Investigation into the circumstances surrounding the death of a prisoner at HMP Bedford in August 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is a report of an investigation into the death of an immigration detainee at HMP Bedford. The man had entered the UK illegally and was awaiting deportation back to Vietnam. He was found hanging in his cell shortly after 4.00pm on 14 August 2008. Despite every effort to resuscitate him, he was pronounced dead at 4.37pm the same day. He was 28 years old.

The loss of a loved one is always distressing and I extend my sincere condolences to the man's family for their loss

The investigation was undertaken by my two of my colleagues. I would like to thank the Governor of HMP Bedford and his staff for their participation and assistance. Particular thanks go to Mr M who acted as the liaison officer.

A clinical review was commissioned by Bedfordshire Primary Care Trust and completed by the Head of Healthcare at another prison. I extend my thanks to the clinical reviewer for recommendations drawn from her findings.

For a number of reasons outlined in my report, the man who died was very concerned about being deported back to Vietnam. I would not normally detail the reasons for imprisonment in my report and I understand that this might be distressing to his family. However in this case, his offence and the shame he felt as a result of committing the offence, are relevant to his state of mind at the time of his death.

I have made four recommendations, one for the Primary Care Trust regarding the quality of record keeping, two for the attention of the Governor of HMP Littlehey, and one for the Governor of HMP Bedford. All have been accepted.

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

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SUMMARY

The man who died arrived in the United Kingdom in October 2003. He had entered the country illegally and was arrested the day after his arrival. He applied for asylum but was refused. In April 2004, he was admitted to hospital and found to be suffering from tuberculosis. Further tests showed that he was also HIV positive and suffering from hepatitis C.

In June 2005, the man was sentenced to six years imprisonment for rape and aggravated burglary with a recommendation for deportation to Vietnam at the end of the sentence.

During his time in prison, the man maintained regular contact with his family in Vietnam. He told them he was in prison for robbery as he was deeply ashamed of his offence and the shame that it would bring on his family. He conformed well to prison life and took the opportunity to learn English and receive treatment for his medical conditions. There is one recorded incident of self-harm in May 2005 when he made superficial cuts to his wrist because he was not allowed to return a CD that he had borrowed.

The man was very concerned about being deported. He was frightened for his life because he had stabbed a man, in defence of his mother, prior to leaving Vietnam and he owed money that he had borrowed to finance his travel to the UK. He feared rejection by his family because of his offence and his medical conditions. He was also concerned that the medication that was controlling the HIV and hepatitis would not be available to him in Vietnam and even if it was, he and his family could not afford it. In an assessment interview with his probation officer in 2007, the man said, that he would kill himself rather than go back to Vietnam.

The process for deportation began shortly before the man completed his prison sentence on 11 June 2007. As a result of his offence, the UK Borders and Immigration Authority (UKBIA) authorised his continued detention in prison custody while the process was completed. Around this time, wing staff at HMP Littlehey started to notice that he was worried about being held as a detainee awaiting deportation. An officer documented his concern in the man's wing record and reiterated the risk identified by the man's probation officer the previous year. However, no consideration was given to opening an Assessment, Care in Custody and Teamwork (ACCT) document (a procedure that monitors and supports individuals thought to be at risk of self-harm).

The man was transferred to HMP Bedford as an immigration detainee on 18 June to await the deportation decision. The Prisoner Escort Form (PER) that accompanied him to Bedford failed to highlight the potential risk of self-harm identified and documented by the probation officer and reiterated by the officer who was concerned.

By late July 2008, deportation was almost inevitable and the man decided to withdraw his appeal against the decision to make a deportation order. His reasons for withdrawing the appeal are not known.

At approximately 4.04pm on 14 August, an officer was unlocking the man's cell to allow his cell mate to go in. The man was found hanging from the bars of the cell window by part of a bed sheet. Every attempt was made to resuscitate him by prison staff and paramedics. A prison doctor, pronounced the man dead at 4.37pm.

