

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

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

Our Vision

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

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Bullingdon in August 2013. He was 26 years old. I offer my condolences to his family and friends.

A review of the clinical care and treatment the man received at Bullingdon was also undertaken. Staff at Bullingdon cooperated fully with this investigation.

The man was remanded to HMP Winchester on 28 January 2013, charged with affray and damage to property. The offence was directed against his former partner. He was convicted on 18 February and sentenced to fifteen months imprisonment, with a release date of 27 September 2013. On 5 May, he transferred from Winchester to Bullingdon prison.

The man had no contact with healthcare staff at Bullingdon other than his initial routine health checks. He was not taking any medication. He had not been identified as a risk of suicide or self-harm.

On the day of the incident the man was asked to move cells but refused to do so. At a subsequent disciplinary hearing he was punished by three days cellular confinement in the prison's segregation unit. When he returned to his wing, his original cell was no longer available and he refused to go to the only vacant cell. He was taken back to the segregation unit where he collected his lunch and was locked in a cell at 12.00pm. At 12.30pm, staff found that he had hanged himself. They began cardiopulmonary resuscitation and called for an emergency ambulance. When paramedics arrived, they confirmed that he had died.

When the man was first remanded to Winchester, he was not identified as at risk of suicide, although he had previously made suicide attempts and had just been arrested for a violent act against a family member. Staff at the court had been sufficiently concerned about him to alert the mental health team at Winchester, but it does not appear that any member of mental health team went to see him. However, he did not display any behaviour later in his sentence which indicated he might harm himself and we cannot know whether earlier intervention and support would have helped avoid his later actions. Overall, I am satisfied that he received appropriate care at Bullingdon and that staff there could not have foreseen or prevented his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was remanded into custody at HMP Winchester on 28 January 2013, after being charged with affray and damage to property after a very violent incident directed at his former partner. Staff at the magistrates' court raised a suicide and self-harm warning form and referred him to the mental health team at HMP Winchester, but no further action was taken. He had been in prison before. He was convicted on 18 February and sentenced to one year and three months, with a release date of 27 September 2013.
2. On 5 May, the man transferred to Bullingdon pending his release in September. Other than a reception health screen, he did not have any contact with members of healthcare staff at Bullingdon. He was not prescribed any medication and was not identified as a risk of suicide or self-harm.
3. In July, the man was asked to move cells but refused to do so and was charged with an offence under Prison Rules of refusing to comply with a lawful order. At the subsequent disciplinary hearing, he was punished with three days cellular confinement which he served in the prison's segregation unit.
4. On a morning in August at approximately 11.30am, the man returned to his wing after serving his punishment, but refused to go to the only cell that was available. He was taken back to the segregation unit where he collected his lunch and was locked in a cell at 12.00pm. At 12.30pm, staff found him hanging in his cell. They began cardiopulmonary resuscitation and called for an emergency ambulance. Sadly, when paramedics arrived they confirmed that he had died.
5. We do not think that staff could have been expected to predict or prevent his actions on 2 August. However, we are concerned that staff at Winchester did not identify that the man might have been at risk of suicide or self-harm despite being advised of this by court staff. We make two recommendations about this to HMP Winchester. The emergency response when he was found hanging in his cell was swift and appropriate.

THE INVESTIGATION PROCESS

6. The investigator visited Bullingdon on 8 August 2013 and obtained relevant records about the man. Notices were issued to staff and prisoners inviting anyone with information to contact him. He met the Governor and interviewed ten members of staff and two prisoners at Bullingdon on 2 and 4 September. Written feedback about preliminary findings was sent to the Governor on 5 September.
7. The investigator spoke to the Chair of the Independent Monitoring Board (IMB) by phone on 12 August and agreed to give some feedback about the investigation to the IMB after the interviews. On 4 September, he asked the prison's liaison officer to arrange this but, when he asked to see the IMB later that day, he was told that the IMB representative had already left the prison.
8. NHS England appointed a clinical reviewer to review the man's clinical care at HMP Bullingdon
9. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. The investigation report has been sent to the Coroner.
10. One of the Ombudsman's family liaison officers contacted the man's family to inform them about the investigation and to invite them to identify issues they wanted the investigation to consider. The family wanted to know:
 - Had he harmed himself and, if so, how often?
 - Was he on any sort of monitoring or being observed?
 - What arrangements were being made to find him accommodation when he was released from prison?
 - What happened and why did he take the action he did?
 - Was he being bullied?

