INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT BEDFORD HOSPITAL IN SEPTEMBER 2005 WHILST IN THE CUSTODY OF HMP BEDFORD

Report by the Prisons and Probation Ombudsman for England and Wales

August 2006

This is the report of an investigation into the death of a man who died in September 2005, in South Wing, Bedford Hospital. The deceased, a prisoner at HMP Bedford, was found that morning, hanging from the ceiling light assembly in his cell. The post mortem examination carried out later that day confirmed that the cause of death was hanging. This report focuses on his time in prison custody and evaluates the systems in place to prevent suicide, self harm and promote wellbeing.

The man had been the subject of suicide and self harm monitoring throughout his time in Bedford. Although he made no physical attempts to harm himself, he made numerous threats to do so. He also talked to staff and other prisoners about his extreme anger with the outcome of his trial and the emotional distress he was suffering over his relationship with his girlfriend. He was assessed by a visiting psychiatrist who found no evidence of mental illness and described him as 'manipulative'. At no time did staff consider the level of watch should be escalated above the basic requirement for suicide and self harm monitoring. The man was the single occupant of a double cell at the time of his death. He had frequently expressed a strong desire not to share a cell and was disturbed by the imminent prospect of having to do so. During the investigation, prison staff, friends and family gave every indication of being shocked and taken by surprise, by his suicidal act.

I offer my sincere condolences to the man's family for the tragic loss of such a young life in such traumatic circumstances. Despite his persistent offending in recent years, they had always remained loyal, loving and supportive.

Two of my colleagues who are registered nurses, led the investigation from my office. I am grateful for the assistance they received from the staff and management of HMP Bedford. I wish to acknowledge too the co-operation of the Bedfordshire Police who carried out their own enquiry into the man's death and shared all available information. My thanks also go to the appointed doctor from Bedford Primary Care Trust who conducted the clinical review.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2006**

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SUMMARY

This is the report of an investigation into the death of a man who was 24 when he died at South Wing, Bedford Hospital on 1 September 2005. He was a prisoner at HMP Bedford and had been found hanging from the ceiling light assembly in his cell early that morning.

The investigation team reviewed his prison records and interviewed prison staff and prisoners. A clinical review was prepared by Bedford Primary Care Trust (PCT).

The man had been at Bedford since July 2005 when he was convicted of aggravated vehicle taking and sentenced to 22 months imprisonment. A custody officer at Luton Crown Court completed a suicide and self harm warning form because he had said he would kill himself with an overdose at the first opportunity. It was not the first time the man had been in prison custody. During the reception procedure, he disclosed that he had taken an overdose while in Bedford on a previous sentence in 2003. He also said he had cut his wrists two weeks prior to coming into custody this time. He told staff he felt unstable and mixed up and might harm himself. Consequently, on the evidence available, including the warning form, he was considered to be at risk of suicide and self harm. Suicide and self harm monitoring was initiated in reception, using the Prison Service F2052SH document.

Initially the cause for concern was his anger and distress over the sentence which was longer than any he had served previously. Later, his distress was compounded by frustration and upset over the deterioration in his relationship with his girlfriend. The man described himself as deeply in love but he was in fear of losing her because of the length of his sentence. After many loving phone calls in the early part of his sentence his fear was exacerbated by his being unable to speak to her because her mobile phone went continually to answer-phone mode.

Over the following weeks, his mood fluctuated and he frequently threatened to self-harm, although he made no physical attempts to do so. He talked to staff and other prisoners about his extreme anger with the outcome of his trial and the emotional distress he was suffering over his relationship with his girlfriend. He was assessed by a visiting psychiatrist on 18 August who found no evidence of mental illness and described him as manipulative. At no time did staff consider the level of watch should be escalated above the minimum requirement for suicide and self harm monitoring. This was despite him having shown an officer a note for his girlfriend 'which read like a suicide note' on 21 August at 7.25pm. The next day at 8pm he described to a member of staff in the health care centre how he could store his medication to obtain an overdose which he would take before hanging himself from the strip light in his cell.

On 25 August there was an incident in the healthcare centre when he was alleged to have thrown a book at a prison officer. He made a counter allegation that the officer had assaulted him. His allegation was the subject of an investigation at the time of his death.

On the morning of 1 September 2005 at 7.45am, during a routine roll check, the man was found hanging from the strip light assembly in his cell. Strenuous attempts were

made to resuscitate him. Actions taken by staff following the discovery of the man hanging in his cell are described in detail within the report. All staff concerned reacted quickly and together with ambulance service personnel every effort was made to revive him. He was subsequently taken to the South Wing, Bedford Hospital, but at 9.30am the nurse who had accompanied him in the ambulance rang the prison to inform the Governor that the man had been certified dead.

