Investigation into the death of a man whilst in the custody of HMP Bedford, at Bedford Hospital South Wing in September 2010

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of the investigation into the death of the man, a prisoner at HMP Bedford, who died at Bedford Hospital.

I extend my condolences and those of my colleagues to the man's family and those that knew him. I trust this report goes some way to answering any questions they may have. I apologise for the delay in issuing this report and for any additional distress this may have caused.

The investigation into the man's death was undertaken by one of my investigators. A clinical review into the man's care was undertaken by a clinical reviewer, Quality Monitoring Manager from NHS Bedfordshire. I am grateful to the clinical reviewer for her thorough review, a copy of which is annexed to this report. Its recommendations are also summarised at the end of this report.

I would also like to thank the Governor of Bedford and his staff for their help and assistance with this investigation. I also thank the liaison officer for his assistance to my investigator during the investigation.

The man died of self inflicted injuries. He had been placed under self-harm and suicide prevention procedures and had received a substantial amount of healthcare and mental health in-reach team (MHIT) intervention and support. He had restricted mobility within the prison due to his disability of being reliant on a wheelchair for mobility. My report examines the support the man received at Bedford and makes nine recommendations to the Governor and Head of Healthcare at Bedford. These cover the recording of MHIT advice on self-harm and suicide prevention documentation, issuing of non-prescribed medication and emergency training and procedure. A further recommendation has also been made to the prison service in respect of services for disabled prisoners at Bedford. The prison service has accepted seven and partially accepted two of the nine recommendations and their comments on these can be found at page 38 in this report.

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

Thea Walton
Acting Deputy Ombudsman **November 2011**

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SUMMARY

1. At the time of his death, the man was 53 years old and serving a thirty three month sentence at HMP Bedford.

2. The man was first remanded to HMP Bedford on 10 February 2010. Records arriving with him indicated he had attempted suicide some six months previously following the death of his mother. On reception he was assessed by prison Dr A. The man had been disabled following serious assaults, had restricted mobility and was wheelchair dependent. As he had complex medical needs, including severe alcohol addiction, drugs problems, cirrhosis of the liver, a severe throat and stomach condition, the doctor admitted him to the healthcare centre for detoxification and to ensure he had the correct medication.

3. Twelve days later the man was assessed as fit for normal wing and moved to D wing which supported prisoners with drug and alcohol dependency. Initially the man settled, though he attended healthcare complaining about his medication and pain. By the end of March his behaviour was deteriorating and he came into conflict with other prisoners. He was increasingly abusive toward staff and prisoners to the extent that he was subject to disciplinary reports.

4. Following behavioural concerns, the man was assessed by the mental health in-reach team (MHIT) on 17 May and was prescribed a mild antidepressant. The next day he was seen by the visiting psychiatrist who arranged for the team monitor him for symptoms of alcohol hallucinosis. On 21 May self-harm and suicide prevention procedures (Assessment, Care in Custody and Teamwork-ACCT) were initiated as he threatened self-harm. He complained of problems with his wheelchair and medications. Actions were taken to address these, and he was moved to a single cell.

5. In early June the ACCT procedures were closed, only to be re-opened towards the end of the month. The man complained that his wheelchair had not been repaired, that he was hearing voices and about his medication. Nurse Manager of the MHIT reviewed him on 25 June. He found he did not experience hallucinations but was stressed. He was prescribed medication to alleviate anxiety. The procedures were closed after his wheelchair was repaired in early July.

6. In early August the man's brother died. The MHIT supported him throughout July and August and, after attending his brother's funeral, though staff noted his low mood, he was assessed as coping well. However, ACCT procedures were reopened on 17 September after he threatened to kill himself. He had been prescribed medication for panic attacks, and wished to be moved to the healthcare centre.

7. At 7.45pm on 24 September an Officer whilst carrying out the ACCT check on the man, saw him was hanging by a ligature in his cell. Uniformed and clinical staff responded promptly to the emergency call and, having recovered a pulse, he was transferred to Bedford South Wing Hospital. The man never regained

consciousness and on 27 September the hospital doctor pronounced he had died at 9.40am.

8. My report examines the support the man received at Bedford and makes nine recommendations to the Governor and Head of Healthcare at Bedford. These cover the recording of MHIT advice on self-harm and suicide prevention documentation, issuing of non-prescribed medication and emergency training and procedure. A further recommendation has also been made to the prison service in respect of services for disabled prisoners at Bedford. The prison service has accepted seven and partially accepted two of the nine recommendations and their comments on these can be found at page 38 in this report.

THE INVESTIGATION PROCESS

9. I appointed one of my investigators, to conduct the investigation into the man's death. My investigator opened the investigation on 29 September 2010, speaking with a number of staff at the prison, including the prison's liaison officer.

10. The Ombudsman's terms of reference, and notices to staff and prisoners, were sent to the Governor at the beginning of the investigation. They were displayed around the prison inviting prisoners or staff to contact the investigator should they wish to. At the time of publication of the draft report, there had been no response to the notices. During the investigation, my investigator provided verbal and written feedback to the Governor of Bedford.

11. My investigator's contact details were made available to members of the Independent Monitoring Board (IMB) and the Prison Officer's Association. (The IMB are volunteers who monitor the day to day life of the prison to ensure that proper standards of care and decency are maintained.)

12. A review of the man's healthcare was commissioned from NHS Bedfordshire, the responsible primary care trust (PCT). The review was undertaken by the clinical reviewer, Quality Manager, Directorate of Quality and Patient Safety, and is annexed to my report.

13. My investigator reviewed the man's medical records and other prison documentation. He also interviewed a number of staff at the prison in conjunction with the clinical reviewer, and spoke to the prisoner who had been in the adjacent cell to the man.

14. One of my family liaison officers wrote to and spoke with the man's sister, informing her of the investigation into his death. She told her the family have a number of concerns which she hoped my investigation would address:

- That a fracture to his skull may have contributed to his death and that the fracture was caused they believe when he was cut down by a new and untrained officer who did not support him.

- That he should have been on more regular observations under the Assessment Care in Custody and Teamwork (ACCT) procedures. They also expressed concern about whether these observations were carried out as required.

- That he wanted to be moved to the healthcare centre as he was disabled and whether his location on a main wing (with restricted access to facilities) which may have contributed to his depression, was appropriate.

- Whether he wrote anything down and if so whether the police took this from his cell.

15. I trust that my report explains the circumstances around the man’s death and answers these and any other questions the family may have.

THE MAN

16. Information taken from the man's Probation Pre-Sentence report, noted that he was born in Letchworth, one of five children. His last known address was in the Royston area, where he had been living for a year. He had two children from his marriage which had ended due to his long term substance misuse.

17. His Pre-Sentence report also recorded that the man suffered from a long history of complex medical problems. His misuse of alcohol and drugs had begun in his teenage years, and he had become dependent on class A drugs and alcohol from the age of 21 years. Prior to his remand in custody he was still drinking an excessive amount of alcohol per day.

18. The man had been diagnosed with cirrhosis of the liver, a condition related to his alcohol misuse, and had been hospitalised in 2009 due to a serious throat condition. He had also been diagnosed with hepatitis C, a stomach ulcer, and arthritis. The man was receiving a complex amount of medications for these conditions under the care of his General Practitioner (GP)'s practice.

19. Due to a serious assault in around 2005, the man suffered irreparable damage to his left leg and, although he had some limited mobility, had become reliant on a wheelchair. This was further complicated by an injury to his arm, which resulted in reduced use of his right hand. A community physical disabilities team had been involved with him, providing him with a care worker.

20. The man had periodically been referred to psychiatric and community mental health services since 1979 due to depression, hearing voices, delusional and suicidal ideas. He had not, however, been diagnosed with any psychotic illness. He reported having made a suicide attempt by pushing himself under a bus in 2009 following the death of his mother. The man reported that he was no longer involved with mental health services immediately prior to his remand in custody.

21. The man had a lengthy history of offending with 29 previous convictions going back as far as 1972 and had served previous periods in custody. The offences for which he was initially remanded and then sentenced were related to drugs and possession of weapons. He had two similar outstanding matters for which he was due to appear in court at the time of his death.

HMP BEDFORD

22. HMP Bedford is a male local prison. The prison takes sentenced and remand prisoners from Luton Crown Court and Bedford and Luton Magistrates' Courts, as well as sentenced prisoners received as a result of overcrowding in London prisons. It has an operational capacity of 506 prisoners. The prison has been on its present town centre site since 1801. A new gate lodge, house block, and healthcare centre were added to the earlier Victorian wings in the early 1990s.

