Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Rajwinder Singh, a prisoner at HMP Wandsworth, on 25 June 2023

## A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Rajwinder Singh died in hospital on the 25 June 2023 after he was found hanged in his cell at HMP Wandsworth on 20 June. He was 36 years old. I offer my condolences to Mr Singh's family and friends.

Mr Singh had been at Wandsworth for 12 days when he was found hanged. For nine of these days, he was monitored by suicide and self-harm prevention procedures, (known as ACCT). He had a history of attempted suicide and self-harm and depression, for which he was prescribed antidepressant medication.

Mr Singh was one of five prisoners who took their own lives at Wandsworth during 2023. Both HM Inspectorate of Prisons and the Independent Monitoring Board concluded that the shortage of available staff seriously undermined the prison's ability to function effectively. Consequently, staff struggled to provide even a limited regime and incidents of self-harm, and the number of prisoners being monitored by ACCT had risen. In May 2024, HM Chief Inspector of Prisons issued an urgent notification to the Secretary of State for Justice in relation to the very poor outcomes for prisoners witnessed at the most recent inspection.

The challenges faced at Wandsworth are tragically demonstrated by the inadequacies in Mr Singh's care. There were stark and repeated failings to adequately assess and manage his risk to himself and support him appropriately. The ACCT process was conducted more frequently in breach of policy than in its observance. Staff also falsified records and failed to answer Mr Singh's cell bell which he had pressed 30 minutes before he was found hanging. Healthcare staff failed to adequately assess or support his deteriorating mental health. Changes in his medication were not communicated directly to Mr Singh and he did not always receive his prescribed medication. This worsened his mental health and increased his risk to himself.

I remain extremely concerned about prisoner care at Wandsworth and I urge HMPPS to consider how they can support meaningful improvements before another prisoner takes their own life. Wandsworth did alarmingly little to appropriately care for Mr Singh, nor did they recognise or attempt to mitigate his obviously increasing risk.

The failures in this case were voluminous and diverse. There were multiple opportunities for meaningful interventions within Mr Singh's care that would have led to a different outcome, that were repeatedly missed. I do not make the following statement lightly, but I consider that had Mr Singh been sent to a different prison in 2023, not in such a state of crisis, he would almost certainly still be alive today.

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

**Adrian Usher**
**Prisons and Probation Ombudsman** **October 2024**

# Contents

# Summary

## Events

1. On 14 May 2022, Mr Rajwinder Singh was remanded to custody and taken to HMP Wandsworth, charged with the acquisition, use and possession of criminal property. This was his first time in prison. On 10 June 2022, he was released from prison on bail, pending his trial.

2. On 9 June 2023, Mr Singh attended court and was sentenced to four years and 14 days imprisonment. He was returned to HMP Wandsworth. He had fibromyalgia (a condition that causes widespread pain and extreme tiredness), asthma, alcohol problems, and depression, for which he was prescribed medication.

3. Mr Singh's Person Escort Record (PER) that he arrived with at Wandsworth, identified that he had a history of attempted suicide and self-harm and had been displaying bizarre behaviour. During Mr Singh's reception screening, no one recorded or acknowledged that they had reviewed the risk information on the PER. The reception nurse referred Mr Singh to the mental health team.

4. From 12 June, staff managed Mr Singh under suicide and self-harm prevention procedures, known as ACCT, after he said he had suicidal thoughts and was struggling with his mental health. Over the next eight days that Mr Singh spent at Wandsworth, he frequently complained that he was stressed. From 17 June, this was compounded by him inconsistently receiving his medication. Mr Singh self-harmed and said that he wanted to take his own life. On 17 June, staff found Mr Singh with a ligature around his neck.

5. On the morning of 19 June, Mr Singh set fire to his hair. At around midnight on 20 June, Mr Singh set fire to his cell. This was the first time that staff had increased Mr Singh's ACCT checks, from hourly to twice an hour.

6. Mr Singh's serious acts of self-harm within this short period prompted an urgent mental health assessment. A mental health nurse saw Mr Singh on the morning of 20 June. However, the assessment failed to identify Mr Singh's currents risks, placed him on a waiting list to see a psychiatrist and made no plans for the mental health team to review him again.

7. When Mr Singh rang his cell bell at 8.36pm on 20 June, staff did not respond. At 9.06pm, an officer checked Mr Singh and saw he had a ligature around his neck. Prison and healthcare staff provided emergency care. Paramedics arrived at 9.19pm and took Mr Singh to hospital. On 25 June, Mr Singh died.

## Findings

## Identifying the risk of suicide and self-harm

8. Mr Singh's risk of suicide and self-harm was not properly assessed when he arrived at Wandsworth. Staff failed to consider information on the electronic PER and from other important sources.

9. The prison made critical and repeated failings in their duty of care to Mr Singh. We found major deficiencies in the prison's management of ACCT procedures. No ACCT case co-ordinator was appointed, and care plan actions were not set and updated. Staff failed to conduct immediate ACCT case reviews following Mr Singh's serious incidents of self-harm. They also did not consider placing Mr Singh under constant supervision after he set fire to his hair. We found that on the day that Mr Singh was found hanged in his cell, staff did not conduct ACCT observations or answer Mr Singh's cell bell (including when he pressed his bell 30 minutes before he was found hanging), as they should have done. They also falsified records.

10. We consider that healthcare staff underestimated Mr Singh's risk of suicide and self-harm despite the increasing medication issues that he experienced. Healthcare staff failed to adequately assess or support his deteriorating mental health. The clinical reviewer noted that the care Mr Singh received was not of the standard reasonably expected, and therefore, not equivalent to what he would have received in the wider community.

## Recommendations

- The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure herself that there is not a systemic issue with false entries.

- The Governor should provide the Ombudsman with a clear plan of how she is addressing the issues identified with assessing and managing prisoners' risk of suicide and self-harm, including training and continuous improvement provision.

- The Governor should provide the Ombudsman with a clear plan outlining how they will improve cell bell response times.

- The Head of Healthcare should ensure that the prescribers have a face-to-face conversation with a prisoner if there is an intention to reduce or cease any high risk prescribed medication.

- The Head of Healthcare should incorporate closer healthcare observations for prisoners who are on a reduction regime and/or are being taken off Gabapentinoids, to monitor withdrawal symptoms and any adverse effects.

- The Head of Healthcare should ensure that agency staff receive an appropriate induction when they start at Wandsworth so that they are clear about the expectations of healthcare staff at the prison.

# The Investigation Process

11. HMPPS notified us of Mr Rajwinder Singh's death on 26 June 2023.

12. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Singh's prison and medical records, CCTV and body worn video camera footage and prison telephone calls. He also obtained the HMPPS Early Learning Review and London Ambulance Service records. During the investigation, he obtained further information from the Governor and the Head of Safety.

14. NHS England commissioned a clinical reviewer to review Mr Singh's clinical care at the prison. The investigator interviewed 11 members of staff at Wandsworth, some jointly with the clinical reviewer.

15. We informed HM Coroner for London Inner West of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Singh's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Singh's wife wanted to know the circumstances that led to his death. She said that she was aware that Mr Singh had a scheduled mental health review on Tuesday 20 June 2023 and wanted to know if he took his medication that day. She said Mr Singh had not phoned her that day, as he normally would.