This report focuses on the man's time in prison custody and evaluates the systems in place to prevent suicide, self harm and promote wellbeing. The clinical review of his health care by Bedfordshire Primary Care Trust has contributed to the findings and conclusions of the investigation.

My investigation makes 10 recommendations. Examples of good practice identified by the Primary Care Trust clinical reviewer have also been acknowledged.

THE INVESTIGATION

1. The investigation into the man's death was undertaken by two investigators both of whom are registered nurses who work for my office. They visited the prison and were shown the areas where the man would have been held including the cell where he died.

2. They issued notices to staff and prisoners inviting anyone with information relating to his death to make themselves known to the investigation team. Three prisoners who knew the man came forward to speak to them. My investigators formally interviewed four prison staff who were involved with the man's management and/or the events surrounding his death.

3. My investigators also spoke to members of the Independent Monitoring Board (IMB), the Prison Officers' Association (POA), two of the prison chaplains, and various other members of staff.

4. My investigators were given early access to the documentation that had been gathered covering his time in prison. On further occasions prison staff sought out and produced a number of documents my investigators noted were missing from the initial bundle. They also met at an early stage with members of the Bedfordshire police who were investigating the man's sudden death. The police later provided copies of the documents and statements in their possession. I am most grateful to them for their co-operation, which assisted my investigation.

5. One of the investigators and one of my family liaison officers visited the man's mother and sisters to discuss their concerns about what had happened to him.

6. My investigators commissioned the Director of Care from Bedford Primary Care Trust, to conduct a clinical audit of the man's health care while in prison.

HMP BEDFORD

7. Bedford prison is a relatively small, local prison, serving courts in the county and further afield. It provides for a rapidly changing population of adult male prisoners. It is a Victorian prison, with some new buildings added in the early 1990s. Its accommodation is ideally for 325 prisoners, and its maximum operational capacity is 494. On 1 September 2005, it was holding 460 prisoners. C wing, which is mainly used as an induction wing, was holding 74 prisoners.

8. The most recent inspection by Her Majesty's Chief Inspector of Prisons was in January 2004 therefore its relevance to this investigation must be taken in that context. She found Bedford to be a fundamentally safe and well-controlled prison. She said that it provided a largely respectful environment with good, mutually respectful staff-prisoner relationships. The Chief Inspector had some specific concerns about the approach to prisoners at risk of suicide or self harm. She said that better co-ordination of elements within the safer prisons strategy would create a preventative rather than a reactive approach.

9. In 2004, the Prison Service conducted its own internal audit of Bedford prison. It found the prison to be operating at a high level and improving, although there were some areas of concern. Suicide and self harm procedures were good (rated 92% compliant) but some inconsistencies of process and monitoring were noted and reviews were not always acted upon.

10. In November 2004, Bedford prison was rated level 4 in the Prison Service's Performance Rating System. Level 4 is awarded to exceptionally high performing establishments, consistently meeting or exceeding targets, with no significant operating problems, achieving significantly more than similar establishments with similar resources. The rating is based on cost performance and output data, compliance with Prison Service standards, findings from external inspections, and the views of the Prison Service Area Managers and Management Board.

11. There have been five previous deaths in Bedford in the past three years. Three prisoners died towards the end of 2002. There was one death in November 2003 and one on 27 December 2004. The Chief Inspector said, following her January 2004 inspection, that the small number of recommendations arising from the investigations into the 2002 deaths had all been implemented.

CHRONOLOGY OF EVENTS 22 JULY – 1 SEPTEMBER

12. On 22 July, the man was received into custody at Bedford prison following sentencing to 22 months imprisonment. A suicide/self-harm warning form raised at court and sent with him to prison stated that he had said he intended to kill himself at the first opportunity by overdose.

13. During the prison reception assessment the man stated that he has had his life taken away from him following receipt of the 'hardest sentence of his life'. He also said that he had had enough of his life. A Suicide and Self Harm monitoring form (F2052SH) was opened and staff noted that he should be in a shared cell, with a Listener[1] if possible. The level of supervision was set by the nurse who assessed him after discussion with the doctor. She set it at 'normal'. From the evidence available it can be deduced that this was implemented in line with the 'minimum' requirement set out in the local suicide prevention policy.

14. The cell sharing risk assessment stated that he did not feel comfortable about sharing but would accept a listener. He was assessed as a 'low risk' to other prisoners, for cell sharing. The man was located in the First Night Centre (FNC) on landing one on C wing at 8.56pm but at 9.16pm he was moved to a cell on landing two without any explanation being recorded.