23. Healthcare services at Bedford are commissioned by the National Health Service (NHS), through Bedfordshire Primary Care NHS Trust (NHS Bedfordshire). The provider arm of NHS Bedfordshire is Bedfordshire Community Health Services (BCHS). BCHS provides a healthcare team based in the prison. The team is made up of doctors, nurses and nurse managers. It provides diagnostics, including blood services, in-patient care, and an integrated drug treatment Service (IDTS), as well as other primary care services. A MHIT is provided by the South Essex Partnership Foundation University NHS Trust. Bedford's healthcare unit can accommodate up to 13 in-patients.

24. Since the Ombudsman started investigating deaths in custody in April 2004, there have been ten deaths at the prison, including that of the man, at the time of his death. Although the circumstances surrounding the man's death are dissimilar from the previous deaths, I note that the issue of improved emergency radio codes was also raised in my report for the previous death in custody at HMP Bedford.

Her Majesty's Chief Inspector of Prisons (HMCIP)

25. The most recent HMCIP inspection led by Inspector of Prisons was unannounced and took place in March 2009. Her report noted that Bedford was "… a well-run prison with positive staff attitudes, which serves to mitigate some of these [its] problems and difficulties". She described Bedford as a small local prison "where good relationships and effective use of limited resources were able to mitigate some of the inherent problems of space, design and population".

26. There are a number of recommendations in the Chief Inspector's report relevant to the circumstances of the man's death. These are:

    - "Prisoners who are identified as being at increased risk of self-harm and needing more frequent observations should not be routinely located in the healthcare centre.
    - "Staff should be reminded of the need to identify trigger points in assessment, care in custody and teamwork (ACCT) documents and the need for unpredictable observations.
    - The disability policy should be renewed and a disability equality scheme established in consultation with prisoners with disabilities.
    - "The system laid out in the diversity strategy for care planning for older prisoners and those with disabilities should be implemented and all

relevant staff, including personal officers, should engage in delivering support plans.

- "Physical adaptations to the environment should be made to ensure equality of access to residential areas, including showers, activity and corporate worship.

Independent Monitoring Board (IMB)

27. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent annual report 2009-2010 published by the IMB for Bedford contains an issue which needs to be reflected upon here. The report identifies that:

    "One area of concern within the prison is that disabled prisoners (notably those in wheelchairs) are unable to move far in this mainly Victorian building and therefore cannot without major assistance and planning get to Healthcare, Visits or Education. There are plans to remedy this situation if funds are forthcoming."

Critical Incident Debrief and 'Hot Debrief'

28. A critical debrief takes place normally two weeks after a serious incident. It gives the staff the opportunity to understand the incident in greater detail identifying any learning points, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment. A 'hot debrief' takes place immediately after a serious incident allowing staff to receive immediate support.

Cut down tools

29. Cut down tools are knives that are specifically designed for safely cutting ligatures and are carried by all officers and healthcare staff in contact with prisoners.

Emergency response codes

30. Emergency codes are used to summon staff to deal with a particular situation. Different codes are usually used for different types of emergency to enable staff to bring the relevant equipment.

Listeners

31. Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners experiencing periods of crisis.

Reception and induction

32. A Cell Sharing Risk Assessment (CSRA) is opened by reception officer who complete the basic details. The form is handed to the First Night Centre staff where a confidential interview is conducted. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. While this is primarily cell sharing it also includes other occasions when space may be shared, for example to accommodate a Listener.

33. Reception staff do not always have access to a prisoner's past records and so the prisoner is the main source of information. All prisoners will also have a Person Escort Record (document used when escorting a prisoner between prisons, court and police stations) which will include risk pertinent information such as risk to others and self.

34. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

35. All new prisoners generally spend their first night on the induction wing. If a prisoner is considered vulnerable they may stay on other more appropriate wings and receive their induction there. Prisoners are asked about any immediate concerns, such as disability, their offence and general well being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained.

Counselling Assessment Referral Advice and Throughcare (CARAT) Team

36. The Counselling Assessment Referral Advice and Throughcare (CARAT) team based in a prison provide a substance misuse service for prisoners assessed with serious drug and alcohol problems. The team work in partnership with the healthcare service and discipline staff to provide a service within the prison and also as a referral agency for ongoing support to prisoners on their release.

Suicide and self harm monitoring

37. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised care and support before, during and after a period of crisis.

KEY EVENTS

Prior to the man's arrival at HMP Bedford

38. The man was arrested by the police on 9 February 2010 and charged with possession of drugs and an offensive weapon. He was held in police custody at Stevenage and was taken to St. Albans Magistrates' Court on 10 February 2010.

39. The Person Escort Record (PER), which records events whilst a prisoner is escorted to and from police stations, courts and prisons, recorded that the man's risks included a previous suicide attempt following the death of his mother, that he had previously been a drug addict and used methadone, and also had charges relating to possession of weapons. His current health risks were noted as "DP[1] in wheelchair" and "High Blood pressure possible other heart problems".

40. Alongside this, escort staff opened a "Suicide/Self-Harm Warning Form". They were informed by the police that the man's mother had died approximately six months previously and following this he had tried to kill himself by throwing himself under a bus. The man had told the police custody officer that if he was released from court later that day, it was his intention to kill himself. In addition to this, he told the escorting officer also that he "would rather be in heaven with his mother". It was noted that the man "seems very depressed" and had a history of harming himself within the last six months.

41. After his court appearance the man was remanded into prison custody and taken to HMP Bedford. His next Court appearance was scheduled for 16 February by video link from the prison.

The man's arrival at Bedford

42. The man arrived at Bedford on 10 February and went through the usual reception procedures. Officer A went through the prison's first night in custody and assessment booklet with the man to assess whether he had any concerns or immediate needs. The Cell Sharing Risk Assessment (CSRA) was completed and identified the man's as a "Low" risk, that is, he was suitable for sharing a cell with another prisoner. It was noted that he "Gets frustrated as he is confined to a wheelchair. Also has no use of right arm". The officer recalled that the man described his frustration as arising from an inability to do things due to his confinement in a wheelchair.

43. Officer A recorded in his first night interview that the man had been suicidal about six months ago when his mother died, but that he "states he is fine now" indicating he did not feel at risk of self harm or suicide. He recalled that the man had been joking in reception and there was no indication from his demeanour that he had any self harm intentions. The record shows that the

[1] DP is used as an abbreviation for detained person

man was "not at all" concerned about being in custody, did not feel at risk and had no immediate concerns.

44. As part of the man's induction into the prison a basic disability and equality questionnaire was also completed. He was then was seen by a variety of agency workers, from the counselling, assessment, referral, advice and throughcare (CARAT) team, Ormiston Trust and Jobcentre Plus. An induction passport was used to record when these events took place. Details about the man's disability were passed on to the prison diversity manager, who was responsible for those with disabilities.

45. Prison Dr A carried out a health assessment on the man during the reception process. The man's history of alcoholism, diagnosis of liver cirrhosis and osephageal varices (a condition of dilated veins in the oesophagus often associated with cirrhosis) were identified, as was his dependency on a wheelchair due to physical injuries. The doctor decided the man should be admitted to the healthcare centre, prescribed medication to assist with alcohol detoxification, recorded his community General Practitioner (GP) details and the need to get medication information from the GP in the morning. The doctor described the man's emotional, behavioural and mental state as "stable". The man's concerns over his physical health were noted and he was assessed as fit for a normal wing, work and any cell occupancy.

46. The man was taken to a single cell in the healthcare centre on his first night, and remained there until 19 February. The following day Staff Nurse A gave the man his librium and pabrinex injection (both medications are given to treat detoxification withdrawal symptoms), and found him to be fairly settled. The man complained of generalised pain in his legs and described the normal pain relief he took which would be discussed with the doctor. He also expressed his concern about an outstanding out patient's appointment with his plastic surgeon at the Lister hospital and gave details of his GP. The staff nurse recorded this would be followed up by administrative staff. The same day Officer B completed the remainder of the induction process with the man.

47. Over the next days the man's clinical record shows that he continued to receive detoxification treatment, progressively became more settled expressing no new concerns, and began taking part in education and association[2]. On 17 February the man was assessed by the CARET worker. A care plan to address his substance misuse, identified primarily as currently alcohol and cannabis, was devised. He was also referred to the chaplaincy for bereavement counselling as he had indicated continuing problems following the death of his mother.

48. On 19 February, at his own request, he was moved from a single cell into a dormitory as he wished to be able to talk with somebody and was seen to be settled, happier and interacting well. Prison doctor A saw the man again on 22 February and assessed him as fit for normal prison wing. The man was moved

[2] Association is the term used to refer to free time that prisoners have out of their cells to socialise on the wing.

to D wing, which holds prisoners undergoing drugs and alcohol treatment, in the afternoon.

