A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Bullingdon in April 2013

Our Vision

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

This is the investigation report into the death of a man who was found hanging in his cell at HMP Bullingdon in April 2013. He was 27 years old. I offer my condolences to his family and friends.

A clinical review was undertaken to assess the clinical care the man received at Bullingdon. The prison cooperated fully with the investigation.

When he arrived at Bullingdon in November 2012, the man was not identified as at risk of suicide or self-harm, even though it was his first time in custody, he was charged with a serious offence and had taken an overdose the previous year.

The man was Polish and spoke very little English. Staff interaction with him at the prison was limited. He displayed extreme emotions and was referred to the mental health team. He received good support for anxiety and sleeping problems but was not regarded as a risk of suicide.

I am concerned that prison staff who assessed the man's risk of suicide and self-harm when he first arrived at the prison did not use an interpreting service even though he spoke and understood very little English. It is clear that they could not have reached an informed decision and it is not apparent that they took into account his range of risk factors including his previous suicide attempt, the charges he was facing and his vulnerability as a foreign national prisoner in a UK prison for the first time. It is also a concern that his risk was not assessed further when he returned to prison after court appearances. The day before he died he had been charged with a violent offence against his partner but this did not lead to a further assessment.

Sadly, it is impossible to know whether suicide and self-harm prevention procedures would have protected the man from his actions, but there is a need to ensure that all relevant factors are considered when assessing risk and that this is done whenever a prisoner returns through reception after court appearances and when facing additional charges.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2014**

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SUMMARY

1. The man was remanded into custody at HMP Bullingdon on 17 November 2012, charged with attempted rape and possession of cannabis. It was his first time in prison in the UK. He was Polish and spoke very little English.

2. When the man arrived at the prison, he told the reception nurse (who used a telephone interpretation service) that he had no thoughts of self-harm and had no mental health, drug or alcohol problems. Prison officers in reception knew the seriousness of the charges he faced but his reception assessment, cell sharing risk assessment and first night assessment were not completed until19 November, two days after his arrival. The telephone interpretation service was not used for these assessments.

3. The man appeared to settle into the prison regime and attended daily English lessons. On 31 January 2013, a wing officer referred him to the mental health team, because his emotions ranged from overly happy to tearful. Over the next three months, the mental health nurse and a consultant psychiatrist saw him five times at Bullingdon. He said he had no thoughts of suicide or self-harm but was anxious about his court case and had problems sleeping for which he was prescribed medication. He understood that he faced a long sentence, if convicted. He told another prisoner that his partner had left the country with his daughter.

4. The man went to court three times and was charged with a further violent offence against his partner on 23 April, the day before his death. He was not assessed by officers after his court appearances, or referred to the healthcare team when he returned to prison as he should have been.

5. One afternoon in April the man's cell mate returned to his cell after a visit. An officer unlocked and opened the cell door and saw him with torn bed sheets around his neck, hanging from a chair wedged on the bunk bed. The officer radioed an emergency code, and an ambulance was called automatically. Nurses and other officers arrived and started cardiopulmonary resuscitation (CPR[1]). He was pronounced dead at 4.57pm.

6. This investigation has found that the man's risk factors were not properly taken into account when he was assessed in reception when he first arrived at the prison or when he returned from court on 23 April. We make recommendations about the assessment of risk and the use of the interpretation services for foreign national prisoners who do not speak and understand English well.

[1] Cardiopulmonary resuscitation (CPR) is a technique where oxygen is pumped around the body using a combination of chest compressions and rescue breaths.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Bullingdon to inform them of the investigation process and asking anyone with relevant information to contact him. No one responded.

8. The investigator visited the prison on 1 May 2013, met the duty governor and collected the man's prison records.

9. NHS Oxfordshire appointed a clinical reviewer to review the man's clinical care in prison. The investigator and the clinical reviewer interviewed eight members of staff and one prisoner at Bullingdon.

10. The investigator informed HM Coroner for Oxfordshire of the investigation. The Coroner provided a copy of the post-mortem report. A copy of this investigation report has been sent to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's mother in Poland and explained the investigation process. She had no specific issues for the investigation to consider.

12. The man's mother received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP BULLINGDON

13. HMP Bullingdon combines the two functions of a training prison and a local prison serving the courts of Oxfordshire and Berkshire. It holds more than 1,100 men. The man lived in a double cell on E wing, which holds up to 185 men charged with or convicted of sex offences.