These issues have been addressed in the report. The family and legal representative received copies of the draft report. Written representations were provided on behalf of the man's mother. Although the comments provided have led to no changes in the investigation report, we have sought to provide clarification by way of separate correspondence to her legal representative

HMP BULLINGDON

11. Bullingdon opened in 1992, and is both a training prison and local prison serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 male prisoners.
12. Healthcare services at Bullingdon are provided by Virgin Healthcare. There are a minimum of two nurses on duty at all times, including throughout the night.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons conducted an unannounced inspection of Bullingdon in July 2012. Most prisoners reported feeling safe but some said they felt threatened and processes to manage bullies needed improvement. Relationships between staff and prisoners were mostly good but there were concerns about a minority of officers. Many prisoners shared cells designed for one. There was insufficient purposeful activity. There was a good and up-to-date strategy to prepare prisoners for release and practical support to help with housing and employment. There was a wide range of programmes to address offending behaviour. Inspectors reported that levels of self-harm were relatively low for the type of population.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recent annual report for 2011-12, the IMB was concerned about what it described as the inadequate provision of healthcare services. The IMB was satisfied that suicide and self-harm prevention procedures operated efficiently and with compassion.
15. The IMB noted that there had been a reduction in numbers of prisoners held in the segregation unit and that previously many prisoners who had refused to move to different accommodation or wanted to have a single cell had gone to the segregation unit. This had been addressed by charging prisoners under disciplinary procedures and the possibility of exemplary punishments had reduced the number of prisoners refusing to relocate.

Previous deaths at HMP Bullingdon

16. The man was the fourth prisoner at Bullingdon to die since January 2013 and the second self-inflicted death. There are no similarities between that death and the man's.

KEY EVENTS

17. The man was born in September 1986. He was remanded into custody at HMP Winchester on 28 January 2013, charged with affray and damage to property. This was a violent offence directed at his ex-partner, and police negotiators were called to assist at the scene. While he was at Magistrates' Court, his solicitor raised concerns with court staff about his state of mind. The escort court staff raised a suicide and self-harm warning form as his solicitor was concerned about his state of mind and risk of suicide. The court custody staff at the court made a referral to the mental health team at Winchester because there was concern that his mental health was poor and suggested it was possible that he had drug induced psychosis.
18. When he arrived at Winchester, the man saw a nurse for an initial health screen (this takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide).
19. The man told the nurse that he had been in custody before, that he did not drink alcohol but smoked cannabis regularly and was not on any prescribed medication. He told the nurse that he had previously harmed himself, the last time in 2006, when he had cut his arms. He said he had no current thoughts of harming himself. The nurse recorded his weight, height and blood pressure which indicated no concerns.
20. On 5 February, the man was discussed at the mental health in-reach team referral meeting. A nurse noted that there was no indication from his medical record that he had a serious mental health problem, and advised him by letter to see a GP if he had any problems. There is no indication that a member of the mental health team saw him in response to the concerns raised at court.
21. On 18 February, the man was convicted and sentenced to 1 year and 3 months imprisonment, with a release date of 27 September 2013. When he arrived back at Winchester, a nurse recorded that he was not in a low mood and said he felt able to cope with his sentence. He was offered an appointment on 25 February with a health promotion specialist to discuss advice about giving up smoking but he chose not to attend.
22. While at Winchester, the man was employed as a kit orderly. His prison records show that he was polite and respectful to staff and adhered to the prison regime.
23. On 5 April, the man transferred to HMP Bullingdon. When he arrived, a nurse conducted an initial health screen and noted that he had not been prescribed any medication, said he had no thoughts of harming himself. His blood pressure was within a normal range. He asked to join the smoking cessation group.
24. An officer saw the man to complete a first night information document. He told the officer that he smoked and had used drugs in the past but was now drug free. He said that he had been in prison before, had no thoughts of harming himself. He told the officer that he was not a member of any gangs and was

not aware of anyone in Bullingdon who might try to harm him. He nominated his ex-partner as his next of kin and emergency contact.