17. Mr Singh's family received a copy of the initial report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out five factual inaccuracies, and this report has been amended accordingly.

# Background Information

## HMP Wandsworth

19. HMP Wandsworth is a local category B/C prison in London. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison. Change Grow Live (CGL) provide psychosocial and substance misuse services.

## HM Inspectorate of Prisons

20. The most recent inspection of HMP Wandsworth was in April and May 2024. The full report of this inspection was not available at the time of writing. However, HMIP issued an urgent notification on 8 May 2024 which the Secretary of State has 28 days to respond to. A debriefing paper had also been prepared and was publicly available.

21. Inspectors noted that despite a high-profile escape in September 2023, significant weaknesses remained in many aspects of security. They found that the rate of self-harm was high and rising but around 40% of cell bells were not answered within five minutes. Inspectors found that many prisoners were clearly in distress without an appropriate level of support. There were weaknesses in the ACCT case management process. Reviews did not always identify appropriate risks and care maps were often blank or contained limited information. In their survey, only 37% of prisoners who had been supported using ACCT said that they felt cared for. Many prison inspectors we spoke to said that ACCT reviews were perfunctory and rarely helped them to deal with their problems.

22. Rates of violence had increased and in February 2024, 44% of prisoners tested positive in random drug tests.

23. HMIP noted that Wandsworth was badly overcrowded, with a transient population, over half of whom were remand prisoners. Living conditions were very poor, cells were cramped and ill-equipped and the prison was too dirty. The buildings and facilities needed investment to make them a decent standard. Only 41% of prisoners said that staff treated them with respect. Inspectors found that very limited time out of cell, absent staff and no key work reduced the opportunity for staff to develop meaningful relationships with prisoners.

24. There was little purposeful activity, with most prisoners unemployed and spending over 22 hours a day locked up. Inspectors found that prisoners had no idea when or if they would be unlocked each day or whether they would get access to fresh air. There were consistent failures to enable access to healthcare services due to prison staff absences.

25. Despite a full complement of officers, sickness, restricted duties and training commitments meant that over a third could not be deployed to operational duties each day. This led to curtailed regimes, cross-deployment and burnt-out staff. Staff at all grades were inexperienced. HMIP noted that they were not wilfully neglectful, they just did not understand their role and lacked direction, training and consistent support from leaders.

26. Inspectors concluded that the poor outcomes they found at Wandsworth stemmed from poor leadership at every level of the prison, from HMPPS and the Ministry of Justice, leading to systemic and cultural failings which had led to a shocking decline.

27. The Governor at HMP Wandsworth advised the London Prison Group Director before the inspection concluded of her intention to step down.

## Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2023, the IMB reported that conditions in HMP Wandsworth reflected the failures of the prison system as a whole. The Board noted that no real progress had been made in resolving problems caused by years of underinvestment in the fabric, facilities and staff at the prison.

29. The IMB noted that during the year, the shortage of available staff seriously undermined the ability of the prison to function effectively. The percentage of available officers rarely reached above 50% of full staffing levels. Consequently, staff always struggled to provide even a limited regime and deliver all the other needs of the prison. The prison was not safe and was reflected by the continued rise of violence and assault rates. The incidents of self-harm along with the number of prisoners that were being monitored by suicide and self-harm procedures had risen.

## Previous deaths at HMP Wandsworth

30. Mr Singh was the seventeenth prisoner to die at Wandsworth since June 2020. Of the previous deaths, three were from natural causes, one was due to drugs, one was unascertained and eleven were self-inflicted. Up to the end of February 2024, there had been three natural cause and four self-inflicted deaths at Wandsworth since Mr Singh died. In our previous investigations, we have highlighted failings in the provision of ACCT review processes, which included the frequent absence of multi-disciplinary teams from ACCT reviews and failure to deliver hourly observations.

31. Due to the number of self-inflicted deaths that have recently occurred at Wandsworth they are receiving additional support and monitoring from regional and national safety teams.

## Assessment, Care in Custody and Teamwork

32. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

33. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant

observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

### ACCT Constant supervision

34. Constant supervision is a period of one-to-one observation of a prisoner who has been identified as a high risk of suicide or serious self-harm. Constant supervision is implemented to reduce this risk and intervene in the case of an emergency. Both the prisoner and staff conducting constant supervision must be supported by a multi-disciplinary case review team as part of the ACCT process.

# Key Events

35. On 14 May 2022, Mr Rajwinder Singh was remanded to custody charged with the acquisition, use and possession of criminal property. He was taken to HMP Wandsworth. This was his first time in prison. On 6 June, staff started suicide and self-harm prevention procedures, known as ACCT, after Mr Singh self-harmed by cutting his arm. He was worried about a wing move. This ACCT stayed open until 10 June when he was released from prison on bail.

36. On 9 June 2023, Mr Singh attended court and was sentenced to four years and 14 days in prison. He returned to HMP Wandsworth.

37. When he arrived, the digital and paper Person Escort Record (PER) that accompanied Mr Singh contained a suicide and self-harm warning (SASH) form, which indicated that he had a history of self-harm (by overdose, cutting and burning himself) and had attempted suicide (by jumping off a roof) in the last six months. The PER also noted that Mr Singh had displayed bizarre behaviour, had alcohol problems and was prescribed medication for depression.

38. A nurse completed Mr Singh's reception healthcare screening. Mr Singh told the nurse that he had epilepsy, chronic obstructive pulmonary disease (COPD – a lung disease which restricts airflow) and asthma. He also had fibromyalgia (a condition that causes widespread pain and extreme tiredness). He said he was prescribed pregabalin (used to treat epilepsy, anxiety and nerve pain), montelukast (maintenance treatment for asthma), and sertraline (an antidepressant). Mr Singh said he drank alcohol heavily. The nurse completed a Clinical Institute Withdrawal Assessment for Alcohol (CIWA) that indicated that Mr Singh had moderate alcohol withdrawal symptoms. He said he had no current thoughts of suicide or self-harm. She referred Mr Singh to the GP and the Mental Health In-Reach Team (MHIRT). The nurse told us that she did not see Mr Singh's PER or SASH form.

39. An officer completed Mr Singh's first night reception interview. He told us that he communicated with Mr Singh in English as well as Punjabi. He had no concerns about Mr Singh who said he had no thoughts of suicide or self-harm. He recorded no details about Mr Singh's suicide and self-harm history from the PER or SASH form that arrived with him. He told us that reception prison staff receive the PER and SASH documents when a prisoner arrives in custody. He did not know why he had not acknowledged the details on the PER and SASH form during his assessment.

40. A GP saw Mr Singh in reception. Mr Singh told the GP that he had fibromyalgia, and vertigo (a sensation of spinning or moving related to problems with the inner ear). He said he drank half a bottle of whisky a day. The GP noted that Mr Singh had withdrawal symptoms (fine tremors) and prescribed him an alcohol detoxification regime, which included chlordiazepoxide and thiamine. The GP confirmed Mr Singh's regular medications including sertraline by checking his medical Summary Care Record (SCR - a national database that holds electronic records of important patient information such as their medication).

41. Mr Singh was located on the Induction Wing in a shared cell on E Wing. Over the next five days, staff completed his alcohol withdrawal observation checks.