14. Healthcare at Bullingdon is commissioned by NHS Oxfordshire. During most of the man's time at the prison, primary healthcare services were provided by Oxford Health and GP services by Cotswolds Medicare. Virgin Healthcare became the healthcare provider from April 2013.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons conducted an unannounced inspection of Bullingdon in July 2012. The Inspectorate found that most prisoners reported decent relationships with staff, although more was needed to support foreign national prisoners. Some foreign national men did not speak English at all but telephone interpreting services had been used on only five occasions during 2012.

16. The Inspectorate described reception as intimidating. Prisoners said that reception staff were unfriendly and uncaring, although most prisoners felt safe on their first night. Reception risk assessments were carried out in private and informed by information received from escort staff.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their annual report for 2011-12, the IMB expressed concern about the limited use of interpreting services, when 15 per cent of the population were foreign national prisoners. The IMB described relationships between staff and prisoners as very positive.

Previous deaths at HMP Bullingdon

18. The man was the fourth prisoner at Bullingdon to die since January 2012, but the first self-inflicted death. There were no similarities between the findings of these investigations and the circumstances of his death.

KEY EVENTS

19. The man was born in May 1985 in Poland. He was arrested on 16 November 2012 for attempted rape and possession of cannabis. Police custody records noted that he spoke only Polish and an interpreter would be needed. There were no recorded concerns about his physical or mental health. He said that he had taken an overdose of drugs the previous year.

20. The man stayed in police custody overnight and appeared at Magistrates' Court on Saturday 17 November. The Person Escort Record (PER), a document that accompanies detained persons and lists details of their risks, recorded "Offence – attempted rape; possession of drugs. Risks identified – S/SH (suicide/self-harm) - overdose of tablets. Cannot read or write English – interpreter booked. No physical or mental concerns. No medication".

21. The court adjourned the man's case until 11 February 2013 and he was remanded to HMP Bullingdon.

HMP Bullingdon

22. When the man arrived at Bullingdon on 17 November, an officer recorded his home address, next of kin (his partner) and his offence details on his personal summary sheet. The officer also recorded that he was a Polish national and indicated that he could not read or write English.

23. At his initial health screen, a senior nurse established that the man spoke very limited English and so she used a telephone interpreting service. He said it was his first time in prison and he had a one year old daughter with his partner. He said he had no thoughts of suicide or self-harm, did not abuse drugs and was not taking any medication. He said he had no physical or mental health problems and gave details of his community GP, but said he had not seen a doctor for some time.

24. The nurse noted that the man appeared tearful and anxious. As an ACCT[2] assessor, she told the investigator that she did not consider that he was at risk of self-harm or suicide. She was aware of his alleged offence of attempted rape but did not see the PER or police custody records, so did not know he had taken an overdose in 2012. She recorded his blood pressure and noted there was no need for him to be referred to the prison GP. He went to the prison's induction unit, E wing, and no concerns were noted on his first night at the prison.

25. Another nurse examined the man for a secondary health screen the next morning. He noted that he spoke very little English and communicated with his hands, but the nurse did not use an interpretation service. The nurse described

[2] ACCT (Assessment, Care in Custody and Teamwork) is the prison system used to identify and support prisoners at risk of suicide or self-harm.

him as calm and composed during the assessment and said he had no concerns about his physical health. He gave consent for his community GP to be contacted.

26. On Monday 19 November, an officer completed the man's first night assessment two days after he had arrived. He noted that he was on remand, it was his first time in custody and that he was Polish and had difficulties reading and writing English. Although the officer noted that an interpreter was required to communicate with him, he did not use one during his assessment. The officer recorded that he smoked, had no alcohol or drug problems and had no thoughts of suicide or self-harm. He recorded that he was charged with attempted rape. He would not give the officer emergency contact details and said his partner was looking after their child. He declined an offer to make a telephone call.

27. A Senior Officer (SO), the induction wing manager, told the investigator that the man's English was limited, but he had had no concerns about him. The SO said he had asked a Polish prisoner to speak to him to check he was okay. He apparently raised no concerns.

