Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Hands, a prisoner at HMP Bedford, on 16 February 2024

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 l 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 Edward Hands died in his cell at HMP Bedford on 16 February 2024 from aspiration pneumonitis (an infection caused by material from the mouth entering the lungs) after taking unprescribed methadone. Mr Hands was 42 years old. I offer my condolences to his family and friends.

Mr Hands had no recorded history of drug misuse while at Bedford and it was clear from his telephone calls that he was optimistic about his prospects of being released at his next court hearing.

Unfortunately, Mr Hands was able to obtain methadone and the staff response to finding him under the influence was poor. In addition, the clinical reviewer found that his GP records were not obtained when he arrived at Bedford meaning that staff were unaware he had a heart condition. Furthermore, the nurse did not use a suction device during the emergency response which the clinical reviewer concluded may have contributed to Mr Hands' 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.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

Contents

Summary

Events

1. On 25 November 2023, Mr Edward Hands was remanded to HMP Bedford charged with controlling and coercive behaviour in an intimate relationship.

2. During reception screening, Mr Hands said that he used cocaine daily in the community. He also said that he had taken an overdose of prescribed Mirtazapine (an antidepressant) and Risperidone (an antipsychotic) three weeks ago, but he had no present thoughts of suicide or self-harm.

3. In telephone calls to family and friends, Mr Hands spoke about his impending court appearance, and he seemed optimistic that he would be released from custody.

4. On the morning of 16 February 2024, an officer unlocked Mr Hands' cell. Around 30 minutes later, a prisoner went into Mr Hands' cell for 24 seconds. At 9.15am, another officer went into Mr Hands' cell and believed that he was under the influence of drugs. Mr Hands was able to talk and get to his feet, so the officer followed protocol and radioed the emergency response nurse directly for her to come and check Mr Hands. The nurse checked Mr Hands at around 10.00am and noted that she instructed officers to check him every 30 minutes for the next four hours and to complete an under the influence monitoring form.

5. Officers checked Mr Hands intermittently for the next two hours. The final check was a routine check at 11.49am immediately before the lunch time patrol period.

6. At 2.13pm, an officer unlocked Mr Hands' cell and a DHL courier placed three bags of canteen (prison shop items) just inside the cell. At 2.44pm, another officer briefly let another prisoner into Mr Hands' cell to retrieve one of the bags of canteen as it belonged to him. The officer and the prisoner noticed that Mr Hands was snoring loudly.

7. At 4.36pm, an officer unlocked Mr Hands' cell for him to collect his evening meal and noticed a smell of vomit. After checking Mr Hands, they found he was unresponsive and radioed an emergency code. Another officer arrived 40 seconds later, and further officers arrived at 4.38pm. The officers moved Mr Hands to the floor and started cardiopulmonary resuscitation (CPR).

8. A nurse arrived a minute later. Officers told the nurse that Mr Hands had vomit in his mouth, but she did not clear the vomit. Staff continued resuscitation efforts. Ambulance paramedics arrived at 4.51pm and took charge of Mr Hands' care. At 5.24pm, the paramedics pronounced that Mr Hands was dead.

9. The post-mortem examination found that Mr Hands had died from aspiration pneumonitis after taking methadone.

Findings

10. Mr Hands obtained methadone illicitly, most likely from another prisoner who was being prescribed that medicine.

11. When Mr Hands was found under the influence on 16 February, neither the emergency response nurse nor the officers followed the under the influence protocol.

12. The officer who noticed Mr Hands snoring loudly at 2.44pm, did not understand that this was a possible sign of a medical emergency.

13. When Mr Hands was found unresponsive the nurse did not suction vomit from his mouth. Healthcare staff also did not obtain Mr Hands' GP records, so they were unaware that he had a heart condition.

Recommendations

- The Governor and Head of Healthcare should review whether the current medication administration process is sufficiently robust and identify any weaknesses to minimise the risk of diversion.

- The Governor and Head of Healthcare should introduce a robust audit process to ensure that when a prisoner is suspected to be under the influence staff understand and follow the protocol.

- The Governor and Head of Healthcare should ensure that staff are aware of the potential significance of a prisoner being in an apparent deep sleep and snoring loudly.

- The Head of Healthcare should ensure that prisoners' GP records are obtained.