15. The man's first F2052SH review was held on 23 July. He stated that he felt like killing himself as he had received a long sentence (the longest he had ever received) and also he was worried that his girlfriend would leave him. He stated that he wanted to get transferred to another prison and complete some courses. He also asked to see the community psychiatric team (CPN). The next F2052SH review was arranged for ten days time (1 August). The man asked to be moved to his friend's cell.

16. On 25 July 2005 he was moved to a cell on landing four in C wing. The records do not make it very clear whether he was sharing a cell or not. However on 27 July a note was made in the F2052SH that he did not want 'anyone in his cell with him anymore'. By 30 July 2005 he was described as appearing happier and much more cheerful than he had done previously. He told staff that he wished to come off the F2052SH at the next review. He moved from C wing to A wing on 31 July to share with a prisoner with whom he had previously shared.

17. On 1 August a F2052SH review was held at 4pm. The man was still concerned about the length of his sentence. It was decided that the F2052SH should remain open and be reviewed in 10 days. On 2 August, he was taken by the police to St Alban's police station. Forensic evidence had come to light that linked him to an accident in a stolen car. He was not charged with any offence, following the police investigation.

[1] A Listener is a prisoner who has undertaken a training course by the Samaritans in order to support fellow prisoners contemplating self harm or suicide.

18. On 5 August he told staff that he had received a 'bad letter'. A note was made in the observation book and staff were asked to be aware. A F2052SH review was held on 11 August at 10.30am. He was frustrated due to security mislaying his cash disbursement form. This had apparently put a lot of strain on his relationship with his partner. The man stated that if he and his partner split up he would take his own life as he felt there was no point in living anymore. The next review was arranged for ten days ahead. At 4pm he threatened to self harm if his visit on Saturday did not go well.

19. On 13 August he told staff that he was concerned about his girlfriend and that she would not talk to him. He reiterated that if she finished with him he would kill himself as he had nothing outside to live for. The man told staff on 14 August that his girlfriend had said she would visit the following week so he was feeling better.

20. On 16 August he was seen by a doctor at 2.50pm (according to F2052SH records). That night, at 2am, he told a member of staff that he did not feel well - No other note was made as to exactly how the man was feeling and no action was documented. On 17 August, at 9pm, he told a member of staff that he was concerned about his girlfriend, but when spoken to, he said he was 'content to leave his problem till the morning'.

21. On 18 August 2005 at 9.15am and at 12.05pm, on A wing, the man threatened to climb up onto the rafters and tie himself up there if the CPN did not come and see him by the end of association and pay him attention. At 2.30pm a wing officer noted that the man was 'in a very agitated state'. The officer reassured him that the CPN was coming to see him. At 3.40pm another officer noted that he was still agitated and requesting to be taken to B1 (the segregation unit[2]). The further records of the events that day conflict chronologically. From careful scrutiny of all the available documents my investigators concluded that events were as set out in the next paragraph.

22. The 'Use of Force' records and the evidence given at a subsequent adjudication indicated that at 4.07pm the man refused to return to his cell. He was protesting because he considered the interview with the CPN and the psychiatrist had been unsatisfactory. The man held onto the bars of a gate and refused to let go. He was restrained using control and restraint techniques (C&R) and taken to the SSU. An entry in the F2052SH at 4.15pm noted his relocation. The Local Inmate Database System (LIDS) printout showed that he moved from A4-28 to B1-05 at 4.21pm.

23. The CPN made an entry in the F2052SH, timed at 4.15pm, in which she recorded that the man was expressing suicidal intentions and saying he was on day two of a hunger strike. She described him as not clinically depressed and refusing medication. In the medical record the CPN described the interview in more detail saying that the man was angry in mood and manner, believed that he was worthless and his life not

[2] At Bedford the segregation unit on B wing is known as the Separation and Support Unit (SSU)

worthwhile. There was no evidence of any thought disorder and/or clinical depression or any requirement for treatment. She noted that she had seen him together with specialist psychiatric registrar (SPR) who also wrote a report for the record. The doctor's findings concurred with the CPN's. However, the psychiatrist also suggested that the man's suicidal ideation was 'in order to manipulate a single cell' and described him as petulant, unpleasant and sarcastic as well as manipulative.

24. The man complained of sore wrists following the C&R and was subsequently seen by the doctor at 5.10pm, when, according to the Report of Injury to Inmate form, no further complaint was made. A Use of Force form (F2326) form was completed. A Segregation Safety Algorithm was signed by the doctor but not completed fully. The decision in part B was that the man was suitable for segregation.