28. Prisoner A told the investigator that he worked as a prisoner orderly helping new prisoners to settle in as part of their induction. He was also a Listener. He said he had met the man as part of the induction process on 19 November and quickly realised that he spoke very little English and struggled to understand what was being said to him. He arranged for him to take part in the English language skills class, a course run every day for foreign national prisoners.

29. On 25 November, an officer recorded that the man had completed his prison induction on 19 November. He noted that an interpreter had been booked for the next week to answer any questions he might have, although there is no evidence that this meeting took place.

30. The man attended the English language skills class daily, Monday to Friday. Prisoner A was an assistant in the class and told the investigator that he worked with him every morning to improve his English. In addition, he met him most Sunday afternoons as an extension to his English classes. He said the man's understanding of English was improving.

31. As a foreign national in prison, the man was interviewed by the UK Border Agency. They confirmed in an e-mail to the prison on 3 December that they would not be taking any action against him regarding his alleged offence and his immigration status. This would be reviewed, if he were to be convicted. There is no record that he was told of the outcome of the interview.

32. The man attended Magistrates' Court on 7 December 2012 in relation to another assault charge. He was remanded back to Bullingdon later that day. Officers in reception did not assess him when he returned to the prison that evening and there is no record that he has seen a member of healthcare staff.

33. An officer spoke to the man on 28 December. She recorded that he spoke very limited English and followed the prison regime. He had been seen to be upset while on the telephone and during his partner's visits.

34. On 1 January 2012, two officers spoke to the man because another prisoner had alleged that the man was being bullied. The officers asked him if he was okay and offered him a move to a different part of the wing. He pleaded not to be moved and said he was settled. He said that another prisoner did not like him but that this was not a problem. He was adamant that he was okay and was not being bullied or threatened by anyone. The officer submitted a security report and officers were told to monitor the situation, but formal anti-bullying procedures were not started. An officer noted that his English had improved and he understood the situation and what she had asked him she said that he thanked the two officers for their concern and said he would speak to staff if he had any problems.

35. Prisoner A told the investigator that the man had seemed settled for his first few months in prison. However, he noticed that he started to withdraw, did not socialise with prisoners and would often pace up and down the landing, talking to himself, acting aggressively and hitting himself. The prisoner believed that he found it difficult to articulate the issues he had on his mind. Another Polish prisoner on the wing told the prisoner that the man said he was worried that he would be moved to the healthcare unit. On several occasions, the man asked the prisoner questions about the healthcare unit.

36. On 31 January, an officer recorded that he was concerned about the man's mental health because of his strange behaviour. The officer noted that he had extremes of emotion, sometimes he was tearful and at other times he was overly happy. His interaction with prisoners and officers was limited because his English was not good enough to communicate effectively. The officer said that it was difficult to describe why his behaviour worried him, but he followed his instinct and passed on his concerns to the mental health team.

37. A community psychiatric nurse carried out a mental health assessment on 4 February. Officer A, who worked on another wing and spoke Polish, acted as an interpreter. The officer said the man appeared suspicious and paranoid about his referral to the mental health team. He repeatedly said that he was scared that he would be sent to hospital. He said he had been in prison for three months and had asked for help, but received none. There is no record that he asked for help in his case history or medical record.

38. The psychiatric nurse recorded that the man was guarded and said that he had slept for only three nights out of the last ten. He was finding it difficult to come to terms with his situation. She noted he was restless and tearful, but said he had no thoughts of suicide or self-harm. There was no mention of his previous

overdose in his prison medical record, and no record that they discussed it at this assessment.

39. The nurse recorded in the man's medical notes that he had no history of mental or physical illnesses and was not taking any medication. He said that he had previously been in prison in Poland for fighting. He had been living in the UK for about a year with his partner and their young daughter. He said his partner was supportive and had visited him in prison. He talked about another Polish prisoner on the wing, who also attended English classes every morning and who supported him. She referred him for an assessment by the prison's consultant psychiatrist.

40. The psychiatrist examined the man on 7 February, accompanied by the psychiatric nurse and Officer A to interpret. She recorded that his eyes were swollen as if he had been crying. He told the psychiatrist that he was having difficulty sleeping and he was worried about his court appearance on Monday. He had had a meeting with his solicitor which went well, and was well supported by his partner. When not in education, he said he watched television as a distraction. She reassured him that he was not being considered for admission to hospital. He said he had no thoughts of suicide or self-harm, but asked for medication to help him sleep. She prescribed zopiclone for seven days. She told him that although it might improve his sleep, his current presentation was a normal response to stress, and the charges against him. She noted that she would review him in two weeks.

