Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wadid Barsoum a prisoner at HMP Wandsworth on 4 May 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Wadid Barsoum was killed in his cell at HMP Wandsworth on 4 May 2015. He was 66 years old. I offer my condolences to Mr Barsoum's family and friends. In February 2016, a prisoner who shared a cell with Mr Barsoum, was convicted of Mr Barsoum's manslaughter on the grounds of diminished responsibility.

We identified a number of concerns with mental healthcare and risk assessment at Wandsworth. In particular, the prison failed to consider and address the report they received from a secure mental health unit. The cellmate was in prison for a violent offence, officers and a nurse raised concerns about his mental health and he reportedly had a fight with a previous cellmate. Despite this, no one fully assessed his mental health, his risk of suicide and self-harm, nor his cell sharing risk, as they should have done.

As I identified in a learning lessons bulletin I published in December 2013 and in a recent bulletin in September 2016, homicides in prisons are rare and identifying potential perpetrators can be difficult. Although better clinical engagement might have revealed that the cellmate's mental health was deteriorating and prompted a review of his risk, we cannot say for certain that this would have prevented Mr Barsoum's death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2016**

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Summary

Events

1. On 20 June 2014, Prisoner A was remanded to Wandsworth after attacking and injuring a stranger. During his early days in custody, his partner and officers all raised concerns about his mental health. Mental health nurses spoke to him, but did not find evidence of mental illness.

2. Prisoner A shared a cell during his whole time at Wandsworth. Officers said they did not remember him ever having an issue with a cellmate. In November 2014, he reportedly had a fight with a cellmate but the prison said they did not have further details of this incident.

3. In September and December 2014, the court asked two consultant forensic psychiatrists to provide reports for the court. They concluded Prisoner A had been psychotic when he committed his offence.

4. In January 2015, a psychiatrist referred Prisoner A to the Shaftesbury Clinic, a secure mental health unit, to evaluate his mental state and observe him. The hospital instead referred him to Wandsworth for assessment and observation. No one at Wandsworth read the psychiatrist's report. The mental health in-reach team accepted him on to their caseload but did not assess him fully and he did not see the prison psychiatrist.

5. From February 2015 onwards, officers noticed a change in Prisoner A's behaviour. He appeared less sociable and became more aggressive and uncooperative. He frequently complained of headaches and often pointed to his head.

6. On 14 February 2015, Mr Wadid Barsoum was remanded to Wandsworth. He had a number of medical conditions including chronic kidney disease, high blood pressure and dementia. Healthcare staff at Wandsworth promptly obtained medical information from Mr Barsoum's GP but did not examine his chronic conditions further.

7. On 13 March, a general nurse referred Prisoner A back to the mental health in-reach team because he thought he might be hearing voices. A mental health nurse and psychiatrist spoke to him on 16 March but did not fully assess him. Apart from an undocumented follow-up visit to give him information about his trial dates, the mental health in-reach team had no further contact with him.

8. On 1 April, Mr Barsoum and Prisoner A began sharing a cell. Officers reported that they appeared to get on well. He collected Mr Barsoum's meals for him and made sure he got his medication.

9. On 3 May, Prisoner A was taken back to his wing from a church service because he was behaving strangely.

10. At about 7.10am on 4 May, an officer answered their cell bell and discovered Mr Barsoum on the floor with Prisoner A on top of him. Another officer opened the door and he told him he had hit Mr Barsoum over the head with the television. The officer said Mr Barsoum had suffered a very serious head injury. Emergency

nurses and paramedics were called but Mr Barsoum was pronounced dead at hospital.

Findings

11. We found a number of deficiencies in the mental healthcare given to Prisoner A. Wandsworth did not properly examine the referral from the Shaftesbury Clinic and no one read the psychiatrist's covering letter and report which had been scanned in to his medical record. We also found that:

    - Wandsworth had no proper system for ensuring information they received from agencies was passed to the relevant clinical team.
    - Prisoner A did not have a full or structured mental health assessment, risk assessment or risk management plan at Wandsworth.
    - There was no plan for monitoring Prisoner A, which appears to have been largely left to officers.
    - Communication between primary and secondary health services was poor.
    - Officers raised concerns about Prisoner A's mental health on a number of occasions but there was no co-ordinated response.

12. Although better practice at Wandsworth might have revealed that Prisoner A's mental health was deteriorating and prompted a review of his risk, it is not possible to say that this would have prevented Mr Barsoum's death.