25. On 19 August an adjudication was held regarding the incident the previous day. The man responded to the charge by explaining that he had been seen by the CPN (whom he referred to as a psychiatrist). When the officer asked her if the man was OK, she replied 'yes'. The man was upset because he felt he was not alright. He alleged that he had not eaten for three days and that he was on hunger strike. He also mentioned that he had nothing to live for if he lost his girlfriend and also that he been 'stitched up by the judge'. He was punished with a seven day loss of privileges suspended for three months. He was told at the adjudication that if he was not happy with his consultation with the 'psychiatrist' he could see another one. He was informed that he would be referred anyway (the person to whom he was subsequently referred was also a CPN and not a psychiatrist). The adjudicating governor sent a memo to the CPN's stating that the man was saying he was on hunger strike and he had some issues that he wanted to discuss and seek help with but with which he felt he was not getting any help.

26. The clinical record entries for 18 and 19 August are out of chronological order. An entry by the primary care doctor on 19 August indicated that having seen the man in SSU, he spoke with a CPN. He noted that the man was to see a psychiatrist on Monday and prescribed medication to 'ease him' until then. According to the record, he was seen by another CPN, on 19 August, although the first CPN made the entry.

27. Later on that day a routine assessment for the issue of lighting materials in the SSU concluded that the man was at risk of self harm, had a 'poor frame of mind at present' and should not be issued with lighting materials. An F2052SH review was held at 3.30pm. The man told the review panel that he wanted to end it all. He has stopped getting letters from his girlfriend. He said he was on hunger strike. The CPN team had arranged for him to see a doctor the following Sunday, 21 August. He left the room whilst the arrangements were being explained to him, returning some 10 minutes later. He made a promise to eat and to see the doctor on Sunday. A segregation form was completed which stated that the man felt with his state of mind he may assault another prisoner if placed on normal location.

It was decided that he would remain in SSU until his next review on 22 August and he was to be seen by the psychiatrist on 21 August.

28. On 20 August the man had been expecting three visitors. When they did not turn up for the visit, he was shown into the visits holding room where he smashed a window. He was placed on report pending adjudication. On 21 August he was recorded as 'making silly comments about self harming'. An officer wrote that the man was 'playing mind games' and staff should be aware. The man was due to be seen by the psychiatrist on this day but due to an administrative oversight concerning another prisoner with the same name, he was not seen.

29. An adjudication relating to the smashed window was held on 22 August at 11.15am. The man said that he was guilty in himself but in his mind he was not. The man told the adjudicator that he felt the sooner he was dead the better. He said he was seeing a psychiatrist that day. He had apparently tried to call a number the previous day but was told he could not ring it. My investigators have been unable to ascertain what this referred to. The man also said that if he was sent back to the wing he would attack the other prisoners so that they would kill him. He said he would climb onto the main beam and tie a noose around his neck. In his reply to the charge, he claimed that he started hearing the voice of the person who had raped him when he was younger. He saw the person's face in the window and so he punched it, in the hope that it would slice his wrists open. He also wrote in his response that they should read his reply to his previous adjudication. He stated that he had nothing left to live for inside or out. He wrote at the bottom, 'Now I'll just have to die'. The man was punished with one day of cellular confinement. He had not been assessed by a doctor in respect of his fitness for cellular confinement.

30. An F2052SH review was held at 3.40pm. The man said he remained depressed over his situation. He showed staff letters which he had written to his girlfriend telling her how he felt. The CPN recommended that he be moved to healthcare. A review was arranged for seven days. The man was admitted to the health care centre (HCC) and in the admission form it was stated that he was continually stating he wanted to die. He became quite aggressive, he pulled his bunk bed apart, said the room smelt and he stuffed tissue paper in his nose.

31. On 23 August the man remained very angry and was making threats of self harm if he was not moved out of HCC to a single cell. He was still very distressed about his relationship, which he believed to be over. He was reported not to be showing any psychotic symptoms but the F2052SH was continued as he appeared not to be coping. He stated that he wanted to go back to SSU. He was reassured and advised to give his medication time to work. At 4pm on 24 August he was found breaking the doors off the locker in his cell in healthcare. He was placed on report pending adjudication.

32. On 25 August he was seen again by the CPNs. At approximately 10am the man allegedly attempted to assault an officer in the HCC when he was

asked to clean his cell. He was controlled and restrained and a Use of Force form was completed where no injuries were noted. In the Use of Force form the F213 was documented as being completed by a staff nurse. However the F213 was not signed by the nurse. A doctor signed that there were no injuries to the man. That entry was dated 27 August. According to the LIDS printout, the man moved from H1-001 to A4-027 at 10.37am, at 11.03am he moved to B4-013 and at 5.01pm to B1-006. At some stage during this day a security information report (SIR) was submitted reporting that the man had made a weapon from a broken knife. It further reported that the man said he was going to 'get' an officer as he had been assaulted by him. The weapon was removed from him and stored to use in any adjudication which followed. The SIR was not signed or dated and timed but numerically it preceded the form submitted by a wing nurse (see below).

