Investigation into the circumstances surrounding the death of a man at HMP Bullingdon in May 2010

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death of a man at HMP Bullingdon. He was found in his cell in May 2010, having hanged himself from the toilet door in his cell. At the time of his death he was on remand and had been committed to Crown Court for trial. He was 29 years old.

I extend my condolences and those of my colleagues to the man's family. I trust that my report goes some way to answering any questions they may have about the circumstances of his death. I must apologise for the delay issuing my draft and I apologise for the distress this may have caused.

The investigation was undertaken on my behalf by one of my investigators. A clinical review of the man's healthcare at Bullingdon was conducted by the clinical reviewer on behalf of the local Primary Care Trust (PCT). I am most grateful to him. I would also like to thank all of the staff at Bullingdon for their cooperation with my investigation. This death was the second self-inflicted death at Bullingdon in 2010.

Speaking very little English, the man communicated with staff at the prison through other Chinese prisoners, one of whom he shared a cell with. He said he was thinking of hurting himself when he arrived at the prison and was made subject to suicide prevention measures for the first week. I conclude that, given how he appeared to staff in the weeks before his death, they could not reasonably have been expected to notice that he was at risk.

In my report I make a number of recommendations. I comment on the use of other prisoners as translators in confidential meetings and suicide prevention measures more generally. Not for the first time in an investigation at Bullingdon, I examine procedures for calling an ambulance in an emergency. Other areas considered in the report include record keeping, notification of foreign consulates and concerns over the training and allocation of family liaison officers at the prison. I make 11 recommendations.

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.

Thea Walton
Acting Deputy Ombudsman **November 2011**

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SUMMARY

The man was a Chinese National prisoner who was remanded into custody at HMP Bullingdon on 29 April 2010. Throughout reception another Chinese prisoner acted as an interpreter for him, who spoke no English. No concerns were raised during the first reception healthscreen and he was about to be located on the wing. However, the 'interpreter' raised concerns about him being at risk of self harm with staff before he left the reception area. The suicide prevention measures were started and he was admitted to the healthcare centre. Despite a history of mental health treatment in China, no mental health referral was made.

The next day, he moved to the induction unit. As part of his support plan, it was arranged for him to transfer to the wing where there were other Chinese prisoners and he agreed to speak to staff through prisoners who could interpret for him. The suicide prevention measures remained open for seven days. At the second case review, staff realised that he had not been able to make an international telephone call to contact his family. They noted this as an outstanding action and then stopped the suicide prevention measures. No one from healthcare was present at the case review.

At the post closure review 12 days later, an officer realised that he had still not been able to speak to his family. He helped him submit an application form for an international telephone call, which he made three days later. There is no further information in his wing history files or medical records until the evening of 26 May.

He was discovered by an officer hanging from the toilet door at 5.55pm. An ambulance was called five minutes later. He was taken to hospital after staff began cardio pulmonary resuscitation (CPR). He remained on a life support machine until the next afternoon and was pronounced dead at 1.56pm.

I consider suicide prevention measures, mental health referrals and the adequacy of resources at Bullingdon for foreign national prisoners. I also comment on resuscitation attempts and the speed at which an ambulance was called. I make 11 recommendations.

THE INVESTIGATION PROCESS

1. The investigation following the man's death was carried out by one of my investigators. Another investigator opened the investigation on his behalf. He was shown around the prison by the Governor and met with the safer custody manager. The investigator also met the Deputy Governor and the Chair of the Independent Monitoring Board (IMB). (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.) My investigator has also been in contact with the Detective Sergeant from Thames Valley Police. During the course of the investigation, the investigator provided both verbal and written feedback to the Governor.

2. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Bullingdon. The notices were displayed around the prison and invited staff and prisoners to contact the investigator should they wish to do so. The investigator obtained documentation relating to the time that the man spent at Bullingdon and visited the prison to interview staff. The investigator also spoke to the man's cellmate via a translator.

3. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the man's clinical care whilst in custody at Bullingdon. His findings are summarised in this report.

4. One of the Ombudsman's family liaison officers wrote to the man's family to discuss the purpose and scope of the investigation and to give them the opportunity to raise any questions or concerns they had about his death. The family raised a number of questions and concerns through the Chinese Embassy. They included:

   - During their last contact with him, he did not give any indication that he was upset. His family therefore found it difficult to accept that he committed suicide.
   - The family expressed their wish to see his belongings, including any notes or letters.
   - The family were confused by the number of agencies that were involved with liaison after his death.

5. I trust that my report helps to clarify the family's concerns and any other issues that remain unclear, helping them to better understand what happened to the man in the time leading to his death. Other issues raised by the family but not within the remit of this investigation have been addressed separately where possible by my family liaison officer.

6. The investigator has also been in contact with the Coroner's office and a copy of this report will be sent to HM Coroner for Oxfordshire, to assist him with his enquiries.

HMP BULLINGDON

7. HMP Bullingdon is a large category C training prison in Oxfordshire, accommodating convicted and un-convicted adult male prisoners. (A category C prison is for those prisoners who cannot be trusted in open conditions but who would not have the ability or resources to make a determined escape.) The prison is made up of six wings or units which are made up of single and shared cell accommodation.

8. Healthcare at the prison is provided by the local Primary Care Trust (PCT). There is a 24 bed inpatient facility which is staffed throughout the day and has two nurses on duty during the night. An outpatients' facility delivers a daily assessment system referring prisoners to a doctor as necessary. A doctor is available every weekday and there is an on-call system during weekends and at night.

Translation services

9. The National Offender Management Service's document "Local Policies for Managing Foreign National Offenders" explains the best approach to translation and language services. The Big Word is the telephone translation service available for staff to use when they need to communicate with a prisoner who cannot understand English. The member of staff dials the translation service and requests the required language. Staff explained to my investigator that it can take time for the service to connect to a translator in the required language. The member of staff then tells the translator what they want to say to the prisoner and then passes the telephone to the prisoner, who listens to the translated message and can reply. The telephone is passed backwards and forwards throughout this exchange.

Independent Monitoring Board

10. In their annual report 2009-10, the IMB wrote that they "continued to be generally satisfied with the overall standard of the prison management, treatment of prisoners and facilities provided" at Bullingdon. The report commented about safer custody measures "that there are effective procedures in place to check on prisoners' welfare, take measures where there are concerns, use the ACCT procedure and care for prisoners".

11. The IMB described translation arrangements as "unsatisfactory". They acknowledge that "although official translation services are available, they are not always used and allowing prisoners to translate to and from other prisoners is a security risk as well as a breach of confidentiality". The man was encouraged to use other prisoners to translate when communicating with staff. They also recommend that "the system for informing foreign national prisoners of their entitlement to telephone calls needs improving". I consider these matters later in the investigation report.

Her Majesty's Chief Inspector of Prisons

12. The Inspectorate carried out a short unannounced follow-up inspection of Bullingdon in July 2010, two months after the man's death. The inspection team reported that the quality of suicide prevention measures was "reasonable", and recognised the efforts of the experienced safer custody coordinator. However, the team were concerned that action plans put in place following deaths in custody were not incorporated into the continuous improvement plan.