The family were contacted through the British embassy in Vietnam and informed of the man's death. His parents, who were not able to leave Vietnam, nominated a family friend in the UK to represent the family. Their friend accompanied the man's ashes back to Vietnam and passed them to the family.

I have made recommendations relating to recordkeeping, self-harm monitoring and communication regarding deportation procedures.

THE INVESTIGATION PROCESS

1. Notices were issued to staff and prisoners informing them of the investigation and its terms of reference, and inviting them to contact the lead investigator should they wish to do so.

2. My investigator opened the investigation by visiting HMP Bedford on 19 August 2008. She spoke to the Governor, a member of the Independent Monitoring Board (IMB), the chairman of the Prison Officers' Association, and the Family Liaison Officer. She visited the cell where the man spent the last few months of his life. All available documents likely to be required for the investigation were collected or requested at this time.

3. My investigator and a colleague carried out nine interviews with members of staff on 29 and 30 October 2008. They also spoke to two prisoners who knew the man who died.

4. The man's clinical records were passed to the clinical reviewer who conducted a clinical review on behalf Bedfordshire PCT and made appropriate recommendations that have been incorporated into my report.

5. My investigators contacted the Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of this report was sent to the Coroner, on completion, to assist in his enquiries.

6. One of my Family Liaison Officers contacted the representative of the man's parents in this country, to offer the opportunity to participate in the investigation. He raised two questions on behalf of the family, which I hope have been satisfactorily addressed within my report. The family asked why the man took his life and why he was unable to return to Vietnam, which was what he had told them? I hope that my investigation has helped the family to better understand the events leading up to the man's death.

HMP BEDFORD

7. HMP Bedford was built in 1801 and is located in the centre of Bedford, a town to the north of London. It serves Luton Crown Court, and Magistrates Courts within the Bedfordshire and Hertfordshire counties. It can hold up to 506 male category B prisoners and often takes prisoners transferred from London prisons. (Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.)

8. The prison accommodation is divided into six wings. “A” wing holds 138 prisoners over three floors. When prisoners are on the unit, five prison officers are on duty, this is reduced to four when prisoners are at work and education.

9. The former Chief Inspector of Prisons, conducted an unannounced short follow up inspection of HMP Bedford in April 2006. Her report commented that, “at the time there were 11 immigration detainees being held on immigration warrants (Form IS91), who had completed their prison sentence ... but were confused as to their status and what the future holds” The Chief Inspector recommended:

   > “Recommendation 2.5 ... There should be systems in place to identify and meet the needs of foreign national prisoners”.

10. In every prison in England and Wales there is an Independent Monitoring Board report (IMB). The members are volunteers who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. The Bedford IMB annual report for 2007-2008 reported that a comprehensive foreign national prisoner strategy had been agreed by the Governor in June 2008. At the time of writing their report, 25 per cent of the prisoners held at Bedford were foreign nationals. The IMB deemed the service to foreign nationals to be “very good.” They noted that induction packs were available in 16 languages and immigration clinics were held every six weeks to offer support and advice. The Refugee Legal Centre gives legal advice and represents foreign national prisoners at legal hearings as required. The report also recognised the “outstanding service” offered to many prisoners with mental health issues by the mental health in-reach team.

11. There were two self-inflicted deaths in Bedford in 2007. However, the circumstances were not similar to those surrounding this death.

KEY FINDINGS

12. The man who died arrived in the United Kingdom on 27 October 2003. He was a Vietnamese national and had entered the UK illegally. He was seen by Surrey police the next day, walking along the M25 motorway and was arrested. He spoke little English and was interviewed by immigration officers. During this interview, he claimed asylum in the UK. This application was refused in November 2003. The man lodged an appeal which was dismissed in February 2004.

13. The man lived with friends in London and worked illegally in restaurants to pay his rent. He was also in debt to those who had funded his travel to the UK. In April 2004, he was admitted to Homerton hospital in London with a fever and night sweats. He was found to have tuberculosis and tested positive for HIV and hepatitis C. He was transferred to St Bartholomew hospital (also in London) for treatment. It is not known how long he stayed there.