33. On 25 August, the wing nurse submitted an SIR at 1.30pm reporting that during the previous day the man had told her about a threat to an unpopular officer on A wing. The security department concluded that this was a repetition of an earlier rumour which had not been substantiated.

34. An adjudication was held on 26 August at 10.55am on the charge of breaking the doors off his locker on 24 August. The man pleaded guilty and his written statement was read out. He stated during the adjudication that he smashed the locker because nobody was listening to him and that he wanted to be on his own. He was told by the acting Governor who was adjudicating, that he would not be given a single cell on the wing until he stopped saying that he was going to harm himself. The man was punished with five days cellular confinement. The man had been assessed fit for cellular confinement by the doctor before the hearing.

35. A second adjudication followed at 11.05am on a charge that the man allegedly threw a book at a wing officer on 25 August. The man counter-alleged that he had been assaulted by the officer. The man wrote in his response that he was scared of this officer and that he had asked security for a photograph to be taken of the bruising he suffered when the officer punched him. The man claimed that photographs had not been taken before the swelling went down. The adjudication was adjourned pending an investigation into the man's allegations. The acting governor commissioned a Principal Officer (PO) to undertake the investigation and a copy of her report was made available to my investigators. It concluded that the man had not been assaulted and that he had been behaving in a threatening manner towards the officer.

36. On 26 August, the man was fitted for segregation by the doctor at 11am. The duty governor, made a note that his violent behaviour deemed him unsuitable for HCC. An assessment for the issue of lighting materials was completed and lighting materials were issued. Although he was on open 2052SH it was noted that there were no self harm concerns at that time.

37. At 2pm the man told a member of staff that when he was moved to the main prison he intended to climb up onto a beam with a noose around his neck

until the prison brought the press in for him. An SIR was submitted to the security manager by an officer about this threat. In the SIR process, on 27 August, security staff noted that the man had mental health issues and might be capable of carrying out his threat. When the acting Governor, signed off the SIR he wrote that when the man was moved out of SSU his location needed careful consideration. However no further action, for example, communicating this recommendation to wing staff was ordered.

38. An F2052SH review was held at 3pm and it was decided that the man should remain on F2052SH for a further ten days. The man had issues about the alleged assault and the investigation. He presented as a very angry man who stated that he was depressed. He was reassured by the residential senior officer that he was safe in SSU. The CPN was made responsible for looking into his medication. A review was arranged for ten days time (5 September). The man was assessed as fit for segregation at 4.45pm, although he was still on an open F2052SH.

39. The doctor saw him on 27 August and declared him fit for normal location. At 2.54pm the man was moved from cell B1-06 in the SSU to C1-03 in the FNC in order that another prisoner could be located in SSU. He was very happy about this. He was still serving his period of cellular confinement. It had not been rescinded before he was removed from the SSU.

40. On 30 August an untimed entry in the wing history sheet showed that when he was unlocked to receive his medication, he refused it and slammed his door shut. The duty senior officer noted in the F2052SH that the man remained adamant that he did not wish to share a cell.

41. On 31 August the man was unhappy to learn from the FNC manager that he was soon to be moved because his period of cellular confinement was complete. At interview the FNC manager told my investigators that she had had a lengthy conversation with him about his girlfriend. She subsequently telephoned his girlfriend for him but could only leave a message. At 9pm that day he was given a prison letter form by an officer. The officer noted that the man had rung his bell a couple of times and described him as ‘wanting to talk’ but that he did not want to share his cell.

EVENTS OF THE MORNING OF 1 SEPTEMBER 2005

42. At 6am on 1 September the man was observed as part of the routine F2052SH checks. He was described as lying on his left hand side and appearing to be asleep. During the morning count he was seen lying on his bed at 6.15am. A second wing officer noted in the record that he was awake. At approximately 7.45am the man was found by a third wing officer hanging from the light fitting in his cell in the FNC. He had made a ligature out of a sheet. The third wing officer summoned help. The cell door was then unlocked and the wing senior officer cut the ligature and removed it while the 3rd wing officer took his weight. Staff laid the man on the floor and officers commenced two-person cardio-pulmonary resuscitation (CPR). Urgent assistance was requested by radio. Initially, health care staff thought they were being called to B wing and this caused confusion, but no undue delay.

