



---

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

---

**Investigation into the death of a man at HMP  
Wandsworth in September 2014**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Wandsworth on 6 September 2014. He was 36 years old. I offer my condolences to his family and friends.

The investigator was appointed. A clinical reviewer reviewed the clinical care that the man received at Wandsworth. The prison cooperated fully with the investigation.

The man was serving a sentence for drug offences at HMP Highpoint, when the police received information that he was wanted in the USA for the murder of his wife and her mother. On 29 July 2014, the man went to court for an extradition hearing and was remanded to Wandsworth. Reception staff at Wandsworth said that they did not know that he was facing murder charges and no one ever considered the man's risk of suicide and self-harm in the light of these serious charges. It is not clear whether the prison had the full court warrant when the man arrived. On 3 September, the man went to court again for a further remand hearing. There is no record that staff reassessed his risk of suicide or self-harm when he came back from court. No one noted anything at the time to suggest that the man was distressed.

The man had shared a cell at Wandsworth but, on 5 September, his cellmate was released. The man was alone in his cell that night. Early on the morning of 6 September, a night patrol officer found the man hanged in his cell. Staff responded swiftly, but were unable to resuscitate him. Paramedics arrived quickly, but pronounced the man dead shortly afterwards.

I am concerned that no one at Wandsworth identified and considered the impact the serious new charges and potential extradition might have had on the man. Reception staff conjectured that the man must have arrived on an interim warrant, without full information. However, this was not recorded and the prison has been unable to provide other documents about his risk that should have arrived with him, including his escort record. Even if the information arrived later, no one considered whether this increased the man's risk of suicide. The investigation found that prisoners often arrive on interim warrants, without details of their charges. This is unsafe, as such information is essential for effective risk assessment. When it occurs, the prison should reassess risk as soon as further information is received.

As can happen with quiet and compliant prisoners, the man did not attract much staff attention. Staff knew little about him and as he had no personal officer this meant that the man received little staff support during his time at Wandsworth.

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.

## **CONTENTS**

Summary	5
The investigation process	6
HMP Wandsworth	7
Key events	8
Issues	14
Recommendations	18

## SUMMARY

1. On 10 July 2013, the man was remanded to HMP Wormwood Scrubs charged with supplying class A drugs. He was later convicted, sentenced to 33 months imprisonment and transferred to HMP Highpoint.
2. On 29 July 2014, the man appeared at Westminster Magistrates' Court for an extradition hearing. It was alleged that the man, living under a different name at the time, had killed his wife and her mother in the USA in January 2003. The man was taken from court to HMP Wandsworth.
3. Staff at Wandsworth who saw the man when he arrived said that they did not know that he faced murder charges. No one at Wandsworth assessed the man's risk of suicide and self-harm in the light of these serious charges. Nothing happened during the man's time at Wandsworth to give staff reason to worry for his safety. The man appeared at court again on 3 September, but there is no record that staff assessed his risk of suicide and self-harm when he got back.
4. On 5 September, the man's cellmate was released from prison. That night was the first time the man was alone in a cell overnight since he had arrived at Wandsworth. At a roll check at 5.18am on 6 September, a night patrol officer found the man hanged in his cell. Staff responded quickly and tried to resuscitate him. Paramedics arrived and took over the resuscitation attempt but at 6.10am, they pronounced him dead.
5. We are concerned that no one at Wandsworth identified the serious charges that the man was facing and therefore did not assess his risk of suicide and self-harm in the light of the charges. It is not clear whether he arrived on an interim warrant without details of his charges. However, no one reviewed his risk at any time afterwards. There was very little evidence of staff interaction with the man. He had no personal officer and, apart from several interviews with nurses and a doctor, when he first arrived at Wandsworth, staff had no further meaningful conversations with him. They knew little about the man and were unaware of his state of mind. Although we are satisfied that the emergency response was quick, we are concerned that the night patrol officer believed she was not allowed to go into cells on her own in an emergency. We make four recommendations.