41. An officer said that on 9 February two prisoners told her that the man was upset after a phone call and they were concerned about him. She asked Officer A to speak to him to check on his well-being. He told the Officer A that he was fine but was stressed about his court case. He said he had a family to look after and he had no thoughts of suicide and would tell staff if anything was wrong. The officer said that he laughed and smiled during the conversation. She noted that his English had improved.

42. On 11 February, the man attended Magistrates' Court in relation to the charges of attempted rape and possession of cannabis. He was remanded back to Bullingdon and scheduled to attend Crown Court at a date to be confirmed. He was not assessed by a nurse when he returned through the prison reception.

43. On 14 February, the man was moved to another shared cell on landing two. Officer A told the investigator that while on landing two the man shared a cell with three different prisoners, including another Polish man, but he did not always get on with other prisoners. He appeared paranoid and believed that he would be transferred to hospital.

44. On 28 February, the man was moved back to landing one and shared a cell with another prisoner. An officer recorded that he appeared far more settled on

landing one. He was still attending English classes and was mixing well with other prisoners. In his statement to the police, his cell mate said that the man did not speak much English and they did not talk much.

45. A psychiatrist carried out a psychiatric review on 28 February with Officer A as the interpreter. His court case was ongoing and he expected his next hearing on 29 April. He was worried about his possible sentence, or that he would be admitted to a hospital. She noted that his mood was fluctuating from day to day because of his court hearing. His sleep pattern had improved and she told him that she would not be prescribing him anymore zopiclone because it could be addictive. She noted that he was not clinically depressed. He said he had no thoughts of suicide or self-harm but he refused to talk about his future and his mood was low. He said that he accepted that the next two months would be difficult and could cause him anxiety. She said she would review him in two to three weeks, but told him that he could book an earlier appointment if he needed it or if officers were concerned about him.

46. At his next psychiatric review on 21 March, the psychiatrist was accompanied by the psychiatric nurse and Officer A. The man was still worried about his court hearing and the future. He was sleeping for four hours a night, but eating well. He continued to attend English classes and said his English was improving. She noted that he displayed no symptoms of depression or mania and said he had no thoughts of suicide or self-harm. She suggested a number of ways to improve the quality of his sleep. He agreed to go to the gym and to stop drinking caffeine. She said he would be reviewed in two weeks, but said he should tell officers if his situation deteriorated.

47. Prisoner A saw the man daily and told the investigator that he thought he no longer had the support of his family, as his partner and child had gone back to Poland. He told the prisoner that he might get a 12 year sentence.

48. At his psychiatric review on 4 April, the man told the psychiatrist (who was again accompanied by the psychiatric nurse and Officer A) that he felt better. The psychiatrist noted that his mood was brighter and he said his sleep pattern had improved. He was still worried about his court appearance, but said he felt better about it. He said he had no thoughts of suicide or self-harm. He asked if he would be transferred to hospital and she again reassured him that there was no plan to transfer him. The psychiatrist planned to review him in two weeks, the week before his court appearance.

49. The next day, on 5 April, it was noted in the man’s medical record that the prison had received a letter from his solicitor. His solicitor said that she had seen him on 26 March and he had found it difficult to talk due to his anxiety. The psychiatric nurse tried to contact the solicitor by telephone on 8 April for more information. The solicitor was not available, so she left a message, but there was no response.

50. Officer A moved to E wing in April, and on 15 April she became the man's personal officer. She explained her role to him, who raised no concerns.

51. The man's cell mate told the police that he believed the man had showed signs of mental illness when they shared a cell. He had noticed him talking to himself day and night, pacing the cell and hitting his fist and head against the wall. He would cry and often tried to argue with him.