43. At interview, the operational support grade (OSG) working in the Communications Room told my investigators that an officer who was working with her (now on maternity leave) thought the first telephone call was from B1, but in a second call she was told it was C1. The OSG explained that depending on which telephone the call comes in to, they may know where the call originates from, but may not. Two phones in the Communications Room have caller display on them, but the one does not.

44. An emergency call was made by the communication room to Bedfordshire Ambulance Control. There was some confusion during this call too. The communication staff had not been fully briefed as to the exact nature of the incident. During interview, the OSG described the pressure she felt at the time. She told my investigators that when an incident occurs there should be a third party in the communications room but on this occasion there was no third party, so she and the officer were trying to deal with the calls as well as making a log of events.

45. An ambulance arrived at approximately 7.55am. There were two technicians in attendance and no paramedics. A second ambulance was requested at approximately 8.05am and although the OSG made the call she was unsure as to why it was required. She thought someone had died. A fairly long conversation between her and ambulance control followed in which ambulance control explained that they did not convey dead patients. It was eventually established that the first ambulance crew were still working on the man and required assistance from another crew. A second ambulance with a crew of two technicians arrived at approximately 8.15am. The request should have been for a paramedic ambulance crew as this would have enabled appropriately qualified staff to make a decision about ceasing resuscitation efforts. The man was taken to South Wing, Bedford hospital. A prison nurse accompanied him in the ambulance. She rang the prison at about 9.30am to inform the Governor that the man had been pronounced dead.

EVENTS FOLLOWING THE MAN'S DEATH

46. At about 9am the duty governor convened a post incident debrief (the so-called 'hot debrief') in the Governor's boardroom. He made a retrospective note of that meeting at my investigator's request. He recalled the attendance of the night staff and the day staff who had found the man and attempted to save his life. The list of attendees did not include the communications room staff. The OSG confirmed at interview that they had not been called to attend. There were no healthcare staff on the duty governor's list. The healthcare manager held a separate debrief for her team later that morning.

47. The family were informed of the man's death by the Bedfordshire police through an arrangement made by the prison's police liaison officer. There was some delay in breaking the news to his mother because he had given his girlfriend's name and address as next of kin. He gave her surname as his, which added to the misinformation. The police went to the given address but she could not be found. The police checked their records of him and found a different address. They checked on the electoral roll and found a person with his mother's surname registered at that address. A police sergeant who went to break the news rang the prison from the house and his mother spoke to the prison's acting family liaison officer. The prison's family liaison officer was a governor grade on loan from the Prison Service Area office. She endeavoured to answer the mother's initial questions and give her necessary information. Subsequently she and the prison's lead chaplain spoke to the man's mother on separate occasions and made arrangements about tributes from prisoners and staff attendance at the cremation in Luton.

48. The acting Governor offered the man's mother financial help in funding the funeral. When my family liaison officer visited the man's mother on 10 October she was still awaiting settlement of the invoice from the funeral director. Prison staff also facilitated contact between the man's prisoner friends and his mother, whom they also knew. The prison staff balanced the needs of the young men with the need to protect his mother from upsetting intrusion.

<u>The family's concerns</u>

49. His mother said she had been happy when she found out that her son was in prison. It meant he was off the streets and she believed he would be safe there. The main concerns she raised with my FLO and investigator were:

    a. She was first told that the last check done on him before he died was 6am and that he was then found dead at 7.45am. In a phone call with the chaplain three day's later she was told that the last check was at 6.30am. Which was the correct time?

b. The mother said she was told that the prison was short staffed as, in her eyes, an inadequate excuse for her son's death. Are they really short staffed?

c. Did her son press his buzzer and if so was it ignored? She told us that knowing him she was almost certain he did not intend to kill himself. It was in her view a cry for help as he "knew the system". She said the fact that he had attached a sheet to the light fitting suggested he did not expect it to take his weight. She said that the prison had confirmed to her that the man might well have expected to be found before he died.

d. Was there a stool in the man's cell?

e. Why did he not want to return to his normal wing? Was it connected with the officer whom the mother believed "beat him up"? She would have expected him to want to return to the wing as his friends were there.

f. When they saw him in the chapel of rest he had a graze on the side of his nose, one on his temple and a small graze or cut on his neck. His sister and mother felt these marks might be from the officer who "beat him up".

g. His mother told us that her son had written several letters to people about being attacked by a "screw" in the HCC and said he had suffered from severe headaches as a result of the attack. She volunteered two letters in which he referred to the incident, one written to his sister on 27 August and one written to a neighbour.

h. The mother said the man was a very heavy sleeper and for him to be awake and dressed at six am would have been very out of character. Why were staff not alerted by this?

i. His sister raised the issue of why he had been placed in a single cell. Why did his cell sharing risk assessment state that he could have presented a risk to others?