25. On 10 April, a supervisory officer completed a cell sharing risk assessment (which assesses the risk of violence that a prisoner poses to others he might share accommodation with). He judged that the man was a high risk but was suitable to share provided he did not to share a cell with any prisoners from a black or minority ethnic background. The form also noted that he was a smoker.
26. On 6 April, a nurse conducted a second health screen (a more in-depth assessment of physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide). The nurse recorded that the man had no physical or mental health problems, was not on any prescribed medication and had no thoughts of harming himself. He told the nurse he smoked four rolled cigarettes a day.
27. The man initially lived in a cell on Blackthorn Unit and then moved to a cell on Arcott wing. His personal officer (who should be a prisoner's first point of contact and support for any concerns) on Arcott Unit told the investigator that she had read his case notes and was aware that he had received a behaviour warning for refusing to go to his cell at the end of an association period when he was on Blackthorn Unit. She told the investigator that behaviour warnings are issued for minor incidents that do not warrant being placed on a formal disciplinary charge. Accumulation of a number of behaviour warnings could result in a loss of privileges under the prison's incentives and earned privileges scheme which is designed to encourage good behaviour. She encouraged him to make a fresh start on the unit and offered to arrange employment for him
28. On 17 June, the man was found smoking in the toilet area by an officer for which he received a behaviour warning.
29. On 8 July, the man's personal officer recorded in his prison records that there had been a marked improvement in his attitude. He was employed as a wing painter and worked to a good standard. He volunteered to work at the weekend, worked unsupervised and worked well with the other wing painters.
30. On 19 July, the man's offender manager (probation officer) visited him to discuss his release arrangements. She told the investigator that he only wanted to live in the Andover area and hoped to live with his father. She explained to him that because of his previous convictions and the risk of re-offending, he would be monitored by the Probation Service and that if he was unable to live with his father then he would be given a place in an approved premises (probation hostel). She told the investigator that a decision about his accommodation would have been made a couple of weeks before his planned release.
31. On 29 July, for logistical reasons the man was asked to move to a different shared cell on Arcott Unit, because there had been an influx of prisoners. He was asked to move to share a cell with a prisoner who was a non-smoker but refused. (The exact reason why he needed to move is not clear but it appears he had said he no longer smoked so officers thought it would be appropriate to

move him to share with another non-smoker.) An officer explained to the investigator that Bullingdon has a strict policy about prisoners who refuse to move as prisoners often refuse to move from the Finmere Unit, where all the cells are single. Under the policy, if a prisoner refuses to move cell they are immediately placed on the basic regime under the incentives and earned privileges scheme. (This means that they lose their television and have restricted association time and lose other privileges.) The next day, the prisoner is asked again to move and if he still refuses, is formally charged with a disciplinary offence under Prison Rules for disobeying a lawful order.