14. Offences of rape and aggravated burglary were committed in February 2004, against two Vietnamese girls. The man who died was charged with these offences, along with two other Vietnamese men, and remanded into custody at HMP Chelmsford in June. He pleaded guilty and gave evidence in court that helped convict his co-defendants. He was sentenced to six years imprisonment, with a recommendation for deportation back to Vietnam at the end of his sentence.

15. The man transferred five times during his sentence. Despite this, it is clear from his medical records that he received good continuity of specialist care to treat his HIV and hepatitis C conditions. He only missed one clinic appointment in four years, due to operational reasons, when he first arrived into custody at Chelmsford.

16. Prison records describe the man who died as a quiet man who kept himself to himself. He initially struggled with the English language which made participation in offending behaviour programmes difficult. In spite of this, he refused to be transferred to HMP The Mount to undertake a specialised sex offenders programme that had been adapted for non English speakers. However, by the end of his sentence, according to his education teachers, he spoke and understood English very well. During his imprisonment, he maintained regular phone contact with his family.

17. On 4 May 2005, at Chelmsford, the man attempted self-harm by inflicting superficial cuts to his wrist. He said that he had cut himself because he was angry that he was not allowed to return a CD that he had borrowed from another prisoner. He was concerned that he would be accused of theft. He was assessed by a senior mental health nurse who opened an F2052SH document in order to provide some structured support. (F2052SH was used to monitor and review prisoners at risk of self-harm and has since been replaced by the Assessment, Care in Custody and Teamwork process). A translation service, Language Line, was used to enable the assessment to take place. He agreed to receive help from the mental health team but said that he had no thoughts of

suicide. The F2052SH was closed on 26 May 2005. There is no evidence of further attempts at self-harm during his sentence and no record of further contact with the mental health team.

18. On 15 January 2007, at HMP Littlehey in Cambridgeshire, an OASyS assessment) was completed with the man who died. (OASyS is a sentence planning and risk assessment system using reports from various prison specialists to inform individual targets agreed with the prisoner.) During the assessment interview, the man said to the officer who conducted it, that while he was in Vietnam he had stabbed a man who had assaulted his mother. He said that his family knew he was in prison but not that he had committed a rape as he did not want to bring shame on them. He admitted that he had suffered from depression because of his difficulty communicating and his health problems. However, at that point he had no problems in coping in custody, therefore no concerns about suicide or self-harm were recorded.

19. A prison probation officer interviewed the man on 22 February 2007, in order to complete a parole report. (Parole is a system that allows a prisoner to be released before they have served their full sentence. It is considered on the basis of reports by prison and probation staff. The decision is based on a number of factors, including the nature of a prisoner's offences, their home circumstances, plans for release and behaviour in prison.) During this interview, he expressed considerable concern over his possible deportation. He was concerned about his family rejecting him because of his offence and his medical conditions. He said that there was no state health provision for HIV medication, he would therefore be dependent on his own and his family's private means. He knew that his family did not have sufficient money and said that he would rather kill himself than return to Vietnam. The probation officer noted this in his report and in the man's prison record, Local Inmate database (LIDs) and his probation file.

20. On 2 March, the man was issued with a notification of liability to deportation by a senior officer. This is likely to have been a form ICD0350 from the Immigration authorities. He was advised to provide reasons as to why he should not be deported. The senior officer discussed the risk highlighted during the man's interview with the probation officer and advised him that "any deportation would not happen until 2008".

21. Early release on parole was refused on 14 May due to the seriousness of the man's offence and that he had not completed offending behaviour work to reduce his risk of reoffending.

22. The man regularly attended hospital appointments to monitor his HIV and Hepatitis C conditions. Letters from a consultant gastroenterologist at Addenbrookes Hospital in Cambridge dated 30 August, 20 November 2007 and 25 February 2008, all indicate that the medication was working well and he was responding to the treatment.

23. A form IS91 was issued by the Immigration Service, Criminal Casework Directorate (CCD), on 6 June. This provided the legal authority to detain the man

in custody after he had served his prison sentence, to await the outcome of the deportation proceedings. There is no right of appeal against the IS91.