42. On 11 June, Mr Singh told healthcare staff that he felt unwell, had not slept well and had a headache. His physical observations were taken and considered normal.

43. On 12 June, Mr Singh was referred to Change Grow Live (CGL, a charity and partner organisation within the healthcare team that provides psychosocial substance misuse support to prisoners).

44. The pharmacist completed Mr Singh's medication reconciliation. He noted that Mr Singh's medical record contained no information to confirm that he had epilepsy, as he had self-reported.

45. A nurse completed Mr Singh's secondary healthcare screening. Mr Singh had mild withdrawal symptoms and said that he had ongoing problems that related to his fibromyalgia. This caused him mobility problems with his right leg and the nurse observed him limping. Mr Singh told the nurse that he had attempted suicide by jumping off a roof two months previously. He said he did not want to be alive and felt like cutting his arm and eating his flesh. After the nurse completed blood tests, she observed Mr Singh squeezing blood from his arm and licking it. At 12.59pm, she opened an ACCT and again referred Mr Singh to the mental health team. Staff placed him on hourly ACCT observation checks. At 3.30pm, staff completed the ACCT immediate action plan.

46. Mr Singh's MHIRT referral was triaged, and healthcare staff noted that he would be seen by the GP the following morning to review his anxiety and depression. Later, Mr Singh told a Healthcare Assistant (HCA) that he had problems with his cellmate. He said that he would harm his cellmate if he continued to annoy him. The HCA noted that they told an officer. No other details were recorded.

47. Staff did not record any conversations with Mr Singh that afternoon or evening or any ACCT checks overnight.

48. On 13 June at 9.45am, a Supervising Officer (SO) completed Mr Singh's ACCT assessment. Mr Singh said that he felt the urge to kill himself when he was stressed and irritated and that he struggled to sleep because of his cellmate. He said that he had previously attempted suicide on several occasions by taking overdoses and jumping off buildings.

49. At 11.08am, a GP reviewed Mr Singh's record and noted that he did not have a confirmed diagnosis of epilepsy. She advised that Mr Singh should also be weaned off his prescription of prochlorperazine (prescribed for vertigo) as this medication was not supposed to have been prescribed long-term. There was no record that the GP's assessment included concerns surrounding Mr Singh's anxiety and depression, as requested by the MHIRT.

50. Soon after, two SOs and a nurse from the MHIRT held an ACCT case review with Mr Singh. Staff noted that Mr Singh had suicidal thoughts although he said he had no plans to act on these. He felt low but said his wife was his protective factor and they spoke daily. It was noted that Mr Singh had already been referred to the MHIRT and the substance misuse team for support. The nurse referred him to Atrium counselling services. Staff agreed to relocate Mr Singh to a ground floor cell to aid his mobility and to resolve the problems he said he had with his cellmate. ACCT observations remained hourly, and staff scheduled the next review for 20 June.

51. The ACCT care plan noted that Mr Singh's wife was his protective factor and that he prayed regularly, which he said helped his mental health. It also noted that he suffered from vertigo, and he would be relocated to a ground floor cell (he was still expected to share with another prisoner). Staff referred Mr Singh to CGL, the mental health and chaplaincy teams. The library staff had agreed to provide Mr Singh with some books written in Punjabi for him to read. The care plan noted that all the identified actions had been completed.

52. On the same day, a substance misuse worker from CGL assessed Mr Singh. He said he misused alcohol and cocaine and had taken an overdose two weeks previously. He said he disliked leaving his cell and preferred to complete any work and support activities in his cell, as opposed to attending group work. He said that he had been pressured and threatened by other prisoners and felt intimidated. (We found no evidence to suggest that this information was passed to prison staff to investigate.) She noted that Mr Singh had already been referred to the MHIRT.

53. At 4.30pm, Mr Singh was moved to a new cell on the second landing. Staff noted in the ACCT observation log that when Mr Singh collected his food, he looked scared and stressed. A HCA noted that Mr Singh had unspecified mental health episodes, and was speaking in different languages, had hallucinations and heard voices. They noted that Mr Singh had already been referred to the MHIRT.

54. The same afternoon, Atrium counselling service responded to a referral they had received for Mr Singh (following the nurse's assessment on 13 June) which said that he had schizophrenia with paranoia, suicidal thoughts and had requested psychological input. The counselling service noted that Mr Singh should be assessed by the MHIRT and then re-referred to Atrium if necessary.

55. Staff recorded no conversations with Mr Singh during that day and only one ACCT check at 4.30pm. Staff started ACCT checks again at 9.20pm.

56. On the morning of 14 June, a GP saw Mr Singh for his five-day alcohol withdrawal review. Mr Singh told the GP that he was not sleeping well, felt tired and dizzy. The GP noted he looked tired but settled. He continued Mr Singh's detoxification regime until 16 June.

57. The same morning, a HCA saw Mr Singh and completed his withdrawal observations. Mr Singh said he felt anxious and had suicidal thoughts. We found no evidence that this information was shared with prison staff or documented in Mr Singh's ACCT document to reassess his risk. The HCA also noted Mr Singh was limping and not able to stand upright.

58. Staff brought Mr Singh's lunch to him in his cell. Mr Singh said he was still not happy that he had to share a cell and asked for his cellmate to be moved. Staff recorded no other information. ACCT checks and conversations with Mr Singh that day were sporadic.

59. Around 6.00am on 15 June, staff discovered that Mr Singh had cut his arm as he said he was stressed. Staff noted this information in his ACCT document and that healthcare staff had treated him. However, there was no record of this incident in Mr Singh's medical or general prison record (NOMIS). Staff did not hold an ACCT

review. From 1.30pm until 6.11pm, staff did not record ACCT checks or record that they had any conversations with him.

60. On 16 June at 4.13pm, an SO held an ACCT review with Mr Singh. Mr Singh said that he had thoughts of suicide and self-harm and did not like to socialise with others. The SO told Mr Singh that he would be moved to D Wing later that day. Mr Singh remained on hourly observations. The next ACCT review was scheduled for 20 June. There is no record that the SO discussed Mr Singh's self-harm the previous day with him. He later moved to a cell on the second landing on D Wing.

61. That night, around 9.00pm, an officer (suspended from duty due to an unrelated matter and not available to be interviewed) recorded in the ACCT ongoing record that Mr Singh complained that the condition of his cell was squalid and that he had no water. Mr Singh showed the officer new cuts he had made on his wrists. Mr Singh also told the officer that he had been banging his head against the wall because he had not received his medication. The officer noted that he had called for assistance and "this was dealt with". (Mr Singh's medical records indicated that he did receive his medication that evening). Staff did not hold an ACCT review or consider whether Mr Singh's level of observations needed to be increased.

62. The next morning, the pharmacy technician noted that they had been unable to give Mr Singh his medication because he was not unlocked from his cell, due to prison staffing shortages. (We have since ascertained that Mr Singh later received his medication, although he did not receive his pregabalin because his previous seven-day prescription had run out.)