## **THE INVESTIGATION PROCESS**

6. We issued notices to staff and prisoners at HMP Wandsworth, informing them of the investigation and inviting them to contact the investigator if they had relevant information. One prisoner responded.
7. The investigator obtained copies of the man's prison and healthcare records. He subsequently interviewed 12 members of staff and one prisoner at Wandsworth. He also interviewed two members of staff and one prisoner at HMP Highpoint, where the man had been before he came to Wandsworth.
8. The investigator informed HM Coroner for Inner West London District of the Ombudsman's investigation and we have sent her a copy of this report.
9. NHS England (London Area) appointed a clinical reviewer to review the man's clinical care at HMP Wandsworth. The clinical reviewer joined the investigator for interviews with prison healthcare staff.
10. We ordinarily contact families to inform them of our investigation and invite them to identify issues for the investigation to consider. We were not able to do so in this case, as the man had not given any details of his next of kin and the prison was unable to trace any members of his family.

## **HMP WANDSWORTH**

11. HMP Wandsworth is a local prison in London which holds up to 1,250 men in eight residential wings.

### **HM Inspectorate of Prisons**

12. The most recent published inspection report of HMP Wandsworth was of an announced inspection in May and June 2013. Inspectors found that safety at Wandsworth had improved significantly since the previous inspection just under two years before and that arrangements to receive and induct new prisoners were satisfactory. At the time, inspectors noted that the personal officer scheme had been reviewed and most prisoners knew who their personal officer was. They found that the quality of case history notes was mixed, and some were irregular and mechanistic. A further inspection of Wandsworth was taking place in March 2015, at the time this report was being prepared. Inspectors told us that prisoners often arrived at the prison from Westminster Magistrates' Court with interim warrants containing little information.

### **Independent Monitoring Board**

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its 2014 annual report, the IMB noted that staff-prisoner relationships had been adversely affected by the reduction in the number of prison officers on the wings. The IMB also noted that there had been considerable redeployment of officers across wings and that these officers had been unable to build meaningful relationships with prisoners.

### **Previous deaths at HMP Wandsworth**

14. The man's death was the fourth apparently self-inflicted death at HMP Wandsworth since March 2014. Before that, there had not been a self-inflicted death since March 2011. We repeat a concern, identified in the investigation into the death in March 2011, about the operation of the personal officer scheme.

## KEY EVENTS

15. The man was born in India. He had been convicted of numerous offences in the UK from 2005, but until 2013, his only other time in prison had been for a sentence of two months, in October 2006. The man had at least ten aliases. On 10 July, he was remanded to HMP Wormwood Scrubs charged with drug offences.
16. At a reception health assessment when he arrived at Wormwood Scrubs, the man said that he drank heavily and smoked heroin daily. He said that he had been treated for depression in the past and he gave the name of his community GP. (There is no evidence that Wormwood Scrubs, or any subsequent prison obtained the man's community health records.) The man said that he did not have any thoughts of suicide or self-harm. The nurse referred him to the mental health team and to the doctor to consider treatment for his drug and alcohol problems.
17. Later that evening, the man told a doctor that he drank five to six cans of strong beer and smoked £70 to £80 of heroin a day. The doctor prescribed chlordiazepoxide for alcohol detoxification and methadone for heroin dependence. After a stabilisation period, the man began to receive 40 millilitres (ml) of methadone a day.
18. Prison staff managed the man under Prison Service suicide and self-harm prevention procedures (known as ACCT) from 18 to 27 July, when he said that memories of seeing a friend being attacked were making him feel suicidal. Staff closed the ACCT after the man said that he no longer had thoughts of suicide or self-harm.
19. On 5 August, the man told the nurse at a mental health assessment, that he was having difficulty sleeping. The nurse assessed him as having mild to moderate depression. The man said that he had no thoughts of suicide. The nurse reviewed the man a month later. He noted that the man appeared settled and was interacting well with others and discharged him from mental health services.
20. On 13 August, the man was convicted of possession of a class A controlled drug, with the intention to supply to others. He was later sentenced to 33 months imprisonment. His conditional release date was 23 November 2014, after which he would be deported to India.
21. On 26 September, the man moved to HMP Highpoint. He worked in the textiles workshop at Highpoint and a workshop instructor told the investigator that the man was quiet, reserved and hardworking. She had noticed a slight change in his demeanour towards the end of his time at Highpoint, which she thought was because he did not want to return to India at the end of his sentence. However, she was not too concerned about him and did not think he was at risk of suicide and self-harm.
22. The man had agreed with a doctor at Highpoint that he would reduce his dose of methadone by 2ml every fortnight. He began on 2 January 2014, with a daily

dose of 38ml (reduced from 40ml). On 3 January, a doctor noted that the man was depressed and prescribed a four-week trial of an antidepressant, mirtazapine.