32. On 30 July, an officer asked the man to move cells again. He told him that he would remain on the unit and would keep his job, but that population moves meant that prisoners could not always remain in the same cell. He still refused to move and told the officer that he did not care if he was placed on report. The officer charged him with a disciplinary offence under Prison Rule 51, paragraph 22 (disobeying a lawful order).
33. On 31 July, the deputy governor heard the charge against the man. He had no questions about the process and pleaded guilty to the offence, but said that as a smoker he should not have been asked to move to a non-smoking cell. He said he had been trying to give up smoking but had started again. She asked him if had ever told staff that he did not smoke and he said no. He said that he was just not prepared to move. She asked him if the reason for his refusal to move was because he was being asked to move to a non-smoking cell and he said that this was not the issue.
34. The deputy governor told the investigator that she had tried to explore whether the order that the man had been given to move was reasonable. Irrespective of where, or what type of cell it was, he told her that he was not prepared to move.
35. The deputy governor concluded that the order for the man to move cells was reasonable and therefore lawful. He was found guilty and punished by three days cellular confinement which he was required to serve in the segregation unit. In addition, he was not allowed to work, lost his canteen facilities, association time and television for the same period.
36. The man went to a cell in the segregation unit immediately after the hearing. A Supervisory Officer (SO) told the investigator that the segregation unit regime does not allow prisoners to associate with each other. They are allowed out of their cells individually to collect meals, have showers, exercise and make phone calls. While a prisoner is segregated a member of healthcare staff and the duty governor is required see them each day.
37. At 11.55am, a nurse checked on the man, completed an initial segregation health screen and recorded that there were no health concerns. Later that afternoon a prison doctor also checked on him and recorded that there were no concerns.
38. On 1 August, at approximately 2.00pm, a nurse checked on the man and recorded that he appeared settled and had no health issues. The SO told the investigator that the man interacted well with staff, complied with the regime and staff were not concerned about his welfare.

39. On the day of the incident, after breakfast, the man was told that his cellular confinement period had ended and he would be returning to Arncott Unit that morning. At 11.00am, he was taken back to Arncott Unit, but once there he refused to move into the shared cell he had been allocated on Spur 2, as it was not his original cell which was on Spur 1.
40. When interviewed, a SO said that on that day there were no spaces on Spur 1 on Arncott Unit and the man was told he would have to be allocated a cell on spur 2 (there are three spurs on Arncott unit) but he refused. He was given an order to occupy a cell on spur 2 but again refused. He was again charged with refusing an order and he was taken back to the segregation unit.
41. At 12.00pm, the man was let out of his cell in the segregation unit to collect his lunch, which he then took to his cell to eat. At approximately 12.30pm, an operational manager began the daily duty governor's rounds of the segregation unit.
42. The operational manager explained that the purpose of the duty governor's check is to give prisoners an opportunity to raise any concerns or complaints with managers in person and to check on prisoners' well-being. A SO accompanied the operational manager on his rounds.
43. When they arrived at the man's cell at 12.32pm, the SO opened the observation panel and saw him hanging from the light fitting by a ligature made from torn bedding. The SO and the operational manager immediately went in, cut him down and began cardiopulmonary resuscitation (CPR). At 12.33pm, a segregation unit officer radioed a code blue (an emergency code that identifies that a prisoner is unconscious or is not breathing). An emergency ambulance was called at 12.35pm.
44. Healthcare staff responded immediately and took over the resuscitation attempt. A prison doctor attended. She said that an automated external defibrillator was used. (This monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary.) The defibrillator advised that there was no shockable rhythm.
45. CPR continued and the doctor gave the man two doses of adrenaline (to increase heart rate and blood pressure) and several doses of atropine (to increase heart rate) in line with resuscitation guidelines, however this had no effect. Paramedics arrived at the cell at 12.57pm, and after a short assessment and consultation with the doctor, it was confirmed that he had died.

Contact with the man's family

46. After the man's death, the operational manager contacted the Governor of Haslar Immigration Removal Centre (which is run by HM Prison Service on behalf of the Home Office) for help in breaking the news to the man's nominated next of kin, his ex-partner. His ex-partner lived in Gosport, which the prison judged was too far for someone from Bullingdon to visit and get the news to her quickly. That afternoon, the Governor broke the news in person and offered support. Bullingdon maintained contact with the family to provide ongoing support and offered financial assistance towards the funeral expenses, in line with national guidance.

Support for staff and prisoners

47. A debrief was held on the afternoon of the man's death for staff involved in the emergency incident to discuss what had happened and to offer support. They were offered the services of the prison's care team.
48. Officers and members of the chaplaincy supported prisoners affected by the man's death. Prisoners assessed as at risk of suicide or self-harm were reviewed in case they had been adversely affected by his death.