63. From 7.00am to 9.00pm, staff did not complete ACCT checks or record that they had had any conversations with Mr Singh. That afternoon, a prescriber reviewed Mr Singh's pregabalin prescription. The prescriber noted that Mr Singh's SCR did not confirm that he was prescribed pregabalin for epilepsy. As such, the prescriber instructed that it should be reduced over seven days with a view to the medication then being stopped. Staff made an appointment for Mr Singh to see a GP the following week to review his self-reported epilepsy and possible alternative treatment options. Staff did not tell Mr Singh that his pregabalin medication would be reduced and stopped.

64. That afternoon, an officer (who no longer works at HMP Wandsworth) found Mr Singh with a loosely tied ligature (made from bedding) around his neck and attached to his bed rail. She radioed a code blue (used when a prisoner is unconscious or has breathing difficulties) and removed the ligature from Mr Singh's neck. Two nurses responded but Mr Singh refused to engage with them. Mr Singh was conscious, breathing and allowed them to complete his physical observations. These were within normal range except for Mr Singh's pulse, which was elevated. No treatment was necessary. They recorded this information in Mr Singh's medical record at 3.28pm.

65. A Custodial Manager (CM) told us that she started work that day around midday and was working in the prison central office. At some point that afternoon, staff told her that Mr Singh had self-harmed. She checked Mr Singh's prison records and noted that it did not contain any information about the incident. She therefore updated his records at 4.05pm, noting that staff had found Mr Singh earlier that day with a ligature around his neck.

66. Later that evening around 7.00pm, the CM checked how Mr Singh was. He said he felt much better as he had received his evening medication. Mr Singh explained that he had been stressed because he had not received his morning medication. She told Mr Singh that an ACCT review would be held the following morning to discuss the incident and maintained his hourly ACCT observations. That evening, Mr Singh was moved to a new shared cell on the third landing that had a sink.

67. At 7.44pm, an officer also updated Mr Singh's record to note that staff had removed a ligature from his neck that afternoon. She noted that she believed Mr Singh was trying to manipulate staff to get out of his cell. Staff did not record their interactions with him that day on the ACCT document, including information about the ligature being removed. Additionally, staff did not record any ACCT observations that day until 9.00pm.

68. After being relocated to a different cell, cell bell records show that Mr Singh pressed his emergency cell bell twice. Staff responded to his cell bell in 14 minutes on both occasions.

69. On the morning of 18 June, staff recorded in Mr Singh's ACCT document that the wing was in complete lock down for the day and that no prisoners had been unlocked from their cells due to staffing levels. Only critical medication was being issued to prisoners. Mr Singh did not receive his medication that morning.

70. During the day, Mr Singh made a number of phone calls to his family (from his prison in-cell phone). He spoke Punjabi in all his calls. A Punjabi speaking member of PPO staff listened to these calls. In one of the calls, he told his wife (who was staying with her mother) that he did not know why "they had stopped his medication" and he needed it to help with his pain. He said that staff were not answering his cell bell when he pressed it. On one occasion he said he had pressed his cell bell constantly for two hours. He also said that he had not been unlocked to collect his food.

71. An officer recorded in the morning summary section in the ACCT record that Mr Singh had covered his observation panel. Mr Singh removed the covering from the panel when asked to do so. Mr Singh told the officer that he had not received his medication that day and had been "banging his head". He recorded that Mr Singh was "genuinely and usually pleasant and quiet, he doesn't kick off, but he is needy". The officer noted in the wing observation book that he had told a nurse but there is no further evidence of this or that he considered whether Mr Singh's ACCT observations needed to be increased.

72. At around 11.45am, the CM held an ACCT review with Mr Singh. No one else attended. (She told us that Mr Singh's was the fifth ACCT review she had completed that day and while healthcare staff had attended the previous reviews, they had had to leave before Mr Singh's review due to other duties. She received no input from the healthcare team about Mr Singh.)

73. At the review, Mr Singh said he had thoughts of self-harm. He felt stressed because he had not received his morning medication (sertraline and pregabalin). The CM told Mr Singh that the healthcare team were only administering critical medication to prisoners that morning due to staffing issues, but she would speak to them. (Despite this, Mr Singh still did not receive his medication.) Mr Singh said that he felt better now that he had moved to a new cell, and he got on with his new cellmate.

74. Around 5.00pm, staff radioed a code blue after they found Mr Singh on his cell floor unresponsive, potentially having a seizure. Staff put him in the recovery position. When the nurse arrived, Mr Singh was alert but did not engage or get up. Although the nurse was unable to complete a full set of clinical observations, she noted that his oxygen saturation and pulse were within a normal range. Staff told the nurse that Mr Singh had not received his morning medication. The nurse advised them that Mr Singh was not on any medication for epilepsy but was prescribed a reducing dose of pregabalin. She requested that prison staff unlock Mr Singh to collect his medication that evening. The nurse made no plans for healthcare staff to see Mr Singh that evening but told officers keep an eye on him and to contact the healthcare team if needed. Mr Singh collected his medication that evening.

75. On this day, Mr Singh pressed his cell bell 13 times. On average, staff responded to Mr Singh's cell bell in 31 minutes.

**19 June 2023**

76. At 10.09am, Mr Singh phoned his wife. At 11.00am, the CM (who was the most senior officer on duty that day and had the radio call sign Oscar 1) noted in Mr Singh's prison record that Mr Singh had self-harmed earlier that morning by setting fire to his hair. (His cell mate had apparently put water on his head to put the fire out.) She had read about this incident on the daily briefing sheets. She told us that it was her expectation that the wing SO would have updated Mr Singh's ACCT document. However, when she checked this had not been recorded on Mr Singh's prison record, so she made the entry herself.

77. At 11.58am, an officer recorded on NOMIS and the ACCT record, that Mr Singh had earlier used a match (which prisoners are not allowed to have) to set fire to his hair. Mr Singh had told the officer that his actions were a result of "inconsistent/lack of adequate medication" which was affecting his mental health. A nurse recorded at 4.06pm that she had examined Mr Singh, and he had no damage to his scalp, only his hair. She referred Mr Singh to the MHIRT. Staff did not hold an ACCT review. In addition, staff did not record Mr Singh's ACCT observations between 2.00pm and 7.00pm or record any conversations with him. From 7.00pm to 11.10pm, staff noted that they completed hourly checks.

78. Staff moved Mr Singh to a different cell. Mr Singh phoned his wife twice that evening. He said that he had received his food that day but said that staff had not answered his cell bell. He asked his wife to tell their GP that he had "cut his arms and set his hair on fire". His wife was shocked at this disclosure. Mr Singh told her to make sure that she told the GP that he was harming himself because he was not getting his medication.

79. On this day, Mr Singh pressed his cell bell eight times. On average, staff responded to Mr Singh's cell bell in 21 minutes.

**Tuesday 20 June 2023**

80. On 20 June at around 12.24am, Mr Singh set fire to a mop in his cell. Officers responded and extinguished the fire. Mr Singh told staff that he was unhappy that he

had not received his mental health medication that day and wanted to kill himself. A nurse examined Mr Singh. He had no burns or respiratory problems.

81. Staff moved Mr Singh to a different cell on the second landing. (Mr Singh was located in a constant supervision cell although he was not placed under constant supervision). A CM (Oscar 1) increased Mr Singh's ACCT observations to "every 30 minutes", with his next ACCT review scheduled for later that day. Staff recorded the increase of observations in the wing observation book. It is not clear whether she assessed Mr Singh in person.