23. On 15 January, the man told a nurse (an agency nurse who no longer works at the prison) that he thought about killing himself every night, but said that he had no active plan to act on his thoughts. The nurse did not open an ACCT. The nurse noted that the man had recently been prescribed mirtazapine, which he said was helping. The man said that he did not want support from the mental health team, apart from having extra mirtazapine. The nurse noted that there was no clinical justification for increasing the mirtazapine dose yet.
24. On 5 February, a doctor saw the man again and changed his antidepressant prescription to amitriptyline (he did not record the reason for the change). When the nurse saw the man for follow-up a month later, he noted that the man looked a lot better.
25. On 22 July, officers told the man that he was going to Westminster Magistrates' Court but did not tell him why. The man refused to go. A prisoner at Highpoint, told the investigator that he was friends with the man. He said that he had told the man not to worry about court as it was probably just for minor charges and it would be better to get it over with. The man said that he was worried as the charges were serious. His court appearance was adjourned until the next week.
26. The officer who worked on the man's wing said that the man was very polite, well behaved and got on well with staff. The officer said that, on 29 July, he told the man that he was required to appear at Westminster Magistrates' Court that day. He said that the man looked a little dejected but agreed to go.
27. A detective sergeant from the Metropolitan Police Extradition Unit told the investigator that his unit had received information that the man was wanted in the USA for double murder (his wife and her mother), under another name. The detective sergeant said that he spoke to the man when he arrived at court on 29 July, and the man had said that both names were his. The man told the detective sergeant that he had no next of kin. The detective sergeant told the investigator that the man had appeared reasonably calm. The court duty solicitor, who acted for the man on 29 July, said that he did not seem surprised or unduly concerned about appearing in court that day.
28. The man went from court to HMP Wandsworth, as one of the prison's functions is to hold prisoners facing extradition. A supervising officer (SO) interviewed the man when he arrived at Wandsworth. Prisoners remanded from court (even when they are already serving a sentence) must be accompanied by a warrant. The SO told the investigator that she believed that the man must have arrived with a handwritten interim warrant, which often contain no information about the charges or offence. When this happens, the court faxes typed warrants to the prison later, with full details of the charges, and the prison destroys the interim warrants.

29. The SO could not remember the man but was certain that she had not seen a full remand warrant stating that he was wanted for murder. She said she was sure about this because people remanded for murder have to be considered for security category A (the highest prison security level) and she would have informed the duty governor. She said she would also have placed the man in the segregation unit, until someone made a decision about his categorisation the next day. The SO said that, had she known the man was facing extradition for murder charges, she would have checked his wellbeing and considered beginning ACCT suicide and self-harm prevention procedures.
30. We have not been able to establish whether the man arrived at Wandsworth with a full warrant, detailing the murder charges he faced in the USA, or an interim warrant, which might not have mentioned the charges. The warrant in his record, dated 29 October, contains full details of his charges and is not a faxed document, which would suggest it arrived with him. Wandsworth could not find the Person Escort Record, which accompanied him from court to prison, and which might have provided information about the seriousness of the charges he faced and whether he had been assessed as at risk of suicide and self-harm. Nor could the prison find a cell sharing risk assessment for the man, which should have been completed when he arrived and would have indicated whether they were aware of his charges at the time.
31. A nurse assessed the man in reception. She told the investigator that she saw around 30 new prisoners a day and could not remember the man specifically. However, she did not think that she had known that he was wanted in the USA for a double murder. The nurse noted in the medical records that the man looked well, that he appeared stable in mood and that he had no thoughts of suicide or self-harm. He was still receiving amitriptyline.
32. The man then saw a substance misuse nurse. She noted that he was receiving 12ml of methadone a day and was reducing at a rate of 2ml each fortnight. She recorded that the man should go to D Wing, Wandsworth's drug treatment wing, and staff allocated the man a shared cell on that wing.
33. An officer spoke to the man that evening and noted that he was happy to share a cell and had no thoughts of suicide or self-harm.
34. An entry in the man's records on 30 July, stated that he had been considered for potential category A status (because of the charges he was facing) but that he did not match the criteria. He did not need to move to a high security prison.
35. On 1 August, another nurse saw the man for a follow-up health screen after his initial reception assessment. She remembered him as a pleasant man and she had had no concerns about his wellbeing.
36. A prison doctor also saw the man that day to review his methadone reduction plan. The man agreed to reduce his methadone dose by 5ml a fortnight, instead of 2ml. The doctor prescribed 10ml of methadone starting that day and noted that the next prescription would be for 5ml.

