Investigation into the circumstances surrounding the death of a man at HMP Bullingdon in September 2006

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the death of a man at HMP Bullingdon in September 2006. The man was found hanging in his cell. He was a foreign national by birth and was 31 years of age.

My colleagues and I offer sincere condolences to the man's family and friends for their sad loss.

This investigation has been undertaken by two of my colleagues. I would like to thank the Governor of HMP Bullingdon, and his staff for their participation in the investigation. Particular thanks go to the officer who acted as the establishment's Liaison Officer.

A medical practitioner of Oxfordshire Primary Care Trust (PCT) undertook a review of the man's clinical care and I also greatly appreciate his assistance.

When he first arrived at Bulingdon, the man was subject to suicide and self harm monitoring and support procedures and was located in the Healthcare Centre in a ligature free cell. This was because he was upset and appeared to be having trouble coping with being in prison. However, he maintained he did not have any suicidal or self-harm intentions, and after just over a week he was taken off the monitoring and support. After that, it seems the long period he spent on remand facing serious charges did cause him unhappiness. However, there is no evidence that he confided in staff any intention to harm himself and concerns raised by his solicitors were properly explored. His death came as a great surprise to his cellmate and other prisoners. I do not think the circumstances were such that staff could reasonably have predicted that the man would attempt to kill himself.

The clinical review has raised as a matter of concern that the member of staff who performed the initial mouth to mouth resuscitation did not have a barrier mask (albeit the resuscitation attempt on the man was appropriately and efficiently carried out). My report includes one recommendation relating to that matter and I draw two other issues to the Governor's attention.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2007**

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SUMMARY

The man was remanded in custody at HMP Bullingdon on 21 November 2005 to await trial for a number of offences, including two of a serious sexual nature. This was his first time in custody. During his induction, he was very upset and, because of concerns about potential mental health problems and his ability to cope in prison, he was immediately located in the Healthcare Centre in a ligature free cell. He was placed on an ACCT (Assessment, Care in Custody Teamwork) form and staff checked him hourly. (ACCT is the system used by HM Prison Service to monitor and support a person at risk of suicide or self-harm.)

On the next day, the man was relocated from the Healthcare Centre to E wing, a unit for vulnerable prisoners, because of the nature of his alleged crimes. He continued to be monitored under the ACCT system until 29 November 2005 when the form was closed. There was nothing in his mood or behaviour that caused concern and he said he had no thoughts of suicide or self-harm. The man was interviewed on 10 December, as appropriate when an ACCT form is closed, and again no concerns were raised.

The man settled on E wing and knew some of the prisoners there from outside prison. He mixed well with a small group of prisoners, but officers tried to discourage this as they felt that these prisoners were not always a good influence on him and sometimes 'led him astray'.

There were no significant events until 15 May 2006 when his solicitors sent a fax to the prison saying that they were concerned that he might be depressed and inclined to suicidal thoughts. They asked that he be 'appropriately supervised'. It is unclear when this information was passed on to E wing, but the man was seen by an officer on 16 May. She noted that she had spoken to him and he had assured her he was alright and had no thoughts of suicide or self-harm. She said she explained the support mechanisms available for him and he seemed content with that. The officer did not consider it necessary to open an ACCT form.

The man had a meeting with his legal representative, during the late morning of 18 September. The solicitor said that the man's trial date had been set and most of the meeting was spent discussing that. They also briefly discussed him having access to his son, as his partner had stopped allowing their son to visit him. The man's legal representative assured him that legal aid could be obtained to hire a solicitor specialising in family law. He had no concerns about the man's wellbeing after their meeting.

The man's cellmate went to the gym on the evening of 18 September. The man declined to go. When his cellmate returned at around 7.27pm, the escorting officer found the man suspended from a ligature made from his shoelaces attached to the top bunk. She called for immediate assistance and, with the help of a Physical Education Officer (PEO), secured the rest of the prisoners returning from the gym in their cells. Other staff arrived and commenced Cardiopulmonary Resuscitation (CPR) at around 7.30pm. Mouth

to mouth resuscitation was commenced without a barrier mask as no member of staff had one. Nursing staff arrived at around 7.35pm. They administered oxygen and attached an automatic defibrillator. The defibrillator did not advise to shock the man at any time. Resuscitation continued until paramedics arrived and pronounced the man dead soon after.