82. An Operational Support Grade (OSG) recorded that he checked Mr Singh half hourly throughout the night. (The investigator arranged to interview the OSG three times, but he failed to attend on each occasion.) In the morning, in response to the incident that had occurred overnight, the Head of Safer Custody put Mr Singh on Wandsworth's Crisis Pathway. This meant that he would be prioritised to be seen by the MHIRT the same day.

83. In the morning summary (no time noted) section in the ACCT document, staff noted that Mr Singh was unlocked for his medication that morning. He did not receive the pregabalin as he expected (because he was on the reducing dose).

84. A mental health nurse saw Mr Singh at around 12.24pm. (His assessment was not added to Mr Singh's medical record until 21 June, after Mr Singh was found hanged in his cell.) The nurse noted that Mr Singh seemed anxious and irritable but maintained good eye contact. Mr Singh said that he was not happy that he was not on the same dose of pregabalin that he had been in the community, and that for three days he had not been given his medication at the doses he expected. The nurse noted that he had checked Mr Singh's medication chart and confirmed that he had been given it as it was prescribed. However, he failed to acknowledge this was not the dose that Mr Singh expected. He noted that Mr Singh would be referred to the psychiatrist (who had a waiting list). He made no plan for Mr Singh to be reviewed by the MHIRT again nor did he record whether he had asked Mr Singh if he had any thoughts of suicide or self-harm.

85. A safer custody administrator noted on Mr Singh's prison record that his wife phoned the prison's safer custody team at 1.37pm. Mr Singh's wife raised concerns about Mr Singh and said that he had not contacted her for a few days, which was unusual for him. (Mr Singh's prison phone records show that he last phoned his mothers-in-law's home number the previous day. We were told by Mr Singh's family that sometimes Mr Singh's wife was out when he phoned, and he would therefore speak to his mother-in-law.) At 2.02pm, the administrator phoned the staff office on D Wing and spoke to an (unknown) officer, who said that Mr Singh would be told that his wife had contacted the prison. She had also checked Mr Singh's finance account and noted that he had limited funds. She told the officer that Mr Singh would need to add some phone credit to his phone account. We found no evidence that wing staff checked Mr Singh or passed on this information to him.

86. Around 2.30pm, an SO chaired an ACCT review. A substance misuse worker from CGL, and part of the healthcare team, and Mr Singh attended. Mr Singh said that his biggest problem was not being unlocked from his cell to collect his medication, and when he was, he did not always get his pregabalin. (It appeared that Mr Singh was still not aware at this point that his pregabalin medication had been reduced.) He said

this had caused his mental health to deteriorate. Mr Singh felt that he was having a hard time on D Wing and was being ignored and neglected, even when he pressed his cell bell. The SO noted that Mr Singh's mood was low, and they discussed him setting his hair on fire. Mr Singh said that he still had thoughts of self-harm and said he "struggled to go on anymore". He said he had been suffering with severe depression for about five years. He wanted to receive his medication and food daily, which he said was not happening. He said he felt anxious when he left his cell, and some days he would ask someone else to collect his food for him. He had mobility problems and asked if the healthcare team would be able to provide him with a walking frame, which he said he used in the community. The SO asked Mr Singh if he was being supported by the MHIRT. Mr Singh said that he had had one appointment with the MHIRT earlier that day. He said that the nurse that saw him was dismissive and said that he was unable to help him. The substance misuse worker said that she could contact the healthcare team to check whether the correct person had seen Mr Singh.

87. The SO told Mr Singh that he would speak to staff to ensure that Mr Singh was unlocked for his medication. He said he would also ask the wing decency rep (a trusted prisoner with allocated duties) to bring Mr Singh's food to him in his cell. The substance misuse worker asked whether Mr Singh had finished his detoxification program and discussed his medication with him. Mr Singh confirmed he had but did not feel good. He said that his family were his support network and he spoke to his wife daily. Staff agreed that Mr Singh's ACCT observations would remain at two per hour and scheduled his next ACCT review for 27 June. None of the actions discussed were added to Mr Singh's ACCT care plan.

88. Staff completed half hourly ACCT checks throughout the afternoon. The investigator was provided with the CCTV from 5.00pm onwards. We have documented in the table below the checks evidenced on CCTV compared to the checks documented in the ACCT. There are more checks documented in the ACCT than took place, suggesting that staff had falsified records. In addition, although Wandsworth provided the investigator with cell bell records for this day, the records did not show that Mr Singh had pressed his cell bell. Wandsworth told us that there was a fault in the cell bell monitoring system that meant that when the cell bell for Mr Singh's cell was activated, this had not been recorded on the cell bell report. They were unable to tell us whether this was also the case for other cells on the wing. We were therefore unable to check how many times Mr Singh pressed his cell on 20 June. The cell bell times below are taken from the CCTV when the cell bell light outside Mr Singh's cell started flashing.

| **Checks evidenced on CCTV** | **Checks documented in ACCT** |
|---|---|
| 5.29pm – Officer A | 5.10pm (Officer A) |
| | 5.50pm (Officer A) |
| 6.36pm (responding to 6.19pm cell bell) – Officer B | 6.30pm (No name) |
| 7.01pm (took Mr Singh to collect medication) - Officer B | 6.59pm (No name) |

| | |
|---|---|
| 7.49pm (responding to 7.44pm cell bell) Officer C | 7.40pm (No name) |
| | **7.58pm (No name)** |
| 8.20pm (responding to 8.11pm cell bell) Officer C | 8.20pm (No name) |

89. Officer C told us that when he responded to Mr Singh's cell bell at 7.49pm, Mr Singh asked if he could leave his cell to take a walk. The officer told him that this was not possible as the prison was in patrol state (meaning there were minimal staff in the prison). He thought that perhaps Mr Singh was confused as to the regime times. Mr Singh accepted the officer's answer, returned to his bed and sat down. The officer had no further contact with Mr Singh and his duty ended shortly afterwards.

90. Officer B (who resigned from the Prison Service and was not interviewed) responded to Mr Singh's cell bell at 8.20pm, after he had rung it nine minutes earlier. We do not know why Mr Singh activated his cell bell at this or the other times that he did. Staff did not record any ACCT observation checks after 8.20pm.

91. At 8.36pm, Mr Singh pressed his emergency cell bell again; we do not know why as staff did not respond to it.

**Emergency response**

92. In his statement, the OSG said that at approximately 8.50pm, he arrived on D Wing for his night shift. He received a handover from an officer who left the wing shortly afterwards, leaving him as the only member of staff on duty. He stated that there were several emergency cell bells ringing on all the landings. He decided to get a piece of paper to make notes on when answering cell bells, while he also did the night routine check of all prisoners.

93. The OSG started the check on the ground floor landing. CCTV shows he arrived at Mr Singh's cell, on the second landing, at 9.06pm. When he looked through the observation panel, he saw Mr Singh hanging from a ligature at the back of the cell. He immediately radioed for staff assistance, stating that a prisoner was hanging.

94. Two officers responded and arrived at Mr Singh's cell at 9.08pm. Officer D told us that although the OSG had not radioed an emergency code blue, they were aware that it was an urgent situation. The OSG was waiting outside Mr Singh's cell for the staff to arrive.