FINDINGS AND CONCLUSIONS

The family's concerns

50. The investigation has found the following answers to the issues raised by the man's mother and sisters:

a. The mother was first told that the last check done on the man before he died was 6am and that he was then found dead at 7.45am. In a phone call with the chaplain three day's later she was told that the last check was at 6.30am. Which is the correct time?

Although unable to explain why the chaplain mentioned 6.30am, the investigation confirmed that the man was checked at 6.00 am and 6.15 and discovered hanging in his cell at 7.45am by a wing officer.

b. The mother said she was told that the prison was short staffed as, in her eyes, an inadequate excuse for her son's death. Are they really short staffed?

The investigation found that the prison was experiencing some shortage of staff but whenever shortages occur priorities are established and less necessary work is dropped. The clinical reviewer elicited evidence from a number of his interviewees which indicated that three individual prisoners were causing a significant drain on resources. The acting Governor told my investigators that suicide and self harm monitoring was always a priority.

c. Did the man press his buzzer and if so was it ignored? His mother told my family liaison officer that knowing him she was almost certain he did not intend to kill himself. It was in her view a cry for help as he "knew the system". She said the fact that he had attached a sheet to the light fitting suggested he did not expect it to take his weight. She said that the prison had confirmed to her that he might well have expected to be found before he died.

The prison does not have the type of call bell system which provides electronic records of use and response, so this question cannot be answered beyond doubt. However, the records show that the interval between the last night staff check and the first day staff check on 1 September were not significantly different from any other morning. There was no evidence that the man could have been sure of being found before dying.

d. Was there a stool in the man's cell?

The seating in his cell was described by witnesses as a chair rather than a stool.

e. Why did he not want to return to his normal wing? Was it connected with the officer whom his mother believed "beat him up"? She would have expected him to want to return to the wing as his friends were there.

The man did not want to return because it meant sharing a cell. The officer whom he had alleged assaulted him worked in the healthcare centre, not in the wing to which he was due to return.

f. When they saw him in the chapel of rest he had a graze on the side of his nose, one on his temple and a small graze or cut on his neck. His sister and his mother felt these marks might be from the officer who "beat him up"; and

g. His mother told us that the man had written several letters to people about being attacked by a "screw" in the HCC and said he had suffered from severe headaches as a result of the attack. She spoke of two letters in which the man referred to the incident, one written to his sister on 27 August and one written to a neighbour.

The man alleged he had sustained a blow to the head and face due to an assault by the wing officer. The man was not granted his wish to have his injury photographed. The only evidence that he saw a doctor following the incident is an injury form (F213) signed two days later. Fellow prisoners told my investigators about marks or bruising on the man's face. Letters home report him suffering headaches. However he does not appear to have complained to staff of pain or discomfort. The local investigation ordered by the acting Governor and carried out by a principal officer found that there had been no assault. It found that it was possible that the man and the wing officer had clashed heads during the application of restraint measures after the man threw a book at the wing officer. Without contemporaneous photographic evidence, it was not possible to resolve the conflicting evidence as to whether there was an injury or whether it was the result of a clash of heads, being hit directly or from hitting the floor.

h. The man's mother said her son was a very heavy sleeper and for him to be awake and dressed at six am would have been very out of character. Why were staff not alerted by this?

The detailed suicide and self harm monitoring record showed that on the majority of mornings in prison, the man was asleep when the night staff carried out the last check of their shift. However, there had been a number of previous mornings when he was awake, perhaps reading, writing or smoking.

i. His sister raised the issue of why he had been placed in a single cell. Why did his cell sharing risk assessment state that he could have presented a risk to others?

The cell sharing risk assessment identified him as having a history of assault and unpredictability. However he was assessed as a low risk for sharing and was therefore eligible to share. He was identified on reception as describing himself as having concerns about sharing. To a great extent his sole occupancy of a cell was his own choice. There was ample evidence that he resisted sharing a cell on a number of occasions. During the investigation evidence emerged that suggested his reluctance to share accommodation might at least in part be attributed to his self-confessed history of suffering sexual assault.

Bedford's local suicide prevention strategy document

51. Bedford's local suicide prevention strategy was dated January 2004. It did not have an expiry date but was noted to be subject to continual assessment. The edition given to the investigators was signed and dated by the then Governor on 5 January 2005. It sets out the role of the Safer Custody Committee and arrangements for dealing with prisoners at risk.