13. Prisoner A only spoke basic English but no one at Wandsworth used a translation service when assessing him. It is unlikely that he would have understood staff interacting with him sufficiently well for them reliably to assess his health, state of mind or risk.

14. The healthcare Mr Barsoum received at Wandsworth was not equivalent to that he might have received in the community.

Recommendations

- The Head of Healthcare should ensure that:
    - All referrals are passed to the appropriate clinical team and examined.
    - All prisoners referred to secondary mental health services have a structured mental health assessment and risk assessment using a comprehensive template.
    - All decisions about a prisoner made in the in-reach case review meetings are recorded in the prisoner's medical record.
    - All patient contact is documented.
    - Concerns raised by health professionals are properly followed up.
- The Governor and Head of Healthcare should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

- The Head of Healthcare should ensure that information supplied by the community GP is used to inform further assessment and management of patients with long term conditions.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. One member of staff responded.

16. NHS England commissioned a clinical reviewer to review Mr Barsoum's clinical care at the prison. He also considered the clinical care offered to Prisoner A.

17. The investigator interviewed nine members of staff, six of them jointly with the clinical reviewer. The clinical reviewer spoke to one member of staff by telephone. The police took statements from officers at the time of Mr Barsoum's death.

18. We informed HM Coroner for Inner West London of the investigation. We have not received a copy of the post-mortem examination at the time of writing. We have sent the Coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Barsoum's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Her solicitors responded on her behalf and asked for details of Prisoner A's state of mind and whether anything else could have been done to ensure Mr Barsoum's safety.

Background Information

HM Prison Wandsworth

20. HMP Wandsworth is a local prison in south west London that holds over 1,250 men and primarily serves the courts in south London. At the time of Mr Barsoum's death, St George's University Hospitals NHS Foundation Trust provided healthcare services at the prison. In May 2014, the South London and Maudsley NHS Foundation Trust took over provision of all mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of Wandsworth was in February and March 2015. Inspectors reported that, for reasons largely out of the prison's control, it faced severe problems. It was unacceptably overcrowded and processes to keep prisoners safe lacked resilience. Arrangements to identify, manage and reduce violence had lapsed since the last inspection. Staff shortages had a severe impact.

22. The capacity of the 12 bed Addison Unit, which provides inpatient care for men with complex mental health needs was insufficient to meet demand. There were unacceptable delays transferring men out of the prison to secure mental health facilities.

Independent Monitoring Board

23. 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 2015, the IMB reported that staff shortages had impacted on service delivery. The number of permanent healthcare staff was at the lowest ever level and the IMB reported that this had delayed assessments. There was a waiting list for places on the Addison Unit, caused partly by places being taken by prisoners suffering the effects of new psychoactive substances.

Previous deaths at HMP Wandsworth

24. There have been 17 deaths at Wandsworth since 2014. Mr Barsoum's was the only homicide. In the death of another man in May 2014, we found that mental health staff had not used interpreting services when assessing prisoners, when they should have done.

Key Events

Mr Wadid Barsoum

25. On 14 February 2015, Mr Wadid Barsoum was remanded to HMP Wandsworth. His person escort record, which accompanied him from court to prison, apparently contained a suicide and self-harm warning form and noted that he had high blood pressure, kidney disease, arthritis, back pain and had tried to take his life a long time ago.

26. At an initial health assessment, Mr Barsoum told a nurse that he had chest pain, high blood pressure and back ache, and took medication for his blood pressure, acid reflux, cholesterol and asthma. He said he had no history of mental illness and was not feeling suicidal or like harming himself. She noted that his mood appeared stable. He then saw a prison GP, who continued Mr Barsoum's medication. During his first night in prison, Mr Barsoum said he had been in prison 20 years earlier for two or three years. An officer assessed him as suitable to share a cell and said he was happy to do so.

27. On 16 February, Wandsworth received Mr Barsoum's medical history from his community GP. On 17 February, a locum GP reviewed the community records and updated Mr Barsoum's medication. He took no further action.

28. On 1 April, Mr Barsoum moved to a cell on A wing, and began sharing with Prisoner A.

29. A Senior Officer worked as an officer on A wing and described Mr Barsoum as amiable. She said his English did not seem very good, which made it hard to build up a relationship. She said he was unsteady on his feet.