95. Officer D looked through the cell observation panel and saw Mr Singh in a seated position at the back of his cell with a ligature around his neck. Mr Singh did not respond when staff called his name. Officer E unlocked and went into Mr Singh's cell followed by Officer D. More officers arrived at the cell. As they approached Mr Singh, Officer D saw the ligature (a bed sheet), was secured to the window. Officer D cut the ligature with his anti-ligature knife, while his colleagues supported Mr Singh's body and lowered him to the floor. Mr Singh remained unresponsive and unconscious. Officer F radioed a code blue. The control room recorded that this occurred at

9.10pm and staff there called an ambulance. Officer F checked Mr Singh for signs of life and found a faint pulse. The officers placed Mr Singh in the recovery position.

96. At 9.11pm, a nurse arrived at Mr Singh's cell. He examined Mr Singh and noted that he had stopped breathing. He instructed staff to commence cardiopulmonary resuscitation (CPR). Officer E started CPR and alternated chest compressions with Officer D and Officer F, until the paramedics arrived. The nurse used the medical equipment, which included the defibrillator, to support resuscitation attempts, assisted by a colleague.

97. At 9.19pm, paramedics arrived and took over Mr Singh's care. At 9.31pm, they established a pulse. At 10.14pm, paramedics took Mr Singh to hospital. He was diagnosed with a hypoxic brain injury (caused by a lack of oxygen to the brain). On 25 June at 12.12pm, Mr Singh died.

## Contact with Mr Singh's family

98. The prison appointed two family liaison officers (FLOs). At around 11.10pm on 20 June, one FLO phoned Mr Singh's wife and told her that he was in a critical condition in hospital having attempted to take his own life. The FLOs then visited Mr Singh's family at their home and escorted his wife to hospital to see Mr Singh. Mr Singh's family were with him in hospital when he died. The prison contributed to Mr Singh's funeral costs in line with national instructions.

## Support for prisoners and staff

99. The prison posted notices informing other prisoners of Mr Singh's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.

100. After Mr Singh's death, the staff involved in the incident were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

## Post-mortem report

101. The pathologist concluded that the cause of Mr Singh's death was hypoxic encephalopathy (brain injury caused by a lack of oxygen) which was caused by ligature compression of neck.

# Findings

## Assessment and management of risk of suicide and self-harm

102. Prison Service Instruction (PSI) 64/2011, Safer Custody, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

### Reception - PER

103. When Mr Singh arrived at Wandsworth on 9 June 2023, he had a number of risk factors for suicide and self-harm: he had a history of attempted suicide and self-harm in the last six months, was withdrawing from alcohol misuse and was prescribed medication for depression. The suicide and self-harm warning form that arrived with Mr Singh noted that he had a history of self-harm (cutting and burning himself) and had attempted suicide (overdose and by jumping off a roof) in the last six months. Despite this, staff did not adequately review and consider Mr Singh's risk factors and were overly reliant on what he said. The nurse said she did not have access to Mr Singh's PER or SASH form. We understand that from July 2023, all reception healthcare staff now have access to the form.

104. However, the officer had access to this information but did not pass it onto the nurse, as was the policy at the time. It is hard to understand how the officer did not open an ACCT in the circumstances. Certainly, he should have recorded how he had reached the decision not to do so in light of Mr Singh's significant risk factors.

### Management of ACCT procedures

105. Mr Singh was monitored under ACCT procedures from 12 June until he was found hanged in his cell, eight days later. Mr Singh's ACCT was extremely poorly managed, and we have identified several serious deficiencies. No case co-coordinator had been allocated to manage the ACCT in line with policy.

### Reviewing risk and recording information

106. PSI 64/2011 instructs that an urgent case review should take place as soon as possible if risk is likely to have increased between planned case reviews. On four occasions staff failed to conduct immediate ACCT case reviews following serious incidents of self-harm by Mr Singh. These are detailed in the table below:

| | | |
|---|---|---|
| **15 June** | Mr Singh made cuts to his arm | Staff did not complete an ACCT review until approximately 34 hours later |
| **16 June** | Mr Singh made further cuts to his arm and reported that | No urgent ACCT review took place, no one reviewed Mr Singh's risk or |

| | | |
|---|---|---|
| | he had been banging his head against the wall | considered increasing his ACCT observations |
| **17 June** | Mr Singh tied a ligature around his neck. | No urgent ACCT review took place, no one reviewed Mr Singh's risk or considered increasing his ACCT observations |
| **19 June** | Mr Singh set his hair on fire | No urgent ACCT review took place, no one reviewed Mr Singh's risk or considered increasing his ACCT observations |

107. We also found serious omissions in the recording of information related to Mr Singh's risk in prison and medical records, and the ACCT document. Not all of his incidents of self-harm were recorded appropriately.

108. Mr Singh's escalation in seriousness of self-harm (from cutting himself and banging his head against the wall to making ligatures, setting fire to his hair and setting his cell on fire) within a short period was stark but did not result in genuine consideration of his risk. The frequency of ACCT checks remained at one an hour until he set a fire in his cell, at which point they were increased to two an hour.

109. PSI 64/2011 says that staff should consider placing prisoners under constant supervision for the following reasons:

- Serious attempts and/or compelling preparations for suicide, e.g. making a ligature, hoarding medication and/or writing a suicide note.
- A credible expression of a wish to die.
- A recent and credible attempt by a prisoner to take her own life e.g. in prison and before admission to prison.

110. Mr Singh had made a ligature and set fire to his cell and hair in the days before he died. Staff should have considered whether Mr Singh needed to be constantly supervised and documented this decision.

### Attendance of healthcare staff at ACCT reviews

111. There were two occasions (16 June and 18 June) where healthcare staff did not attend Mr Singh's ACCT reviews. Given Mr Singh's history of attempted suicide and self-harm and that he was prescribed antidepressant medication, having healthcare staff present would have helped to assess his mental health. Healthcare staff told us that sometimes prison staff undertook ACCT reviews without inviting them. Other times healthcare staff were unable to attend. Since Mr Singh's death, healthcare staff meet each morning and are given a list of all ACCT reviews scheduled for that day and attendance at the ACCT reviews is allocated at the meeting. This has improved healthcare's attendance at ACCT reviews.

### ACCT care plan

112. PSI 64/2011 states that support actions must be set at the first case review to mitigate and lower risk for all prisoners subject to ACCT monitoring. These should be completed as part of a care plan in the ACCT document, identifying action points required to reduce risk, who is responsible for completing these actions and when they should be completed. They should be reviewed at each subsequent case review, with additional support actions added as required.

113. While a care plan was started at Mr Singh's case review on 13 June, it was not updated after this. The actions which staff had identified were all marked as complete the same day, which was incorrect. The plan stated that Mr Singh would be referred to the MHIRT and chaplaincy. Yet, the outcome of his referral to the chaplaincy and MHIRT was unknown on 13 June. Some issues were also omitted from the care plan such as Mr Singh's cellmate being one of the causes of his initial distress, or later, the increasing issues that he experienced with his medication and not receiving his food. Mr Singh's needs were not therefore addressed in his ACCT care plan, and it offered him little practical support to help him through his crisis or manage his risk effectively.

