatment.

The Governor should ensure all staff are aware of the importance of recording information about potential risk when prisoners move between wings.

Accepted.

Staff will be reminded via a Governor's Order that:

- (a) All risk related information should be noted on the prisoner's case notes.
- (b) Also, if there is any risk information in relation to a prisoner's move to another wing, this should also be recorded in the wing observation book of the receiving wing.

The Governor should develop a form for prisoners requesting vulnerable prisoner status which includes all pertinent facts.

Accepted.

This form/process is currently under review. When amended, will include adding date and time.

The Governor should ensure that an explanatory leaflet describing the arrangements for offending behaviour courses is produced, shared with sending prisons and issued to prisoners coming to Wandsworth to take part in their courses.

Accepted.

An explanatory leaflet is currently shared with sending prisons which provides information on the courses provided at Wandsworth. However, this will now be

adapted to provide information on the assessment and suitability process also – including information on timescales and clarification that no specific space on a course has been assigned until the assessment has been completed.

The Governor should ensure there is a robust system in place for the relevant departments to be informed when a prisoner arrives for a specific reason.

Accepted.

In cases where a department request the transfer of prisoner(s) to Wandsworth, the OCA department will inform the requesting department that once this transfer has been formally agreed via under the London Area Protocol, it is the responsibility of the requesting department to arrange the specific of the transfer including the date of transfer with their contact point at the sending establishment. It seems reasonable that the contact point at the sending establishment be informed that the expectation is that they will inform the receiving establishment of when this transfer is due to take place.

The Governor should ensure that family liaison at the time of a death is conducted sensitively.

Accepted.

This was an unfortunate oversight at the time and we apologise for the distress caused the man's mother. We will raise this with our current group of Family Liaison Officers as a learning point.