24. The man completed his sentence on 11 June 2008, but had to remain in prison to await the decision on his deportation. He was not released to await this decision in the community or transferred to an Immigration Removal Centre because of the seriousness of his offence and the potential risk of reoffending. A doctor at Littlehey wrote to the UK Border Agency (UKBA) to confirm that the man had been diagnosed with HIV and hepatitis C.

25. An officer at Littlehey noticed that the man was worried that he was now being held in custody as a detainee. On 14 June, the officer noted in the man's prison file, that he was scared of being deported back to Vietnam. He also reminded staff of the probation officer's concern in February 2007 that the man might try to take his own life. There is no record of the officer who made the entry considering monitoring the man under the Assessment, Care in Custody and Teamwork (ACCT) procedures.

26. A Prisoner Escort Record (PER) form accompanies each prisoner when they move between prisons. It provides information about both the prisoner's needs and the risk he poses to others. The man was transferred to a local prison, HMP Bedford, on 18 June to await the deportation decision. The PER completed by staff at Littlehey highlighted that he had a medical condition and that he was threatening and violent. The box relating to the potential for self-harm was blank.

27. At Bedford, the Cell Sharing Risk Assessment (CSRA) form was completed the same day, using information from the PER, IS91, previous convictions record, the pre sentence report and his responses to set questions. (The CSRA ensures that prisoners are suitable to share a cell by assessing their risk of harming a cellmate.) An officer completed the CSRA, but failed to note the previous sex offence or aggravated burglary. The man also denied any acts of self-harm in the past and was therefore assessed as low risk. In interview, the officer who completed the CSRA said that he deliberately listed the man's offence as burglary for his own safety as, "he's going to have an easier time in prison if it's known that he's in for burglary rather than rape". It should be noted that the CSRA is a document for staff information only.

28. A nurse, in her assessment in the CSRA, said that the man did have a history of self-harm but "no self-harm ideation at present". In interview, the nurse who conducted the assessment said that he told her that he had cut his wrist four years ago but had not attempted anything since and that he had no self-harm issues.

29. On 26 June, the Criminal Casework Directorate (CCD) of UKBA wrote to the Governor of HMP Bedford asking him to inform the man of the decision to make a deportation order against him. This was signed on behalf of the Secretary of State on 2 July and officially delivered to the man by the foreign national clerk, on 9 July. The documentation given to the man included a disclaimer to be completed if he did not wish to appeal, an appeal form and a letter from CCD

outlining the deportation process. The foreign national clerk spoke to him and explained the paperwork and the appeals process to him.

30. The foreign national clerk explained the deportation process to my investigators. He said the man had an opportunity to appeal against the decision to make a deportation order. If this was unsuccessful and the order was made, he would have had another opportunity to appeal at that later stage.

31. The man lodged an appeal against the decision to make a deportation order on 21 July, which was arranged to be heard on 25 September at Nottingham Magistrates Court. However, he signed a disclaimer withdrawing his appeal on 30 July. The disclaimer appears to have been sent to CCD either directly from the man or from his solicitor as there is no record of the document in his prison files. My investigator was unable to determine why he had changed his mind and withdrawn his appeal.

32. CCD send monthly reports to detainees to keep them advised of progress. The man received a progress report dated 11 August that noted the withdrawal of his appeal. The report advised him that CCD would be making arrangements for him to be interviewed regarding an emergency travel document that would allow him to be deported back to Vietnam. The prison received a copy of this report.

33. The weekday routine at Bedford is for all prisoners on a wing to attend work and education either in the morning or the afternoon and have the opportunity for exercise, gym and association during the other half of the day. The next day the routine is reversed.

34. The man who died attended key and life skills education classes in Bedford. My investigator interviewed one of his tutors (who taught him on Monday, Tuesday and Friday). She described the man as “the perfect student”, whose attitude was “absolutely brilliant”. He always shook her hand at the end of the Friday session and said, “Thank you Miss, have a lovely weekend”. On the Monday before his death, he knew that she would not be in on the Tuesday. She recalled that, at the end of the session, he took her hand but then took her other hand as well and said, “Goodbye Miss, thank you”.