30. An officer worked on A wing and although she did not know Mr Barsoum well, she said he always appeared jolly. He had a few friends on the wing who were also from the Middle East. She said he and Prisoner A seemed to get on very well and the prisoner was always concerned to make sure Mr Barsoum got his medication.

Prisoner A

31. On 19 June 2014, Prisoner A (a Ukrainian national) was arrested and charged with wounding with intent to cause grievous bodily harm after attacking a stranger on Wimbledon Common. He told police he had lived in the UK since 2002 under an alias. Immigration staff subsequently served him with immigration papers, which gave them authority to detain him. The Home Office Immigration database indicates that he claimed asylum, but we do not know the progress of this claim. He said he was happy to speak English but asked for a Ukrainian or Russian interpreter for his asylum interviews. Police records indicate he was interviewed using telephone translation services.

32. On 20 June 2014, Prisoner A was remanded to Wandsworth. A nurse recorded that he said he had not been in prison before, had no history of mental illness, no history of drug or alcohol misuse, was not on medication, had no GP in the UK and no physical health problems.

33. On 23 June, a nurse completed a second health assessment. Prisoner A said he had been in prison before and had used illicit drugs. He declined vaccinations and screening for sexually transmitted diseases. The same day, officers asked a mental health nurse to review him because they thought his behaviour "odd". She noted his English was poor but did not use translation services during the assessment. She said he was guarded when asked about his mental health history and evasive when asked about his immigration status. She said she could not detect any sign of mental illness. She asked officers to clarify their concerns but the officer who had raised them was not on duty and colleagues said he had been vague when describing them. The officers agreed to advise the mental health team if they had further concerns.

34. On 2 July, Prisoner A's partner telephoned the prison and told a member of the Safer Prisons team that she was concerned about his mental health. The member passed on this information to officers and the wing supervisor. Prisoner A told her that he was fine but wanted to see a doctor. She explained she would refer him to the primary mental health team. She noted that he had limited English but told her he understood what she said.

35. On 4 July, a Supervising Officer (SO) raised concerns about Prisoner A's mental state. A nurse said the SO described Prisoner A's behaviour as strange and chaotic. He repeatedly rang his cell bell, kicked his door and asked to speak to medical staff. He would not speak to officers and often covered his cell observation panel. On one occasion, he had held his pillow case and said there was a virus in it. He had not been aggressive or violent but was difficult to reason with and obsessed with time.

36. At interview, the SO was unable to remember specifically what had concerned him about Prisoner A's behaviour. He said he would not have remembered him at all, had it not been for Mr Barsoum's death. He said he was "strange'. He rang his cell bell a lot and kept asking what time the daily events of the regime were happening.

37. The nurse said Prisoner A was calm and communicative during assessment. He could detect no sign of mental illness and decided further intervention was unnecessary at this stage. He advised officers to monitor him and report any further concerns.

38. On 18 July, Prisoner A's partner telephoned the prison and spoke to a prison chaplain. She said he had an infected thumb. The chaplain was assured by the emergency response nurse that he had an appointment for treatment but she would also see him that day.

39. On 23 July, the healthcare manager noted that a member of the public (we believe this was Prisoner A's partner) had telephoned the prison to tell them that he had an undressed wound (an old injury to his thumb sustained before he came to Wandsworth). She said he had failed to attend his last two appointments to dress the wound and telephoned the healthcare centre to instruct that he must be seen that day. Officers escorted him to an appointment that afternoon but, after five minutes, he said his food was more important than his appointment and left the waiting area. Two nurses went to his cell that evening to try to dress his wound but he shouted at them and was verbally abusive.

40. On 25 July, Prisoner A broke the glass on his cell observation panel and was moved to the segregation unit. A nurse examined him and reported bruising to his face.

41. On 6 September, Prisoner A was taken to the segregation unit again because officers suspected he had swallowed something during a visit. He denied taking anything. He was observed hourly throughout the night and a urine test the next morning was negative for all substances.

42. On 12 September, an independent consultant forensic psychiatrist assessed Prisoner A for a court report. There is no record of this on his prison medical record. The psychiatrist concluded that he had an acute psychotic episode when he committed his offence. He saw no symptoms of mental illness but thought his condition should be investigated. He thought that his risk of violence was closely linked to his mental health.