13. In a previous inspection in January 2008, the Inspectorate recommended the appointment of a full-time foreign national liaison officer. In the follow-up inspection two years later, they reported that an appointment had not been made, but that a manager had been given the role as part of her wider remit, supported by the race equality officer and two foreign national orderlies. The inspectors observed:

    "… foreign national orderlies offered support to wings, gave presentations to prisoners during induction and supported individual prisoners were necessary (primarily foreign national prisoners with limited English)."

14. The Inspectorate found "little use of telephone interpreting services, even for confidential matters, and an over-reliance on prisoner interpreters" in the inspection two years earlier. Specifically, they commented that "prisoner interpreters were inappropriately used in the suicide prevention procedures and for healthcare appointments". In addition, they were concerned that the application process for securing an international telephone call was too complicated for prisoners and putting them off.

Previous deaths at HMP Bullingdon

15. There were three deaths at Bullingdon in 2010, two of which (including the man's) were self-inflicted. While the other self-inflicted death happened just 11 days before he took his life, I think that there is little in common between them. However, I note that I made a recommendation about the time taken to call an ambulance in an investigation report of a death in Bullingdon in January 2009. I am disappointed to repeat my recommendation in this report.

KEY EVENTS

16. On 19 April, the man was held in police custody for attempting to purchase goods with fraudulent credit cards and for having someone else's passport. He was already on bail for another charge of fraud allegedly committed earlier in the month.

17. He was transferred from the police station to the Magistrates' Court on 21 April. A Person Escort Record (or PER, a form that records information about risks for prisoners on escort or transfer) was completed by staff indicating that he was at risk of self harm although no detail of the risk was recorded. The PER also indicated that he suffered from heart disease. (There is no other evidence that he suffered from this condition in his records.) Appearing before magistrates that afternoon, he was remanded into the custody of HMP Bullingdon.

18. He arrived at Bullingdon at about 7.00pm that evening. During the reception process, staff noted the contact details of his next of kin in Wrexham, North Wales and other personal details. The reception officer completed a Cell Sharing Risk Assessment (or CSRA, an assessment of the risk a prisoner might pose to others to determine whether they can safely share a cell). The officer considered that he was at low risk of harming others and therefore suitable to share a cell. Nurse A completed the healthcare element of the form. Despite the warning on the PER, the nurse recorded that there was no indication or evidence that he was at risk of harming himself.

19. The nurse went on to complete the man's first reception healthscreen. (A first reception healthscreen is an interview by healthcare staff which takes place when a prisoner arrives at the prison. It should determine any physical or mental health conditions that require treatment and any risk that the prisoner may pose of harming himself or attempting suicide.) The nurse recorded that he had a history of coronary heart disease, but had neither been assessed by a doctor nor received medication in recent months. Although she noted that he complained of stomach cramps, she recorded no other physical health concerns or issues.

20. Through a Chinese speaking prisoner who acted as an interpreter, he told her that he had previously been admitted to a psychiatric hospital in China and had received mental health care. He said that he had no current thoughts of harming himself but had previously taken an overdose of sleeping pills, although the nurse did not record when this happened. She assessed his behaviour in reception. She noted him as being, "… calm, chatty and feels low at the moment. No emotion and answering questions appropriately via an interpreter. Good eye contact."

21. While waiting to be taken to the induction unit, the interpreting prisoner told staff that he had now said that he felt very low in mood and might attempt to harm himself. He was assessed for a second time by Nurse B and reception officers. She recorded that he was "worried he may not cope and feeling suicidal" and decided to admit him to the inpatients' unit. She raised a Concern and Keep Safe form, the first part of the Assessment, Care in Custody and Teamwork (ACCT) process, used to identify, monitor and support prisoners at risk of suicide

or self harm. The nurse recorded that he did not speak English, she wrote “need interpreter”.

22. Two nurses completed an immediate action plan. The nurses determined that he should be admitted to the healthcare centre for hourly observation. Staff were going to arrange for him to use the telephone the following morning to make an international call and the nurses asked the reception officers to remove “potentially dangerous items” from his cell. Nurse B arranged for the interpreting prisoner to explain to him about Listeners. (Listeners are prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) It was noted that the ‘interpreter’ could be contacted “if needed”. According to his medical record, he “took a while to settle” in the healthcare centre that evening, but the nurse observed that he “appeared to sleep from 1.00am”.

23. When a prisoner has an open ACCT document, staff record a prisoner’s behaviour and significant conversations with the prisoner in an on-going record. At 8.55am on 22 April, Officer A recorded that he had “collected a razor” from him, which looked as though it had been tampered with. The officer speculated that he might have been trying to remove the blade from the razor.

24. About 20 minutes later, Healthcare Assistant (HCA) A carried out a second healthcare assessment of him, with the assistance of “an interpreter from B wing”. (A secondary healthcare assessment is a physical health check, similar to that received in the community when a patient joins a community practice.) She recorded that the ACCT support procedures had been opened and that he was suffering from stress. The healthcare assistant went on to note that he was concerned about his physical health, and in particular, pain in his chest and stomach.

25. After his secondary healthscreen, he was assessed by Prison Doctor A. Following the appointment, the doctor recorded that the man attempted an overdose in February 2009 and that he possibly had mental health problems. He told the doctor that he felt “isolated in the healthcare centre due to language problems”. Despite recording tenderness in his upper abdomen, the doctor concluded that he was fit enough to be on one of the prison’s wings.

26. At 10.30am, Nurse C, a Registered Mental Health Nurse (RMN) completed an ACCT Assessment with him, with the help of a Chinese-speaking prisoner. He told her that it was his first time in prison and he was unsure what would happen next. The nurse noted that, although he had made no recent attempt to harm himself, he had taken an overdose in February 2009. He said that he had “no current suicidal thoughts/intentions”, although he felt “low in mood” and was not sleeping well. He told the nurse that he wanted to go to a residential wing, saying that he felt he would have more support from other Chinese prisoners there.

27. During interview for this investigation, the nurse told my investigator that at the time of the assessment he “was not mentally unwell”. The mental health nurse was confident that “in her opinion” he “did not display any psychotic symptoms”

throughout the ACCT assessment. She said that he made “very good” eye contact and described his “rapport” with her as “very good”. The mental health nurse said that there “was no evidence of suicidal thoughts or self-harm” during her dealings with him.

28. Shortly after the ACCT assessment, Nurse D, the unit manager, chaired the first ACCT case review which was attended by Nurse C, the Suicide Prevention Co-ordinator and the prisoner who had been interpreting for the man. At the case review, it was established that he had not been in prison before and that he was “very scared” and was “unsure of any outcome” of his offence. The record of the case review reflected the information that he had shared with Nurse C in his ACCT assessment. He repeated to the case review, through the interpreter, that he had “no unpleasant thoughts going through his head”. He said he “was looking forward to the future”. He asked to be located on a wing where there were other Chinese prisoners. The panel agreed.