35. The support lecturer, in the Education department, also taught the man key skills. He described the man as quiet with a good understanding of English. In interview, the lecturer recalled that he attended his class a few days before his death. They had discussed assertiveness and addressing personal issues and concerns in a positive way. During the class, the man became very outspoken and angry about not being given help with his problems on the wing. He did not specifically say what help he needed but was very animated which was out of character. The class discussed the process for getting help and the lecturer was pleased with the man’s ability to articulate his feelings. He did not think that his behaviour was a “cry for help”.

36. On Thursday 14 August, one of the man’s friends was on his way to work and saw him leaning against the landing on the third floor, where his cell was located. He asked him if he had education and the man, with what his friend described as

"a wry smile", said he did not. The man's friend said that his friend appeared relaxed and was smoking a cigarette.

37. At approximately 4.04pm, an officer was escorting the man's cell mate back to his cell from his computer course. When he unlocked the cell, the cell mate stopped abruptly at the door and the officer saw the man hanging from the bars of the window by part of a bed sheet. The officer immediately raised the alarm using his radio, he also shouted to another officer, who was on the upper landing, and entered the cell to cut him down. The two officers then tried to resuscitate the man.

38. A nurse arrived a few minutes later and continued attempts to resuscitate the man using an Automated External Defibrillator (AED). (This device measures electrical activity in the body and advises on action to be taken.) The ambulance arrived at 4.15pm. The paramedics removed the AED and attached a cardiac monitor which showed no electrical activity. They carried out advanced life support (ALS), giving adrenalin and atripene and continued cardio pulmonary resuscitation (CPR) for another 20 minutes. This is in accordance with the ALS guidelines. Every effort was made to resuscitate the man. The prison doctor, oversaw the ALS attempts and agreed that efforts should cease. The man was pronounced dead by the doctor at 4.37pm.

39. The contingency plans for a death in custody were activated and all relevant authorities were advised. A "hot" debrief was conducted for all staff involved, by one of the governors and no issues were raised. All staff were offered support from the staff care team. A critical incident debrief was held approximately two weeks later and attended by staff from the Prison Service area office. (A debrief is a meeting for staff to discuss any lessons learned as the result of a serious event.)

40. The prison records listed a family friend as the person the man would have lived with in the UK, if he had been released from prison. One of the prison chaplains, contacted the Metropolitan Police who informed the family friend of the man's death later that evening. The Governor appointed a senior officer as the prison family liaison officer. It was confirmed that the family friend was their representative in the UK and he and his family notified the deceased man's family in Vietnam on 15 August.

41. The Governor published a Notice to Staff and Prisoners to inform them of the man's death and offered support to anyone who felt they needed it. The notice included the name of a contact person for both the Coroner's office and my investigation team should anyone have information they wished to share.

42. The family liaison officer accompanied the family representative and his family to identify the man's body and offered advice and support. She also liaised with the Vietnamese Embassy in London and the British Embassy in Vietnam to ensure that the man's parents were formally informed of his death.

43. The family representative was offered a meeting with the Governor and the opportunity to view the man's cell, both were declined. The Governor offered to

repatriate the man’s body to Vietnam as the family were not able to come to the UK for the funeral. The family decided to cremate the body in the UK and the Governor contributed to the cost of the funeral and to the travel costs for the family representative to return the ashes to the man’s parents in Vietnam. Prison staff attended the funeral on 16 October, which was very much appreciated by the family.

ISSUES

Health care services

44. The man who died was diagnosed as both HIV and hepatitis C positive. Both conditions required consistent monitoring and treatment. He was transferred five times in the four years he was in custody. Nevertheless, it is clear from his medical records that there was consistency in the quality of healthcare provided to him. Hospitals were informed when he was being moved and care was appropriately transferred to another hospital as required. It is worth noting that He only missed one clinic appointment during his time in custody and this was due to operational reasons when he first arrived at HMP Chelmsford. The clinical reviewer assessed the consistency of his care as excellent. I agree with her assessment.

