Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Bailey, a prisoner at HMP The Mount, on 1 March 2022

A report by the Prisons and Probation Ombudsman

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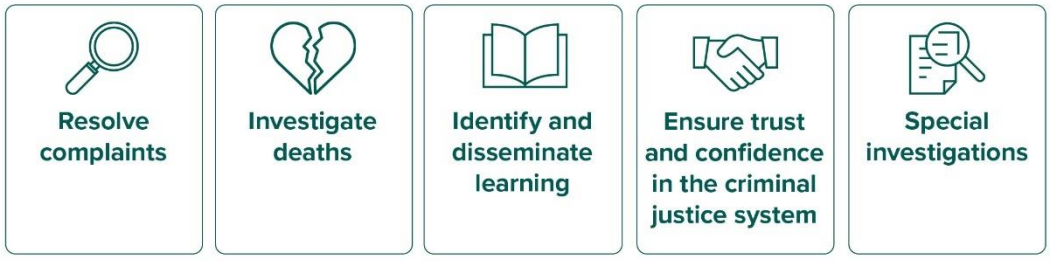
OUR VISION

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.

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 James Bailey died of asphyxiation on 1 March 2022, after he was found hanged in his cell in HMP The Mount. Mr Bailey was 24 years old. I offer my condolences to his family and friends.

On 26 February, Mr Bailey received some upsetting news about his partner's pregnancy. Two days later, Mr Bailey was transferred to HMP The Mount and the documentation that travelled with him did not make reference to his circumstances. He died the following day.

The clinical reviewer concluded that the mental healthcare provided to Mr Bailey was not equivalent to that which he could have expected to receive in the community and made a number of recommendations to address this.

I am concerned that information about a very recent and significant event in Mr Bailey's life was not shared with The Mount, despite the information being recorded in prison systems and accessible to staff completing the paperwork. The Mount was therefore unaware of Mr Bailey's circumstances when completing initial risk assessments. I am unable to measure the impact of this omission on the outcome for Mr Bailey but consider it a significant risk to future outcomes. I am also concerned that when Mr Bailey asked to be referred to the mental health team, the nurse who spoke to him did not explore the reason for his request. When staff found Mr Bailey, they did not use the correct code to call for emergency aid.

I am concerned that Mr Bailey's next of kin heard of his death through rumours and before the prison or police had broken the news to her.

I am also disappointed that we experienced the same issues with obtaining evidence from the prison that we highlighted during a previous investigation in March 2021.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

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Summary

Events

1. On 21 February 2022, Mr James Bailey was convicted of further offences and recalled to HMP Bedford. He said that he had no active thoughts of self-harm but had had mental health issues in the past. He was referred to the mental health team, who continued his prescribed antidepressants and assessed that he did not need further mental health support.

2. On the afternoon of 26 February, Mr Bailey told staff that he was concerned about his partner's pregnancy and the wing officer let him make an emergency telephone call to his partner. Mr Bailey received difficult news. A supervising officer offered support, but Mr Bailey said that he did not want any. She checked on him later in the day but concluded that he did not need additional suicide and self-harm monitoring.

3. On 28 February, Mr Bailey was transferred to HMP The Mount. The Person Escort Record (PER) that travelled with Mr Bailey from Bedford to The Mount did not identify any risk of suicide or self-harm and staff did not identify any concerns about how he presented or his answers to initial screening questions. No additional monitoring was put in place to check on his wellbeing. During his initial healthcare screen, Mr Bailey asked to be referred to the mental health team. This was actioned, but Mr Bailey was not asked about the reason for the referral.

4. On the morning of 1 March, a member of the chaplaincy team saw Mr Bailey as part of his induction programme. He said that he did not need any help or support. He made some telephone calls that morning, including to his partner. When an officer unlocked Mr Bailey's door after lunch, at 3.52pm, she found him hanging. An ambulance was called and staff, including nurses, tried to revive Mr Bailey until paramedics arrived and took over. Mr Bailey was declared dead at 4.17pm.

Findings

Assessment of risk

5. When Mr Bailey received difficult news about his partner's pregnancy, the supervising officer to whom he spoke offered support but did not assess that the risk he posed to himself was increased and did not put any additional monitoring in place. She recorded information about the news that Mr Bailey had received in his electronic NOMIS record and in the wing observation book. She also informed wing staff about what had happened and that she had agreed that he could have a telephone call the next day.

6. The PER did not make any reference to the recent news about his partner's pregnancy.

7. Mr Bailey's family said that his partner had telephoned the prison on the night of 28 February and expressed concerns about his wellbeing. The prison told us that they had no record of the call and we are unable to verify this information.