29. Nurse C completed the ACCT CAREMAP, recording the actions which were intended to support him and reduce the risk of him hurting himself. The nurse noted his request that he wanted to be on the same wing as other Chinese prisoners and recorded that he had been located on B wing, in a cell with another Chinese prisoner. The nurse recognised the difficulty with communication and suggested that staff overcome this by offering him conversations on a one-to-one basis, as well as encouraging him to approach staff himself. According to the notes on the CAREMAP, he “agreed to speak [to staff] via the Chinese community”.

30. Although a place was reserved for him on B wing, that afternoon he was transferred to Finmere Unit, the prison’s induction unit. At 3.15pm, there is an entry in his ongoing record when he spoke to an officer through one of the prison’s Chinese interpreters. He told the officer that “he felt safe from himself but would prefer to be with some Chinese speakers”. The entry went on to record that he was given a telephone call, which he used to call to a friend. (He had still not had the international telephone call Nurse B had requested on the immediate action plan.) He continued to be checked by staff every hour throughout the night with no concerns being noted.

31. The following day, 23 April, Officer B opened a Prisoner Passport and First Night Information document for him, a prison document that records various types of information relating to a prisoner during the first days of their imprisonment. The officer noted his history of harming himself and that he was on an open ACCT. He told the officer that it was his first time in prison and that nobody knew he was there but that he had been able to make a telephone call. During the induction process he signed a number of prison compacts, which are agreements to follow the prison’s regime or use prison property in accordance with prison rules, all written in English. The officer confirmed with my investigator that information booklets given out during induction were available to prisoners in a variety of languages on the unit.

32. For the remainder of the day he continued to communicate with staff with sign language, calling on a prisoner to interpret for reviews and other more complex

interactions.

33. On the morning of 24 April, he was moved to B wing. He was allocated to a cell with another Chinese prisoner and near to those who had interpreted for him during earlier assessments by staff. He signed a communications compact the same day, to confirm that he had read and understood the terms and conditions of use of the telephone system, again written in English. Officer C countersigned the compact, suggesting that the man had some difficulty understanding the document, and he went over the terms and conditions with him. Over the following days, Officer D made a number of entries in the ACCT ongoing record that he appeared settled and was adjusting to prison life.

34. His next ACCT case review took place at 8.30am on the morning of 28 April. A SO chaired the review as the case manager. The Safer Custody Manager, Violence Reduction Coordinator, and another senior officer were at the meeting, which was again interpreted by a prisoner on the wing.

35. At the case review, he said he was "not feeling suicidal" and had "settled" on B wing. In line with the action on his CAREMAP, he was by this time located on B wing and shared a cell with another Chinese prisoner. There were three more Chinese national prisoners on that wing. This was intended to give him "support from other prisoners who can speak his language". He agreed to make contact with staff through other Chinese prisoners should he need to. According to the record of the case review, he said that "he was eating and sleeping properly and had no further medical issues". His next court appearance was scheduled for 29 July and he expected to receive a two year sentence.

36. Two nurses had noted that he still had not had an international telephone call which was planned as part of his immediate action plan on 21 April. When the case review had been completed on 28 April, seven days later, he had still not been able to speak to his family in China. At the case review, the case manager agreed to take responsibility for arranging an international telephone call so that he could speak to his wife and son. The CAREMAP was updated with this new action. Despite a new action being recorded on the CAREMAP, the ACCT document was closed following this case review, "all agreed that the ACCT can be closed and he says he understands that staff are here to help".

37. During interview for this investigation, the case manager explained that the man needed to fill out a form to apply for an international telephone call. As the case manager, it was her role to provide him with the correct application form, help him to complete it and then pass the form to a governor for authorisation. She explained that "[another Chinese prisoner] knows what paperwork they need to be able to complete phone calls". It was her understanding that it was the Chinese prisoner, not herself, who was to complete the application form for the man and help him have the international telephone call. The senior officer had no further involvement with arranging the telephone call.

38. The Suicide Prevention Co-ordinator described him as "quite calm" during the case review. She remembered asking him "about eating and sleeping", and he assured her that he was "not feeling suicidal". He told her that "he would be

happy to speak with the Chinese translator if things were getting on top of him" and suggested that the Chinese interpreter could speak to staff on his behalf.

39. She said that he "didn't really say anything about deportation" during the case review. However, she remembered "he was clear that he didn't want to return to China". When asked by my investigator what contact he would have had with the immigration department, she said that he would not have any contact until he was sentenced. The senior officer thought that he might have discussed the possibility of deportation with the other Chinese national prisoners on his wing, two of whom had completed their sentence and were awaiting deportation. Although she thought that he might have become anxious as a result of discussions about deportation with other prisoners on the wing, she did not think he was at risk of self harm or suicide at the case review on 28 April. She described his body language as "quite open. He was smiling, he was very happy with what the Chinese interpreter was saying." She told my investigator that she agreed with the decision to close his ACCT document that day.

40. The next day, 29 April, he was prescribed 20miligrams (mgs) of Carbimazole, used to treat thyroid problems. In his clinical review, the clinical reviewer comments, "it is not clear why thyroid function tests were taken (it may be because he had a raised pulse rate)". According to the clinical reviewer, patients prescribed this medication "are warned to report any symptoms suggesting an infection, especially a sore throat". There was no entry that he was warned to this effect in his medical file.

41. The guidance annexed to 'Prison Service Order (PSO) 2700 – suicide and self-harm management', sets out prison requirements about the management of prisoners at risk of self harm. A post-closure review "must be [held] within seven days of closure". On 10 May, 12 days after his ACCT was closed, the man's personal officer and the wing's foreign national representative, completed a 'Post Closure of ACCT' interview. The officer noted that the man was "feeling a lot better", was being supported by his peers and staff.

42. However, the officer noted that he still had not received an international telephone call. Later that day, one of the Chinese prisoner interpreters completed an application for an international telephone call on his behalf. On the application form, it was noted that he missed his family very much. The officer approved the telephone call and passed the application to a manager. A five minute telephone call was subsequently facilitated by another officer. At around 2.50pm on 13 May, 22 days after he arrived at Bullingdon, he spoke with his wife in China. No more information about him was recorded either in his medical record or wing history sheet until he hanged himself on 26 May, nearly two weeks later.

43. When asked by my investigator what contact he had with him, his personal officer explained:

> "I had quite a bit of contact with him because I was his personal officer. He didn't mix much with other prisoners. He spent most of his time with […] other Chinese prisoners on the wing. He didn't speak much English, so it was

hard to talk to him personally and generally it was done through a translator or through other prisoners … He pretty much kept himself to himself."

26 and 27 May 2010

44. The man's cellmate had a court appearance on 26 May. He returned to the prison and two officers escorted him back to the cell he shared with the man. They reached the cell at about 5.55pm. Officer E opened the cell door and saw him suspended by a ligature (made from a bed sheet) from the front of the toilet door. He immediately shouted 'Level One' (the term used to alert staff of a life threatening incident). Officer F then shouted out to other staff on the wing that a Level One incident was taking place.