45. The continuity of the man's clinical notes was difficult to establish and handwritten entries, including the signatures, were often illegible. This is a common finding in my investigations and once again I make a recommendation to Bedfordshire PCT that applies equally to most PCTs in the country.

    Bedfordshire PCT should ensure a common standard of record keeping across the prisons where they deliver services. Clinical notes, both hand written and summaries from IT systems, should be kept in chronological order. Handwritten notes should include the time the entry was made, a clear signature, a printed name and the date.

46. Staff involved in the attempt to resuscitate the man were appropriately trained and responded quickly and professionally. They used the correct equipment that was made available without delay. I share the clinical reviewer's conclusion that staff acted professionally and every attempt was made to resuscitate.

Communication

47. In January 2007, an officer interviewed the man for an OASyS assessment report. During this interview, he expressed concern about returning to Vietnam. He said that he had stabbed a man who had assaulted his mother and was frightened to return. He also said that he did not want to bring shame on his family who did not know that he had been convicted of rape, as he had told them he was in prison for robbery. The man admitted to suffering from depression, however, the officer did not record any concerns about potential self-harm.

48. The prison probation officer interviewed the man in February 2007. During this interview, the man first expressed his considerable concern over his potential deportation back to Vietnam. He was deeply ashamed of his offence and concerned about the shame that it would bring to his family and the possibility of rejection. He was also concerned about his health. He knew that even if his medication (which was recognised as working) was available in Vietnam he or his family would have to pay for it themselves. He knew that they might not be able to afford it. The man said that he would rather kill himself than return to Vietnam.

The probation officer took this threat seriously and correctly noted it in the report, in the man's F2052A (his prison wing file), his probation file and on LIDs.

49. This risk was discussed with the man again the following month when a senior officer gave him immigration forms that required him to provide reasons why he should not be deported. The senior officer advised him that any deportation would not happen until the following year.

50. The man completed his sentence on 11 June 2008, but was detained in custody to await the outcome of the deportation proceedings. A Form IS91 had been issued to him by the UKBA. He was, therefore, aware of the reasons for his continued detention and why he had not been released on 11 June. At this point the issue of deportation must have become a reality for him and therefore the risk of self-harm identified earlier should have been acted upon.

51. An officer noticed that the man had become more concerned and recorded on 14 June that he was scared of being deported. He also reminded staff of the probation officer's concerns that the man might try to take his own life. Despite these concerns, there is no record of staff considering placing the man on ACCT monitoring and support to help him cope with his fear of deportation. Had the self-harm prevention procedure been activated, the risk would have been highlighted to everyone who came into contact with the man, including staff in HMP Bedford where he was transferred on 18 June.

52. The PER that accompanied the man to Bedford on 18 June made no reference to any potential for self-harm. In view of the concerns raised by staff at Littlehey, this is a serious omission.

53. The risk of suicide identified by the prison probation officer was not recorded in the medical file and therefore was unknown to the nurse who conducted a medical assessment with the man when he arrived at Bedford. From her discussion with him, the nurse recorded that whilst he did have a history of self-harm four years before, he had no thoughts of harming himself at that time. If the PER had identified potential self-harm or the man had been on an active ACCT, the nurse's assessment might have been different.

The Governor of HMP Littlehey should ensure that consideration is given to whether additional support such as ACCT monitoring is required whenever there is a change in an individual's status from prisoner to detainee and that this is documented.

The Governor of Littlehey should ensure that PER documents are completed correctly and contain all the known information on the transferring prisoner's risk profile.

54. During the interview with my investigator, an officer admitted that he had incorrectly recorded the man's offences in order to give him "an easier time in prison". This issue is not relevant to the man's subsequent death but might be something that the Governor of Bedford will wish to address.