ISSUES

Assessment of risk

49. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners assessed as at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. We have considered whether the ACCT process should have been used for the man.
50. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. A prisoner's presentation is obviously important and reveals something of their level of risk, but all risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged.
51. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action". The PSO lists a number of risk factors and triggers for suicide. Potential triggers and risk factors include previous deliberate self-harm, mental illness and early days in custody. Prisoners charged with an offence of violence against another person, especially against family members or partners are regarded as at heightened risk.
52. When the man arrived at Winchester, he had just been arrested for a very violent offence, which was related to his domestic circumstances. His solicitor was concerned about the risk of suicide and alerted staff at Magistrates' Court who completed a suicide and self-harm warning form. A referral was also made to the mental health team at HMP Winchester. However, he was not seen by a member of the mental health team and they did not discuss his case for over a week after he arrived there. There is no record that his heightened risk because of his offence and the alert from court was considered by staff in reception when assessing his risk of suicide and self-harm. We make the following recommendations:

The Governor of HMP Winchester should ensure that that reception staff check and record all relevant documents and that all the known risk factors of a newly-arrived prisoner are fully considered and documented when determining his risk of suicide or self-harm.

The Head of Healthcare at Winchester should ensure that prisoners are assessed in person when a mental health referral is made from court.

53. At the time of his death, the man had only a further eight weeks of his sentence to serve. In most cases, his proximity to release would have been regarded as a protective factor. Other than his earlier self-harm, which was some years previously, and the circumstances of his offence, which was seven months earlier, there were no obvious known risk factors which would have led anyone to consider that he was at risk of suicide, especially as his potential risk had not

been highlighted when he arrived at Winchester. He gave no indication to staff at Bullingdon that he had thoughts of taking his own life.

54. The investigator has established that during his current sentence the man received only one visit while at HMP Winchester and no visits at Bullingdon. From his arrival into custody on 28 January until his death, he made no phone calls whatsoever so had very little outside contact. He no longer had anywhere to live. Although release is usually a protective factor, it is possible that the prospect of release without settled accommodation and support in the community was preying on his mind in the days he spent in segregation.
55. We have considered whether or not the man had been bullied while at Bullingdon. The investigator liaised with the security department to establish if there was any intelligence that directly linked any allegations of bullying to him. He read over 200 security documents but found no evidence to suggest that he was the victim of bullying.
56. The clinical reviewer commented in his report that he did not think that staff had overlooked any warning signs. The short time left on the man's sentence made it all the more difficult to understand the reasoning behind the action he took and it appears an extreme reaction to being required to move cells. There is no obvious explanation for his action and we do not believe that the prison could have predicted or prevented his death.

Clinical care

57. The clinical reviewer noted that the man had very limited contact with healthcare staff during his time at Bullingdon. He was assessed for physical and mental health issues by triage assessment, the same method used in the community. The clinical reviewer has found that his contacts with medical staff and levels of care were appropriate.

Emergency response

58. The clinical reviewer commented in his report that the staff response when they found the man was immediate and cardiopulmonary resuscitation was begun appropriately, without any hesitation. All required emergency procedures were followed.

RECOMMENDATIONS

1. The Governor of HMP Winchester should ensure that that reception staff check and record all relevant documents and that all the known risk factors of a newly-arrived prisoner are fully considered and documented when determining his risk of suicide or self-harm.
2. The Head of Healthcare at Winchester should ensure that prisoners are assessed in person when a mental health referral is made from court.

Action Plan: The Man - HMP Bullingdon and HMP Winchester

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor of HMP Winchester should ensure that that reception staff check and record all relevant documents and that all the known risk factors of a newly-arrived prisoner are fully considered and documented when determining his risk of suicide or self-harm.	Accepted	Reception staff will check all available documents and known risk factors of newly arrived prisoners when determining the risk of suicide or self harm. They will record any alerts that have been raised by court or escort staff.	20th January 2014	
2	The Head of Healthcare at Winchester should ensure that prisoners are assessed in person when a mental health referral is made from court.	Accepted	All prisoners are screened on entry to HMP Winchester by a nurse and any concerns raised the prisoner is referred to the appropriate agency. All referrals to the Prison CMHT will be forwarded to them.	27th January 2014	