45. After shouting 'Level One', the officer went into the cell and supported the man's weight. Officer F helped him to hold the man, while he used the anti-ligature knife he carried on his belt to cut the ligature. As he did so, the officer noticed deep red marks around the man's neck. They laid him on the cell floor and checked for signs of life. Officer F told my investigator that she checked his wrist and neck for a pulse, but was unsure as to whether she found one. She described his pupils as "fixed and dilated". The two officers started cardio pulmonary resuscitation (CPR). Officer F gave him mouth to mouth breaths, and Officer E gave him chest compressions.

46. Officer G was walking to the wing office when she heard the officers shouting 'Level One'. She used her radio to call for medical assistance and went to the cell. (The communications log records that the request for medical assistance was received at 5.56pm.) Four other officers, including Officer D, all ran to the cell. When Officer D got there, he handed Officer F a resusci-aid (a plastic device used to prevent infection when performing mouth to mouth resuscitation). In her statement, Officer G said "a short while after" Officer D handed Officer F the face mask, she took over mouth to mouth resuscitation.

47. Officer G told my investigator that the face mask became contaminated, as the man vomited. She resumed mouth to mouth resuscitation but, as none of the other officers had a resusci-aid, she improvised with a plastic bag. Unfortunately, the improvised face mask was not effective at protecting the officer during mouth to mouth.

48. A SO asked those officers not performing CPR to leave the cell. A Developing Prison Service Manager (DPSM) was the orderly officer that evening. In this role he was operationally in charge of the prison and required to attend any emergency. He arrived on the wing two minutes after he heard the Level One emergency being called. He was briefed by Officer E, while Officer G continued with mouth to mouth breaths. The DPSM understood from the officer that healthcare staff were on their way. According to his statement, at that point the DPSM "requested through control for an ambulance and for Duty Governor attendance". The communications room log (otherwise known as 'control') recorded that the ambulance was called at 6.00pm, five minutes after the man had been found hanging.

49. According to the communications room log two nurses got to the cell at 6.03pm. They took over the resuscitation attempts, with the assistance of the officers. They attached a defibrillator to the man's chest. (A defibrillator is a small portable machine that searches for an irregular heart rhythm. If one is found, the defibrillator can deliver an electric shock to reset the rhythm.) No rhythm was found and the defibrillator instructed not to shock him, so staff continued with CPR.

50. Prison Doctor B arrived at the cell two minutes after the nurses. The doctor checked his vital signs, but found no pulse and noted that his pupils were "fixed, dilated and unreactive". The doctor helped with chest compressions until the paramedics arrived at approximately 6.21pm. According to the doctor's entry in the medical record, the paramedics took over CPR and gave an adrenaline injection. When his condition was stabilised, he was transferred to the waiting ambulance and taken to hospital at 6.50pm. Nurse E accompanied him to hospital, along with two escorting officers.

51. On his arrival at hospital, he was admitted to the Intensive Treatment Unit (ITU). He was given a Computerised Tomography scan (an x-ray that produces a three-dimensional image of the body for diagnosis) and was put on a ventilator. At 10.10pm that night, Officer H, a bedwatch officer, started an ACCT ongoing record "due to his attempting suicide by hanging with ligature". At the time of this first entry, the officer had been told that he was in "a non-responsive vegetative state and is being kept alive by a ventilator". At 11.45pm, the officer was told by the nursing staff that he was "not responding to treatment" and was not likely to survive the night.

52. The chaplain was told of the man's critical condition by Governor A while the response efforts continued. He was asked to provide staff support through the hot debrief. (A hot debrief is a meeting for staff to discuss issues and any lessons learned following serious events such as deaths in custody.) At about 8.00pm he went to the hospital along with other staff. He telephoned Governor B at Bullingdon to keep him informed about his condition.

53. The chaplain was asked by hospital nursing staff to get in touch with the man's family. He explained to the nurses that the man had registered his next of kin as living in Wrexham with a mobile telephone number, but staff knew that his wife lived in China. He spoke to Governor B and agreed that he would call the listed next of kin on their mobile telephone number and the governor would attempt to call the Chinese Embassy. When he called the mobile telephone number, he realised that the person who answered the telephone "did not understand English". Eventually, he stopped the conversation and spoke to Governor B, who had made contact with the Chinese Embassy. He left the hospital at 9.40pm, after saying prayers by the man's bedside.

54. According to the man's ongoing record, at 6.00am on 27 May, the nursing staff asked officers on bedwatch duty to obtain contact details for the Chinese Embassy "as they believe [he] will die fairly soon". He was still not responding to treatment. Two further officers took over the bedwatch duty. Officer I continued

to make entries in the man’s ongoing record at about 7.00am that morning. The officer was told that he was “poorly but stable”.

55. At 9.45am, the officer rang the prison to explain that doctors were preparing to carry out brainstem tests on the man. (A brainstem test or Auditory Brainstem Response test is a test for unresponsive patients to measure electrical activity in the brain.) He spoke to Governor B, who confirmed that efforts were being made by the prison to inform the family of his critical situation.

56. Later that morning Nurse F, another of the prison nurses, was advised by the hospital that he remained in ITU on a ventilator and was in a critical condition. By 1.30pm, the decision had been made not to proceed with brainstem tests and he remained unresponsive to treatment. Officer I telephoned the prison and told Governor C that a clinical decision had been made to withdraw life support treatment “as [the man’s] body is gradually closing down”. At 1.56pm, he was pronounced dead.

57. On 27 May, he was due to appear at Magistrates Court on charges of fraud and to appear again on 29 July at Crown Court.

Support for prisoners

58. After he was taken to hospital on the evening of 26 May, arrangements were made for any prisoners on open ACCT documents to be reviewed. According to ‘Prison Service Order (PSO) 2710 – follow up to deaths in custody’, it is compulsory to review prisoners on ACCT documents following a death in custody. However, there is no requirement to carry out reviews after an attempted suicide. I am pleased that staff at Bullingdon took the initiative to carry out reviews after he had been taken to hospital without knowing the outcome in his case, even though there was no formal requirement to do so.

59. The morning after he had been taken to hospital, Governor A and the Suicide Prevention Co-ordinator met five Chinese prisoners to explain what had happened, including his cell mate. Two of the prisoners at the meeting acted as interpreters between staff and the rest of the group. The Co-ordinator assured the prisoners that the Chinese Embassy had been contacted and efforts were being made to contact his family, but at that time the outlook for him was not good. They told the prisoners that it was thought that his life support would be stopped at some point that day.

60. The two members of staff asked the prisoners if they had thought about harming themselves. They told the staff that they had no thoughts of hurting themselves at that point and they would use each other for support. If their feelings changed and they did experience such thoughts, they would “allow the interpreter to speak to staff” on their behalf.

61. During the meeting with the Chinese prisoners, the man’s cellmate said that the man had been worried about the prospect of deportation to China. Apparently, he was particularly concerned about the consequences of the court appearance due to take place on 27 May. The other prisoners agreed that they had difficulty

understanding the immigration system. The Governor and Co-ordinator reminded them to speak to their immigration legal advisor, as well as to attend regular immigration surgeries at the prison.