Emergency response

8. The officer who found Mr Bailey hanging did not use an emergency code and this resulted in a short delay in calling an ambulance.

9. When staff tried to activate a body-worn video camera, the battery was flat.

Liaison with the Ombudsman's office

10. The Mount did not provide our office with electronic evidence when it was requested as part of our investigation.

Family liaison

11. When the police agreed to break the news of Mr Bailey's death to his next of kin, the family liaison officer did not keep updated about whether this had happened, when it was likely to happen and if there were any problems with doing so. Although we recognise that it was the police who did not break the news, this resulted in Mr Bailey's next of kin hearing of his death through other sources.

Mr Bailey's healthcare

12. When Mr Bailey asked to be referred to the mental health team during his initial healthcare screen, a referral was submitted but the nurse who spoke to him did not ask what it was for.

13. The clinical reviewer concluded that the mental healthcare provided to Mr Bailey was equivalent to that which he could have expected to receive in the community. The clinical review makes a number of findings about the lack of training provision for healthcare staff on assessing the risk of suicide and self-harm and problems with the mental health team referral process. She makes a number of recommendations that the Head of Healthcare will need to address.

Recommendations

- The Governor of Bedford should ensure that all relevant information about prisoners' circumstances and potential suicide and self-harm risks are reflected in Person Escort Records so that receiving prisons are aware of and respond to them.
- The Governor of The Mount should ensure that all staff understand their responsibilities about calling emergency codes so that emergency responses are timely.
- The Governor of The Mount should ensure that body-worn video cameras are properly maintained and ready for use when necessary.
- The Governor of The Mount should ensure that all evidence, including electronic evidence, relevant to a death in custody is retained and made available to the PPO in line with PSI 58/2010.

- The Governor of The Mount should ensure that when the police break the news of a prisoner's death to their next of kin, the family liaison officer keeps in contact with the police so that they are kept updated about when this will likely happen, when it has been done and so that they can try to address promptly any problems with doing so.

- The Head of Healthcare at The Mount should ensure that the reasons for mental health referrals are clearly documented so that staff can assess any potential risks.

The Investigation Process

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

15. The investigator visited The Mount. He obtained copies of relevant extracts from Mr Bailey's prison and medical records.

16. The investigator interviewed seven members of staff at The Mount and two members of staff at HMP Bedford between June and August 2022.

17. NHS England commissioned a clinical reviewer to review Mr Bailey's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

18. We informed HM Coroner for Hertfordshire of the investigation. He provided us with the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Bailey's next of kin, his aunt, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked whether checks were made on Mr Bailey in the period before his death.

Background Information

HMP The Mount

20. HMP The Mount is a medium security prison holding approximately 1,000 men. Hertfordshire Community NHS Trust provides primary healthcare and GP services. Hertfordshire Partnership University NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

21. The most recent full inspection of HMP The Mount was in March 2022. Inspectors found that the prison was dealing with significant weaknesses identified in previous inspections, but prisoners were more positive about many aspects of their care. Recorded levels of self-harm had slightly increased, with too little support for prisoners in crisis. Staff had struggled to implement the new case management support process, which sometimes ended without having addressed the prisoner's risks and needs. Not enough support was given to new arrivals.

Independent Monitoring Board

22. 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 28 February 2022, the IMB reported that on the whole, the prison was a clean and tidy environment. The new healthcare provider gave a satisfactory service.

Previous deaths at HMP The Mount

23. Mr Bailey was the second prisoner at The Mount to take his own life since the beginning of 2020. There have also been two deaths from natural causes during this period. Since Mr Bailey's death, there have been four further deaths. The Mount has previously accepted our recommendations about providing the PPO with documentation to aid our investigations.

Assessment, Care in Custody and Teamwork

24. 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.

25. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support, and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

26. 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.

Key Events

Background

27. On 11 April 2015, Mr James Bailey was sentenced to nine years and six months imprisonment for various offences, including wounding with intent to cause grievous bodily harm. During a period in prison in 2016, Mr Bailey made some superficial cuts to his arm and staff monitored him under ACCT procedures for a few days. He was released on licence in 2017, 2018 and 2021 but was recalled each time due to further offences.

HMP Bedford

28. On 21 February 2022, Mr Bailey was recalled to HMP Bedford after committing further offences. At his initial health screen, he told a nurse that he had no thoughts of self-harm. He had been prescribed antidepressants in the past, so she referred him for a mental health assessment.