52. When the psychiatrist reviewed the man on 18 April (with the psychiatric nurse and Officer A), she noted that he was still anxious. He had spoken to his legal team and was told to expect a sentence of between 10 and 15 years. He said he was okay although he had no contact with his family or friends. He continued to experience problems sleeping. Part way through the meeting, an officer interrupted and asked to speak to the nurse. The officer passed on that he had been seen by his cell mate banging his head and knuckles against his cell wall. The psychiatrist recorded that he displayed no thought disorder or psychotic symptoms and his anxiety was related to his court case. He said he had no thoughts of suicide or self-harm and that he had to learn to accept his current situation. He denied hitting his head against the wall, but admitted to hitting the wall with his fist out of frustration. He agreed to see the psychiatrist again in two weeks or sooner if required. The psychiatrist said staff should monitor him two to three times at night for supporting information about his behaviour and sleep pattern. Officers kept a sleep pattern log for him between 9.00pm to the morning of 22 April. No concerns were noted.

53. The man attended Magistrates' Court on the morning of 23 April to answer charges of battery against his partner. He was remanded to custody to return to court on 30 April 2013. When he arrived at reception, it was noted on his core record that he was charged with battery against his partner. There was no documented evidence on his prison or medical record to indicate that he was assessed or referred to the healthcare team when he came back through prison reception after his return from court.

Day of the incident

54. On the day of the incident the man complained to his cell mate that their cell was untidy. The cell mate told the investigator that it was the man who had made the mess, so he was unsure what he was complaining about. The man went to his English class. Prisoner A said he did not remember having any concerns about him at the class. Afterwards, all prisoners returned to their cells around 11.30am. Lunch was served and then prisoners were locked in their cells for the roll check at 12.25pm. No concerns were recorded about him.

55. At about 1.55pm, an officer unlocked the cells of prisoners expecting a visit, which included the man's cell mate. Other prisoners, including the man, remained locked in their cells until the evening. The officer said he saw him

briefly when he let his cell mate out of the cell. He was standing over the sink, possibly washing. The officer said he had no concerns about him, locked the cell door and escorted the cell mate to the visits area.

56. The officer brought the cell mate back to his cell at about 4.15pm. When he unlocked and opened the cell door, he saw the man hanging. He had wedged an upturned chair between the bunk bed and wall supported by the toilet divider. He had tied strips of bed sheets to the base of the chair and around his neck. His feet were not touching the floor.

57. The officer shouted for assistance and made a level one emergency radio call, to indicate a life-threatening situation. The prison incident log recorded this at 4.16pm, and noted that a prisoner had been found with a ligature around his neck. The communications room called an ambulance immediately. The officer supported the man's body until help arrived.

58. Three officers responded to the officer's shout for help in seconds and helped him to support the man's body. An officer cut the bed sheet with his anti-ligature knife. They laid him on the cell floor. An officer said he was not breathing and his body was cold. He started cardiopulmonary resuscitation (CPR), helped by a colleague. A SO and a custodial manager attended.

59. Medical staff arrived at the cell at 4.19pm. They used the emergency equipment (including a defibrillator and oxygen) they had brought. They assessed the man for signs of life, but there were none. They attached a mouth piece and oxygen and continued CPR. A doctor and more nurses arrived around five minutes later.

60. At 4.35pm air ambulance paramedics arrived followed by land ambulance paramedics. They used their equipment and continued to assess and try to resuscitate the man. In spite of their efforts, the paramedics and the doctor agreed that resuscitation was futile. His death was confirmed at 4.57pm.

Support for prisoners

61. Notices were displayed in the prison to let prisoners know of the man's death and the support that was available to them. All prisoners subject to suicide and self-harm monitoring procedures were reviewed in case they had been adversely affected by his death. Prisoners were reminded of the services of the Listeners and Samaritans. The cell mate was moved to another cell and offered support from officers and healthcare team. The chaplaincy and Governor visited the wing to offer support. A memorial service was held the next weekend.

Support for staff

62. After the man's death, the custodial manager held a hot debrief to support all the staff who had been involved in the incident. They were offered the services of the staff care team if they needed further support.

Family liaison

63. The prison appointed a family liaison officer (FLO) immediately after the man's death. The man's partner was identified as the next of kin. (He was unaware that the man had said his partner and child had returned to Poland.) The FLO, Officer A and a prison chaplain took a taxi to her house to break the news of the death. Her neighbours told them that she no longer lived there and they did not have a forwarding address. The FLO left his contact details with the neighbours just in case she contacted them. He also tried to contact her by telephone but there was no answer. For the next two days the family liaison officer went back to his partner's address and tried calling her, but without success.

64. On 26 April, an operational manager obtained the man's mother's telephone number in Poland. We understand that the telephone number was in his records all the time, but the prison had wanted to inform his partner first because she was his nominated next of kin.