49. Three days later the man was seen by prison Dr B as he was complaining about his medication. He indicated that he had been prescribed a beta blocker (a drug used to control heart rhythm and reduce high blood pressure) in the community. The doctor recorded that the prison healthcare unit had no information on this and noted the need to contact his community GP. The following day he contacted the GP in Royston to confirm the man's medications.

50. The man was examined by prison Dr B on 3 March. He reported that he had "blacked out" on a couple of occasions. The doctor noted that he was adjusting to life without alcohol. On testing he found the man's blood pressure to be normal, and there was no need for him to be prescribed a beta blocker. He did, however, prescribe dosulepin (a mild antidepressant also used to relieve sleeplessness caused by chronic pain).

51. The CARAT worker saw the man on 8 March, by which time he had completed an in-cell work pack (educational work which could be completed in his cell) on alcohol issues. He was issued with a similar work pack for cannabis.

52. The next day the man attended healthcare complaining that his medications were still not right. The duty doctor was informed and it was noted he had a further appointment booked with prison Dr B.

53. Prison Dr B saw the man again in healthcare on 17 March. He recorded he was complaining about his medication but was satisfied with a simple painkiller (name or type not recorded) after discussion with the doctor. The man also agreed with the plan to attend for a bath once a week in the healthcare centre.

54. The following week, on 26 March, the man was seen by prison Dr C. The doctor noted his previous heroin dependence, cirrhosis of liver and presenting night cramps. The doctor requested blood, liver and renal function tests to be carried out.

55. On the same day the man was issued a formal first warning for breach of the incentives and earned privileges scheme (IEP)[3]. The recorded reason for this was that he had been given an in-cell cannabis workpack to complete which he had returned to the CARAT drugs worker uncompleted but with abusive messages written on it, together with apparent smears of blood and other substances.

56. A further incident of deteriorating behaviour occurred on 30 March at the surgery. When he was given medication required to be taken in front of staff

[3] The Incentives and Earned Privileged Scheme (IEPS) is a scheme that is designed to encourage and reward good behaviour in prisons. There are three levels under IEPS – basic, standard and enhanced – with all new prisoners initially being on standard level. Changes to that level will then depend on their conduct and progress through their sentence plan.

the man is recorded as deliberately dropping and hiding one of the tablets for which he was challenged.

57. The man attended Luton Crown Court on both 7 and 9 April when he was convicted of a number of offences. He returned to Bedford following conviction and was to return to court at a later date for sentencing. On both occasions following his return from court, he was seen by healthcare staff. No concerns were raised.

58. Following the prison Dr C's request for blood, liver and renal functions tests to be carried out, the results were made available on 12 April. No further action was recorded. The man was however prescribed quinine sulphate (a muscle relaxing painkiller), codeine (used to treat mild to moderate pain) and lansoprazole (used to treat certain conditions caused by too much acid being produced in the stomach). The same day the man was issued with a formal second warning for breach of the IEP scheme, the reason given being that he became abusive to an officer answering his cell bell call.

59. A week later the man was seen by prison Dr A in healthcare as he experienced abdominal pain which his painkiller was not easing. He was prescribed dihydrocodeine (a stronger painkiller which has opioid properties and euphoric effects), and an iron supplement. Due to its potential addictive properties his use of this painkiller was to be monitored albeit he received repeat prescriptions for it throughout the rest of his time at Bedford.

60. During the next two weeks the man attended healthcare once complaining of further pain in his left leg which appeared a little swollen. The decision was taken to continue to monitor this condition. On 5 May he returned to healthcare and was seen by prison Dr B. The man said he had fallen hurting his left hip some ten days previously and wanted additional painkillers. On examination he was found to bear his weight reasonably with no obvious pain and was able to walk to the couch. When he was refused more painkillers, specifically diazepam (a hypnotic sedative used as a muscle relaxant and to treat anxiety, sleeplessness and alcohol withdrawal), he became abusive.

61. The man appeared before Luton Crown Court on 7 May when he was sentenced to 33 months imprisonment less 83 days for a number of offences. The probation court duty officer circled the box on the result information form to indicate there was a suicide risk and that staff in the holding cells were informed of this. This information (which was already known to Bedford) was not based on an interview at court with the man, but on information in the pre-sentence report provided to the judge. This detailed the man's suicide attempt following his mother's death. The man returned to Bedford later that day. He was seen by the prison doctor, his medication (dihydrocodeine) was continued and no further concerns were raised

62. On 9 May the man reported to an officer that someone had left excrement on his wheelchair. This had already been cleaned by another prisoner who said that the man was being bullied, but declined to say by whom and no further information was given. A second prisoner however stated that the man had

attempted to run him over with his wheelchair. The man was found to have blocked his cell observation panel and obstructed the cell door with his wheelchair. There was no evidence on the man's prison records to suggest that these alleged incidents were considered as potential bullying. It is also not clear whether it was believed that the man's negative behaviour contributed to the incident that allegedly occurred.

63. A Community Psychiatric Nurse (CPN) assessed the man on 17 May following a referral made by wing officers. She found the man was experiencing low moods and anxiety and was feeling distressed due to his physical pain and mobility problems. He also mentioned the loss of his mother, but said he was coping with this spiritually by seeing the chaplain each week. The CPN recalls his main concerns appeared to be over medication issues for his pain. He complained he was only receiving paracetamol, but that he had been taking diazepam and morphine in the past.

64. The CPN took a full social history, during which the man said he interacted well with some prisoners but that others were mocking him and placing bets on whether he would kill himself. He admitted occasional self harm thoughts, but had no current suicidal intentions and wanted to prove he was "brave". The CPN encouraged him to speak to staff at any point should suicidal ideas arise and formed an action plan comprising involvement of the wing officers in securing some education and light gym exercises, discussing with the doctor a low dose antidepressant, securing more information from his community GP surgery. Prison Dr C started the man on citalopram antidepressant following this assessment.

65. The following day, 18 May, the CPN received information from the man's GP indicating his diagnosis of alcohol dependency and drug misuse, and providing a psychiatric history. The last mental health referral had been in 2007 following the man's suicidal tendencies. When assessed by the community mental health team his main complaints had been of pain and accommodation issues but there was no presentation of suicidal thoughts. The man had been discharged with no follow up arrangements.

66. The CPN saw the man again in his cell that morning together with Officer C. The man had been losing his temper and breaking furniture and said this was due to hearing noises from the next cell the previous night. This was checked with his newly arrived cell mate who confirmed there had been noises but that he was better able to tolerate them than the man. The CPN gave the man reassurance, discussed the issues with wing officers, and due to her concerns immediately referred him to the visiting psychiatrist for an assessment in the afternoon. Despite the man's behaviour, there appears to be no record of whether a cell sharing risk assessment review was considered at this point.

67. The visiting psychiatrist assessed the man and noted he presented as an angry and unhappy man. She noted his unhappiness over receiving a longer sentence than expected his complaints about the noises and name calling from his cell neighbour, and his dissatisfaction with his medications. She found he was unwilling to take treatment at that time. At interview with my investigator,

the CPN explained that this related to the antidepressant which was subsequently discontinued following discussion with the doctor.

68. The visiting psychiatrist noted the man's long history of alcohol dependence, his liver disease and that he underwent forced abstinence only when in hospital or prison. She considered that the man may be suffering from alcohol hallucinosis[4]. The visiting psychiatrist formed a plan for the MHIT to continue monitoring his mental state and review his medication.

69. On 21 May the man barricaded his cell by pushing his locker against the cell door and threatened to set light to his bedding saying that he wished "it was all over". He removed the barricade when requested and said he was protesting against several ongoing issues. Senior Officer (SO) A opened an Assessment, Care in Custody and Teamwork (ACCT) document on the basis of his statement of intent to self harm, very low mood, and problems related to drug/alcohol withdrawal. An immediate action plan was initiated which comprised of changing his cell to single on the basis of the man's issues with sharing a cell, ensuring he had phone access on association and also Listener scheme access. The SO also undertook an immediate cell sharing risk assessment review increasing his risk to 'high' and noting the man was always shouting at other prisoners, was on an open ACCT, and had threatened to set fire to the cell. He was also placed on half hourly observations by staff.

70. The man was moved to another cell, D-209, on the same landing which moved him some distance away from the cell from which he had been complaining of hearing banging noises. Later in the afternoon he was observed as being calmer and he told staff he felt his issues were being taken seriously and that he preferred his new quieter cell.

71. The next day, Officer C undertook the follow up ACCT assessment interview with the man, and afterwards a review meeting with him was chaired by SO B and attended by Officer C. During the assessment the man complained of anxiety, panic attacks and depression which he related to medication issues. He denied any intentions of self harm or suicide, and indicated he would try to write to his brother and send a visiting order to his step brother. Other issues discussed included getting a repair to his wheelchair, sorting out medication, his need of glasses for reading and his wish to go to education.