The Investigation Process

14. HMPPS notified us of Mr Edward Hands' death on 19 February 2024.

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

16. The investigator obtained copies of relevant extracts from Mr Hands' prison and medical records.

17. The investigator interviewed six members of staff at Bedford on 2 and 3 May 2024. He interviewed one prisoner by MS Teams on 13 May 2024. He interviewed three further members of staff by MS Teams in May and June, and he interviewed one more prisoner by telephone in August.

18. NHS England commissioned a clinical reviewer to review Mr Hands' clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with clinical staff.

19. We informed HM Coroner for Bedfordshire and Luton of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. We contacted Mr Hands' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Hands' mother responded with several questions, and we later received a letter from the family's legal representative asking further questions. Their questions and concerns were:

    - Why was Mr Hands' mother not allowed to bring a monitor into the prison that connected with the 'Reveal' heart monitor (a small device inserted under the skin) that he had had fitted to check his heart activity.
    - Mr Hands complained to his mother that he was receiving all of his medication together at 4.30pm, including a sleeping tablet that should have been given at night.
    - Mr Hands' asthma inhaler ran out and he waited three to four weeks for a replacement.
    - Mr Hands complained to his mother about the condition of his cell, including that the window was broken and there was an infestation of cockroaches. He also complained that there were rats in the prison kitchen.
    - Mr Hands complained to his mother about being cold, but he was not allowed access to a parcel of warm clothing she had sent to him: she was told that his request had been denied as the prison had mislaid paperwork.
    - Was Mr Hands under the care of the mental health team at Bedford?
    - Was Mr Hands being supported through prison service suicide and self-harm monitoring procedures (known as ACCT)?

- Was Mr Hands prescribed methadone and, if not, how did he acquire methadone?
- What other medication was prescribed to Mr Hands?
- What time was the last roll check prior to Mr Hands' death and at what time was he last seen alive?
- Was Mr Hands sharing a cell at the time of his death?

21. We have answered these questions in this report, the clinical review and in separate correspondence.

22. We shared our initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

23. Mr Hands' family also received a copy of the initial report. They did not make any comments.

Background Information

HMP Bedford

24. HMP Bedford is a small, local, inner-city Victorian prison. Northants Healthcare NHS Foundation Trust provides all healthcare services. Bedford also has a small inpatient unit. There is 24-hour healthcare provision.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Bedford was in October and November 2023. The Chief Inspector wrote that standards had fallen badly since the last inspection in 2022.

26. Inspectors found that while the majority of prisoners said that staff treated them with respect, the interactions they observed were mostly transactional to support the delivery of the regime. Inspectors noted that the key worker scheme had ceased and been substituted with a telephone call to the cell, which was inappropriate as most prisoners were sharing cells so could not speak in confidence. Inspectors noted that in the cases they reviewed, key work contact levels and quality were poor and many prisoners had been in Bedford for several months with no contact.

27. Inspectors found that too many cells were in a poor condition with mould and broken windows. Inspectors also found that there was widespread infestation of rats, cockroaches and other vermin.

28. Inspectors noted that pharmacy services had been subcontracted and this had caused considerable disruption, particularly with the management of medicines and which had affected continuity of care and resulted in gaps in patients receiving their medication.

29. Following the inspection HM Chief Inspector of Prisons invoked the Urgent Notification process because he was so concerned about conditions at Bedford (the Urgent Notification process allows HM Chief Inspector of Prisons to directly alert the Lord Chancellor and Secretary of State for Justice if he has an urgent and significant concern about the performance of a prison). The Chief Inspector noted that the Urgent Notification process had also been invoked after an inspection of Bedford in 2018 when many similar concerns were highlighted. The Chief Inspector noted that he had reported more favourably in 2022, showing that progress was possible despite the many challenges face by the prison.

Independent Monitoring Board

30. 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 June 2023, the IMB reported that the key worker scheme had stopped during the Covid-19 pandemic and had not since been fully reinstated. The IMB noted that in their prisoner survey, 21 out of 72 responses were positive about officers, but 22 responses said that officers were not

helpful. As with HMIP, the IMB referred to the poor standard of the physical infrastructure of the prison and the abundance of vermin.