### ACCT observations

114. PSI 64/2011 states that ACCT observations and conversations must be documented immediately after they take place. From the outset, the recording of ACCT observations by staff was poor and inconsistent. These issues included:

- 12 June - failure to complete the ACCT immediate action plan within the timeframe of one hour, no conversations documented in afternoon/evening, no recorded ACCT checks overnight.
- 13 June – only one ACCT check recorded during the day and no conversations.
- 15 June – from 1.30pm - 6.11pm – no observations or conversations recorded.
- 17 June – no conversations or ACCT observations recorded until 9.00pm.
- 19 June – no observations recorded between 2.00pm - 7.00pm (after Mr Singh had set fire to his hair).
- 20 June – from 5.00pm onwards, two ACCT checks missing, and records falsified.

115. We referred the issue of falsified ACCT checks to Wandsworth police. The falsified ACCT checks on 20 June were also the subject of an internal investigation. The prison said they could not determine who signed for the unnamed ACCT checks. The former Governor told us that this was therefore addressed with all wing staff, but they were unable to take any further action with individuals. We have not seen any evidence that the prison has investigated whether the falsifying of records is more widespread. The fact that possibly two different officers falsified Mr Singh's records suggests that this might be part of a wider cultural issue. We were only given the CCTV of the cell from 5.00pm onwards on 20 June, so have been unable to check whether any other ACCT checks were falsified. We make the following recommendation:

**The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure herself that there is not a systemic issue with false entries.**

### ACCT quality, communication and sharing of risk information

116. Throughout Mr Singh's ACCT and prison documentation, there are instances when information about his well-being was not shared with staff and therefore could not be taken in account when assessing his overall risk of suicide and self-harm.

117. On 12 June, Mr Singh told healthcare staff that he would harm his cellmate if he continued to annoy him. We found no evidence that this information was recorded in Mr Singh's prison or security records, or any action taken to investigate the situation and ensure his and his cellmate's safety. On 13 June, Mr Singh told a member of the substance misuse team that he had been threatened by other prisoners and felt intimidated and pressured by his peers. We found no evidence to suggest that this information was passed to prison staff to investigate whether Mr Singh was being bullied. On 14 June, Mr Singh told healthcare staff that he felt anxious and had suicidal thoughts. We found no evidence that this information was shared with prison staff, nor was it documented in Mr Singh's ACCT document. On 20 June, Mr Singh's wife phoned the prison and raised concerns about him. We found no evidence that anyone spoke to Mr Singh and passed on this information to him or completed a welfare check.

### Previous investigations

118. In previous investigations, we have highlighted failings in the provision of ACCT review processes at Wandsworth, which included the frequent absence of multi-disciplinary teams from ACCT reviews and failure to conduct ACCT checks. Wandsworth's response was that, following the introduction of revised ACCT procedures in 2021, they had reminded all staff of their responsibilities to identify prisoners at risk of suicide and self-harm, which included guidance on how to use ACCT procedures. Refresher awareness sessions had also been delivered to staff in March and April 2023. Sadly, the care that was afforded to Mr Singh indicates that Wandsworth's delivery of ACCT procedures is little more than shambolic. HMIP also highlighted their significant concerns in the recent inspection.

### Action taken since Mr Singh's death

119. Following an internal investigation related to the events of 20 June, Officer C and the OSG were subject to a gross misconduct hearing on 19 March 2024 (we were not given details of the precise nature of the allegations about either member of staff). The outcome of this was that both were given 18-month written warnings. Officer B had already resigned from the Service, so he could not be subject to an investigation.

120. Due to the number of recent self-inflicted deaths at Wandsworth, the prison is receiving additional support and monitoring from regional and national safety teams. This has focused on improvements to the early days processes, improving ACCT quality assurance and providing additional ACCT training, and improved safety admin support. In March 2024, the prison also appointed an additional member of staff for 12 months to provide safety support.

121. The Head of Safer Custody assured us that she was aware of the issues which we have raised in relation to the assessment and management of Mr Singh's risk. She outlined some of the improvements the prison has made. When a prisoner on an open ACCT self-harms, the most senior officer on duty must now record whether an ACCT review has already taken place or schedule it to take place as soon as possible. The safer custody team monitors this through the daily briefing sheets.

122. The Head of Safer Custody said that missed ACCT observations are a key focus for improvement, with improved quality assurance. The safer custody team is now fully staffed and had completed over 500 interactions with prisoners considered to be at risk in February 2024.

123. We are aware that extra resource and support are currently in place at Wandsworth, and they are making efforts to improve ACCT quality. However, we make the following recommendation:

**The Governor should provide the Ombudsman with a clear plan of how she is addressing the issues identified with assessing and managing prisoners' risk of suicide and self-harm, including training and continuous improvement provision.**

## Cell Bells

124. On 18 June, Mr Singh rang his cell bell 13 times and staff responded to these in an average of 31 minutes. On 19 June, Mr Singh rang his cell bell eight times and staff responded to these in an average of 21 minutes. While we do not know how many times Mr Singh pressed his cell bell on 20 June, cell bell records for D Wing show that staff's response time varied, sometimes exceeding 15 minutes. HM Chief Inspector of Prison's expectation is that staff answer cell bells within five minutes.

125. Wandsworth did not provide an accurate electronic cell bell record that included Mr Singh's cell for 20 June, the day he was found hanged in his cell. From watching CCTV from 5.00pm onwards, we can see that it took staff 17 minutes to respond to the bell Mr Singh rang at 6.19pm and five minutes to respond to the bell he rang at 7.44pm. At 8.36pm, Mr Singh rang his cell bell again. Staff did not respond to this until the OSG did the routine count of prisoners and found Mr Singh unresponsive half an hour later. We do not know how soon after he rang his bell, Mr Singh hanged himself. However, this was a serious missed opportunity to save Mr Singh's life.

126. The former Governor of Wandsworth said that wing custodial managers and senior managers now review cell bell reports weekly. Any concerns about the length of time it takes staff to respond are addressed with staff individually. She said that their analysis showed that around 85%-90% of cell bells were now answered within the target time of five minutes. Where cell bells were not responded to within the target time, managers could identify and respond to any themes. However, since she told us this, HMIP have found that there have been no improvements in cell bell response times. It is deeply troubling that the former Governor told us that the situation had improved, when, in fact, it had not. We make the following recommendation:

**The Governor should provide the Ombudsman with a clear plan outlining how they will improve cell bell response times.**

## Prison staffing issues

127. Both healthcare and prison staff told us that the prison had been short staffed for a long time. The Governor told us that the prison had run a very restricted regime as a consequence. This issue is highlighted in both HMIP and the IMB's most recent reports.

128. Such restrictions on regimes increase frustration among prisoners and affect staff morale. It is likely to have prevented Wandsworth from dealing robustly and meaningfully with prisoners at risk, such as Mr Singh, who reported that he felt neglected.

129. In February 2024, the former Governor of Wandsworth told us that staffing at Wandsworth had improved significantly with the employment of around 100 new officers. However, some of these staff were still in training and were not yet able to work on the wings where they were most needed. The prison was operating with only 60% of officers available for work, therefore a restricted regime was still in place.