Deportation procedures

55. The administration of the deportation procedures at Bedford is carried out by the foreign national clerk, working in the discipline office. He impressed my investigators with his knowledge of the immigration system. The foreign national clerk took pride in personally serving immigration documents on detainees and ensuring that they understood the process. This is commendable, however, it could result in wing staff being unaware of the current status of their detainees with regard to their deportation. It is possible that wing staff did not know that the man had withdrawn his appeal against deportation. Had they known this and read the entries in his F2052A made by staff at Littlehey, they would have had an opportunity to discuss his concerns and fears with him and offer support.

    The Governor of Bedford should ensure that wing staff are advised of progress with deportation procedures and a note of meetings between the foreign national clerk and detainees is entered into the detainee's F2052A held on the wing.

Education at HMP Bedford

56. The teachers who taught the man life skills, spoke highly of him. They both, during interview, spoke of a noticeable change in his behaviour that in hindsight may have indicated his intentions, in the days before he allegedly took his life. My investigation has found that the man was a quiet individual who did not share his problems with staff unless directly asked. With the exception of the conversation that he had with the prison probation officer over a year previously, there was no record of any known risk of suicide. The teachers were neither aware of this risk nor of his impending deportation. In the circumstances they could not have been expected to link his change in behaviour to his decision to take his own life.

Family Liaison

57. Family liaison was complicated by not having address details for the man's next of kin. He had stated to prison staff that he did not have any next of kin. The prison's family liaison officer is to be commended for her work in liaising with the Vietnamese Embassy in London and the British Embassy in Vietnam as well as the families authorised representative in the UK.

58. The family representative and the family confirmed to my family liaison officer that the prison was "very helpful" with all the arrangements and they particularly appreciated staff attending the funeral to pay their respects.

CONCLUSION

59. The man who died was a young Vietnamese man who did not share his feelings with prison staff unless directly asked to. He had entered the UK illegally and was evidently afraid of being deported back to Vietnam. He was ashamed of his offence and feared rejection by his family if they found out the nature of it. He was also in debt for money loaned to fund his trip to the UK, which he had not repaid and was concerned about the potential repercussions for stabbing a man in Vietnam, in defence of his mother, prior to his departure.

60. Medication for his HIV and hepatitis C conditions was likely to be expensive in Vietnam, if it was available, and he was concerned about how he and his family would fund his continued treatment.

61. It is clear that the man had serious concerns about returning to Vietnam, so much so that he had said to his probation officer that he would kill himself rather than go back. He had put a case forward for remaining in the UK which had been rejected. My investigators were not able to establish why he decided to withdraw his appeal. As a result of this withdrawal, deportation was inevitable.

62. Whether additional support from prison staff could have prevented the man's actions will remain unknown. It is certainly evident that, from the information available, he should have been assessed for ACCT support. However this would not have changed the deportation decision which, from my investigation, is the probable reason that he decided to take his own life.

RECOMMENDATIONS

1. Bedfordshire PCT should ensure a common standard of record keeping across the prison contracts. Clinical notes, both hand written and summaries from IT systems should be kept in chronological order. Hand written notes should include the time the entry was made, a clear signature, a printed name and the date.

   This recommendation was accepted. The response was:

   "This is a qualified nurse duty and is mentioned in the code of conduct which should be adhered too. All nursing staff will be reminded of these requirements at team meetings."

2. The Governor of HMP Littlehey should ensure that consideration is given to whether additional support such as ACCT monitoring is required whenever there is a change in an individual's status from prisoner to detainee and that this is documented.

   This recommendation was accepted. The response was:

   "Staff have now been informed to action this."

3. The Governor of Littlehey should ensure that PER documents are completed correctly and contain all the known information on the transferring prisoner's risk profile.

   This recommendation was accepted. The response was:

   "Staff have been advised to ensure that PERS are correctly completed."

4. The Governor of Bedford should ensure that wing staff are advised of progress with deportation procedures and a note of meetings between the foreign national clerk and detainees is entered into the detainee's F2052A held on the wing.

   This recommendation was accepted. The response was:

   "A system has been introduced to ensure that wing staff are advised of progress with deportation procedures and note of meetings between the Foreign National Clerk and detainee is entered in the F2052A."

   There were no comments from the man's family.