62. Following his death, the Governor posted notices around the prison and reminded prisoners that Listeners were available as an extra measure of support. The Governor also posted notices about the Ombudsman's investigation to invite those who wanted to contribute information to my investigator. No one responded to these notices.

63. During his interview with my investigator, the personal officer said that the other Chinese prisoners approached him after the death. The prisoners said that the man had told them about problems regarding money he owed to people in China. They thought that a couple of the Chinese prisoners were "winding him up a little bit" about his situation and, as a result, he was more concerned about deportation than he needed to be.

Staff support

64. At 6.50pm on 26 May, Governor B held a hot incident debrief with all the staff that were involved in the response efforts before the man was taken to hospital. The chaplaincy were contacted to provide extra support at this point and the chaplain attended the debrief session as well. The chaplain remained in the prison for some time after the debrief and spoke to those who seemed affected by the events of that evening.

65. No staff interviewed as part of the investigation raised any concerns with the support that they received after the man's death.

Family contact

66. Once contact with the Chinese Embassy had been established on the evening of 26 May, Governor B confirmed the details of the man's condition by fax the same evening. The chaplain was unable to communicate with the listed next of kin using the telephone number, because he could not make himself understood. Contact with the Chinese Embassy continued and they were told when the man had died. It was not until two days later on the morning of 28 May that Governor A was able to speak to a family representative directly about the circumstances of the death when she received a call from a family representative via a mobile telephone in China. Unfortunately, that contact was brief and contact details, as well as funeral arrangements were not discussed.

67. The chaplain was asked by Governor A to re-establish contact so that ongoing family liaison and funeral arrangements could be made. The co-ordinating chaplain telephoned the mobile number given to him by the prison that afternoon, but the lines were busy and he could not get through. The co-ordinating chaplain wrote in a report following the death that he tried the mobile telephone number on several occasions but without success.

68. On 8 June, Governor D emailed Governor A, Governor B and the chaplain to confirm that he had consulted with Bullingdon's Police Liaison Officer and the National Offender Management Service's Offender Safety, Rights and Responsibilities Department. It was agreed that a Detective Sergeant from Thames Valley Police would lead all future contact with the man's family in China.

69. My family liaison officer spoke to the Chinese Embassy on 6 July following a telephone call from a family member. In a subsequent email exchange, the family member told my family liaison officer that the family had only been in touch with the Ombudsman since the man's death and had heard nothing from the prison. He was understandably anxious to learn the outcome of this investigation. I trust that my investigation report has provided the family with a clearer understanding of his time at Bullingdon and the circumstances of his death.

ISSUES

Clinical care

70. The clinical reviewer was asked by the local Primary Care Trust (PCT) to conduct a clinical review into the medical care that the man received while he was in custody.

71. In his report, the clinical reviewer concludes that:

    > " … there is no evidence that different treatment of management of the man by healthcare staff or officers would have prevented his suicide, there are however some recommendations I would like to make."

    The doctor goes on to make four recommendations about face masks, medical records, telephone translation service and access to international telephone calls. I agree with his findings and commend his clinical review to the attention of the Governor and the Head of Healthcare.

Use of interpreters

72. The man was a Chinese prisoner who could not speak English. When he arrived at the prison, officers working in the reception area of the prison arranged for another Chinese prisoner to act as interpreter for him. That prisoner was present for the first reception healthscreen, opening the suicide monitoring ACCT procedures and each time when the man needed to communicate with staff for the month he was at Bullingdon.

73. ACCT case reviews and health screens should be confidential meetings. During her interview for this investigation, the Suicide Prevention Co-ordinator estimated that in around 99 per cent of ACCT reviews where the subject of the review cannot speak English, another prisoner is used to translate. When asked about first reception health screens, Nurse C said that a telephone translation service is used. In interview, she explained: "… you do not use another prisoner to interpret another prisoner's medical records because that's breach of confidentiality". Despite these assurances, I am disappointed to learn that the man's first reception health screen was translated by another prisoner.

74. During the course of the investigation, my investigator asked for information about the foreign national population at Bullingdon. The prison provided him with the total number of prisoners on 31 May 2010 and a breakdown of nationalities. There were 1,102 prisoners that day at Bullingdon, of whom 129 were classified as foreign national prisoners (of those prisoners, only four were Chinese). Therefore, more than ten per cent of the prison population were foreign nationals on that day. I accept that many foreign nationals may speak English as a first language, and some may have mastered it as a second language. However, with 39 recorded nationalities residing at the prison, I would have expected that the demand for interpretation and translation services should have been higher.

75. However, along with the population statistics, the prison disclosed the details of the official interpretation service, known as 'The Big Word', including how many times it was used each month between December 2009 and July 2010. Over these eight months, prison staff used The Big Word on just 30 occasions. Between 7 April and 7 May, while the man was at the prison, staff only used the interpretation service three times which did not include their dealings with him.

76. The Big Word is the telephone translation service available for staff to use when they need to communicate with a prisoner who cannot understand English. The member of staff dials the translation service and requests the required language. Staff explained to my investigator that it can take time for the service to connect to a translator in the required language. The member of staff then tells the translator what they want to say to the prisoner and then passes the telephone to the prisoner, who listens to the translated message and can reply. The telephone is passed backwards and forwards throughout this exchange.

77. There is no record that this service was used to communicate with the man while he was at Bullingdon. The NOMS document "Local Policies for Managing Foreign National Offenders" specifically discusses the best approach to translation and language services. I recognise that the telephone translation service has serious limitations for communicating with prisoners who do not speak English as their first language. I also understand that the PSO does not prohibit the use of other prisoners to translate for those subject to ACCT procedures.

78. The clinical reviewer considered the use of telephone translation services in his clinical review. It is his view that such a service "would be appropriate when either the prisoner wants it used or there are concerns about confidentiality". The clinical reviewer concludes that:

> "… a suitable compromise may be to use a telephone translation service for the medical questions for new prisoners but also have another prisoner present to translate and help explain the system."

79. I agree with the clinical reviewer that there are occasions where using other prisoners to translate is appropriate. However, I think that using prisoners as translators for the first reception health screen could stop a new prisoner disclosing all relevant information about his immediate needs. Similarly, another prisoner being present through all ACCT processes could prevent the open communication upon which the system relies.

80. Such a system is also open to an abuse of power by prisoners acting as translators, who can learn significant personal information about other prisoners. The Suicide Prevention Co-ordinator explained that all the prisoners used as interpreters are interviewed by the Race Equality Officer. If selected, they are named on a list of those suitable to be used for translation. This is an appropriate safeguard, but I do not think that it goes far enough.

81. Following the inspection in January 2008, the Inspectorate recommended that "prisoners interpreting services should be used when prisoners are discussing

confidential and sensitive information with staff and prisoner interpreters used only with their fully informed consent". The recommendation was repeated at the follow-up inspection in July 2010. I am concerned that The Big Word was used on so few occasions between December 2009 and July 2010, despite the significant number of foreign national prisoners.

82. I agree with the clinical reviewer and the Chief Inspector that more must be done to safeguard confidential information for those who do not speak English and I make the following recommendation:

    The Governor must ensure that prisoners are not used to interpret meetings where confidential information is discussed, including ACCT reviews and healthcare meetings.