65. The operational manager telephoned the man's mother using a Polish speaking member of staff as an interpreter, and told her that her son had died. The FLO liaised frequently with the man's mother to assist with funeral arrangements. A Polish funeral director in London assisted with the repatriation of the man's body to Poland. The prison offered to pay repatriation costs and reasonable funeral expenses in line with national guidance. On 21 May, the man's mother contacted the FLO to tell him that her son had been buried. She told him that her son's partner had returned to Poland. His property was posted to his mother.

Post-mortem report

66. The post-mortem examination report dated 2 July 2013 found that the man's cause of death was through hanging.

ISSUES

Clinical care

67. The clinical reviewer notes that the medical care the man received at Bullingdon was comparable to that he could have expected to receive in the community. In particular, the clinical reviewer highlights the good standard of care he received from the mental health team, although we are concerned about interpreting arrangements and that he was not assessed by healthcare staff in reception when he returned from court.

Interpreting services

68. A professional telephone interpreting service was used for the man's initial health screen when he arrived at Bullingdon. There is no evidence that the service was used again throughout his time at the prison. His secondary health screen was conducted without an interpreter, and the nurse and he found it difficult to understand each other. An officer acted as an interpreter for psychiatric appointments, which should have been confidential. There is no evidence that he consented to the officer's presence for these sensitive appointments.

69. HM Inspectorate of Prisons last inspection report of Bullingdon highlighted that, despite the prison's high number of foreign nationals, the service was underused. Prison Service Instruction (PSI) 64/2011 – safer custody states:

> *"All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and / or during the risk management process."*

70. None of the officers in reception used the telephone interpretation service to assist in their assessment of his risk, neither did the officer who completed the first night assessment. It is difficult to understand how officers could effectively assess the man's risk if he could not speak English.

71. The investigator could not establish exactly how frequently telephone interpretation services are used at Bullingdon because this information is not centrally collated. It was confirmed that the service was not used for the man after his initial heath screen. Although his English improved while he was at Bullingdon, communication was difficult.

72. The man's right to patient confidentiality was breached when sensitive medical information was discussed in front of an officer. His level of risk was not effectively assessed by officers, or the nurse at the second reception health screen, because they did not use interpreting services at all. We make the following recommendation:

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.

Reception and First Night in Custody Assessments

73. Prison Service Instruction 64/2011 – Safer Custody, lists a number of risk factors for suicide. These include a background history of deliberate self-harm, violence against another person and early days in custody. All of these factors were present with the man but it is not clear that they were taken into account in assessing his risk of suicide and self-harm or what weight was given to them if they were.

74. Prison Service Instruction 74/2011, Early Days in Custody states that,

    "The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRA assessments, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others."

75. Officers in reception noted that the man was charged with a serious offence of attempted rape. His PER had identified that he had taken an overdose of tablets, but there is no evidence that anyone spoke to him about that to establish the circumstances or whether it had a bearing on his risk. The nurse did not see the PER, was unaware of his overdose and did not speak to him about it or record it on his medical record. The nurse did not consider that he was at risk of self-harm and suicide and no one from the mental heath team discussed his attempted suicide with him throughout their interaction.

76. Although the man was seen by a nurse when he arrived, officers did not conduct his reception and first night risk assessments until two days later. There was no recorded reason for this delay. It is concerning that his reception assessments did not take place as soon as he arrived in prison. The SO said it was not unusual that his first night assessment was completed two days after his arrival, because first night officers are often unavailable at the weekend and therefore would not be able to complete the first night checks until Monday. This is concerning, especially given the limited prison regime at weekends.

77. While it is possible that a full consideration of all the man's risk factors while he was in reception could still have reached the conclusion that he was not at serious risk, it is a concern that insufficient weight was given to his known risk factors. This is particularly true as he was unable to give his own account of his risk because of his limited English. The failure to pass the PER to the reception nurse meant that key information about his risk, including his recent attempted suicide, was not passed on to other healthcare professionals.

The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide and risk assessments are completed as soon as possible after prisoners are first received into custody.