43. On 14 November, Prisoner A had a fight with his cellmate. A nurse examined him but found no sign of injury. Apart from the nurse's entry on the medical record, we have not seen any other records of this incident and the prison did not know who his cellmate was. We have not seen any evidence that Prisoner A's cell sharing risk assessment was reviewed, as it should have been. On 19 November, he complained of insomnia.

44. On 15 December, Prisoner A was assessed by a consultant psychiatrist commissioned by Prisoner A's solicitor to provide a second report for the court. The psychiatrist was asked to assess whether he was mentally ill at the time he committed the offence, his current condition and risk of further offending. He met him at Wandsworth and spoke to him for two hours with a Russian interpreter. He described his competence in English as "sub-optimal". There is no entry recording this assessment took place on his medical record.

45. The psychiatrist completed his report on 7 January. He concluded that Prisoner A had had a psychotic episode when he committed his offence. He said he showed some signs of depression but no clear psychotic experience during the assessment.

46. The psychiatrist concluded that Prisoner A's mental state may, "…be less stable than first appears and he may in fact have a more chronic enduring psychotic illness". The first psychiatrist agreed with the second that he should be assessed in hospital so that his behaviour could be monitored over a prolonged period of time by experienced nursing staff. On 12 January, the second psychiatrist referred him to the Shaftesbury Clinic at Springfield University Hospital (a medium secure mental health facility) for assessment.

47. On 20 January, a psychiatrist from the Shaftesbury Clinic emailed the mental health in-reach team at Wandsworth, suggesting that they observed and assessed Prisoner A and if they found evidence of mental illness, they should refer him back to them. She attached a copy of the second psychiatrist's referral to her email.

48. On 21 January 2015, Prisoner A was allocated to the caseload of a mental health nurse. She saw him in his cell the next day. At interview, she said she read the referral letter from a psychiatrist but not the second psychiatrist's report. She said Prisoner A was alert, spoke normally and his English was good enough for her to

understand. He told her that he did not want to speak to her. She said he was sarcastic but she did not see signs of mental illness.

49. On 26 January, the nurse went to see Prisoner A again. He spoke willingly and told her that prison life was stressful for him and he felt guilty and sad about his offence. He said he did not have any mental health issues but alcohol and stress about his relationship had caused him to attack a stranger. She could not detect any signs of mental illness and concluded that he was not suitable for the mental health in-reach team's caseload. The mental health in-reach team discussed him at their case review meeting and decided to monitor him because of the referral from the Shaftesbury Clinic.

50. On 2 February, Prisoner A moved to another cell in A wing. On 6 February, the nurse saw him again. She said he was polite and calm and told her he had spoken to his solicitor, been to court and would be going to trial soon.

51. On 24 February, the mental health in-reach team decided to see Prisoner A once more with a view to discharging him from the team. (This meeting is not noted on the medical record but appears on the South London and Maudsley NHS Foundation Trust's Mental Health Investigation Report completed on 25 September 2015.)

52. On 25 February, it appears that Prisoner A was taken to the segregation unit after trying to assault an officer. His prison record shows he refused several times to return to his cell and wanted to fight. The medical record notes he had a scratch to his hand. Wandsworth have been unable to provide us with segregation records for this incident. The nurse said she was not aware of this incident either.

53. On 26 February, the mental health in-reach team discharged Prisoner A from their caseload. The nurse said she saw him before the meeting and told him he was due to be discharged from the caseload. She said he seemed perfectly normal and understood what she was saying. This meeting is not documented in the notes. She said there had not been a formal plan of how often he was to be monitored while he was on her caseload. She said she often went to A wing and had perhaps seen him in passing. She added that none of the officers raised concerns about him during this time.

54. At 8.30am on 13 March, Prisoner A told a nurse that he had a pain in his forehead and thought he had meningitis. The nurse explained he did not have any symptoms of meningitis and he thanked him and abruptly left the clinic. That evening, officers radioed the emergency nurse. A nurse said Prisoner A told him he had a headache and wanted antibiotics. He gave him painkillers. He said Prisoner A communicated well but appeared slightly disorientated and kept pointing to his head. He wondered whether he might be hearing voices and re-referred him to the mental health in-reach team.

55. The mental health nurse saw Prisoner A again on 16 March. She did not speak to a colleague first. She said communication between the mental health in-reach team and primary care nurses was minimal. He told her that his court case was "not good" but would not elaborate. She decided to refer him to the visiting psychiatrist because he was not communicating with her. The next day, she saw him with a locum consultant forensic psychiatrist. He was preoccupied with his

court case and said he was unsure what was happening as he had not seen his solicitor.