Two prisoners who knew the man well described him as being a little despondent and feeling fed up with the length of time his trial was taking. However, they did not feel his behaviour or mood indicated he was going to commit suicide and his death came as a shock to both of them.

My report contains just one recommendation.

THE INVESTIGATION PROCESS

1. My investigators studied all relevant prison records relating to the man. These included his main prison record, medical record and statements made by prison staff.

2. The Clinical Governance Lead for Oxfordshire PCT was asked to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a timely manner.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation, and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of the investigators and one of my Family Liaison Officers met with the man's family. His sister was unhappy with the contact from the prison after her brother's death. She asked what had been done to risk assess her brother's cell. She also believed her brother's work applications had been refused, and she questioned why prison officers would not provide him with reasons for this. She said that her brother had not gone out for association for two weeks prior to his death and questioned why this was not picked up by staff.

5. The man's sister felt her brother was sometimes singled out at the prison and said he was strip searched before all his visits. She asked whether it was usual for prison officers to know about prisoners' medical conditions and for prisoners on remand to share cells with those already sentenced.

6. The sister spoke about her brother's concern about receiving a long sentence. She asked for clarification about her brother banging on his cell wall calling out for another prisoner who was in the cell next to him on the day he died. She also asked for further information about what was discussed at her brother's meeting with his solicitor on the same day. These concerns are fully discussed in a later section of my report.

7. My investigators discussed aspects of the man's treatment with both staff at Bullingdon and the clinical reviewer. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. During the course of the investigation three members of staff were interviewed. My investigators spoke with Bullingdon's police liaison officer and the man's solicitor. They also met with two prisoners and a prison chaplain.

HMP BULLINGDON

8. HMP Bullingdon operates jointly as a local and category B training prison for adult males. The primary catchment area is the Crown Courts at Oxford and Reading as well as the local Magistrates' Courts.

9. Bullingdon was opened in 1992. It has four main houseblocks, which have been supplemented by a fifth since 1998, and the prison can currently accommodate 963 prisoners. Edgcott wing (E Wing) accommodates those prisoners defined as vulnerable because of the nature of the offences they have committed or are accused of.

10. Provision of healthcare within Bullingdon is the responsibility of the North Oxfordshire Primary Care Trust. Overnight and weekend cover is provided by local GPs who are on call. There is also a clinically qualified member of healthcare staff on duty at these times. There is an in-patient unit with 24 beds, and all cells have integral sanitation. The unit is staffed by discipline and clinical staff who provide health and social care for patients with mental health needs, and for some with physical needs who require a 24 hour nursing presence.

11. The most recent report by HM Chief Inspector of Prisons was published in August 2004 following an unannounced short inspection conducted in June 2004. HMCIP report noted that, 'There were no specific recommendations on the protection of vulnerable prisoners in our previous report (full unannounced inspection September 2002). However, we noted that the Edgcott Wing was now entirely for sex offenders and operated as a vulnerable prisoner unit. Prisoners on this wing raised few issues about their protection and the prison had addressed some particular concerns, such as procedures for visits.'

KEY EVENTS

12. On 21 November 2005, the man was remanded in custody at HMP Bullingdon. He was assessed as a low risk for sharing a cell with other prisoners and was said to be upset. It was his first time in prison. The First Reception Healthscreen noted his GP's name and that the man had some outstanding clinical appointments. He said he had suffered from TB two and a half years previously and had been treated at the specialist hospital. There were no concerns about his health. The man said he had not taken any drugs in a month.

13. The man was admitted from reception to healthcare because of possible mental health problems and poor coping. It was noted he was crying. An ACCT form was opened by a senior nurse. According to the ACCT care plan, the man was located overnight in Healthcare, in a ligature free cell, and was observed hourly.