72. During the review meeting the man is recorded as freely admitting making earlier statements of intent to self harm so he could move cells. It was noted that the MHIT were aware of the man, and he was found to be talkative and willing to share his feelings. The action plan was changed to one significant staff interaction with him each morning, afternoon and evening, and irregular hourly observations at night. The ACCT caremap addressed four issues: mental health issues to be covered by the MHIT, repairing a puncture in his wheelchair tyre, arranging gym attendance to deal with inactivity, and reviewing his medication with the doctor.

[4] Alcohol hallucinosis is a condition characterised by auditory hallucinations, persecutional delusions and mood disturbance. It usually presents as a symptom in the early stages of alcohol withdrawal, but it is thought it may become chronic and longer lasting in a small number of cases

73. The on-going ACCT records show that just before midday on 23 May the man's cell was unlocked for him to collect his meal. He went straight over to a neighbouring prisoner and accused him banging on his cell door earlier. Staff noted in the ACCT record that the man was "demonstrating very bizarre behaviour" and making unfounded accusations. He refused his meal and returned to his cell swearing at staff. SO B completed a violence reduction investigation report which noted his "behaviour has become increasingly aggressive towards staff and prisoners on the wing" and that he "is displaying more and more aggressive behaviour". The investigation carried out by staff found the man had been displaying negative behaviour. A violence reduction action plan recorded the decision to place the man on stage two of the prison's violence reduction strategy. This meant that he lost his IEP privileges and was placed on the 'basic regime' (reduced association and television) for seven days.

74. Later in the evening he was seen by CPN B on the wing. She gave him an opportunity to discuss his thoughts and feelings, and provided him with a self help booklet on depression. She encouraged him to use the suggestions to help him cope when he was feeling low. She explained the position regarding his antidepressant medication, and that it had been stopped by the healthcare team following a review of his previous treatment. The CPN recorded that the man appeared settled and happy with the explanation.

75. Following the incident on 23 May, the man apologised to staff for his behaviour. However, over the next few days he became increasingly abusive and uncooperative. He is recorded as arguing with himself and throwing furniture around in his cell. Prison Dr D saw the man in healthcare on 27 May. He was complaining of hearing voices, some directly addressing him, but denied paranoia. He felt one of the prisoners on the wing was "out to get him". The man was seeking medication and implying he may harm himself. The doctor, however, found he engaged well although he became agitated when describing his symptoms. He decided to liaise with the MHIT.

76. The man's ACCT was reviewed on 29 May when he said he had no thoughts of suicide or self harm and was feeling calmer. The following day he did, however, receive a formal final warning for breach of the IEP scheme after he swore at an officer. The ACCT was further reviewed on 1 June by SO B with CPN C and the man in attendance. Finding he had no thoughts of self harm, that he felt good and had improved his appearance it was decided to close the ACCT as the man had "made very good progress". All agreed the ACCT would be reopened should he regress. A post-closure interview was arranged for 7 June.

77. CPN A saw the man together with CPN D on 4 June. The man said his main concern was the loss of his facilities following disciplinary decisions. He presented as agitated requesting medication to "calm me down" and complained he had not received any support in prison. He was reminded of support from the MHIT and, as he was unable to attend day care activities, he was to be provided one to one sessions as required to discuss his feelings and

worries. Later, in the early evening, because of his disruptive and aggressive behaviour in the medication queue, he was not able to collect his medication.

78. On the morning of 7 June, the man was moved to A wing. The ACCT post-closure interview was undertaken by SO B later that day. He recorded that he felt the reasons for opening the ACCT had been resolved. The man was now in a single cell and his medications were correct. It indicated support from friends outside the prison and that he had in cell education activities. A new inner tube had also been purchased for his wheelchair (and was awaiting delivery). The post-closure review concluded that there were no outstanding issues to be addressed for the man at that time.

79. On 10 June the man saw prison Dr D in the surgery. He angrily requested more medication for depressive symptoms, reported having persistent suicidal ideas, anxiety and panic attacks and complained he was not being taken seriously. The doctor assured him of ongoing MHIT care and requested a review from them. There is no evidence documented to suggest that consideration was given to opening the ACCT procedures. (There is also no evidence that the MHIT team saw the man until 22 June following this doctor's appointment.) Later, wing officers reported the man's wheelchair tyre was flat to Staff Nurse B who immediately forwarded a service request and was assured wheelchair services would come within four days.

80. Prison Dr D issued a letter to the man on 16 June informing him that his dosulepin antidepressant medication was to be stopped. His clinical record shows this was due to his not being clinically depressed and that there was a potential interactive conflict with another of his medications (Quinine Sulphate). The following day the man queried why this medication had been stopped (originally prescribed from March), complained of experiencing "shakes" and requested to see the MHIT.

81. CPN E saw the man on the wing on 22 June. The man complained of hearing voices, but was unable to tell the source of them, and also of his frustration given his limited mobility. The nurse noted he was undertaking education in his cell and attending fortnightly bereavement counselling. He concluded the man was not in need of the extra medications he had requested. Later, the man approached the staff nurse when medications were being issued with the impression he was due more medications, and complaining that his wheelchair tyre puncture had still not been mended. The staff nurse undertook to chase this up.

82. The following morning, 23 June, SO C initiated ACCT procedures for a second time. The man was very low in mood and had said he had nothing to live for, he had thought of ways to kill himself and said "if one more thing goes wrong he will go through with it". SO D planned immediate actions including half hourly staff observations, ensuring he was informed of telephone access to the Samaritans and access to the Listener scheme.

83. Officer D undertook an assessment interview with the man. . The assessment identified that he was depressed due a number of issues including the repairs

needed to his wheelchair, issues with other prisoners, losing his home accommodation, trouble sleeping and writing letters as he hears voices, and medication. During the case review held later in the day with SO D and two officers, the man said he was feeling fine and had no thoughts of self harm. He said he was happy his wheelchair was to be replaced, was fine with his medication, and agreed to be monitored.

84. SO D reviewed the man the following morning, when he appeared settled, and completed his caremap. This identified goals to ensure the wheelchair puncture was repaired, to lessen his reliance on the wheelchair, to use the exercise yard, and to get assistance with housing. Corresponding actions and referrals were made. Observations were reduced to hourly at night with three required significant staff interactions during the day and evening. Only discipline staff were present at the review with no representative from the MHIT being in attendance.

85. The man barricaded his cell the next morning. Wing staff cleared the obstruction and Officer E found the man to be in tears and, whilst denying any suicidal intent, also said he wished he was dead. SO E and Officer E undertook an immediate case review including the MHIT nurse manger in the discussion by telephone. Observations were increased to hourly throughout the day and night.

86. The MHIT nurse manager saw and assessed the man following this review. The man complained of hearing voices from a prisoner who he said had threatened him when he was on D wing, and that the antidepressant which had helped settle him had been stopped. Wing staff reported he had been isolating himself and was disruptive when his door was locked. The MHIT nurse manager found no evidence of thought disorder or psychosis and found that he had good insight when settled. He told the man he did not believe him to be psychotic or experiencing hallucinations but that he was stressed due to the combination of his addiction and imprisonment causing him to obsess over experiences on D wing. He reassured the man of his safety, which calmed him.

87. The MHIT nurse manager followed through three planned actions. After discussion with prison Dr A the man was prescribed chlorpromazine, an antipsychotic used also to alleviate anxiety, for a brief period. Governor A agreed to ensure the man could access exercise and association to reduce his isolation. This had not been possible for the man whilst his wheel chair was awaiting repair (noted on his ACCT caremap as being fixed on 2 July). The MHIT were tasked to liaise with wing staff over input, and began to see the man more regularly.

88. Over the next week records show that the man settled and began to undertake outside exercise. The only occasions when he became disruptive were associated with his complaint that his wheelchair was still not repaired.

89. The CARAT worker held an individual session with the man on 29 June when he said he was feeling happier and did not want to do any more CARAT work for the time being. CPN A reviewed the man the following day when she found

his mental state improved with no signs of anxiety and that he was "composed in his interaction".

90. A new tyre was fitted to the man's wheelchair on 2 July. SO F reviewed his ACCT in the afternoon with the man and Officer B in attendance. It was agreed to close the ACCT given the wheelchair had been repaired and the man's mood remained positive.

91. During the next week the man received dental treatment and two new pairs of glasses and was seen on two occasions by CPNs B and E. He presented as calm, pleasant and settled and said he enjoyed being on A wing. He agreed with a reduction in his chlorpromazine medication due to its potential side effects, and started a reduction plan. On 9 July SO E undertook the ACCT post-closure interview during which the man said he was happy all issues had been resolved, indicated he had support from his brother and son, and expressed a positive goal to "get walking more".