Previous deaths at HMP Bedford

31. Mr Hands was the eighth prisoner to die at Bedford since July 2020. Of the previous deaths, three were self-inflicted and four were from natural causes. There were no similarities between Mr Hands' death and any of the previous deaths.

Key worker scheme

32. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

33. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

34. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

35. On 25 November 2023, Mr Edward Hands was remanded into prison at HMP Bedford charged with controlling and coercive behaviour in an intimate relationship. It was Mr Hands' first time in prison.

36. A nurse saw Mr Hands for a reception health screen. Mr Hands said that he had a history of mental health problems, including a psychotic disorder and was in receipt of medication. He said that he had had asthma since he was a child and also said that he had suspected epilepsy, potentially diagnosed the year before. Mr Hands reported daily use of cocaine. Mr Hands said that he had taken an overdose of prescribed Mirtazapine and Risperidone three weeks earlier, but he had no present thoughts of suicide or self-harm. Mr Hands did not mention any other concerns and did not mention heart monitoring. (His mother told us he had been fitted with a heart monitor which had a separate bedside monitor to check his heart activity.) The nurse referred Mr Hands to the mental health team.

37. A reception GP prescribed Mr Hands a number of medicines, including Lamotrigine (for epilepsy), Mirtazapine and Risperidone. He was not allowed to hold these medicines in possession and had to collect them daily.

38. On 27 November, an officer had a key worker session with Mr Hands via his in-cell telephone. Mr Hands asked for clarity on his next court date and after checking, the officer telephoned Mr Hands the next day to confirm he would appear at court on 29 November.

39. On 28 November, a substance misuse worker gave Mr Hands harm minimisation advice and an intervention service self-referral form. If Mr Hands wanted to engage with the service, he needed to fill this in.

40. On 5 December, a mental health nurse reviewed Mr Hands. She noted that Mr Hands was stable on his current medication, and he said that he had no thoughts of deliberate self-harm. The nurse added Mr Hands to the psychiatrist's waiting list.

41. On 6 December, a substance misuse worker gave Mr Hands a replacement self-referral form as he had lost the form previously given to him.

42. On 14 December, another substance misuse worker noted that Mr Hands had still not completed a self-referral form. The worker sent Mr Hands a letter to say that he would not be seen again, but he would be able to apply for help in the future if he wished. Mr Hands did not request help.

43. On 23 January 2024, Invisible Walls (an organisation that supports prisoners' families), emailed one of Bedford's managers who they previously had contact with, to say that Mr Hands' mother was trying to bring his heart monitor into the prison, but she needed authority from the prison to do so. The manager was on leave at the time, but on 31 January she replied to say that she had emailed healthcare to check that Mr Hands required the device and said that once she had this confirmation, she would agree the request. The investigator understood that the monitor that Mr Hands' mother was trying to bring into the prison connected electronically to a device inserted in Mr Hands' body to give ongoing data about his heart function. There is no reference in Mr Hands' medical records about any such

device or of Mr Hands telling prison staff that he used a monitor in the community and that his mother was trying to bring the monitor into the prison. She did not receive agreement to bring the monitor into the prison. We incidentally note that there is no reference in Mr Hands' post-mortem examination report to say that any internally fitted device was discovered.

44. Also on 23 January, an officer noted that he spoke to Mr Hands for a welfare check and that Mr Hands raised no concerns.

45. On 1 February, a GP saw Mr Hands and noted that he was taking his medication, and his mental health was stable. The GP also prescribed an asthma inhaler, which he noted had last been prescribed in January 2023.

46. The investigator listened to Mr Hands' telephone calls during the last month of his life. The majority of his calls were to his mother, along with several calls to two friends. Mr Hands was generally positive in conversation, and he spoke frequently about his court appearances and his belief that he would soon be granted bail.

47. Mr Hands' final telephone call was a call to his mother in the early afternoon of 15 February. She said that she was unable to book a visit to see him the next day as the visiting list was full. (She had regularly visited him over his time at Bedford.) Mr Hands told his mother that he would telephone her again in two days' time.

48. Staff the investigator spoke to said that Mr Hands was a quiet, polite and well-behaved prisoner. However, Mr Hands did not have a key worker and none of the entries in his record indicate detailed interaction with him.