130. In April 2024, following a death at the prison in November 2022, we recommended that the Director General of HMPPS should consider what additional support could be put in place to address staffing shortages at Wandsworth and how a meaningful regime and key work could be delivered in these circumstances. As a result, we make no further recommendation here.

## Clinical care

131. The clinical reviewer noted that the care Mr Singh received was not of the standard reasonably expected, and therefore, not equivalent to what he would have received in the wider community. She noted that these failings included poor risk assessment and management, an uncompassionate approach to reducing and ceasing Mr Singh's medication and poor mental health assessment and treatment.

### Medication

*Reduction in prescription*

132. Although it was unclear exactly why Mr Singh took pregabalin, he had been prescribed the medication in the community from around February 2023. On 17 June, a nurse prescriber started the process of reducing his pregabalin dose, with a view to stopping it completely after seven days because his self-reported diagnosis of epilepsy could not be confirmed. The nurse prescriber did this as part of her prescribing duties for the day which meant she was unable to see Mr Singh face to face to change his medication.

133. The Royal College of GPs (RCGP) guidance on 'Safer Prescribing in Prisons' (second edition, 2019) recommends that pregabalin is not prescribed in prison due to the high risk of abuse and diversion. Therefore, it was reasonable that the nurse prescriber took a cautious approach to prescribing pregabalin, especially because the reason for prescribing it in the first instance was unclear. However, the guidance also states that clinical decisions to suspend medication need to be considered on an

individual basis, and not used to generically stop a specific medication without consultation with the patient.

134. It is clear that the reduction and eventual discontinuation of pregabalin was not done in consultation with Mr Singh. The clinical reviewer notes that this was a missed opportunity to discuss his understanding of the prescription and to obtain more information. Healthcare staff should have done more to explore the reasons why Mr Singh was prescribed pregabalin rather than assuming it had been for epilepsy, because he also suffered with fibromyalgia and chronic pain. We make the following recommendation:

    **The Head of Healthcare should ensure that the prescribers have a face-to-face conversation with a prisoner if there is an intention to reduce or cease any high risk prescribed medication.**

135. Furthermore, when staff reduced Mr Singh's prescription, they did not consider how this affected his mental health and his risk to himself. This was especially important as stopping pregabalin can sometimes cause side effects such as anxiety, agitation, mood changes, behavioural changes and suicidal thoughts and behaviour.

136. Mr Singh sometimes did not receive the rest of his medication due to short staffing. When this occurred on 18 June, healthcare staff were only administering 'critical medication' to prisoners. (Critical medication is defined as a drug that could potentially result in harm to a patient if the dose is not given or delayed.)

137. From Mr Singh's perspective, not only had he not been given his medication for his mental health on days mentioned, but he was also not receiving his anticipated dose of pregabalin and was unaware why. Mr Singh was adamant, and told staff on more than one occasion, that not having his medication caused his mental health to suffer. There was an increase in the severity and seriousness of self-harm by Mr Singh, particularly following the reduction of his pregabalin medication. We make the following recommendation:

    **The Head of Healthcare should incorporate closer healthcare observations for prisoners who are on a reduction regime and/or are being taken off Gabapentinoids, to monitor withdrawal symptoms and any adverse effects.**

### Assessment of Mr Singh's mental health

138. Mr Singh was appropriately referred to the MHIRT when he arrived at Wandsworth. He was referred again on 12 June, when the ACCT was opened and on the same day, the referral was triaged. Staff planned that Mr Singh would be reviewed by the GP first in regard to his anxiety and depression. However, when the GP saw Mr Singh the next day, her assessment did not include a review of his mental health or his mental health related medication. The Head of Healthcare told us that the GP was not aware that they also needed to review Mr Singh's mental health medication because the information had not been added to the appointment request.

139. Due to confusion about the sequence of appointments and what the GP was expected to review, Mr Singh was not placed on the MHIRT caseload until he was referred via the Crisis Pathway by the Safer Custody Manager on 20 June, after the increase in seriousness of his self-harm. This meant that Mr Singh had been at

Wandsworth for eleven days without a mental health assessment despite his clear needs.

140. A mental health nurse, employed to work at Wandsworth through an agency, assessed Mr Singh on 20 June. The clinical reviewer noted that this assessment was poor. Despite Mr Singh's deteriorating mental health and significant risks, the nurse did not plan for him to be seen again by the MHIRT. The nurse told us that he had asked Mr Singh whether he had any thoughts of suicide or self-harm (which he said Mr Singh denied) but this was not documented and there was no subsequent consideration or assessment of his risk factors. This poor assessment appeared to support Mr Singh's claims made during the ACCT review (after the mental health assessment), that he had been "dismissed" by the MHIRT and was not given any help. Mr Singh clearly required immediate mental health support because he was in crisis, and it was not appropriate for the mental health nurse to put him on the psychiatrist's waiting list when he needed more immediate mental health support and intervention.

141. The mental health nurse told us that he had not put Mr Singh onto the MHIRT caseload because he did not present with psychosis. The Head of Healthcare told us that this should not be the only reason a person is accepted onto the MHIRT caseload. She said that since Mr Singh's death, the mental health nurse no longer works at Wandsworth due to their concerns about his assessment. We make the following recommendation:

    **The Head of Healthcare should ensure that agency staff receive an appropriate induction when they start at Wandsworth so that they are clear about the expectations of healthcare staff at the prison.**

## Governor to note

### Staff availability for interview

142. The investigator arranged to interview the OSG three times, but he failed to attend on each occasion. We have raised this both with the Head of Safety and Governor.

### Emergency response

143. The OSG did not radio an emergency code when he discovered Mr Singh hanging. He also did not go into the cell straight away. Due to his non-attendance at interview, it has not been possible to determine why. Two minutes later, additional staff arrived, went into the cell and cut Mr Singh down. They also radioed a code blue (this was four minutes after Mr Singh had first been found) and control room staff requested an ambulance immediately. We bring this delay to the Governor's attention.

## Head of Healthcare to note

### Clinical follow-up

144. On 18 June, a nurse reviewed Mr Singh after it was reported that he had had a seizure. She did not plan to review him later that day to check his well-being and

ensure that he was medically stable. Nor did she refer Mr Singh to the GP to be reviewed. The clinical reviewer notes that this should have been arranged to gain some further clarity on his diagnosis of epilepsy and to see whether the apparent seizure could have been an adverse effect of pregabalin withdrawal. Although unconnected to his cause of death, the Head of Healthcare will want to ensure staff appropriately review seizures in the future.

## Inquest

145. An inquest was concluded on 6 August 2025, that the cause of Mr Singh's death was hypoxic encephalopathy (brain injury caused by a lack of oxygen) which was caused by ligature compression of neck.

146. The coroner concluded the circumstances of Mr Singh's death was due to misadventure, contributed to by neglect. He gave a verdict in which he said the probable cause of this was:

> **(a)** the reduction of pregabalin dose, and the failure to communicate this to Mr Singh; **(b)** the inconsistent provision of medication and the consequential effects on Mr Singh's physical and mental health; **(c)** the failure to provide Mr Singh with adequate mental health support in a timely manner and **(d)** the failure to answer his cell bell within 5 mins on the night of 20 June between 8.36pm – 9.06pm. Also, the possible failure to conduct observations as directed by Mr Singh's ACCT on 20 June.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100