92. Through the remainder of July the man maintained the progress he had made. He was seen on a further four occasions by the MHIT indicating his interest in continuing with the counselling he had received from them. The man expressed his frustration over his limited mobility and the records show support was offered through both encouragement and practically through a referral to occupational therapy by both the MHIT and the healthcare department. He also said that he was awaiting the outcome of a psychiatric report (which had been requested when he attended court on 21 July with respect to his last outstanding offences).

93. Prison Dr D saw the man on 28 July, during which he used a standard depression screening questionnaire (the PHQ-9). By this date the man had successfully ceased taking chlorpromazine. He reported some sleeping difficulty due to arthritis and also feeling depressed, which was confirmed by the depression screening. The doctor discussed a possible nightly sedative antidepressant with the nurse manager of the MHIT, but it was agreed not to start him on this as his outlook had much improved over the previous weeks.

94. On 1 August CPN B saw the man briefly on the wing. He reported pressure sores (subsequently recorded as a boil requiring little treatment) making it painful to sit on his cell chairs but otherwise said he was doing well and getting out on exercise.

95. The following week the man was told that his brother had died on 4 August. CPN B saw him on 8 August and gave him time to express his thoughts and feelings. He told her he was still unable to take in the news about his brother, and spoke about future plans. The CPN found him fairly settled in mood and manner, and assured him of the support of the MHIT. There was however no recorded plan documented that this was assessed at appropriate time intervals.

96. On 9 August Dr D saw the man in healthcare. The man spoke of his worries that his brother's sudden death may have been violent or suspicious, and mentioned that he himself had been receiving threats from other prisoners. The

doctor diagnosed acute anxiety for which he re-prescribed chlorpromazine for a limited period and liaised further with the MHIT.

97. Over the next two weeks the man received routine dental treatment, and received a session with two community physiotherapists with which he expressed some discontent. He was also seen on two occasions by CPN E who found the man neither to have self harm ideas or clinical depression, albeit he was quiet and in low mood, and by the end of the second week was coping without further medication.

98. Following a Prison Service risk assessment, the man was granted a special release licence to attend his brother's funeral on 20 August and was escorted in handcuffs by staff. (A risk assessment is carried out for all prisoners who are being escorted from prison to determine what arrangements should be in place to ensure that escape is prevented and the public is protected). On his return he was seen by the prison chaplain and was offered bereavement counselling, which he initially declined. The following day CPN B found the man quite low in mood and very angry. He expressed anger at not being allowed contact with his family and over his handcuffs, despite being told these were prison rules that applied to everybody. She saw him again on 22 August during association when he was interacting well with other prisoners and seemed more settled.

99. Two days later CPN E saw the man in his cell and found him to be coping well following the death of his brother and not needing antidepressants. He told the CPN he was pleased with the help escorting staff had given him at the funeral, but expressed his anger about being in prison and discussed his forthcoming court case.

100. There are occasions where it is recorded in the prison medical computer system (SystemOne) that the man was given paracetamol, but this is not recorded on his drug chart. This occurred on 17 occasions in May, six occasions in July and seven occasions in August. In addition, on 26 August there is a prescription for paracetamol on SystemOne with a record of a letter to the man from prison Dr D, warning about consumption of paracetamol in regard to his liver failure. The drug chart does not indicate the day paracetamol was prescribed but it was dispensed by pharmacy on 15 September, and subsequently given regularly three times a day from 18 to 24 September prior to the man's admission to Hospital.

101. On 7 September CPN E saw the man again on the wing. He noted him to be calm and settled and still coping well with a stable mood and "no psychotic features". The man did, however, express frustration over being unclear about his release date. Five days later, on 13 September, the man appeared again at St Alban's Magistrates Court, and was remanded for two weeks for a further court appearance.

102. The man saw the dentist for treatment on 15 September. He told her he believed he would be transferred to HMP The Mount in three or four week's time.

103. The man then complained of further panic attacks and sleeplessness due to a racing heart. Prison Dr D saw him on 16 September. There was some discussion about his panic feelings and, given he had received beta blockers before, the doctor prescribed him propranolol, a beta blocker used to treat and relieve hypertension and high blood pressure.

104. In the afternoon of the next day, 17 September, a member of staff from the Education Department took some education work to the man in his cell. She asked him how he was, and he complained of his stomach ulcers and that he should have been moved to the healthcare centre. He said he was "fed up and had had enough of being punished" and that he was suicidal and would take an overdose. She initiated opening an ACCT document and SO G planned immediate half hourly staff observations. It was also decided that the man would remain in his current cell and that staff would ensure that he had access to Samaritans, Listeners and the healthcare centre. The ACCT ongoing record shows that he spent the rest of the day and evening in his cell watching television and not raising any issues with staff.

105. An ACCT assessment was undertaken the next morning by Officer F. The man said he still felt depressed and he "would rather be with his brother and mother". He said if he could get hold of enough paracetamol he would have taken them. He said he had no visits currently, and did not want anyone from outside to visit him. He complained that he had no counselling or physiotherapy which healthcare had said would be given and that his canteen payments (canteen includes items such as toiletries, stationary and snacks that prisoners are able to purchase in prisons) had been incorrect for three weeks. He also said that his wheelchair needed repairing.

106. SO F chaired a case review with the man and the officer in the afternoon. The caremap had identified two issues to be addressed, regarding his medical issues and his pay for canteen. Both these were addressed immediately by SO G ensuring there was an appointment to see the doctor, and also providing the man with a smokers' pack (a pack normally consisting of tobacco and tobacco paper). The man, although still in low mood, was recorded as having no immediate intentions to self harm and it was agreed by all that observations were reduced to hourly. A referral to healthcare was also made for a replacement wheelchair to be obtained.

107. The record shows that over the next three days the man asked officers a number of times when he would be going to healthcare and that he said he should be located in the healthcare centre due to his medical problems. On a number of occasions he moved his bed against the cell door, but when requested quickly complied in putting his bed back in its correct place. When asked about this behaviour he said he was protesting about not being moved to healthcare. Whilst his mood was described as low, at times not engaging with staff, he also said he was "o.k", "still here", and "alright" when asked how he was. Mostly he spent his time in his cell watching television, declining exercise on one occasion, but later saying he wanted association.

108. On the 22 September when he was unlocked to be taken to the doctor he was found to have barricaded his door again. As before he quickly moved the furniture back when requested and said he was "scared as he felt people were out to get him" as other prisoners had been "having a go" at him recently. He was seen by prison Dr D in healthcare. He claimed he had taken six tablets (propranolol) at once in order to stop his heart, but then said he did not want to die. He complained of being frightened on A wing, but did not know who he was frightened of, and wanted to be transferred to the healthcare centre. On examination the doctor found him to be anxious and dissatisfied but engaging well. The man was prescribed a daily citalopram antidepressant tablet and was to be maintained on the beta blocker daily. The doctor said that the man was to be given these medications on a See to Take (SST[5]) basis to ensure he did not hoard tablets. There was no documented evidence as to whether staff considered holding an immediate review of the man's ACCT.

109. After seeing the doctor the man barricaded his cell twice, but again quickly moved the furniture back when requested. He told staff he was "o.k". He received a first breach of IEP warning for barricading his cell.

110. The man's ACCT was reviewed on 23 September. In the morning he was not very communicative and had again placed his bed against the door saying he was "paranoid". He did, however, attend the ACCT review in the afternoon chaired by SO H with CPN F, a student nurse and Officer G. Arrangement was also made for an assessment to be conducted as soon as possible for a replacement wheelchair for the man.

111. The ACCT case review record shows that the man was reluctant to discuss "private issues any further as he feels he has already gave (sic) enough information on his current medical condition". The caremap was updated with three further issues and actions. The record shows the man had raised questions regarding his waiting for an operation, need for a replacement wheelchair and also being transferred to another prison, HMP The Mount. The man's level of risk at this review was recorded as low, and it was decided to maintain hourly observations with staff undertaking a 'quality interaction' in the morning, afternoon and evening. The next review was scheduled for the day after his return from his next court appearance fixed on 27 September.

112. Immediately following the review SO H spoke with prison Dr D informing him that the man had said he was on a waiting list for an operation. It was agreed the man should request to see the Doctor and list concerns so he could deal with them. She also e-mailed a request for a replacement wheelchair assessment, and spoke with the Offender Categorisation and Allocation senior officer who explained that the man could not be transferred to another prison until all court appearances were complete, but a suitable prison would be identified once complete. SO H advised the man of the outcome of her discussion with the doctor.

[5] Being given medication on a See to Take basis means that the individual must be physically observed taking the medication by a member of staff

113. The man spent the rest of the day in his cell watching television. When unlocked for association he remained there saying he “wanted time to think”. Later, when asked what he had been thinking about he replied “nothing in particular”, and did not want further conversation. He moved his furniture back into position on two occasions when requested.