Events of 16 February

49. The investigator watched CCTV and body worn video camera (BWVC) footage, listened to the staff radio communications, and obtained information from the East of England Ambulance Service. He studied staff response statements and records and interviewed key staff. The account below is based on all these sources of information.

50. On 16 February at 7.34am, Officer A carried out a routine check on A wing, including Mr Hands' cell. She did not note anything of concern. At 8.05am, another officer unlocked cells on A wing for prisoners to use the showers. The officer did not check on the welfare of the prisoners while unlocking cells.

51. At 8.31am, another prisoner went into Mr Hands' cell and came out again 24 seconds later. The prisoner was transferred to HMP Peterborough shortly after Mr Hands' death and was then released from prison. The investigator wrote to his home address to arrange to speak with him, but he did not respond. The prison told the investigator that the prisoner was prescribed methadone.

52. It seems that Mr Hands' cell was re-locked sometime after this but, from speaking to staff and watching CCTV, the investigator could not establish when this happened.

53. At 9.15am, Officer B unlocked Mr Hands' cell for him to socialise with other prisoners. The officer said that Mr Hands was in bed, and he did not return his greeting as he usually did. He said that he went into the cell and as Mr Hands

began to stand, he saw that he was unsteady his feet. He called for help from Officer A and then radioed Hotel Two (the emergency response nurse). Officer B said that as Mr Hands was conscious, it was not standard practice to radio an emergency code that all staff could hear, and instead he radioed the nurse directly and told her that Mr Hands seemed under the influence of an illicit substance.

54. The morning emergency response nurse told the investigator that she was issuing controlled medicines when she received the call from Officer B. She said that if she had received an emergency call, she would have responded immediately, but as she did not, she decided that completing the controlled medication round was the more pressing task at that time.

55. Officer B said that he made a further call to the nurse due to the time it was taking for her to attend.

56. The nurse went to Mr Hands' cell at 9.53am. She noted that Mr Hands was lying in bed and breathing normally. She noted that he was talking in full sentences, but his speech was slurred, and his responses were slow. She also noted that his gait was unsteady when he tried to walk. She told officers to observe Mr Hands twice an hour for the next four hours and to contact healthcare if they had any further concerns. She told the investigator that she went to the wing office and asked officers to start an under the influence (UTI) monitoring form detailing their checks. She said that staff seemed reluctant to start a UTI form, but she insisted that they should do so (officers did not complete a UTI monitoring form). She told the investigator that she was an agency nurse and had only just started working at Bedford.

57. Officers searched Mr Hands' cell and found a rolled-up piece of paper with traces of a white substance. They also found a container holding cigarette butts and a dark powder that smelled of tobacco. Results of the tests on these items were still unavailable when we issued this report.

58. CCTV shows that officers relocked Mr Hands' cell at 10.18am.

59. At 11.04am, Officer B went into Mr Hands' cell to check him. He said that he asked Mr Hands if he was okay, and he said that he was. He told us that he understood that healthcare staff and not officers were responsible for checking Mr Hands until he fully recovered.

60. CCTV shows that officers looked into Mr Hands' cell three more times that morning: at 11.21am, 11.48am and 11.49am. Staff did not carry out any checks on Mr Hands between midday and 2.13pm.

61. In the afternoon, prisoners' canteen (prison shop) orders were delivered to the wing. At 2.13pm, Officer C unlocked Mr Hands' cell and he saw Mr Hands in bed, apparently asleep. A DHL operative carried in Mr Hands' canteen items. He told the investigator that DHL visited Bedford every Friday to deliver prisoners' canteen orders. He said that DHL staff delivered the orders and remained in the prison for a time to allow prisoners time to check that their orders were correct. He said that most of the time prisoners would stand at their cell doors ready to take their canteen orders. However, if the prisoner was asleep, he would place the canteen order just inside the cell and the officer would then relock the door. He said that he did not

fully step into cells, and he had no recollection of Mr Hands that day. (CCTV shows that he stepped fully across the threshold of Mr Hands' cell entrance, although he did not walk further into the cell.)