14. A Secondary Healthscreen was completed on 22 November by the prison doctor. An initial questionnaire completed by a student nurse noted that the man was depressed and wanted to give up smoking. In terms of his physical health, he wanted a hepatitis B vaccine and was HIV positive. It does not appear that he needed any antiviral medication but regularly attended the specialist clinic at the local hospital. The prison doctor noted that the man was 'calm and rational, not depressed, not suicidal and fit for ordinary location.' He was also seen by a chaplain who did not note any concerns. The man was located on E wing at 3.30pm and seemed to settle in quickly. There was no indication he was contemplating suicide or at immediate risk of self-harm.

15. On 28 November 2005, the man went to the Crown Court. On return he was seen by a member of healthcare and deemed 'fit'. On 29 November 2005, the ACCT form was closed and it was noted that he had no thoughts of deliberate self-harm, was more settled and had good family support.

16. On 30 November 2005, a member of the public protection unit interviewed him and noted he smelt strongly of cannabis. This was also recorded in a Security Information Report.

17. The man's personal officer and he made various notes in his core record which are referred to in my report. On 1 December 2005, the officer noted that the man had settled on E wing and was friends with prisoner A.

18. On 10 December 2005, the personal officer noted that the man had become an industrial cleaner and had no issues. The man's post ACCT closure interview on 10 December 2005 noted that he got on well with his cellmate, was receiving letters and had put in an application for work.

19. On 22 December 2005, the personal officer noted that the man was having trouble making international telephone calls. This was addressed as the man later applied to use an official telephone to make an international telephone call which was allowed. Records show that the man then spoke to his parents in his home country for five minutes on 20 February 2006. Through the same procedure he also telephoned his parents on 16 May and 4 August.

20. On 3 January 2006, the personal officer noted that the man had settled and made friends with a select few prisoners on E wing. On 11 January, the man was seen by a doctor as he said he was feeling tired and having problems sleeping. He was examined and the diagnosis was given as 'insomniac'. He was issued a seven day prescription of what was possibly Trazodone, but the entry is not legible. (Trazodone is an antidepressant used to treat depression when accompanied by anxiety, insomnia or both.) No follow up consultation is recorded. During his time at Bullingdon, the man was seen in the GUM clinic (Genito-urinary medicine or sexual health clinic) on 24 January, 11 April, 27 June and 4 July.

21. On 3 February, the senior officer (SO) noted that the man demanded to go back to the wing after his legal visit finished early. On 8 February, he refused to move to the top bunk to accommodate an elderly prisoner in the cell. The man said he did not think he would get on with the prisoner because of the age difference. The prisoner was located in a different cell. His personal officer did not identify that the man had any other concerns or issues.

22. On 22 February 2006, the man was remanded for trial at the Crown Court on 21 November 2006. On return to Bullingdon he was seen by a member of healthcare staff and deemed 'fit'.

23. On 5 March, his personal officer noted that he had not been at work for three weeks and in that time the man had remained quiet and compliant with no concerns or issues raised with staff. On 11 March, an entry in his core record by the SO notes that he warned the man about his behaviour as he had been absent from work. The man complained of being 'poorly'.

24. On 1 April, the man spoke to his personal officer at length about his trial and general wellbeing whilst the officer was escorting him back from reception. The officer noted, 'It seems that it may be a long drawn out process, although he seems quite positive about everything. He is, however, mixing with the wrong crowd on the spur and they are leading him astray without him knowing it.'

25. On 4 April, the man's cellmate asked to move cells due to possible intimidation by the man. On 10 April, there is another record of a

complaint from the cellmate of possible intimidation/bullying by the man and his friends. The man's cellmate was moved out of the cell and no further action was required. Some time in April, prisoner A moved into the cell with the man.

26. There is a security report about an incident on 21 April when the man was involved in an argument with three prisoners, including prisoner A. It appears from the security report that the man then pushed one of these prisoners in the gym on 23 April. The security report noted that, on 24 April, two of the prisoners had 'kept the argument going.' Staff were concerned that the dispute was in danger of spilling over into the work area and gym as all four prisoners involved were industrial cleaners. The Wing SO was told and a note was made for staff to keep an eye on the situation.