    Following feedback given to the Governor during this investigation, the Deputy Governor issued a Notice to Staff in July 2010. The notice reminded staff that other prisoners should only be used for "non confidential translations". I am pleased that the Senior Management team at the prison took prompt action following the findings of this investigation. I am sure that they continue to audit the implementation of this notice and hope that there has been renewed confidence in The Big Word translation service since the issue of this Notice to Staff.

Assessing the risk of suicide

Identification of risk

83. When he arrived at the prison on 21 April, the man was accompanied by a Person Escort Record (PER) that indicated that he was at risk of harming himself. Nevertheless, he was initially assessed as not being at risk of self harm by staff in reception. Nurse A completed the healthcare element of the Cell Sharing Risk Assessment and the first reception healthscreen. Although she did not reflect the information about risk on the PER, she did record her assessment of his behaviour on the clinical record. She described him as "calm, chatty and feels low at the moment. No emotion and answering questions appropriately via an interpreter. Good eye contact." Taking into consideration his presentation at that time, and his assurance to her that he had "no thoughts of deliberate self harm on reception", the nurse did not consider that he was at risk of self harm.

84. In fact, shortly after her assessment, the prisoner who was acting as his interpreter through the reception process told staff that he was concerned he seemed "very low". The prisoner was worried that he was at risk of harming himself. I must be careful not to apply the benefit of hindsight in my investigations. The nurse completed the first reception healthscreen by following the required questions, including questions about his risk of suicide or self harm. The nurse formed a view of his presentation through observations, which she recorded on his medical record. I do not criticise her judgement that he was not at risk of self harm, given his presentation at the time of the healthscreen.

85. As soon as the interpreter brought his concerns about the man to staff's attention, two nurses raised a Concern and Keep Safe form, which is the first step of the ACCT process. I have found that the nurses acted quickly to admit him to the inpatients' unit for further observations.

Mental health referral

86. During his first reception healthscreen, he told Nurse A that he had received mental health treatment from his doctor in China. Yet, despite an ACCT document being opened and him being transferred to the healthcare centre, no mental health referral was made when he first arrived in prison. In fact, he was never referred for a mental health assessment while at Bullingdon. I am surprised that a prisoner unknown to staff at Bullingdon, who described a history of mental health treatment, was not referred for a mental health assessment. Moreover, I am concerned that he was not referred once ACCT support procedures were opened.

87. The clinical reviewer does not consider the issue of his mental health. Nevertheless, I make the following recommendation:

The Head of Healthcare should remind staff to make a mental health referral for prisoners with a history of mental health treatment or at risk of harming themselves.

The Assessment, Care in Custody and Teamwork suicide support procedures

88. He was subject to monitoring under the ACCT process for nine days, until 28 April. During that time, he had two ACCT case reviews. Registered Mental Health Nurse (RMN) C chaired the first case review, after carrying out his ACCT assessment at 10.30am on 22 April. PSO 2700 – Suicide Prevention and Self-Harm Management governs the management of prisoners at risk of suicide or self harm in prisons.

89. The PSO requires that an ACCT assessment is carried out within 24 hours of an ACCT form being opened. The nurse carried out the assessment within the required timescales. As a trained ACCT assessor, she had received sufficient training to be the case manager for the purpose of the case review that morning. The ACCT assessment, CAREMAP and first ACCT case review appear to have been completed in accordance with the guidance. Staff planned support measures aimed at improving communication with staff and locating him with other Chinese-speaking prisoners. I am pleased that staff responded to his individual needs promptly.

Being discharged from the healthcare centre

90. He was discharged from the healthcare centre later on the day of his first ACCT case review, 22 April. When a prisoner subject to ACCT is discharged from the healthcare centre, a 'Review prior to discharge from healthcare' should be completed. The review should be attended by a member of staff from the wing

to which the prisoner is being transferred. Strictly speaking, a review prior to discharge should have been carried out on the day of his move to the induction wing. However, I recognise that a case review had already taken place that day. Nevertheless, I am concerned that there is no evidence of communication either in the case review or the ACCT ongoing record between the healthcare centre and the induction wing about his needs.

The Governor and the Head of Healthcare must ensure that, when a prisoner subject to ACCT is discharged from the healthcare centre, there is a formal handover between case managers.

ACCT case manager training

91. The next ACCT case review took place on 28 April. According to the record of the case review, it was chaired by the case manager. During interview for this investigation, she explained that chairing ACCT case reviews "just comes with the job title, the role of senior officer". She had received "standard" ACCT training (a three hour foundation course for all staff who come into contact with prisoners), but had not received the specialist training to be a case manager. PSO 2700 requires:

> "*All Senior Officers, Principal Officers and Operational Managers (F and above), including Governors and Directors, must be trained to at least ACCT Case Manager level."*

92. The PSO goes on to require that any senior officer must have received case manager training before chairing a case review.

The Governor must satisfy himself that all staff at senior officer grade or above have received case manager training, in accordance with the mandatory requirements of PSO 2700.

93. Although the record of the case review recorded that the SO was the case manager, she told my investigator that the case review was actually led by the Suicide Prevention Co-ordinator who also wrote the record of the case review.

Healthcare contribution to ACCT reviews

94. No healthcare staff were present at the ACCT case review on 28 April, although the Violence Reduction Co-ordinator and Suicide Prevention Co-ordinator attended the meeting. I acknowledge that none of the outstanding actions on the CAREMAP at that time were allocated to healthcare to resolve, however the man had been an inpatient in the healthcare centre in the short time he was subject to ACCT procedures. In his first reception healthscreen, he had told the nurse that he had previous mental health treatment in the community, which should have resulted in a mental health referral.

95. The role of a case manager is to run the case review and ensure that all appropriate staff have had the opportunity to contribute, either in person or to make a written contribution before the meeting. I am concerned that there was

no one from healthcare at the review. At least, a written contribution from healthcare staff should have been sought.

The Governor and Head of Healthcare must ensure that healthcare staff consulted about ACCT case reviews where it is relevant.

<u>The ACCT CAREMAP</u>

96. PSO 2700 requires that the case manager:

> " … must ensure that the documentation is completed to reflect subsequent case reviews. That is, he or she must complete a 'Record of Case Review' (pages 15-17), update the CAREMAP, update (if required) the triggers box, and update (if required) the frequency of conversations and observations - and the frequency of recording them - on the front cover of the ACCT Plan."

The case manager is also required by the PSO to ensure that CAREMAP actions are carried out. The Suicide Prevention Co-ordinator revisited his CAREMAP during the case review on 28 April. She noted that his communication issues had been addressed because he had "agreed to speak [to staff] via the Chinese community". She also recorded that he had been located to B wing, with Chinese prisoners. She described him as "very happy" with the arrangement and noted on the CAREMAP that he was "cell-sharing with another Chinese prisoner".

97. Finally, she added another issue to the CAREMAP during the case review, that he needed contact with his family for support. The senior officer wrote that the action required to address this issue was "international public expense, monthly phone call appropriate". She recorded that the case manager was responsible for the action and the senior officer would issue a form that same day.