62. At 2.39pm, a group of prisoners returned to the wing following the Friday Muslim service. One of the prisoners stood in front of Mr Hands' cell door. Officer C asked him if that was his cell and he said that it was. The officer unlocked the door, and the prisoner went in. Another prisoner then called from the upper landing to say that that was not his cell, so Officer C and Officer A unlocked the cell again and brought him out. He had remained alone in the cell with Mr Hands for 14 seconds. Officer C did not normally work on that wing and said the photos of prisoners on cell doors were often not clear, hence his mistake. The prisoner told the officers that one of the bags of canteen had been bought by a previous occupant of the cell and belonged to him in repayment of a debt. The officers told him that they needed to lock away all of the other prisoners first and they would then deal with the bag of canteen.

63. The prisoner told the investigator that he had tried to wake Mr Hands, but he seemed to be in a deep sleep and was snoring loudly. He told the investigator that the prison later published a notice to say that loud snoring could be a sign of a drug overdose, but he did not realise that at the time. Officer C also said that Mr Hands was snoring loudly, but he again did not recognise the significance.

64. At 2.44pm, having established that one of the bags of canteen did not belong to Mr Hands, Officer A briefly let the prisoner back into Mr Hands' cell to collect his canteen. The officer said that he noticed Mr Hands snoring loudly and he just thought that he was having 'a good sleep'.

65. At 2.48pm, Officer B went into Mr Hands cell to check him again. He said that Mr Hands was asleep and snoring and he thought he was okay. He said that he understood that some drugs can cause paranoia so he did not try to wake him as he thought this might have scared him.

66. At 4.36pm, Officer A unlocked Mr Hands' cell so he could collect his evening meal. He said that when he unlocked the door, he could smell vomit. He went into the cell and shook Mr Hands' shoulder to try to wake him. He said that Mr Hand's body was warm. He tried to find a pulse and thought he was doing something wrong as he could not find one. He radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). Control room staff immediately requested an ambulance. An officer came into the cell and another officer arrived a few seconds later. Officers moved Mr Hands from his bed to the cell floor and an officer began CPR.

67. Two nurses arrived at 4.39pm (Nurse A was the afternoon response nurse and Nurse B was a new nurse who followed Nurse A for experience). As Nurse A began preparing her equipment, audio captured on the BWVC recording included two of the officers making repeated comments that Mr Hands' mouth was full (of vomit) and asking whether his mouth should be suctioned.

68. Nurse A acknowledged at interview that she saw a black substance coming from Mr Hands' mouth, but she did not ask for a suction unit to clear his mouth and could not fully explain why not. Instead, she took over giving CPR and she and officers

then took turns with further CPR. Staff brought a defibrillator but each time they checked Mr Hands they were instructed that no shock could be given (a defibrillator will only shock if the heart is in a rhythm that will respond to a shock). The investigator noted that Nurse B did not take an active part in the attempts to resuscitate Mr Hands. A nurse who was Hotel One that afternoon (Hotel One should provide back-up support to the emergency response nurse) said that he was screening new receptions that afternoon and he did not hear the code blue call.

69. Paramedics reached Mr Hands at 4.51pm and took over his care. Efforts to try to resuscitate him proved unsuccessful and, at 5.24pm, they declared that he was dead.

Contact with Mr Hands' family

70. Bedford appointed a family liaison officer (FLO). He and a colleague drove to Mr Hands' mother's home. Due to heavy traffic, they did not arrive until 9.55pm. The FLO informed Mr Hands' mother of her son's death and offered her condolences.

71. Bedford contributed to the cost of Mr Hands' funeral in line with national instructions.

Support for prisoners and staff

72. After Mr Hands' death, the Duty Governor debriefed prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Staff were also offered support from the care team and officer specific trauma support. The healthcare team held a separate debrief meeting.

73. The prison posted notices informing other prisoners of Mr Hands' 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 Mr Hands' death.

Post-mortem report

74. Toxicological investigation found that Mr Hands' blood was positive for his prescribed medicines at a therapeutic level (therapeutic level refers to the level prescribed to treat an illness). Investigation also found that he had taken methadone, which he was not prescribed. His post-mortem report explained that while the blood methadone concentration was within the range encountered in therapy, the concentration may be associated with fatalities in those not prescribed methadone. Examination found gross aspiration of gastric contents in Mr Hands' airways (when a significant amount of food or liquid enters the airway) and established aspiration pneumonitis (an infection caused by a relatively large amount of material from the mouth entering the lungs). The pathologist gave Mr Hands' cause of death as aspiration pneumonitis with methadone use having contributed to but not caused his death.