27. On 25 April, the man put in a formal complaint about missing tobacco. The response from the Acting Governor said that the man should not have used the confidential access system to lodge his complaint as such complaints have to go to the governor in charge. The acting governor explained the issue had been passed to another governor to look into. In future the man should use the open access complaints system (not in a sealed envelope) or address concerns through senior wing officers. There is no evidence of any further action being taken on this issue.

28. On 9 May, the man appeared at the Crown Court and was remanded in custody until 24 November 2006. On 12 May, the personal officer recorded that the man had returned from court: 'Long time to wait until his next appearance, not entirely happy but seems to be taking it quite well.'

29. On 14 May, the personal officer was informed by Physical Education Officer (PEO) that, due to poor attendance, the man was off the gym list and would need to reapply if he wanted to use the gym.

30. On 15 May, a letter addressed to the Governor was faxed to the prison by the man's solicitors. This said the man was depressed and had suicidal thoughts. The letter said that the man was 'suffering from a depressive state of mind and has shown an inclination to suicidal thoughts.' The solicitors asked the prison 'for appropriate supervision' for the man 'to avoid any unforeseen events.' The fax is timed at 4.16pm.

31. On 16 May, there is an entry in the Wing Observation log noting the concern from the man's solicitors regarding his intention to self-harm: 'Received phone call from the prison officer (legal visits) who received a fax from said prisoner's solicitors. Stated that prisoner said he felt suicidal. Asked the officer to send copy of the fax to E wing. The man could not be interviewed because he was on Alpha course this a.m. Needs interviewing this afternoon.' The man made a five minute

telephone call to his parents in his home country that afternoon and the wing officer spoke to him after that. He noted in the man's core record, and said in interview, that the man told him he was not suicidal and was 'ok'. He wrote, 'I explained the support mechanisms that we have in place in Bullingdon, ie Chaplaincy, Listeners, Samaritans phone, staff support. He said he will be ok and thank you for the phone call.' The wing officer did not consider it necessary to open an ACCT form for the man. (It is not clear whether the wing officer was aware of the concerns raised when the man had arrived at Bullingdon six months previously.) There is a note by the wing SO, dated 17 May, on the letter from the solicitors indicating that staff had spoken to the man.

32. On 21 May, the second wing officer noted in the man's core record that he had introduced himself as the man's new personal officer. The officer wrote that the man was trying to improve himself and his general attitude after he had addressed him about the previous entries. The officer also noted that he had started to let the man help wing cleaners and that he had regular visits from his family and associated with a small group of prisoners. There were no current issues.

33. On 1 June, the man's personal officer recorded that there were still no problems with the man. He also said that the man was continuing to try to get on the wing cleaners list and had offered to help out in the mornings and afternoons. He said that the man was still associating with the same prisoners and in his opinion was being influenced by others in the group. The officer was going to try to encourage him to break away from this crowd and make his own choices.

34. On 2 June, the man appeared again at the Crown Court. He returned to the prison and was seen in reception and said he was fit. On the same day, there is a note in his core record that he went to the visits hall as he had a visit booked. However, he asked to leave shortly after as his visitor did not turn up and he said the children in the visits hall were bothering him. It is not clear what he meant by this and there is no visit listed in his visits record for 2 June.

35. On 6 June, the man changed the next of kin details he had given to the prison from his partner to his sisters. On 12 June, the man again appeared at the Crown Court and his case was adjourned for trial.

36. On 15 July, the personal officer noted, 'Remains a quiet lad but still hangs around with the wrong crowd. Gets on ok with staff and other peers, no issues.' On 28 July, the officer again noted that the man did not have any issues.

37. On 4 August, the man made a five minute telephone call to his parents in his home country and was said to be in good spirits after the call. On 12 August, the personal officer noted that the man was still a fairly passive member of the wing and that his regular visits from his family and friends were his highlights. He recorded that the man was

currently an unemployed industrial cleaner but that would soon be rectified. When interviewed, his personal officer said the man would have applied to become an industrial cleaner and part of the application process involves getting security clearance. He was not sure how far his application had progressed, but he explained that he always encouraged him to help out with the wing cleaning.

38. On 8 September, the man appeared at the Crown Court and the date of his trial was to be fixed. On 16 September, he had visits from his brother-in-law, and his sister. Prisoner A said he was aware that the man spoke about his ex-partner to his brother-in-law but he was not aware of the details of the conversation.