98. In interview for this investigation, she explained that she felt the issues identified when he had first arrived at the prison had been addressed by the time of this case review. She described him as "much more settled", "smiling" and assessed that he was no longer at risk of harming himself. Those present at the case review agreed with her and so the ACCT procedures were closed. I do not question the case review panel's judgement in this case. She is an experienced Suicide Prevention Co-ordinator. She described to my investigator the body language signs that she took into consideration when making her judgement about his level of risk.

99. However, she added an action to the CAREMAP just before closing the ACCT document. The action had not been resolved when the ACCT document was closed. The requirements of PSO 2700 are clear:

> "The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so."

The man's ACCT should not have been closed until all of the issues that were associated with his level of risk had been resolved. It is clear from his records

that he missed his family in China. Unfortunately, it took more than two weeks to organise an international telephone call for him following this case review.

The Governor should remind staff to ensure that all actions noted on CAREMAPs are complete before ACCTs are closed, in line with the requirements of PSO 2700.

ACCT post closure review

100. It was not until the ACCT post-closure review was held on 10 May, twelve days after his ACCT was closed, that the matter of the international telephone call was picked up again by staff. The date for a post closure review is to be decided by those present at the ACCT review when it is closed. The Suicide Prevention Co-ordinator did not complete that section of the form. PSO 2700 requires that: the date of the first post closure interview is a matter for the case review team to decide but must be within 7 days of closure". It is particularly concerning that the post closure review was five days late in this case, when there was an outstanding issue on the CAREMAP.

The Governor should satisfy himself that ACCT post closure interviews are held according to the requirements of PSO 2700.

101. He was quickly identified as at risk of harming himself by the prisoner who acted as his interpreter through the reception process. I am satisfied that staff acted quickly and appropriately to manage that risk as soon as it was raised with them. However, I am concerned about the ongoing management of his risk factors. The requirements set out in PSO 2700 are properly demanding, and implemented properly, they should help to safeguard prisoners at risk of self harm.

The man's telephone call to his family

102. At the time of the post closure ACCT review, he had still not completed an application for an international telephone call. The Suicide Prevention Co-ordinator told my investigator that she asked the Chinese prisoner who acted as an interpreter at the final case review on 28 April, to ensure that he had the right form to apply for an international telephone call. After she had passed the responsibility for arranging the telephone call to a prisoner, she told my investigator that "that was the last really that I ever spoke to him". Unfortunately, he did not make an application for an international telephone call for a further 12 days.

103. Following the post closure review on 10 May, the officer who was also the man's personal officer, helped him to complete a prisoner application for foreign national telephone call. During interview, he told my investigator that he was not aware that the man had requested a telephone call until that day. He explained:

> "He needed a phone call so I, to be honest I think I did it that morning. I went upstairs, got him the foreign national phone call app, gave it to the interpreter

to help him fill in, which he did pretty much straightaway, and I put it in I'm pretty sure the same day."

104. In interview, he said that he would have been expected to have been told about his request for an international telephone call after it was raised during the ACCT case review on 28 April. He said that he was often left to organise international telephone calls on the wing and he was confident about the processes. It is disappointing that it took so long for his request to come to his attention. The officer's swift action demonstrated how easily the matter could have been resolved weeks earlier. I think that the man was needlessly left without the reassurance of being able to talk on the telephone to his family. New prisoners are entitled to telephone someone to tell them where they are. He did not receive his entitlement.

105. In her inspection in January 2008, the then Chief Inspector of Prisons recommended that "foreign national prisoners should routinely be given a free monthly international telephone call to enable them to keep n contact with family abroad". Far from a matter of routine, his application for a telephone call was not made until he had been at Bullingdon for three weeks. There was no system to ensure that he was given this opportunity, despite staff being aware that he wanted such a call. It is clear from his application how much he missed his family. In fact, contact with his family had been identified as connected with his risk of self harm in the ACCT document that was nevertheless closed.

106. My investigator asked the Race Equality Officer at Bullingdon what measures were in place to give prisoners access to international telephone call upon their arrival in the prison. She explained that "there is an issue here at Bullingdon due to international lines not being available after 5.00pm". However, she went on to say that the local induction policy was being reviewed and the immediate need for foreign national prisoners to contact their families will be highlighted in the amended policy. I agree with the Inspectorate that foreign national prisoners should be given international telephone calls as a matter of routine and I am pleased that this matter is being addressed by the prison. Nevertheless, I make the following recommendation:

The Governor should introduce a system to ensure that foreign national prisoners are offered an international telephone call as soon as they arrive in prison and then every month afterwards.

Calling for an ambulance

107. The man was discovered by his cellmate at 5.55pm. A 'Level 1' radio call was made, indicating a life-threatening situation. It was not until five minutes later, at 6.00pm, that an ambulance was requested through the communications room. During her interview for this investigation, Nurse C said that it was obvious from his condition that an ambulance was needed. The nurse thought that Officer E had called an ambulance. The officer was not carrying a radio and did not summon an ambulance, but told my investigator that he understood an ambulance would automatically be called once a Level 1 radio call had been made. Officer F, one of the first officers on the scene, said that she was not

aware of what arrangements were in place to call an ambulance to an emergency. Nurse E understood that it was a senior officer's role to call an ambulance. In fact, the DPSM called an ambulance when he attended the cell.

108. In such critical situations, the swift attendance of an emergency ambulance could save someone's life. I am concerned by the lack of certainty about arrangements to call an ambulance. In a previous investigation, I made a recommendation to the Governor of Bullingdon and the Head of Healthcare to strengthen arrangements for summoning emergency ambulances. The recommendation was accepted at the time and assurances were given that it would be complied with. While the outcome for the man may not have been any different had an ambulance been called without delay, I am disappointed to repeat that recommendation in this case:

The Governor and the Head of Healthcare should ensure that a local protocol is in place that provides clear advice about how and when the Ambulance Service should be called.

109. Just before this report was issued in its draft version in March 2011, the Department of Health wrote to all Governors, Directors of Offender Managers, Heads of Healthcare and Primary Care Trust Offender Health leads to remind them that "it is essential that internal procedures do not waste undue time in summoning emergency assistance".

Attempts to resuscitate the man

110. He was discovered hanging in his cell when his cell mate returned from court on 26 May. In his clinical review, the reviewer writes, "I was impressed at the speed and professionalism with which the cardio pulmonary resuscitation (CPR) was undertaken". I agree that staff acted quickly and professionally. He was transferred to hospital where he sadly died the next day.

111. I am concerned that a face mask was not available for Officer F when she was performing mouth to mouth resuscitation. A face mask could have meant that her attempts to introduce air into the man's airways might have been more effective. Also, it would have protected the officer from the distress and anxiety associated with the transfer of bodily fluids during her resuscitation efforts.

112. I appreciate that it is not compulsory for officers to carry face masks, as it is with ligature knives. I also understand that face masks are available in emergency response kits situated around the prison, which must contain face masks. However, I make the following recommendation:

The Governor should consider issuing all operational staff with face masks.