The man's risk assessment following court

78. The man attended court on 7 December 2012, 11 February 2013 and 23 April 2013, the day before his death. In addition to his original offence, on 23 April, he was charged with a further violent offence against his partner. There is no record of his risk being assessed after he returned to prison from court. This was his first time in prison in the UK, he was on remand for a serious offence and officers noted that he was charged with a further offence of domestic violence

79. Prison Service Order 3050 (PSO) Continuity of Healthcare highlights that when a prisoner faces further charges, it could trigger an increased risk of self-harm, suicide or violence. Prison Service Instruction (PSI) 64/2011 Safer Custody recognises that a prisoner charged with a violent offence against a family member could also be at heightened risk of self-harm. PSO 3050 includes events such as attending court, sentencing at court and being questioned by the police as increasing an individual's risk. It says that for prisoners passing though reception prisons must have protocols to screen them for any potential healthcare, suicide or self-harm issues. The lack of such screening when the man returned from court, particularly when he had been charged with a violent offence against his partner the day before his death, was a further missed opportunity to identify him as at risk of suicide. We consider that an assessment at this stage, which took account of all his risk factors, ought to have resulted in a suicide and self-harm prevention procedures being implemented. Whether this would have resulted in a different outcome it is impossible to say.

The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances, should be assessed for potential health or suicide and self-harm issues.

Family liaison

80. PSI 64/2011 says that time is of the essence when breaking the news of a prisoner's death to his family. The man's mother was not informed of his death until two days later. The prison told the investigator that they had wanted to contact his nominated next of kin, his partner before contacting other family members, but they could not get in touch with her. There is no requirement to wait until the nominated next of kin has been contacted before speaking to another family member. In some cases this would mean a considerably delay before family's could be informed of a death. As his partner, his nominated next

of kin, could not be found, we consider that the prison should have contacted his mother sooner.

The Governor should ensure that a prisoner's family is informed of a death as soon as possible, including when the nominated next of kin cannot be contacted.

RECOMMENDATIONS

1. 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.

2. The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide and risk assessments are completed as soon as possible after prisoners are first received into custody.

3. The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances, should be assessed for potential health or suicide and self-harm issues.

4. The Governor should ensure that a prisoner's family is informed of a death as soon as possible, including when the nominated next of kin cannot be contacted.

ACTION PLAN: The man - HMP Bullingdon - April 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	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.	Accepted	Interpreting services are commissioned (by the prison) - however, guidance to use can be considered for all staff groups when the need arises. Virgin Health and Oxford Health have their own policy and protocols (especially in relation to confidentiality) therefore consideration will need to be given of where responsibility lies of ensuring that interpretation services are used. To be placed as an agenda item on the Healthcare and Prison Partnership Board to decide joint protocol.	January 2014	Prison Commissioned interpretation service is tendered for every April in line with the financial year.
2	The Governor and Head of Healthcare should ensure that staff take account of all known potential	Accepted	There are now more trained ACCT Assessors available. The training has been extended to include healthcare staff.	This has been included as an essential requisite of	Completed.

	risks and triggers when assessing a prisoner's risk of self-harm or suicide and risk assessments are completed as soon as possible after prisoners are first received into custody.		HMP Bullingdon has now revised all procedures involved with First Night in Custody, and a Local Operating Procedure has been finalised and published.	ACCT procedures and is quality checked as part of compliance.	
3	The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances, should be assessed for potential health or suicide and self-harm issues	Accepted	The procedures for prisoners returning from court have been reviewed, and have included improved communication between prison and healthcare staff in reception. Details from the court warrant are communicated to the reception nurse who can then assess for any immediate issues and concerns and then refer to the appropriate area to provide advice and support. All returns from court will be seen by the duty reception nurse to ascertain any change in circumstances and to ensure they	Subject to ongoing quality checks from both prison and healthcare managers.	Completed.

			are safe to return on normal location. HMP Bullingdon has now revised all procedures involved with First Night in Custody, and a Local Operating Procedure (LOP) has been finalised and published Further, a LOP relating to Prisoners at risk of harm to self and others has also been finalised and published.		
4	The Governor should ensure that a prisoner's family is informed of a death as soon as possible, including when the nominated next of kin cannot be contacted.	Accepted	Next of kin as nominated by the prisoner is always the first point of call. However, if no contact can be made it is accepted that another family member can be informed provided we have the contact details and there has been known contact between them. This has been communicated to all operational managers and our trained Family liaison officers to consider in the event of need to contact.		Completed.