Findings

Mr Hands' reported substance misuse

75. When Mr Hands arrived in Bedford in November 2023, he reported daily use of cocaine. He was seen several times by the substance misuse team who gave him information leaflets and self-referral forms. Mr Hands did not complete a self-referral form so he was told he would not be seen again, although he could request support in the future if he wished. He did not request support.

76. There is no record that Mr Hands used illicit substances or took any medication not prescribed to him until 16 February.

77. We are satisfied that Mr Hands was offered appropriate support for any substance misuse issues he might have had.

Methadone distribution

78. As noted, Mr Hands was found to have taken methadone in the hours before his death. Methadone is a liquid medicine used to treat heroin dependence. Mr Hands was not prescribed methadone so he would have obtained the medicine from another prisoner. CCTV shows that another prisoner went into Mr Hands' cell at 8.31am, where he remained for 24 seconds. The investigator was told that the prisoner was being prescribed methadone. As already indicated, we were unable to interview him. However, we consider it more likely than not that he diverted his methadone and sold or gave it to Mr Hands that morning.

79. The acting Head of Healthcare told us that prisoners at Bedford who are prescribed methadone are required to first swallow the methadone and then drink 200 millilitres of water in front of the nurse to prevent them from saving or passing the methadone to another prisoner. She said that good practice would be for prisoners to also be asked to open their mouths, although she was unsure if this was always the practice. In addition to the presence of nurses involved in the distribution of the methadone, officers are responsible for supervising the methadone queue. It is clear that the processes broke down in this instance leading to Mr Hands' death. We make the following recommendation:

    The Governor and Head of Healthcare should review whether the current medication administration process is sufficiently robust and identify any weaknesses to minimise the risk of diversion.

Response on 16 February to Mr Hands being found under the influence

80. Bedford's protocol for non-emergency responses to prisoners found under the influence is for staff to telephone either Hotel Two or Hotel One. Officer B correctly followed protocol by telephoning Hotel Two (the emergency response nurse). However, he was concerned about the time it took for the nurse to respond, which indicates that he did not properly understand the principle of a non-emergency response.

81. After the nurse assessed Mr Hands, she told officers that they should check him twice an hour for the following four hours and to contact healthcare again if they had concerns. She asked them to complete a UTI monitoring form, but said officers seemed reluctant to do so. None of the officers with whom the investigator spoke could recall being asked to complete UTI monitoring (and no one started a UTI monitoring form).

82. The investigator spoke to Bedford's temporary Drug Strategy Lead. She said that she had taken up post in mid-March. She acknowledged that there were apparent problems at the time with officers completing UTI monitoring forms. She said that there had been 15 recorded UTI incidents at Bedford in February, and she had not been able to locate a completed UTI monitoring form for any of the incidents. She said that on taking up post she began to re-write policy documents and had in place a programme for training staff on their responsibilities. She said that around June 2024, the Prison Officers' Association (POA; the officers' trade union) had raised concerns that UTI monitoring forms were a healthcare document and should not be completed by officers. She said that this was a national concern to the POA, not a local one. She said that while the issue was still under discussion, it had been agreed that officers would record UTI observations in the wing diary.

83. The Lead agreed with the investigator that Officer B had apparently misunderstood that telephoning Hotel Two meant that there might be a delay in the response depending on what Hotel Two was doing at the time. She said that the instruction to staff included the need to also inform the Orderly Officer (the officer in charge) who would be able to follow-up if there were any problems with the response from healthcare. (There is no record that Officer B called the Orderly Officer). She also acknowledged that the healthcare team at Bedford used a lot of bank nurses and that there was room for improvement in the relationships between prison and healthcare staff.

84. We also note that the protocol for ongoing checks on prisoners found under the influence included that the prisoner should be observed every 10 minutes for the first hour and reassessed by healthcare after the first hour. At interview, it was clear that none of the staff understood the protocol. We note that officers maintained a reasonable level of checks on Mr Hands up to 11.49am, but after that the checks became intermittent and some of them only occurred because it was canteen delivery day and not because they understood that he needed to be checked until he had recovered. We also note with concern that Mr Hands was one of 15 prisoners found under the influence in February with no UTI forms completed.