Contact with Border and Immigration Agency (BIA) and the Chinese Embassy

113. According to PSO 4630 – immigration and foreign nationals, a prison must inform the BIA of any foreign national prisoners who come into their custody. Prisons should also remind foreign national prisoners of their right to speak to their Embassy once they have been taken into custody.

114. My investigator found no evidence that there was a systematic approach to the management of foreign national prisoners, as required by the PSO. The BIA should be notified of prisoners arriving in custody in order to ensure that immigration policies are correctly applied in their case. Ensuring that prisoners have an opportunity to speak to their Embassy is an important safeguard for those unfamiliar with the criminal justice system in this country.

The Governor should remind staff of the requirements of PSO 4630 and ensure that they are enforced.

Wing history records

115. No wing history entries were made between 13 and 26 May, when the man was discovered hanging in his cell. Officers should make an entry each time they have a meaningful interaction with a prisoner. In the announced inspection in July 2010, the Inspectorate reported that staff-prisoner relationships were "reasonably good", describing them as "courteous and friendly". The man required a translator to be able to communicate with staff. I am disappointed that no entries were made in his record in the two weeks before he died and I have no other evidence of contact between himself and the staff. He was many miles from home and spoke no English. The criminal justice system must have been bewildering and he is likely to have been very uncertain about his future. It is disappointing that staff apparently made so little effort to communicate with him.

Family liaison

116. There was a delay notifying the man's next of kin of his death. The mobile telephone number which he gave on reception led to a friend who did not understand English. Staff recalled that he had called his family in China and made efforts to contact the Chinese Embassy. Eventually, Governor A told a family representative of the man's death on 28 May, the day after he died.

117. The family told one of my family liaison officers that their experience of liaison with agencies has been confusing. I understand the difficulty of establishing contact with next of kin, caused by language difficulties and distance. In this case, it is clear that the Embassy were contacted at an early stage and efforts made to keep them informed. In his report, the chaplain confirmed that the prison tried to establish further contact with the family's representative in China. Regrettably, the family's representative told my office that they have not received contact from anyone. I am satisfied that the prison worked hard to contact the

family and tried to re-establish contact once it had been lost.

118. The family were also worried because they thought it was unlikely that he would have taken his own life. He was discovered in his cell alone. As a matter of routine, the police attended the cell after he had been taken to hospital to examine it for any evidence of suspicious circumstances. My investigator contacted the police at the beginning of the investigation and confirmed that there was no evidence of third party involvement. The post mortem found that his injuries were consistent with "self-suspension", and that his cause of death was "multi-organ failure", "brain injury" and "hanging". While I understand the difficulty his family have in accepting the circumstances of his death, I can see no evidence to suggest that it was not self inflicted.

CONCLUSION

119. When he arrived at Bullingdon, a fellow prisoner quickly indicated that the man was at risk of harming himself. Staff reacted quickly and took measures to safeguard him, but no mental health referral was made. He remained subject to suicide prevention measures for his first week and was moved to a wing where he could associate with other Chinese prisoners. Despite being entitled to an international telephone call, it was 22 days before he could speak to his wife and child in China. He was eventually assisted by another prisoner to make the application.

120. His ACCT support procedures were open for only a week, and shut three weeks before his death. However, the decision to close the ACCT was taken without input from healthcare and with an outstanding action on the CAREMAP. He had still not spoken to his wife when the ACCT support was brought to a close.

121. Reliance on bilingual prisoners for translation is understandable. However, it can be open to abuse by prisoners, who may take advantage of those for whom they translate, and staff, who let prisoners take on duties that should be their own. I think that confidential meetings about risk or healthcare matters should be conducted in private, regardless of the first language of a prisoner. I trust that the Governor will reassess and strengthen the interpreting arrangements in place at Bullingdon. This issue has already been raised by Her Majesty's Chief Inspector and it is disappointing to learn from the investigation into his death that it has still not been resolved.

122. I appreciate the difficulty of looking after the individual needs of prisoners who do not speak English. My enquiries have found that, on any one day, ten per cent of prisoners are foreign nationals. I hope that the Governor will review his systems to ensure that the prison regime and support structures are accessible to all prisoners.

RECOMMENDATIONS

1. The Governor must ensure that prisoners are not used to interpret meetings where confidential information is discussed, including ACCT reviews and healthcare meetings.

   Accepted - A notice to staff was published 16/07/10 to remind staff to only use prisoner translators for non confidential translations and in all other cases to use our official interpreting service, “The Big Word”. This notice will be reissued annually or in the event of management believing that it is not being adhered to.

2. The Head of Healthcare should remind staff to make a mental health referral for prisoners with a history of mental health treatment or at risk of harming themselves.

   Accepted - A reminder will be issued to all Healthcare staff and training amended to ensure that this is continually reinforced.

3. The Governor and the Head of Healthcare must ensure that, when a prisoner subject to ACCT is discharged from the healthcare centre, there is a formal handover between case managers.

   Accepted - This is now in place and is incorporated into the local ACCT training package.

4.
5. The Governor must satisfy himself that all staff at senior officer grade or above have received case manager training, in accordance with the mandatory requirements of PSO 2700.

   Accepted - Case management training is now included in the 2011/2012 training plan and it is now being offered to SO’s.

6. The Governor and Head of Healthcare must ensure that healthcare staff consulted about ACCT case reviews where it is relevant.

   Accepted - This advice is now included in all ACCT training and monitored through our regular checks of ACCT documentation.

7. The Governor should remind staff to ensure that all actions noted on CAREMAPs are complete before ACCTs are closed, in line with the requirements of PSO 2700.

   Accepted - This is included in all case manager ACCT training and is also part of the management check and post closure reviews. Deadline relates to the need to ensure all SO’s are trained as per recommendation 4.

8. The Governor should satisfy himself that ACCT post closure interviews are held according to the requirements of PSO 2700.

   Accepted - This is now covered in all training and quality assurance of post closure reviews is completed monthly and the results fed back to the Governor and SMT.

9. The Governor should introduce a system to ensure that foreign national prisoners are offered an international telephone call as soon as they arrive in prison and then every month afterwards.

   Accepted - The foreign national telephone call system has been reviewed in light of these recommendations and prisoners are now offered a phone call at least every month. The offering of a phone call on initial reception will be reviewed and implemented subject to a suitable system for this being identified.

10. The Governor and the Head of Healthcare should ensure that a local protocol is in place that provides clear advice about how and when the Ambulance Service should be called.

    Accepted - An Operational Instruction will be issued which will state that an ambulance should be called as soon as the first on scene has identified that there is an individual who is suspended. This will then be reinforced via first on scene training.

11. The Governor should consider issuing all operational staff with face masks.

    Accepted - To ensure that face masks/vent aids are always suitable for use they are stored in our emergency boxes located on all units. The box is checked on a monthly basis to ensure that all equipment is fit for purpose.

12. The Governor should remind staff of the requirements of PSO 4630 and ensure that they are enforced.

    Accepted – Publish a Notice to Staff reminding them of PSO 4630 and the local published policy on the management of foreign national prisoners.