29. On 22 February, a nurse completed a secondary health screen for Mr Bailey. He noted that Mr Bailey appeared fit and well but said that he was experiencing mood changes and depression and felt constantly alert.

30. That afternoon, the mental health team manager discussed Mr Bailey with the psychologist and assistant psychologist. They found that he was not known to mental health teams in the community, had not been under the care of the prison mental health team before his release, and had no prescribed mental health medication at the time. They agreed that he did not need to be under the care of the mental health team.

31. That afternoon, a prison GP met Mr Bailey to discuss and assess his request for continued antidepressants. The GP prescribed mirtazapine daily, while waiting for confirmation of Mr Bailey's community prescription.

32. On 26 February, Mr Bailey told staff that his partner was having problems with her pregnancy. The wing manager approved emergency telephone credit to let him call his partner.

33. That afternoon, Mr Bailey told a Supervising Officer (SO) that he was concerned about his partner's pregnancy. She let him make a telephone call from an office telephone, and during the call, Mr Bailey received difficult news. When the call ended, Mr Bailey said that he wanted to go back to his cell. She asked if he needed any support, such as speaking to a member of the chaplaincy or a Listener (prisoners trained by the Samaritans to provide peer support), but he declined the offer. She checked his record and found that he did not have a significant history of self-harm. Later, she checked on Mr Bailey who was upset and said that he wanted to go to the segregation unit. She took him to the exercise yard so that he had the space to process the news. He talked about his past, his family and previous prison sentences. She asked how she could further support him, and Mr Bailey said that he had no telephone credit. She said that she would facilitate telephone calls the following morning and afternoon. Mr Bailey appeared to settle and returned to his cell.

HMP The Mount

34. On 28 February, Mr Bailey was transferred to The Mount. The Person Escort Record (PER) that went with him did not note Mr Bailey's circumstances or any potential risk of self-harm. The SO at Bedford signed Mr Bailey out. Mr Bailey told the SO that he was looking forward to his new location and showed no signs that he was a risk to himself.

35. On arrival at The Mount, Mr Bailey met an officer for his initial reception interview. The officer told us that he did not have access to Mr Bailey's electronic prison records during the interview. He said that the initial safety assessments of prisoners involved analysing their presentation, information in their PER and set questions for arriving prisoners, which include questions about past and current risk of self-harm. The officer did not find any information or signs that suggested that Mr Bailey posed an imminent risk to himself and no additional monitoring was put in place.

36. A nurse completed Mr Bailey's initial health screen. She noted that he was calm and said that his mental health was stable. Mr Bailey said that he had no thoughts of self-harm. He asked to see the mental health team and she made a referral.

37. Mr Bailey met an officer for his first night interview. She explained the regime and the support systems available and completed an assessment of the risk of harm that Mr Bailey presented to himself. Mr Bailey said that he had no thoughts of self-harm but would speak to staff or Listeners if he felt low. The officer said that he seemed upbeat, and she had no concerns about him. Wing staff made wellbeing checks on Mr Bailey throughout the night, as was the standard process for prisoners on their first night. She assessed that he should be checked at least four times throughout the night.

38. At 10.45pm, during wellbeing checks, Mr Bailey was seen on his in-cell telephone. At the 1.05am, 3.00am and 5.45am checks, he was seen sleeping.

39. On the morning of 1 March, Mr Bailey spoke to a nurse by telephone for his secondary health screen. Mr Bailey reported no physical health problems and made no requests. The nurse made sure that he was aware of how to access healthcare services if he needed them.

40. Later that morning, Mr Bailey met a member of the chaplaincy team as part of his induction programme. The chaplain asked Mr Bailey if he needed any help or support from the chaplaincy and Mr Bailey said that he did not.

41. Mr Bailey made some telephone calls to his partner during the morning of 1 March. He also made a call to an aunt, in which he apparently said that he was going to take his own life. The call was not checked at the time and was only heard after he died. The prison did not provide us with recordings of telephone calls, so we are unable to verify what was said.

42. Prisoners were locked in their cells over the lunch period. Cell bells are not recorded in The Mount, so we are unable to confirm whether Mr Bailey called for help. At 12.00pm, an officer completed a roll check. CCTV footage shows that the officer looked into Mr Bailey's cell and, at interview, he said that he saw Mr Bailey

and he was okay. At 3.37pm, another officer was delivering post on the spur, which included something for Mr Bailey. At interview, she confirmed that she had pushed the letter through the door and had not looked into the cell.