Events of 24 September

114. In the morning the man had again moved his bed against the door, saying it was to stop people coming in, but moved it back on request. Later he remained in his cell during association and in reply to Officer G mentioned no other problems other than saying “his head was a little all over the place”. He declined the offer of being taken to the healthcare centre for a bath in the afternoon.

115. At mid-day he rang his cell bell to say he was stressed and wanted to move wings. Later, he was observed watching television, and then writing a letter. In the mid-afternoon he told Officer E he was “cracking up” and was described as “very paranoid”. The man collected his evening meal at 5.00pm, and Officer G asked him if he had any problems that day to which he replied “No Guv”. He had moved his bed again for which he was warned and told to replace it. Later he was observed watching television and said he was “o.k.”. At 6.50pm he told Officer H that he was scared someone would get him. As this was a non-association day all prisoners had been locked in so Officer H reassured him, “I told him that everyone is away and this put his mind at rest”.

116. The first officer on the scene opened the observation panel on the man’s cell door at 7.45pm to undertake the ACCT observation and saw him hanging from the window. He immediately shouted for assistance and used his radio to call for ‘Hotel 2’ emergency medical assistance. Seeing SO D and Officer H within seconds running towards the cell the first officer on the scene entered the cell. The man was unconscious, pale and not breathing and so his first reaction was to cut the ligature. SO D entered the cell just as the man, released from the ligature, fell to the floor hitting his head on a table as he fell.

117. SO D quickly radioed the control room to call for an ambulance and to inform the duty governor. He began clearing space in the cell. The first nurse on the scene and second nurse on the scene arrived within two minutes, carrying the emergency bag. Finding no verbal responses, breathing or pulse they turned the man on his back and immediately began Cardio Pulmonary Resuscitation (CPR) applying compressions and breaths via a bag and mask having cleared his airway. The second nurse on the scene called for the defibrillator (AED), a machine that applies electrical impulses to the heart and advises whether there is any rhythm which might be stimulated, which was brought quickly.

118. Shortly afterwards the third nurse on the scene and the arrived. The third nurse on the scene applied the defibrillator which advised to continue with CPR. The third nurse on the scene and the first nurse on the scene and the third nurse on the scene continued with the CPR until the paramedics arrived at the cell shortly after 8.00pm. The paramedics took over emergency treatment and after

finding a pulse and providing oxygen prepared the man for transfer by ambulance to hospital.

119. Officers I and J were briefed to escort the man to hospital without applying cuffs. The ambulance left the prison at 8.35pm, arriving at Bedford South Wing Hospital about ten minutes later. Following further emergency treatment he was transferred to the critical care unit, where his breathing was assisted by a ventilator.

120. Duty Governor had initiated the prison's contingency plan, this included ensuring a notice of explanation was posted for all prisoners detailing support where required and undertaking a review of all prisoners on a current ACCT. At 8.45pm he made a telephone call to the man's sister to inform her of what had happened and that her brother was in hospital. Immediately afterwards he appointed SO C as Family Liaison Officer (FLO) who contacted the man's sister again and arranged for a taxi to take her to the hospital. The SO met the man's sister and her friend at the hospital at 10.50pm, explained what had happened, and then accompanied them in to see the man.

25 to 27 September

121. Over the next two days the prison undertook a bedwatch at the hospital with a single officer in the room at all times. On one occasion, at the family's request, the officer stood outside the room to afford them a degree of privacy. The man remained unconscious and, although at one point he was breathing without assistance, his condition slowly deteriorated.

122. The man's son and daughter visited him on 25 September, and SO C met them to offer support and answer any questions. The following day the SO visited the hospital again with the prison chaplain and met with the man's sister and children. After discussion with the hospital consultant, the family made a decision that the man should not be resuscitated in the event that he suffered a cardiac arrest (heart attack).

123. Throughout the day the man continued to be unresponsive to tests and his condition deteriorated. Early in the morning of 27 September the family were informed by nursing staff of his worsened condition, his children arrived and were with him shortly before the man died at 9.40am.

124. SO C had been called to the hospital earlier that morning and she and SO I, who was undertaking the bedwatch, withdrew to allow the man's family some privacy. After the man's death SO C spent time with the man's children giving them information and support. She then went later in the morning with the chaplain to visit the man's sister at her home.

125. Bedford's governing Governor wrote a letter of condolence and support to the man's sister dated 27 September. SO C, as family liaison officer, liaised with the coroner and kept contact with the family up to and beyond the funeral which she attended with another staff member. In accordance with Prison Service

Order (PSO) 2710, the prison offered a contribution towards the cost of the funeral.

126. Following the man’s funeral on 15 October, SO C visited the man’s sister again to return her brother’s property. The family expressed gratitude for the support and assistance they were given.

127. On notification of the man’s death the prison implemented the death in custody contingency plan ensuring all necessary actions were taken. A ‘hot de-brief’ for staff involved had been held on 24 September after the man had been taken to hospital. A further, fully recorded, ‘hot de-brief’ for all staff involved with assisting the man over the period he was in hospital was held on 27 September. The prison’s care team were made available to support and allow staff affected to talk through their experience, and a ‘critical incident debrief’ was subsequently held.

128. A hand written note, together with a cartoon drawing, had been found in the man’s cell. It may be what he had been observed to be writing on 24 September. The note was not addressed, but was titled “Monday Morning”. It includes three statements written as a list: “I want my belongings back from Group 4”, “Pee test for doctor about my bladder”, “No.5 stay alive try to survive a little longer”. Monday 27 September was the man’s next date to appear in court.

129. The cause of the man’s death was primarily due to pulmonary oedema (fluid on the lungs causing respiratory failure), a diffuse cerebral infarction (a stroke caused by restricted blood supply to the brain), and an obstruction to the carotid artery which takes blood to the head caused by suspension. Secondary factors were reported as subdural haematoma (a collection of blood between layers of the brain’s covering), and micronodular cirrhosis (liver disease).

ISSUES

Clinical Care

130. A clinical review was undertaken by the clinical reviewer, on behalf of Bedfordshire Primary Care Trust. The clinical reviewer noted the post mortem report recorded the man's death as primarily due to pulmonary oedema resulting from intracranial pressure and a diffuse cerebral infarction, in turn the result of obstruction to the major arteries carrying blood to the brain. She notes that the subdural haematoma, commonly the result of a blow to the head, "did not reach sufficient dimension to cause problems" and that the cirrhosis was not involved as an immediate cause of death.

131. The man, as a prisoner with complex medical needs, received a substantial amount of clinical contact, care and intervention at Bedford. The clinical reviewer concludes that "there are no causal factors within the delivery of healthcare services which could have prevented" the man's death. She does consider, however, that there were some deficiencies in the identification and management of his health conditions and mobility issues. She considers that these issues were "possible influencing factors" and that their management "did not follow a systematic plan of care and there is little evidence of systematic review". She concludes that the outcome for the man was not affected by this but, nonetheless, the Governor and Head of healthcare will wish to carefully consider the contents of the clinical review.

Medication

In-possession medication

132. The man had no in-possession medication and the prescribing and cessation of medication he received, except paracetamol which I refer to below, was appropriately managed and recorded by healthcare staff.

The man's paracetamol intake

133. It has been detailed that the man was prescribed several medications for his health issues. He was also issued with paracetamol, which is recorded on SystemOne as being given to him by staff nurses on request, although it does not state why he was given it. There is also no evidence that this was prescribed and there were no systems in place for medication to be prescribed, which can be done by nurses for example, under the Patient Group Directions (PGD's).

134. The clinical reviewer also notes that paracetamol can be given at the low doses, in patients with liver cirrhosis such as the man without causing undue effects. However, the investigation found there were no obvious checks in place to monitor the effect on the man's liver condition, which became an issue as Dr D wrote to the man advising him that he should reduce his paracetamol intake. In spite of this, there appears to have been no checks to ensure that the

man was not stockpiling paracetamol given to him nor evidence of a medication review as described in the ACCT plan.

135. Indeed although the man admitted to a self administered overdose of propranolol he continued to be provided with paracetamol with no recorded documentation of the dose and quantity actually taken.

136. In the community, paracetamol is widely available over the counter and is therefore easily accessible. The issue in this instance was that the issuing of paracetamol appeared to have been overlooked alongside other medications that were being prescribed. From the staff interviews and the evidence within the records, it is apparent there is no formal system for assessing patients and recording actions for patients requesting paracetamol. This does not support good practice of clear and accurate records reporting the relevant clinical findings and decisions made. I therefore make the following recommendation:

The Head of Healthcare should ensure that accurate and clear records are made of all prescribed and non prescribed medications to ensure accurate monitoring of a prisoners healthcare can be maintained.