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39. In interview, the man's solicitors recalled that he saw the man in the late morning of 18 September. He said the man was concerned that he was no longer able to see his child and felt let down by his ex-partner. The solicitor said that he explained to him that legal aid could be obtained for a solicitor specialising in family law, but the focus for most of the meeting was the forthcoming trial. He said the man seemed to accept this, and acknowledged that this was the priority. The legal visit lasted for approximately 90 minutes, of which ten minutes was spent talking about access to the man's son. The solicitor did not have any concerns about the man's state of mind when the legal visit concluded in the early part of the afternoon.

40. The wing officer escorted the man to the legal visit. She recalled in interview that he did not talk to her, but did chat with another prisoner as he was being escorted to the Healthcare Centre at the same time. Prisoner B was located in the cell next to the man and spoke regularly to him. Prisoner B has told police and my investigators that he saw the man in the afternoon when they were both being escorted by the wing officer. He said the man told him he was frustrated at the length of time he had been on remand and told him he was generally fed up with everything. He said the man appeared to be more open than usual when they were talking. In his opinion, the man's talk about being fed up was the usual talk from prisoners and he did not think it was said seriously. He said the man mentioned he was upset with people outside the prison, perhaps with his family, but he was not sure. The man complained that his trial was taking a long time. He said that the man was fed up and said things like 'you feel like ending it here'. He thought this was out of character but was not concerned about him after their conversation and did not tell any members of staff. (Information from others indicates that the man met his legal representative late in the morning.)

41. Prisoner B told my investigators he saw the man again in the evening when they were in the queue for food. He said the man looked jolly, although he could see in his eyes that he wanted to talk but it was too public an area to engage to do so. The PEO2 escorted some prisoners to the gym. She remembered the man using the gym on previous occasions.

42. The wing officer opened the cell door to let prisoner A, the man's cellmate, go to the gym at around 6.00pm. Prisoner A recalled that, when it was announced over the tannoy that it was time for the gym, the man pressed the cell bell to let staff know prisoner A wanted to go. In hindsight, prisoner A considered this was unusual and out of character for the man. The man said 'see you later'. Prisoner A recalled that the man had been 'a little despondent' and had been having trouble sleeping for a few months.

43. Prisoner B did not go to the gym. He said he realised that the man was on his own in the cell when he heard banging coming from his cell next door. He explained to my investigators that this was not unusual as prisoners often do this to let each other know if there is anything interesting on television. There is no evidence that prisoner B spoke to any member of staff about this.

44. At around 7.25pm, the wing officer and PEO2 were locking prisoners back in their cells after gym. The wing officer was locking up cells 132-148 on the left and the PEO2 was locking up cells 162-149 on the right. The wing officer arrived at the man's cell at around 7.27pm. She opened the observation flap on the cell door and looked in. The wing officer described what happened in interview, in her incident report and in her police statement. In her police statement, she said that it was getting dark and the lights were off and she saw a white shoe lace coming from the top bunk and down at an angle. She unlocked the cell door (E145), and called to the PEO2 there was a level 1 emergency. (A Level 1 emergency is a call for medical assistance and indicates a serious medical emergency.) She removed prisoner A, the man's cellmate, from the area and asked him to wait upstairs. Again in her police interview, she said 'it went through my mind that the man had hung himself.' She recalled the man had his back to her and it looked like he was crouched down. She did not go in as there were other prisoners who still had not been secured in their cells. She said she was 'very conscious for everybody's safety'. She locked the other prisoners up, with the help of the PEO2.

45. Prisoner A recalled that he returned from gym and waited outside the cell. He spoke briefly to prisoner B through his cell door. He was taken to healthcare and was later told the sad news of the man's death.

46. PEO2 said in her incident report and police statement that she responded to the wing officer's call for help and, after she had looked in the cell, she called the Level 1 emergency over the radio. With the wing officer, she continued to lock up other prisoners who had returned from the gym. She also helped to move prisoner A away from the area.