37. The man had long-standing nerve pains, for which the doctor prescribed naproxen (an anti-inflammatory drug used to treat pain). The man was concerned that his sleep would be affected when his methadone prescription ended, so the doctor wrote a future prescription for a five-day course of zopiclone (a sleeping tablet) to start on 20 August.
38. The doctor told the investigator that he would generally refer prisoners with a history of mental health problems, or who seemed vulnerable or overly anxious to the mental health team. He offered to refer the man to the mental health team because of his history of depression, but he declined as he said that he was fine. The doctor judged the man to be at low risk of suicide or self-harm.
39. On 11 August, the man's methadone prescription was reduced to 5ml a day. He received 5ml of methadone a day for the next ten days until 21 August, when he stopped receiving methadone altogether.
40. On 23 August, another nurse noted that the man had asked for zopiclone that day and that the doctor had previously intended the man to receive a short course to help him cope with the end of his methadone prescription. A second doctor prescribed the man zopiclone for the next three nights.
41. The man attended court for a further extradition hearing on 3 September. The same duty solicitor who had represented the man in July acted for him again that day. The solicitor told the investigator that he had spoken to the man for about ten minutes and he had no concerns that the man might be intending to harm himself.
42. When the man returned from court to Wandsworth, there was an interim warrant on which "extradition" had been hand written but with no mention of the charges he was facing. There is no record that anyone in reception saw the man and assessed his risk of suicide and self-harm when he came back from court. A full warrant detailing his charges was faxed later.
43. A D wing officer told the investigator that he had some contact with the man. He said that the man was quiet and spent most of his time lying in bed watching television. The officer said that this was not unusual for an unemployed prisoner, as there was little else for them to do. The officer did not notice that the man had any particular prison friends, but he did not think that the man was reluctant to leave his cell to collect meals and there was nothing about his demeanour to suggest he had any worries or concerns. The officer did not know that the man was facing possible extradition to the USA for two charges of murder.
44. An SO was named as the man's personal officer. Personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress. The SO told the investigator that the personal officer scheme was not operating at Wandsworth at the time. He said that he was named as the man's personal officer as an administrative convenience, but that he did not expect and was not expected to meet the man. The man had no

contact with a personal officer while at Wandsworth and no other officers on his wing made any entries in his record about him.

45. A Sikh chaplain at Wandsworth told the investigator that each Monday he visited all of the Sikh prisoners to invite them to a service and Sikh teaching in the chapel. The chaplain said that the man came to the first few Monday services after he arrived at Wandsworth. He always came alone, was very quiet and he did not talk much with other prisoners. The chaplain said that on one occasion, he had asked the man why he seemed sad and the man had told him it was nothing. The man did not attend the final few services before his death as he said he was not feeling very well.
46. A prisoner living on the same landing as the man told the investigator that the man was quiet and, although they had no proper conversations, they would say hello to one another. They sometimes went to the gym at the same time and they had both gone a few days before the man's death. The prisoner thought that he had seemed his usual self at the time.
47. On 5 September, the man's cellmate went to court and was released from prison. The man remained in the same cell, on his own. This was the first time that he had not shared a cell since he had arrived at Wandsworth. (The investigator wrote twice to his cellmate asking to speak to him about the man, but he did not reply.)
48. The night patrol officer on D Wing that night told the investigator that she had carried out a roll check between around 8.30pm and 9.00pm. She could not recall what the man was doing at that time. She said that she made ACCT checks through the night and answered cell bells. The man did not press his cell bell that night and she did not need to check him for any other reason.
49. On 6 September, the night patrol officer began a morning roll check at around 5.00am and reached the man's cell at 5.18am. When she looked into his cell she saw him hanging by a bed sheet tied to a privacy curtain bracket attached to the ceiling. The man was fully suspended with his feet off the floor. The night patrol officer radioed to say there was a code one (life threatening) emergency. Staff in the control room called an ambulance immediately.
50. The night patrol officer told the investigator that she had looked into the cell twice because she did not want to believe what she was seeing. She said that she had discovered someone hanging previously, and finding the man hanging, affected her badly. Although she carried a cell key in a sealed pouch for use in emergencies, she said that she had been instructed never to go into a cell on her own during the night, so she waited for other officers to arrive.
51. Two officers arrived at the cell about a minute and a half later. They went into the cell and one supported the man's body while the other cut the sheet by which he was hanging. They lowered the man to the floor and one of the officers checked for signs of life. The officer told the investigator that the man's skin was slightly discoloured and he thought that he was probably already dead. However, rigor mortis had not set in and he was about to start cardiopulmonary

resuscitation when the nurses arrived. (CCTV shows that the nurses arrived just over a minute after the officers.)