43. After the lunch period, staff were unlocking prisoners to escort them to get their medication. A SO went to Mr Bailey's cell and CCTV footage shows that she arrived at his door at 3.52pm. She tried to open the door, but it had been blocked. She looked through the observation panel and saw Mr Bailey suspended from the light fitting by a ligature made from a torn bed sheet. She pressed her personal alarm and called for assistance as she forced the door open. Other staff heard the call and went to Mr Bailey's cell. The SO held Mr Bailey's body to take his weight, and an officer cut the ligature. They lowered him to the floor and were unable to detect a pulse or any signs of breathing so began to perform cardiopulmonary resuscitation (CPR). Another SO radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has trouble breathing). Records show that this was at 3.53pm. The call prompted the control room to call an ambulance.

44. Nurses from the healthcare team responded to the emergency call and joined the prison officers in Mr Bailey's cell. They applied a defibrillator (a machine that in some cases can apply an electric shock to restart the heart), which advised them to continue with CPR. They did so until ambulance paramedics arrived and took control. At 4.17pm, paramedics confirmed that Mr Bailey had died.

Contact with Mr Bailey's family

45. An officer was appointed as the family liaison officer (FLO). She identified Mr Bailey's aunt as his next of kin. Local police told the FLO that they would contact Mr Bailey's aunt to inform her of Mr Bailey's death. Mr Bailey's father was a prisoner in The Mount at the time of his son's death, and staff informed him of what had happened and offered support.

46. The following day, Mr Bailey's aunt telephoned the prison to say that she had heard a rumour that he had died. The prison confirmed the news. The police had not yet been in contact with her because the address provided was incorrect. The prison found an older reference to the next of kin, with a different address, and shared the information with police. Officers then visited her and formally told her of Mr Bailey's death. The FLO later made and remained in contact with Mr Bailey's aunt to provide ongoing support. In line with Prison Service guidance, The Mount offered a contribution to the cost of Mr Bailey's funeral.

Support for prisoners and staff

47. After Mr Bailey's death, staff involved in the emergency response were invited to a debrief to ensure they had the opportunity to discuss any issues arising, and to be offered support. The staff care team also offered support.

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

Post-mortem report

49. The post-mortem examination concluded that Mr Bailey died from asphyxiation due to hanging.

Findings

Assessment of risk

50. On 26 February, Mr Bailey told staff that his partner was experiencing issues with her pregnancy. Based on the evidence we have seen, we are satisfied that the SO's approach to risk assessment, management and supporting Mr Bailey was of a high standard and compassionate. She appropriately allowed an emergency call in the staff office, given the exceptional circumstances. When Mr Bailey received difficult news, she checked Mr Bailey's record to see if he had a significant history of self-harm, which he did not. She also took him to the exercise yard so that he could process what had happened away from the wing. At interview, she said that Mr Bailey talked of future plans. She considered whether ACCT measures should be opened but found nothing in Mr Bailey's presentation that made her concerned and concluded that additional monitoring was unnecessary at the time. She also notified Mr Bailey and staff that she had authorised a phone call the following day, and she checked on his wellbeing later that afternoon. She appropriately noted what he had told her in the wing observation book and briefed staff working on the wing.

    However, the PER that travelled with Mr Bailey from Bedford to The Mount did not make any reference to the news he had received recently about his partner's pregnancy. HMP Bedford was unable to identify who completed the PER because the responsibility was shared among a group of officers. We were therefore unable to explore this matter further. An SO, who is a trained ACCT assessor and case manager, spoke to Mr Bailey before he was discharged from Bedford and identified no concerns in his presentation at the time. However, we consider that risk information about Mr Bailey's circumstances should have been recorded in the PER to ensure that staff at The Mount were aware and able to consider whether additional support might have been necessary. We make the following recommendation:

    The Governor of Bedford should ensure that all relevant information about prisoners' circumstances and potential suicide and self-harm risks are reflected in Person Escort Records so that receiving prisons are aware of and respond to them.

51. An officer completed Mr Bailey's reception interview when he arrived at The Mount and another officer took him through the induction process. At interview, they both confirmed that they had no cause for concern about Mr Bailey's wellbeing and did not find any signs that he posed a risk to himself. The induction officer set the first-night wellbeing checks for Mr Bailey at four, the minimum number, based on her assessment that the risk of suicide and self-harm was low. We consider that this was reasonable in the circumstances.

52. Mr Bailey's family said that his partner had telephoned the prison on the night of 28 February and said that she was concerned about him. The prison said that they had no record of receiving any calls about Mr Bailey before he died, and his family were unable to provide us with any additional details. In the absence of evidence to confirm what happened, we are unable to comment further about this matter.