47. PEO3 heard the emergency call and arrived at the cell at around 7.30pm. The wing officer returned and gave PEO3 her anti-ligature knife. He cut the ligature (white shoe laces) from around the man's neck and unravelled it. He said he checked for but could not detect any pulse. PEO3 opened an airway to check for breathing but could not detect any breath present. He asked for a barrier mask to commence Cardiopulmonary Resuscitation (CPR) but no member of staff had one. He began CPR without a barrier mask and gave him two rescue breaths. He checked for circulation but noticed that the man was cold to touch. The wing officer cut the shoelaces from around the man's ankles then left the cell.

48. The principal officer (PO) arrived and assisted PEO3 with CPR. Three nurses arrived around 7.35pm. Nurse1 saw the PO and PEO3 performing CPR and took over with Nurse2. Nurse2 asked PEO3 how long he had been doing CPR, and he replied approximately five minutes. Nurse3 saw Nurse2 apply the oxygen mask and airway. The duty SO responded to the emergency call and arrived with the Duty Governor. The three nurses were in the cell. An ambulance was called around 7.31pm. The PEO3 re-entered the cell to take over chest compressions from Nurse2 until the paramedics arrived in the cell at around 8.00pm and pronounced the man dead.

49. The duty SO spoke to prisoner B, who was distressed, and the prisoner then spoke to a Listener. The cell was sealed following the arrival of the police and the removal of the man's body at around 8.37pm.

ISSUES

Family concerns

50. The man's sister was concerned about the contact from the prison after her brother's death, and was very upset by the way in which her family were notified. She told my family liaison officer that a police officer was sent to her home to break the news on 19 September at around 9:30am. However, she was at work so, unable to inform her in person, the officer contacted her elderly parents in their home country. The sister had by this time sought permission to leave work early. On arriving home she was presented with a number for the police officer who had seen her younger sister. However, she explained that despite numerous attempts she was unable to contact him. By this time, her family abroad had contacted her and confirmed her brother had died. She said she then telephoned the prison but they would not give her any information and were insistent that she speak with the police.

51. The man's sister said that she did not receive any further contact on 18 September or the next day, from either the police or the prison. She said she has since found out that the police initially called at her home at midnight on Monday 18 September to notify her. However, when no one answered, they left. She said that on 20 September an article appeared in the local paper about her brother's death which reported that he had died on 19 September, not 18 September. She said she contacted the paper that day to ask for information.

52. The sister told my family liaison officer that she spoke to the Deputy Governor and family liaison officer at Bullingdon, on 21 September and was anxious to establish the circumstances surrounding her brother's death. She said he confirmed that her brother had died on Monday 18 June. However she did not feel she was given even basic information. The sister felt generally that all subsequent contact with the prison was largely initiated by her. She said the prison was not forthcoming either in providing information or in making arrangements such as for her to view her brother's body or see his cell. Finally, she said she was not invited to meet the governing Governor of Bullingdon, and was upset that no member of the Prison Service visited her at home.

53. Prison Service Order (PSO) 2710 provides guidance on liaison with bereaved families. The guidance provides a recommended option for delivering the news of a prisoner's death and explores the issues to be considered when taking the decision on how to do this (paragraphs 4.7 to 4.14). The PSO recommends that the news is broken to a family as soon as possible after the death, face to face, by a dedicated Family Liaison Officer along with the Chaplain, Governor or most senior individual available. The PSO indicates that asking the police to break the news of a death is, generally speaking, poor practice although it does explain that in certain circumstances this may be necessary. In deciding whether the police should be asked to break the news of a

prisoner's death, the PSO encourages Governors to consider the following (paragraph 4.12):

- The prison should demonstrate its duty of care and show that it is taking the death seriously by making a personal visit.
- Failure to make a personal visit can sour the prison's entire future relationship with the family.
- Families who have experienced deaths in custody say they prefer a personal visit and regard anything less as a shirking of responsibility.
- The police officer deployed to speak to the family may not be trained in breaking bad news or know anything about prisons. Many police forces have dedicated trained family liaison officers but it is likely that an untrained local police constable will be tasked with visiting the family, especially at night.
- The police officer will have limited information about the incident and it is frustrating for families not to have access to all the information they want.