85. One of the most important omissions in keeping Mr Hands safe after he was suspected to be under the influence was the absence of an appropriate healthcare review of his condition after the first hour. Currently, most prisoners found under the influence will have used a psychoactive substance (PS) where generally prisoners recover quite quickly following use. In Mr Hands' case, he had used methadone that he presumably obtained from a prisoner prescribed that medicine. With methadone overdose, individuals recover much more slowly, and unconsciousness and loud snoring are signs of deteriorating health and signify a medical emergency. Both officers and a prisoner noticed these signs in the early afternoon, but they did not recognise the significance.

86. We recommend that:

The Governor and Head of Healthcare should introduce a robust audit process to ensure that when a prisoner is suspected to be under the influence staff understand and follow the protocol.

The Governor and Head of Healthcare should ensure that staff are aware of the potential significance of a prisoner being in an apparent deep sleep and snoring loudly.

Clinical care

87. The clinical reviewer found that the care Mr Hands received for his mental health and substance misuse needs was of a good standard and equivalent to that which he would have received in the community.

88. However, the clinical reviewer considered that Mr Hands' physical healthcare was only partially equivalent to that which he would have received in the community. In particular, she noted the inadequate recording of information about Mr Hands' mother's attempts to bring a heart monitoring device into the prison and whether he required any such device. She also noted that Bedford had not obtained Mr Hands' GP records so it would not have been possible to verify that he had been fitted with the device. We make the following recommendation:

The Head of Healthcare should ensure that prisoners' GP records are obtained.

89. The clinical reviewer also noted that Nurse A did not request suction equipment to clear the vomit from Mr Hands' mouth. At interview, the nurse said that she had since reflected on her actions that day and regretted failing to ask for a suction device. The acting Head of Healthcare reviewed the CCTV/BWVC footage and spoke with Nurse A about her actions. She also arranged with Northants Healthcare NHS Foundation Trust provision of bespoke training for staff in use of suction equipment and maintenance of the patient's airway. Bedford has also ordered additional portable suction units to be held on all wings. In view of the actions taken, we make no recommendation.

Key worker scheme

90. Mr Hands was at Bedford for almost three months and had just one key worker meeting in that time. The last entry in his records before his death was made on 23 January when he said that he had no concerns. HM Inspectorate of Prisons found at their last inspection that the key worker scheme had been replaced by telephone calls to prisoners in their cells which was deemed inappropriate as most prisoners were sharing cells. Bedford has subsequently reinstated face to face key worker meetings.

91. Bedford's Head of Residence told the investigator that in the last three months the prison had delivered 718 key worker sessions, but he explained that it was difficult to determine how many sessions were being delivered per prisoner due to prisoner churn and a fluid population level (the population was 334 at the time of the last

HMP inspection). He told the investigator that Bedford aimed to deliver one key worker session each week to the priority group comprising young adults, prisoners at risk of suicide and self-harm and prisoners in the segregation unit. For other prisoners the aim was to deliver one key worker session each month. In view of the apparent improvement since Mr Hands' time in Bedford we make no recommendation.

Governor to note

Unlock procedures

92. When Mr Hands' cell was unlocked at 8.05am on 16 February, the officer did not check his welfare before moving to the next cell. There is no evidence to suggest that Mr Hands was unwell at that time, however the Governor will wish to ensure that officers check prisoners' welfare when unlocking cells in the morning.

Resuscitation guidance

93. The clinical reviewer noted from reviewing the BWVC that officers were unclear about how to set up the defibrillator and needed guidance from Nurse A. The clinical reviewer also noted that some officers were unclear about the rate and depth when giving CPR, but the nurse did not give guidance on this. The Governor and Head of Healthcare may wish to consider these issues further.

Inquest

94. An inquest into Mr Hands' death held between 24 November and 2 December 2025 concluded that his medical cause of death was aspiration pneumonitis following consumption of methadone. The inquest jury found that Mr Hands' death was contributed to by neglect and could have been prevented had prison and healthcare staff given him appropriate follow up care after he was found under influence on 16 February 2024.

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 l 020 7633 4100