Integrated approach to healthcare

137. The man had a significant amount of contact and intervention from the MHIT. There was no formal diagnosis of mental illness, and monitoring by the MHIT team had not found evidence of continuing auditory hallucination. The man had told staff a psychiatric report was to be prepared for the court, but there is no prison record of this request and it had not been undertaken by the end of September.

138. Wing staff talked positively to my investigator about how responsive the MHIT were to requests to see prisoners. However, much of the communication between wing staff and the MHIT was verbal and not well recorded.

139. The investigation found no evidence either recorded in the ACCT plan records or the medical records of how an integrated approach to managing the risk the man posed to himself was devised by healthcare, MHIT and prison staff. This is important given that different aspects of the man’s care were being managed by different people. Such systems should involve healthcare assessments and care plans should be devised and applied to improving integrated approaches between the different areas of responsibility, who were all ultimately involved in the man’s ACCT risk reduction planning.

The Governor and Head of Healthcare should ensure a multidisciplinary approach is developed between healthcare assessments and ACCT care plans for receiving, recording and monitoring a prisoners at risks and that this information is shared to all those involved in the care of the prisoner.

Allegations of bullying

140. Although there were allegations of the man being bullied there appeared to be no evidence to support this. He displayed negative behaviour on many occasions towards his peers and staff and was described as paranoid and difficult. The man was understandably frustrated by the issues he experienced with his wheel chair and with the restricted mobility he experienced at times. It is perhaps surprising that the alleged incident where excrement was left on his wheel chair was not investigated as potential bullying and the Governor and Violence Reduction Co-ordinator will no doubt wish to consider this further.

Assessment, Care in Custody and Teamwork (ACCT)

141. The man had been subject to three ACCT plans during his time at Bedford, the last of which was current at the time of his death. All three plans had been opened and maintained appropriately. There were common concerns raised by The man through all three ACCT assessments to do with medication and medical issues, depression and problems with his wheelchair. There is evidence that under the first two ACCT plans actions taken to address these issues did reduce his risk to himself.

142. A similar approach was adopted in the third ACCT plan and actions were taken to reassure the man in respect of his medical issues. He had been seen by the doctor the day before this ACCT was opened and prescribed medication due to his panic attacks and irregular heartbeat. After the ACCT was opened he was re-referred to the doctor, and during the initial review it was agreed to reduce his observations to hourly. Dr D saw him again on 22 September and, finding him anxious and dissatisfied but engaging well, prescribed him an additional mild antidepressant, all medication to be given under clinical supervision. There is no record of a response, however, to the man's wish to be moved to the healthcare centre. Nor does it appear that consideration was given to reviewing the ACCT subsequent to the man's admitting that he had taken six tablets (propranolol) at once, in order to stop his heart.

143. There were some indications that the man was experiencing increased levels of stress. Staff told my investigator that the man's mood had lowered since news of his brother's death, although there are also records he had been coping with this bereavement. Also there were some signs of stress over his final court case. He had complained of not being clear of his release date and said he was "fed up" with being punished. However, his request for information about transfer to HMP The Mount indicates some forward planning and awareness of the next stage after being sentenced for outstanding matters. The man had refused to sign his updated ACCT caremap, albeit he had attended the review. The reason for this refusal is not recorded, but the senior officer had seen him again shortly afterwards to assure him of actions taken.

144. Throughout the day on 24 September the pattern of the man's behaviour was similarly inconsistent as in previous days, varying from normally watching television to expressing his fear of others and feeling stressed to saying he had no problems. At one point a prison officer describing him as very paranoid and

the ongoing record also recorded that the MHIT "state he is ok for normal location".

145. The ACCT ongoing record shows that the man's level of monitoring was appropriately actioned and maintained. This was balanced with the need to manage some of his complex, and at times demanding needs. Staff also felt that, at times, the man's behaviour could be manipulative. However the approach to such reviews for a man of such needs should be as multidisciplinary as possible. There were occasions when the man's ACCT reviews were conducted by only wing prison officers. Other prison staff such as chaplaincy and general nurses should also be invited to attend reviews to provide a holistic view of his care.

146. It would appear that there was an over reliance on verbal sharing of information and that there is an insufficient recording of the MHIT's advice, based on their assessment, in ACCT records. Recording the advice and information is essential to ensuring it is maintained through shift handovers and to assisting wing staff manage risk according to the plan. This would certainly be considered good multidisciplinary approach to care for a prisoner.

147. I therefore make the following recommendations:

The Governor and Head of Healthcare should ensure a multidisciplinary attendance of staff at ACCT reviews is maintained as far as possible.

The Governor and Head of Healthcare should ensure the Safer Custody Manager and the Nurse Manager of the mental health in-reach team devise a protocol to ensure that advice given by the mental health in-reach team is appropriately recorded in ACCT documentation.

The man's disability

148. The inherent physical design problems of Bedford prison, combined with the man's restricted mobility and dependency on a wheelchair, undoubtedly contributed to his frustration and stress. There is little evidence of any coherent assessment leading to a systematic care and support plan to mitigate these problems and assist the man in maximising what opportunities he had within the prison. There was also no evidence to suggest that the man had met with the diversity manager (who is responsible for disability matters) to discuss any concerns he may have.

149. Both within the records and in interviews with staff it is evident that the man experienced a significant degree of difficulty in terms of the physical environment at Bedford. The cell doors required the man to collapse his wheelchair to simply enter and exit his cell. Similarly he was unable to use the wing shower facilities and had to rely on a weekly visit to the healthcare centre for a bath. He was unable to access the education department or chaplaincy both of which were located on a higher floor. It took six weeks from his reporting a puncture in his wheelchair tyre to it being fixed (by an external company) on 2 July. During the third ACCT assessment the man complained

his wheelchair again needed repairs, but this was not immediately attended to, and it took another five days before a request for a replacement wheelchair was emailed. Staff were aware that the man used his wheelchair at times as a walking frame, yet, even after it was known and assessed that he could use a walking frame no action is recorded to provide him with one. Staff told my investigator that his access to day care centre activities in the healthcare centre or to the computer based cognitive behaviour therapy programme, which may have been of benefit to him, were also limited by the restricted movement his disability placed on him.

150. In these circumstances there is evidence that staff did consider how to provide the man with increased opportunities for activities. Education was provided for him in his cell and he had weekly access to a bath, one to one interventions from the mental health team and bereavement counselling from the chaplaincy. He was eventually able to access outside association.

151. However, I find it unsatisfactory that these efforts appear to be piecemeal and reactive responses. The records contain no evidence of a proactive and coordinated support plan to enable the man to navigate the limitations of the prison design and give him, as a disabled person, equality of access to all activities. I consider that the length of time it took to repair the puncture to the man's wheelchair was also unsatisfactory.

152. The clinical reviewer's report makes recommendations in this regard for the healthcare services at Bedford. However, the responsibility for a support plan for disabled prisoners at Bedford lies equally with the discipline staff. I have reviewed both the recommendations of Her Majesty's Chief Inspector of Prisons 2009 report for Bedford, and the Independent Monitoring Board's 2010 report above. This highlights there was little accommodation suitable for those with significant mobility problems. Prisoners were asked a range of questions on induction around ethnicity, sexuality and disability but this did not result in any further care planning.

153. The IMB's report makes clear that senior management at Bedford are well aware of the problems the prison faces in enabling disabled prisoners' access to facilities. Some progress toward consulting with disabled prisoners has been made, indeed the man was interviewed himself on one occasion by an Officer Salisbury who had been given the consultation task for the prison's disability project.

154. However, given the problematic situation The man found himself in, I make the following recommendations:

The Governor at Bedford should ensure that the disability equality scheme is communicated to all staff and prisoners.

The Governor at Bedford should ensure that care and support plans for disabled prisoners are completed as soon as possible and no later than two weeks following reception, that these are regularly reviewed, and that

discipline, healthcare and all other relevant staff should engage in their delivery.

The man's location within the prison

155. The man was located appropriately in the healthcare centre on his first reception given his healthcare needs and the initial stage of his detoxification programme. While there he was moved into shared accommodation to increase his opportunity for company. On 22 February he was assessed as fit for normal location and was appropriately moved to D wing, which is the wing providing the integrated drug treatment system (IDTS) of support for prisoners during or following their detoxification.

156. During his time on D wing the man's behaviour deteriorated and he was subject to disciplinary actions due to his increasing abusive and intimidating behaviour toward staff and other prisoners. He had also made allegations of receiving threats from other prisoners, although there no substantive information recorded about this by staff. Immediately on the first ACCT being opened he was moved from a shared into a single cell as he had requested and as his risk of harm to other prisoners had been re-assessed as high.

157. The man first told a member of staff from the education department, that he should have been moved to the healthcare centre on 17 September. He repeated this to an officer on 19 September after the third ACCT had been opened. Officer K told my investigator he had reassured him that he would be seen by a doctor who would assess whether his needs were best met by relocation to the healthcare centre.