52. One of the first response nurses told the investigator that, when she heard the code one alarm, she and another nurse went quickly to D Wing, taking emergency equipment. When they arrived, the second nurse checked the man for a pulse and they then started cardiopulmonary resuscitation. They checked the man with a defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest) which found no shockable heart rhythm and they continued to try to resuscitate him. Paramedics arrived 16 minutes later and took over the resuscitation efforts. The paramedics pronounced the man dead at 6.10am.

### **Contact with the man's family**

53. The man had not given details of his next of kin and had previously said that both his parents were dead. In his records, the man had named a person who he variously described as a friend and an uncle. Two staff from Wandsworth visited him but he told them that he had once been a neighbour of the man's parents and had no other connection with the man. He believed the man's parents had gone back to India some years before. The prison was unable to trace any members of the man's family. The Coroner took charge of the man's funeral arrangements.

### **Support for prisoners and staff**

54. The duty governor debriefed the staff involved in the emergency response and informed them of the support available from the prison's care team. Staff reviewed all prisoners being managed under ACCT procedures, in case they had been affected by the news of the man's death.

## ISSUES

### Assessing risk of suicide and self-harm

55. The SO who was in charge of reception when the man first arrived at Wandsworth from court on 29 July, said that he must have arrived with an interim warrant that contained no details of the murder charges he faced in the USA. The SO was adamant that, if she had seen this information, she would have moved him to the segregation unit until a decision had been made about whether he should be a category A prisoner. (There is no record of an interim warrant but the SO said these would usually be destroyed after a full warrant was received by fax. The only initial warrant for the man is not a faxed document and is dated 29 July.)
56. The SO recognised that the charges, and the fact that he was facing extradition, meant that the man would have been at raised risk of suicide or self-harm. However, if reception staff did not have that information, they would have been unable to consider it when assessing his risk. No one in reception noted anything about the reasons why the man was at Wandsworth and there is no record that they asked him. We are concerned that Wandsworth has been unable to provide us with the man's Person Escort Record, which might have contained further information about his risk. Nor is there a cell sharing risk assessment, which would have indicated whether staff were aware of his charges when he arrived. No one in reception regarded the man as at risk of suicide and self-harm.
57. While we have not been able to establish that the man arrived on an interim warrant on 29 July, when he returned from court in 3 September, an interim warrant was completed with no detail of his charges. Reception staff told the investigator that the issue of inadequately completed interim warrants was a specific problem with prisoners arriving from Westminster Magistrates' Court. The first night and early days in prison are a particularly vulnerable time and it is crucial that reception staff in prisons, assessing the risk of suicide and self-harm of newly arrived prisoners, have all the available information to make their assessments. The details of charges a prisoner is facing, is essential information, which staff need to take into account when assessing risk of suicide and self-harm. It was particularly important in this case, as the man was accused of murdering two family members. It is likely that had staff known this, they would have begun to monitor him under Prison Service suicide and self-harm prevention procedures. We make the following recommendation:

**The Governor should agree a protocol with Westminster Magistrates' Court to ensure that essential information about charges and offences is included in all warrants that arrive with a prisoner, to inform decisions about risk of suicide and self-harm.**

58. We have not been able to establish for certain what information accompanied the man to Wandsworth and it is regrettable that the prison has been unable to provide such important documents as the Person Escort Record and a cell sharing risk assessment. However, it is certain that by 30 July, the day after he arrived, staff at Wandsworth had received a fully completed warrant, which set

out the double murder charges the man faced in the USA. That information significantly raised the man's risk of suicide and self-harm, particularly as the charges related to family members, but there was no process to review his risk.

59. Prison Service Instruction 64/2011, which contains guidance on safer custody, states that:

*'Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form.'* [The use of italics denotes a mandatory instruction.]