56. The psychiatrist said she remembered the email from a psychiatrist but had no recollection of seeing the second psychiatrist's report until after Mr Barsoum's death. She was not sure whether it had been attached to the email or sent by post. The second psychiatrist's report had been scanned and uploaded to SystmOne but she was not sure when. She said she would have noted the phrase, "The psychiatrist did not find him psychotic" and this would have meant he was low down her list of priorities to see, unless the mental health nurse had thought it necessary.

57. The psychiatrist said Prisoner A appeared to be a typical anxious prisoner who did not know what was happening with his court case. She did not complete an in-depth mental health assessment because it is a nurse-led service and the mental health nurse would have already done this and taken background information. She said the purpose of her seeing him was just to check how he was and ask some short questions to explore his mental state. She saw him for about ten or 15 minutes and did not write up the meeting.

58. On 19 March, the psychiatrist contacted Prisoner A's solicitor and found that his case was listed for mention on 23 March and his trial was likely to start on 22 April. The mental health nurse relayed this information to him the next day. She confirmed that he remained on her caseload until 21 April but continued to be monitored by officers. There is no further contact with mental health staff documented in his medical record.

59. On 1 April, Prisoner A complained of headache again and was given paracetamol. He had several appointments with dental services at Wandsworth but they raised no concerns about his mental health.

60. A SO said she knew Prisoner A throughout his time on A wing when she was an officer. She said he was very friendly and sometimes gave her information. She said his English was not especially good – he could get by but not hold a long conversation. He shared a cell throughout his time on A wing without any incident that she remembered. On one occasion, he had shared a cell with a prolific self-harmer and had helped the man to stop harming himself.

61. In February and March 2015, Prisoner A became less sociable. The SO said he was more reluctant to go into his cell and would look blankly at her when she spoke to him, which was very strange. She said she telephoned the mental health team about him but was not sure how they followed up her call. She was not especially concerned about him and did not see any behaviour that caused her to think he should not share a cell.

62. Prisoner A appeared to be protective of Mr Barsoum and used to collect his meals for him. They usually ate their meals together on the bottom bunk in their cell. He would tell the SO when Mr Barsoum needed his medication. The SO thought he looked after Mr Barsoum and they seemed to get on very well.

63. An officer said Prisoner A had always shared a cell and she did not remember him ever having an issue with his cellmate. He used to like to wander around the wing

before being locked in and she used to let him because he was not bothering anyone. She said sometimes Prisoner A would hold his head as if he had a migraine. She said it was obvious that something was wrong with his head. She said she had thought about contacting the mental health team about him, but had not done so.

64. An officer said he often saw Prisoner A in the visits hall. Once, after a visit, he had spoken to a woman he thought was his wife. They spoke in Russian and she asked him if he though he was mentally well. The officer said he would help him if he asked him for anything. Because he spoke Russian, the officer thought that he was quite honest with him. Whenever he asked him if he was OK, he told him he was. The officer said it always looked like Prisoner A and Mr Barsoum got on well. He thought they spoke Russian together.

65. An officer said he worked regularly in visits and saw Prisoner A often. On 30 April, Prisoner A had an argument with his partner and she left abruptly. She was due to visit again on 2 May but did not turn up. He waited for her for 30 minutes and was taken back to his wing.

3 and 4 May 2015

66. A SO remembered returning to work on 3 May after one or two weeks away. She said Prisoner A's behaviour seemed remarkably different. He was aggressive when asked to go into his cell and seemed very angry. She tried to speak to him but he would not talk to her.

67. An officer said she was due to patrol the church service that afternoon. When she arrived, Prisoner A was pacing up and down and officers were trying to get him to sit down. She said she could see that he was not listening to them so she asked if she could take him back to A wing. She managed to persuade him to go with her and tried to talk to him. He walked ahead of her and would not talk to her. She let him on to the wing and he went straight to the 3s landing and sat down on the window ledge with his head in his hands. She returned to the church service.

68. When the officer came back to A wing, Prisoner A was still wandering around holding his hands to his head. She made a note to phone the mental health in-reach team about him.