54. The duty governor at the time of the man's death said she was told by the officer in charge of the police investigation not to speak to the man's family until the police had done so. The police told the prison they would contact them when they had spoken to the man's family. The duty governor passed that information on to Governor of Bullingdon. The duty governor explained that the police had not telephoned Bullingdon by the morning of 19 September, despite efforts by the prison to contact them.

55. The duty governor said that a governor spoke with the man's sister on 19 September after she had contacted the prison. A second governor spoke with the man's sister on 20 September and took a message after which the first governor returned her telephone call. The duty governor spoke to the sister on 21 September, again after she had contacted the prison. The man's sister went to Bullingdon on 26 September accompanied by other family members. Before the family went to the cell they visited the chapel where they prayed for the deceased. The family then visited the man's cell and his sister spoke to his cellmate, prisoner A. After visiting the cell the family returned to the chapel.

56. The prison provided financial assistance towards the funeral costs. They contributed towards repatriating the man's body to his home country and towards a plane ticket for one family member. They also contributed towards the cost of the wake.

57. There is some inconsistency in the accounts given of contact between the man's family and the prison which I simply report. Clearly the man's sister has found her contact with the prison frustrating, and I do feel the prison could have been more proactive in their contact with the family. In any event, I am firmly of the view that the police should only be asked to break the news of the death, without prison staff in

attendance, when distance and the time of night make this truly necessary. In addition to assessing the practical difficulties of asking staff from another prison to deliver the news of a death, the decision over whether to ask police to break the news of the death should take into account the way this may be perceived by the family. (This is a point made in the PSO and perhaps borne out by what I have recorded here.) While I do not make a formal recommendation, the Governor should ensure that the guidance on liaison with bereaved families in PSO 2710 is followed in all cases.

58. The man's sister asked what had been done to risk assess her brother's cell. She also believed her brother's work applications had been refused and she questioned why prison officers would not provide him with reasons for this.

59. My investigators found that the man was appropriately placed overnight in a ligature free cell when he first arrived at Bullingdon. There was no subsequent indication that he was at special risk by being located in an ordinary cell. An appropriate cell share risk assessment was completed and the man was then properly located in a shared cell on E wing.

60. The man completed an Industrial Cleaning course between December 2005 and April 2006. Work activity for this takes place in the visits hall during the morning. As a remand prisoner after completion of the industrial cleaning course he would only be required to work if he completed an application for employment. My investigator has not been able to discover why he stopped working. The prison does not have any information either on his apparent outstanding work application as they only keep records of work applications for six months.

61. The personal officer entry in the man's core record on 21 May clearly says that he had started to let him help out wing cleaners. The officer said in interview, "I tried to get him out of his cell to make him feel worthwhile by encouraging him to do the cleaning. After his training to become an industrial cleaner I let him help cleaning on the wing, needed to get him security cleared for him to be further employed. There are 8 or 9 cleaners on the wing. I am not sure how far he got with the security clearance. He would have put an application in to do the job. In the meantime I always encouraged him to help with the cleaning on the wing."

62. The man's sister felt her brother was sometimes singled out at the prison. She questioned why he was always strip searched before prison visits. The sister asked whether it was usual for prison officers to know about prisoners' medical conditions. I have found no evidence that the man was singled out at the prison or that he was strip searched before prison visits. This would have been recorded in security records and in the man's core record. There is no evidence

either that prison officers were aware of any medical conditions that the man had or that the confidentiality of his medical record was breached.

63. On the day of her brother's death, the sister understood that he had been banging on his cell wall, calling out for prisoner B who was in the cell next to him. She believes prison officers spoke with prisoner B. However, she questioned why they did not talk to her brother directly about the incident. Prisoner B explained in interview that prisoners often bang on their cell walls usually to alert each other about an interesting programme on television. There is no evidence that prison officers spoke to prisoner B about this before the man's death.

64. The man's sister mentioned that her brother had not gone out for association for two weeks prior to his death and questioned why this was not picked up by staff. Again, I have found no evidence to substantiate that the man had not gone out for association for two weeks before his death. Certainly, there is nothing noted in his core record to that effect.