60. Once the prison received the information about the charges the man was facing in the USA, someone should have identified that this was information that might indicate a risk of suicide and self-harm. It appears that this led to a review of his security category but there does not appear to have been any process to trigger a review of his risk to himself or that anyone considered whether to open an ACCT in the light of this information. We make the following recommendation:

**The Governor should ensure, that staff examine full warrants when they are received after a prisoner arrives and any other information which indicates a risk of suicide or self-harm, and consider whether to open an ACCT and record the information and action taken in the prisoner's record.**

61. When the man returned from court on 3 September a nurse did not assess him and there is no record that anyone else considered his risk of suicide and self-harm after this court appearance. Prison Service Order (PSO) 3050 notes that appearances at court can have a significant impact on the health of the prisoner and states that prisons should have a protocol that screens prisoners passing through reception for any potential healthcare or suicide/self-harm issues. We are concerned that Wandsworth missed a further opportunity to assess The man's risk, just a short time before his death. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health problems and risk of suicide and self-harm after all court appearances.**

### **Personal officer scheme**

62. The man spent only five weeks in Wandsworth. He does not appear to have come to staff's attention because he was well behaved and to some extent, overlooked. No one identified any concerns that he might harm himself but it does not appear that anyone knew the man well enough to recognise any signs of changes. The investigator spoke to a number of officers and managers at Wandsworth, but he was unable to identify any member of staff who had any significant contact with the man. The Sikh chaplain met the man a few times when he attended faith services, but he stopped going to the services a few weeks before he died.

63. The man did not have a personal officer while he was at Wandsworth. The investigator was told that this was because Wandsworth was still adjusting to the prison wide staff reductions combined with high sick-leave absences at the time. Although an SO was noted as the man's personal officer, he said that this was for administrative reasons and no personal officer had been appointed. The SO had never met the man and said he would not have expected to have had any contact with him.
64. According to Wandsworth's personal officer scheme, personal officers were required to get to know the prisoners they were responsible for including knowing their history, risk factors and problems. Personal officers were supposed to have fortnightly interviews with the prisoners and to make entries in their prison records of their discussions. During his time at Wandsworth, no officers on his wing made any entries in the man's records. It is of course possible that, even if the personal officer scheme had been working well, the man would not have told his personal officer how he was feeling. However, when the scheme works well, it is an opportunity for staff to get to know a prisoner and to be able to spot any changes in their demeanour. The investigator was told that the personal officer scheme was now operating again, but we are concerned that it was not operating at all at the time of the man's death. We make the following recommendation:

**The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.**

### **Clinical care**

65. The clinical reviewer found that, over all, the clinical care the man received at Wandsworth was equivalent to that he could have expected to receive in the community. He noted that on several occasions, Wandsworth healthcare staff assessed the man as at low risk of suicide and self-harm. The clinical reviewer concluded that there was nothing in the man's clinical presentation to suggest otherwise. However, the clinical reviewer noted that clinicians did not further assess the man's risk of suicide or self-harm when his methadone prescription ended on 21 August. The clinical reviewer has made some recommendations for improvement, which the Head of Healthcare will need to address.

### **Emergency response**

66. When the night patrol officer on D Wing found the man hanging, she immediately called a code one emergency, which was the correct thing to do. The control room called an ambulance as soon as they got the emergency call and other staff attended and had started cardiopulmonary resuscitation within two minutes. We are satisfied the emergency response was appropriate and it does not appear that anything could have been done to save the man.
67. Although, we do not consider it affected the outcome in this case, we noted that the night patrol officer did not go into the cell immediately when she saw the

man hanging. Although she had a cell key in a sealed pouch for use in an emergency, she said that she had been told never to go into a cell on her own at night under any circumstances, but to wait for other officers to arrive.

68. National instructions in PSI 24/2011 say that staff have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger and should first make every effort to get a verbal response from the prisoner. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment of the situation. While the night patrol officer might have decided to wait for other officers before she opened the man's cell, staff should not be instructed never to go into a cell alone. In some emergencies, an immediate response by one member of staff could save a life and staff are provided with emergency keys for that purpose. We make the following recommendation:

**The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.**

## RECOMMENDATIONS

1. The Governor should agree a protocol with Westminster Magistrates' Court to ensure that essential information about charges and offences is included in all warrants that arrive with a prisoner, to inform decisions about risk of suicide and self-harm.
2. The Governor should ensure, that staff examine full warrants when they are received after a prisoner arrives and any other information which indicates a risk of suicide or self-harm, and consider whether to open an ACCT and record the information and action taken in the prisoner's record.
3. The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health problems and risk of suicide and self-harm issues after all court appearances.
4. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.
5. The Governor should ensure that managers and staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