Emergency response

53. The SO who first identified that Mr Bailey was hanging did not radio an emergency code blue. She also failed to use the code when shouting for help from other officers. An emergency code was not used until another SO arrived and called a code blue. The prison was unable to supply recordings of the radio traffic, so we do not know the exact length of the delay. We were unable to interview the SO because she was on long-term sick leave. The records we do have suggest that the delay was minimal and therefore unlikely to have impacted on the outcome for Mr Bailey. However, in another emergency, we know that even a short delay might make a difference to the outcome. We therefore make the following recommendation:

    The Governor of The Mount should ensure that all staff understand their responsibilities about calling emergency codes so that emergency responses are timely.

54. An officer tried to activate the SO's body-worn video camera when officers found Mr Bailey, but the battery was flat. Body-worn cameras provide an important source of evidence to protect prisoners and staff. We make the following recommendation:

    The Governor of The Mount should ensure that body-worn video cameras are properly maintained and ready for use when necessary.

Cooperation with the PPO

55. Prison Service Instruction (PSI) 58/2010 on the Prisons and Probation Ombudsman requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigations. On 2 March, we asked for recordings of Mr Bailey's telephone calls and the radio traffic relating to the emergency response to be preserved and provided to us. The prison agreed to do so. However, the records were never provided. We make the following recommendation:

    The Governor of The Mount should ensure that all evidence, including electronic evidence, relevant to a death in custody is retained and made available to the PPO in line with PSI 58/2010.

Liaison with Mr Bailey's family

56. The prison appointed a family liaison officer who identified Mr Bailey's next of kin as his aunt. Local police said that they would inform her of Mr Bailey's death. The family liaison log does not set out why the police agreed to break the news and the family liaison officer was not available when our investigator visited the prison for interviews. Wherever possible, we would expect the family liaison officer and another member of staff to visit the next of kin to break the news of a prisoner's death in line with PSI 64/2011 on safer custody. However, we were not able to verify the reason for the police's agreement to break the news and therefore do not make a recommendation about this.

57. The police did not break the news to Mr Bailey's aunt on the day he died as they had an incorrect address. We are concerned that his aunt regrettably first heard

rumours of his death from other sources and called the prison the next day to confirm Mr Bailey's death, which they did.

58. PSI 64/2011 is clear that "time is of the essence [in breaking the news to a next of kin] in order to try to ensure that the family do not find out about the death from another source". While we recognise that the police had agreed to break the news to Mr Bailey's aunt, the prison had a responsibility under the PSI to arrange a follow-up visit as soon as practicable after the police had visited her. However, there is no evidence that they chased the police for an update about whether the news of Mr Bailey's death had been broken to his aunt and they did not know that the police had not done so until the following day when Mr Bailey's aunt contacted them about the rumours she had heard. Had they kept in contact with the police and sought an update on the day of Mr Bailey's death, they could have given the police the correct address for his aunt or had the option to break the news themselves that day before she heard from other sources.

59. We acknowledge how difficult and distressing it must have been for Mr Bailey's aunt to hear of his death through rumours and outside of the formal process. We consider that the prison should have had a more co-ordinated approach with the police to ensure that the news was broken to Mr Bailey's in a timely manner. While we recognise that prison officers visited Mr Bailey's aunt the next day after the prison learned that she had found out about Mr Bailey's death and appropriately provided ongoing support, we make the following recommendation:

The Governor of the Mount should ensure that when the police break the news of a prisoner's death to their next of kin, the family liaison officer keeps in contact with the police so that they are kept updated about when this will likely happen, when it has been done and so that they can try to address promptly any problems with doing so.

Mr Bailey's healthcare

60. The clinical reviewer found that Mr Bailey's mental healthcare was not equivalent to that which he could have expected to receive in the community. When Mr Bailey asked to be referred to the mental health team on arrival, the nurse who spoke to him did not ask why. The nurse had not received ACCT training or mental health training beyond her original nursing qualification. The Head of Healthcare told us that there was no specific risk assessment training for healthcare staff working in reception. The clinical review makes recommendations about this which the Head of Healthcare will need to address.

61. The mental health team discussed Mr Bailey soon after his arrival at the Mount and decided that he did not need to be under their care. Their reason was that he was not known to community mental health services and was not prescribed any medication for his mental health. This was incorrect because Mr Bailey had been prescribed, and later re-prescribed, antidepressants. We therefore make the following recommendation:

The Head of Healthcare at The Mount should ensure that the reasons for mental health referrals are clearly documented so that staff can assess any potential risks.

Inquest

62. The inquest, held from 10 to 19 June 2024, concluded that Mr Bailey died by suicide.

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