69. The SO put Prisoner A in his cell. She tried also to talk to him but he was aggressive and surly. She was worried about his behaviour and contacted the emergency response nurse because it was a Sunday and there were no mental health staff on duty. She said the nurse came over at about 3.00pm or 4.00pm. He kept repeating, "My head, my head" and grabbing his head. The nurse gave him some paracetamol. The SO said she did not think he meant he had a headache but the nurse said, "Well, there's nothing else I can really do". This incident is not documented in his medical record. The SO went off duty at 6.00pm.

70. The night patrol officer on A wing during the night of 3-4 May told the police that he did not specifically remember checking Mr Barsoum and Prisoner A at early morning roll check at 5.00am, but he saw nothing in any of the cells to give him reason for concern.

71. At about 7.10am, an officer answered a call from Mr Barsoum and Prisoner A's cell bell. She said she saw Mr Barsoum lying on the floor with Prisoner A sitting on top of him. She noticed their television was on the floor of the cell. Prisoner A asked her to open the door to help Mr Barsoum. She did not have a radio with her so she ran towards the tea room shouting for staff. Two officers heard her and ran towards her.

72. As they all returned to the cell, Prisoner A was putting a pillow under Mr Barsoum's head. His hands and Mr Barsoum's head were covered in blood. The officer radioed a code one emergency using a colleague's radio. Her colleague opened the cell and asked Prisoner A in Russian what he had done. He said, "I smashed his head with the telly". The officer asked why and he replied, "I just looked in the mirror". The officer said he was cradling Mr Barsoum's head in his hands. There was a lot of blood on the floor. He could see that Mr Barsoum had suffered a serious head injury. He told him to move away from Mr Barsoum. He collected some of his possessions and he took him to a holding cell nearby.

73. Two nurses arrived in response to the emergency radio message. They began chest compressions and attached a defibrillator but it had no power. An officer brought another defibrillator which showed no cardiac output. The nurses continued chest compressions.

74. Prison records show that an ambulance was called at 7.12am. Paramedics arrived at 7.18am and took over life support. Mr Barsoum was taken to hospital by ambulance where he was pronounced dead at 8.52am.

Contact with Mr Barsoum's family

75. A SO acted as a family liaison officer. She visited Mr Barsoum's partner with another officer and the police investigator during the afternoon of 4 May and broke the news of Mr Barsoum's death. The prison offered to contribute financially to Mr Barsoum's funeral in line with national instructions.

Support for prisoners and staff

76. A senior prison manager debriefed the staff involved in the emergency response and informed them of her support and that of the prison's care team.

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

Post-mortem report

78. The post-mortem report gave the cause of death as head and neck injuries.

Findings

Assessment of Prisoner A's mental health and risk

79. The decision by the Shaftesbury Clinic to refer Prisoner A to Wandsworth is not within our remit to examine. However, we would question their expectation that Wandsworth would be able to provide an appropriate level of monitoring given their extremely limited mental health care resources. The only potential healthcare facility for long-term monitoring, the Addison Unit, had limited beds and was designated for prisoners who had severe, acute mental illness, which he did not have at the time. Meaningful monitoring was not possible on the wings, especially because of the limited number of psychiatric nurses and their high caseload.

80. Despite this, no one at the prison read the email attachment, which included the second psychiatrist's letter and assessment, even though it was scanned in to Prisoner A's medical record. A psychiatrist and a mental health nurse said they were not informed that the report had been received and scanned. A comprehensive examination of his record might have revealed its existence, but there does not appear to have been an adequate process in place for informing the relevant clinical team when Wandsworth receive information from agencies. Crucially, staff missed the psychiatrist's conclusion that Prisoner A might have an underlying psychosis not visible in snapshot assessments and that his risk of reoffending was linked to his mental health.

81. Prisoner A did not have an in-depth, structured mental assessment at Wandsworth. The mental health nurse said using a standard template, which would have provided structure and covered questions about history and risk, was not the practice in Wandsworth at that time. (The prison commented at draft report stage that a structured mental state assessment template to assess a client's mental state was not be appropriate). A psychiatrist's covering letter, which was read by the mental health nurse and a psychiatrist, said that two psychiatrists had concluded he was insane when he committed his original offence. It also referenced to serious, longstanding concerns from family and friends about his mental state. Despite this, neither explored his original offence with him and its link to his mental state. No one formally assessed his risk to himself and others, as is usual in a mental health assessment. There was no coherent plan to monitor him and he was seen only briefly twice before being removed from the mental health in-reach team's caseload.