158. When he was seen by Dr D on 22 September the man's request to be moved to the healthcare centre was recorded, but there is no record of the reasons for this move not being decided. Dr D told my investigator he believed the most effective thing for combating depression is exercise and that the man had little opportunity for that. Interviews with staff show that the healthcare centre generally was limited in the amount of activities and opportunity for exercise it could offer. Officer D understood that moves to the healthcare centre for prisoners in wheelchairs were limited to those with more severe nursing needs.

159. The last HMCIP 2009 report included a recommendation that Bedford should not routinely locate prisoners with an increased risk of self-harm needing increased observations in the healthcare centre. PSO 2700 also states that it is better to manage prisoners on ACCT on normal location where possible and that healthcare should not be the default location. Given the man's continual interaction with healthcare staff I believe they were aware of his situation and location needs. The decision about his relocation to healthcare was just not recorded. Whilst I make no formal recommendation in this regard, however, I consider best practice would be that prisoners subject to ACCT procedures requesting relocation are given a timely decision with an explanation which is fully recorded.

Emergency Response on 24 September

160. Both discipline and clinical staff responded to the man's emergency on 24 September in a speedy and appropriate manner. Their combined interventions resulted in successfully restoring his pulse and giving him a chance of survival.

161. The first officer on the scene raised the alarm and seeing support on the way quickly entered the man's cell. Both in statements and in interview with my investigator the officer said that as he could see that the man was unconscious and not breathing his first, and instinctive, response was to cut the ligature and free him. The man fell to the floor, hitting his head on a table, as he fell. SO D by this time was just behind the officer, but not close enough to support the man's weight.

162. The first officer on the scene had been a qualified prison officer for nearly four months, having undergone the full two months training since joining the prison service. He told my investigator he had found the training he had in emergency situations had helped him focus on communicating the man's emergency clearly. PSO 2700 states that in such emergency circumstances when releasing a prisoner suspended from a ligature, the prisoner's body should be supported, staff utilising other methods of support, such as furniture. The officer wanting to release the man as quickly as possible, had no support in place and as a consequence, the man hit his head on a table as he fell.

163. SO D told my investigator that the man was in a single cell and still alive, and in this circumstance, he considered the officer did the right thing in freeing him as soon as possible in order to get him breathing again. Whilst I agree that the first officer on the scene's reactions were driven by the aim to preserve life, it is important that staff are reminded that it is necessary to support the weight of a person in such circumstances to avoid further injuries as they are released from a ligature.

The Governor should remind staff that, in line with guidance in PSO 2700, in the event of discovering a prisoner who has self harmed through hanging, immediate action should be taken to support the body until the body can be released from the ligature.

164. SO D, taking control of the situation found that no uniformed staff that had arrived first had up to date first aid training. On this occasion this had no serious consequence as clinical staff responded very promptly to the first officer on the scene's 'Hotel 2' call for emergency medical assistance, and were able to start CPR.

165. Furthermore, however, the emergency radio call used at Bedford did not distinguish between types of medical emergency, with the consequence that whilst clinical staff arrived with the emergency medical bag, the defibrillator (AED) machine had to be collected separately. This was in the event undertaken swiftly

166. However, in respect of these two issues, I consider it best practice both that uniformed prison officer staff who are usually the first responders to medical

emergencies do have up to date first aid training which enables them to start CPR, and also that radio codes are used distinguishing medical emergencies so that clinical staff can arrive with the AED machine and are better prepared for the sort of emergency they are responding to.

167. I also refer to the Chief Executive Officer's letter dated 29 October 2010 to all prison governors. The letter highlights the need for each establishment to review their first aid arrangements for prisoner-related incidents and where inadequacies are identified, action plans must be put in place with timescales to remedy the situation.

168. Clinical Services Manager and other staff, told my investigator that Bedford has subsequently ensured a back up 'Hotel 1' radio has been provided which enables two clinical staff to respond, and also consideration is being made for a simple medical emergency radio code system. This is welcome, however, I do make these recommendations:

The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.

The Governor at Bedford should ensure there is an agreed emergency radio code call which distinguishes medical emergencies.

Family Liaison

169. After the man had been taken to hospital the duty governor contacted his sister by telephone to advise her of events and also appointed a family liaison officer. Liaison with the family was maintained until after the man's funeral and was undertaken.

170. On the man's death the prison Governor wrote a letter of condolence and support. The prison assisted with the family's funeral expenses. There is evidence the family appreciated the support given them by the prison.

Conclusion

171. It is very evident from reviewing the man's prison records that he had a number of health issues. He was also frustrated at not only being in prison, but also the restrictions this placed upon him because of his mobility problems. He was a difficult prisoner to manage because of his many outbursts against staff and other prisoners, whilst at the same time presenting as low in mood and being at risk of self harm.

172. Despite it not being fully documented, the man had a lot of interaction with staff who tried to address his risks and attend to his needs. At times, as the investigation has found, a number of processes could have been improved upon to ensure risks identified were minimised as much as possible. No doubt staff at Bedford themselves found it difficult to manage the man's mobility issues given the prison is not wheel chair friendly. However these were unlikely to have had the effect of totally dissuading the man from wanting to take his own life. This was a feeling he had had prior to being in custody and of which it would appear remained with him.

173. I believe that given the amount of healthcare and staff intervention the man received, staff could not reasonably have been expected to foresee his death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that accurate and clear records are made of all prescribed and non prescribed medications to ensure accurate monitoring of a prisoners healthcare can be maintained.

   The National Offender Management Service accepted this recommendation, writing:

   "Patient Group Direction in place for paracetamol, which was noted in the report. Administration and Prescribing systems have been improved, new drug administration chart being launched 1/52."

2. The Governor and Head of Healthcare should ensure a multidisciplinary approach is developed between healthcare assessments and ACCT care plans for receiving, recording and monitoring a prisoners risks and that this information is shared to all those involved in the care of the prisoner.

   The National Offender Management Service accepted this recommendation, writing:

   "Healthcare and Safer Custody regularly have ACCT reviews together for patients held on the Inpatient unit and in Primary Care. With the development of the Primary Care Mental Health Nursing posts, this will further give Healthcare and Safer Custody opportunities to have integrated working. The posts have been appointed too, awaiting start dates."

3. The Governor and Head of Healthcare should ensure a multidisciplinary attendance of staff at ACCT reviews is maintained as far as possible.

   The National Offender Management Service partially accepted this recommendation, writing:

   "Accept principal, however this can be difficult to ensure happens due to staffing constraints."

4. The Governor and Head of Healthcare should ensure the Safer Custody Manager and the Nurse Manager of the mental health in-reach team devise a protocol to ensure that advice given by the mental health in-reach team is recorded in ACCT documentation.

   The National Offender Management Service accepted this recommendation, writing:

   "MHIT members record interaction with prisoners on ACCT routinely on System 1. All now instructed to ensure this information is also included in ACCT documentation."

5. The Governor at Bedford should ensure that the disability equality scheme is communicated to all staff and prisoners.

   The National Offender Management Service accepted this recommendation, writing:

   "The Bedford Equality Plan is currently under review. Once review is completed, it will be communicated via Notices to staff and prisoners."

6. The Governor at Bedford should ensure that care and support plans for disabled prisoners are completed as soon as possible and no later than two weeks following reception, that these are regularly reviewed, and that discipline, healthcare and all other relevant staff should engage in their delivery.

   The National Offender Management Service accepted this recommendation, writing:

   "Disabled prisoners are assessed by Health Care staff on reception into custody. As part of the review of the Bedford Equality Plan, the Diversity Manager will put in place measures to ensure that care planning for older prisoners is clear and effective."

7. The Governor should remind staff that, in line with guidance in PSO 2700, in the event of discovering a prisoner who has self harmed through hanging, immediate action should be taken to support the body until the body can be released from the ligature

   The National Offender Management Service accepted this recommendation, writing:

   "To be included in annual ACCT refresher training. Governor's NTS re this report to include reminder to staff that if discovering a body hanging, the immediate action should be to support the body."

8. The Governor should review the need for first aid or basic life support training, including refresher training for staff on frontline duties.

   The National Offender Management Service partially accepted this recommendation, writing:

   "HMP Bedford has 24 hour health care services in place therefore there it considers there is not a need for all front-line staff to be trained. Risk assessment in place (last reviewed 21/02/2011 and subsequently on an annual basis) identifies First Aid requirement – all permanent night staff to be trained."

9. The Governor at Bedford should ensure there is an agreed emergency radio code call which distinguishes medical emergencies.

   The National Offender Management Service partially accepted this recommendation, writing:

“OSRR, in consultation with Security Group and Offender Health, are currently drafting national policy on the use of emergency codes.”