65. The sister asked whether it was normal practice for prisoners on remand to share cells with those already sentenced. If a prisoner on remand shares a cell with a sentenced prisoner the remand prisoner has to sign a disclaimer form. In this case the man shared a cell with prisoner A, a sentenced prisoner, between April and September 2006. There is no evidence that the man signed a disclaimer form. I draw this to the Governor's attention.

66. The man's solicitor told my investigators about the meeting he had with the man on 18 September. He recalled that the man was upset that he was no longer allowed to see his son. The solicitor said he explained to him that legal aid could be obtained for a solicitor specialising in family law, and the focus of the meeting was on his impending trial. The solicitor said the visit lasted for approximately 90 minutes. Ten minutes were spent talking about access to the man's son, the rest of the time being devoted to discussing the trial. He did not have any concerns about the man's state of mind when the legal visit concluded.

Clinical review

67. On 25 September 2006, my investigator asked North Oxfordshire Primary Care Trust to conduct a clinical review of the man's treatment in custody.

68. In his review, the clinical reviewer says, 'full and appropriate resuscitation was implemented. Whilst the risk of serious infection being transmitted by mouth-to-mouth resuscitation is low, it would have been prudent for all attending staff to have had a resuscitation mask immediately available.'

69. Prison Service Order (PSO) 3845, Blood Borne and Related Communicable Diseases, Chapter 2 section 6 'Resuscitation' states: 'Existing standards of good practice are designed to protect both the giver and receiver of resuscitation. It would be unethical to refuse resuscitation to anyone on the grounds that they may be infected with HIV, hepatitis B or C, or tuberculosis, and the best precaution against infection is to follow procedures correctly. Prison healthcare staff must be trained in the use of resuscitation aids for use in mouth to mouth resuscitation, as must any staff who carry them. Brookes airways or similar resuscitation aids are included in first aid packs widely available in all establishments, but must only be used by those trained to do so.'

70. In this case, staff who were immediately involved did not have barrier masks. As staff may be called on to perform mouth to mouth resuscitation, they must have immediate access to barrier masks. This is to reduce the chance of transmission of infectious disease from the victim to the person attempting resuscitation. There are a number of small systems that are available that could be carried unobtrusively on officers' belts. I believe masks are not issued to all staff.

    The Governor should ensure that staff who may be called on to perform mouth to mouth resuscitation have immediate access to barrier masks.

71. The clinical review considered whether an ACCT should have been opened on 16 May following the concerns raised by the man's solicitors. I agree with the conclusion reached by the clinical reviewer: 'The documented response to concerns raised by the deceased's solicitors is brief, and no new ACCT plan was instituted then. The tone of the solicitor's letter is sufficiently strong that a Medical/Psychiatric assessment might have been felt to be appropriate. It seems however that the conversation that took place as soon as possible between the PO and the deceased was reassuring, and indeed no untoward incident followed at that time to suggest there had been an error in judgement in not requesting a further opinion.'

72. I have reflected on whether it was correct for the officers who discovered the man hanging to continue to lock prisoners up rather than immediately entering the cell. Bullingdon's Contingency plan for dealing with a death in custody instructs the first person on the scene: 'You may enter a cell alone, your priority is to preserve life. However, you need to balance this against any security or safety concerns.' I suggest that consideration should have been given to one of the officers locking up the remaining prisoners while the other attended to the man. However, I appreciate that the officers had to make an instant assessment of a very difficult situation. They decided that the appropriate course of action was to finish locking up the remaining prisoners. I feel this was a not unreasonable course of action in the circumstances described.

Conclusion

73. In retrospect, it may now seem apparent that the man was in distress over the long period he had spent on remand and the pressure of his impending trial. However, neither staff nor prisoners believed he was at special risk. In the circumstances, I do not believe that his actions could have been predicted.

RECOMMENDATION

The Governor should ensure that staff who may be called on to perform mouth to mouth resuscitation have immediate access to barrier masks.

The Prison Service response to the recommendation:

'Barrier masks are available for staff to carry if they wish. There are grab boxes on each residential unit held in the unit office to be used in such instances which contain a barrier mask. In light of this recommendation the Governor will review the system and reinforce the availability of resuscitation.'