82. A psychiatrist saw Prisoner A briefly in March when he was no longer part of the in-reach team's caseload but did not document her only contact with him. This was after a nurse raised concerns about his mental health. When concerns are raised by a healthcare professional, they should be properly followed up. Neither the mental health nurse nor the psychiatrist spoke to this nurse and the mental health nurse described communication between the primary care team and the in-reach team as "minimal". This is poor practice. It is not clear whether Prisoner A was put back on the caseload of the in-reach team, but no plan and no further contact with him was recorded. The mental health nurse said he was being monitored by officers. We consider this was inappropriate, especially as there is no evidence that officers were even aware of this.

83. Officers raised concerns about Prisoner A's mental health on several occasions but these were not all documented on his medical record. His partner contacted the prison by telephone and also spoke to an officer in visits because she was concerned about his mental health. There was no coordinated follow up, and liaison between prison officers and the mental health team was poorly documented.

84. Although better practice might have revealed that Prisoner A's mental health was deteriorating and prompted a review of his risk, it is not possible to say that staff would have predicted his actions on 4 May. His original offence indicated a risk to others. Records also refer to a fight with a previous cellmate in November 2014 and we have seen no evidence that anyone reviewed his cell sharing risk assessment in light of this, as they should have done. Apart from that, he appears to have shared a cell without incident before 4 May. Officers who had known him for some months and observed him with Mr Barsoum were deeply shocked by the events that morning.

85. We make the following recommendations:

The Head of Healthcare should ensure that:

- **All referrals are passed to the appropriate clinical team and examined.**
- **All prisoners referred to secondary mental health services have a structured mental health assessment and risk assessment using a comprehensive template.**
- **All decisions about a prisoner made in the in-reach case review meetings are recorded in the prisoner's medical record.**
- **All patient contact is documented.**
- **Concerns raised by health professionals are properly followed up.**

Wandsworth responded at initial report stage:

"Mental health staff do not use a structured mental state assessment template to assess a client's mental state. Mental health assessments consist of open questions and depend on the client's response as to what the areas of focus are. Each client would be different so a template is not appropriate. Mental health professionals know the areas to focus on depending on the client's presentation."

Use of translation services

86. Prison Service Instruction (PSI) 64/2011, which gives instructions to staff about safer custody, says that staff must consider the use of translation services when dealing with prisoners whose first language is not English, particularly when assessing risk.

87. The Prison Service's policy on foreign national prisoners says that language barriers make all other problems worse and staff should not assume that prisoners with some comprehension of English have completely understood what is said to them. It also says that poor communication between staff and prisoners may have implications for issues such as risk of self-harm and good order and discipline.

88. It was evident that Prisoner A spoke and understood only basic English. It was noted in the police custody record that accompanied him to Wandsworth that he

needed a translator. A psychiatrist assessed him on 15 December with a translator. As with all prisons, Wandsworth has a contract with a professional telephone interpreting service, yet there is no record of any staff - either officers or healthcare staff - using this service. The nurse and psychiatrist who assessed his mental health did not use a translator. It seems highly unlikely that he would have been able to understand these interactions sufficiently well for staff to make reliable assessments of his health, state of mind or risk.

89. In 2014, we investigated the death of another prisoner at Wandsworth where we found staff failed to communicate effectively through appropriate translation services. It is particularly concerning that this is an issue at Wandsworth, which is a designated foreign national prisoner 'hub', with a high proportion of foreign national prisoners. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that accredited translation services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

Healthcare offered to Mr Barsoum

90. Mr Barsoum had a number of medical problems before he arrived at Wandsworth. These were identified at initial health screens and his medication was continued. His GP surgery sent a copy of his medical notes to Wandsworth promptly. These were read by a GP and some modifications made to his medication. The GP did not act on information in these notes that Mr Barsoum had been referred to a memory clinic for dementia and was under the care of a specialist for chronic kidney disease.

91. In his clinical review, the clinical reviewer said that, although these health problems did not contribute to his death, they were so significant that they warranted further assessment and management. He concludes that the care Mr Barsoum received was not equivalent to that he should have expected had he been in the community. We make the following recommendation:

    The Head of Healthcare should ensure that information supplied by the community GP informs further assessment and management of patients with long term conditions.

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