52. Once an F2052SH is opened, a case conference must take place within 72 hours. The local policy requires the review to be chaired by "a Residential or Health Care Manager and **must** involve the minimum of three multi-disciplinary persons with health care and wing staff input." (Section C 3 iii.) Once raised, an F2052SH can only be closed following a case review, as a result of team discussion, and normally only if there is a unanimous decision.

53. The policy dictates the frequency that prisoners should be observed, dependent on the assessed level of risk: -

- **Minimum (or normal)** – The schedule is laid out comprehensively in the policy document and repeated in each individual F2052SH record. It requires:

1 x visit/entry at roll check	07.30 – 08.00
1 x visit/entry during morning	No more than 2 hours after unlock
1 x visit/entry during afternoon	13.30 – 17.30
1 x visit/entry during evening	17.30 – 21.00
7 x visits during the night	By night staff on taking over the roll
	22.00 – 23.30
	23.00 – 01.00
	01.00 – 02.30
	02.30 – 04.00
	04.00 – 05.30
	05.30 – 07.30

- **Frequent** – to be observed randomly every two hours. Authorised by the orderly officer for those needing a higher level of supervision than normal.

- **Intermittent** – to be observed at irregular intervals at least five times every hour. Authorised by the doctor or a nurse (in consultation with the duty governor) or the duty governor (in consultation with the doctor or a nurse).

- **Constant** – to be observed constantly. Authorised by the doctor or a nurse (in consultation with the duty governor) or the duty governor (in consultation with the doctor or a nurse). Case review to be held as soon as is practicable and certainly within four hours (or immediately before unlock the following morning if constant watch is commenced during the night). Prisoner should be referred urgently for a mental health assessment.

54. The local policy states that "following all cases of self-harm, the next of kin must be informed, unless the prisoner refuses consent, there is a clinical reason not to do so, or the prisoners support plan indicates otherwise".

55. At Bedford, all F2052SH documents have a locally devised sticker added to the front cover showing target dates for case reviews and when a review has been completed. This enables staff and managers to see easily if a review is required and when the last one was completed. A locally devised information page providing a series of tick-box prompts to assist staff in completing and managing F2052SH documents is inserted inside the front cover, together with a sheet setting out the minimum observation schedule.

<u>The management of the man's suicide and self harm risk</u>

56. There is no doubt that the deceased was a vulnerable and troubled young man, who was not easy to manage in the prison setting. He was on suicide and self harm monitoring (F2052SH) throughout his period of imprisonment. Although he made no actual physical self-harm attempts, he talked about killing himself on many occasions, sometimes citing overdose as a method, sometimes starvation by hunger strike and sometimes by hanging. He wrote statements for his adjudications which mentioned having nothing to live for and showed staff a letter to his girlfriend which an officer described as reading 'like a suicide note'.

57. On one occasion when he was distressed about his girlfriend, a member of staff rang her and conveyed a positive message to him. Prison Service Orders require next of kin be contacted after a self harm attempt unless the prisoner has refused permission for this. Since he did not make any actual self harm acts or attempts (except once suggesting he had swallowed a razor blade) his family were not contacted. They therefore did not know how distressed he was except from what he said in telephone calls to his sister. He had only one visit when his girlfriend and two other friends came to see him. (His girlfriend was under 18 and therefore unable to visit without an accompanying adult).

58. The man's behaviour was described by the psychiatrist as manipulative. Regarding manipulation, the Prison Service Order says:

"An act of self-harm should always be taken seriously. Even if the prisoner appears to be using self-harm as a means of gaining something, it is still a desperate act and the prisoner should be helped to find constructive ways to meet the underlying need."

59. It is of concern that not only the man, but, on some occasions staff, appeared to be unable to distinguish between a community psychiatric nurse and a psychiatrist. The roles, although complementary, are different, not least because a psychiatrist has the knowledge and authority to diagnose and prescribe. In the opinion of the clinical reviewer, not seeing a psychiatrist for a planned appointment (due to an administrative error) had almost certainly detrimentally affected his state of mind. This, coupled with his anger over what he saw as a disappointing encounter with the CPN indicated that he was very concerned about his mental state and wanted professional help.

60. On 21 August, in the SSU, an officer made entries in his history sheet and F2052SH referring to him playing 'mind games'. This reference was repeated even after the officer had read the note which looked 'like a suicide note'. The officer quite appropriately contacted the orderly officer (OO) to report the note. The officer recorded that the OO instructed him/her to keep an 'extra eye' on The man but the officer's entry continued in brackets NOT INTERMITTENT WATCH. The only reference throughout the F2052SH document to the level of watch to be applied to the man was the nurse's entry on 22 July. The registered nurse who completed the nursing assessment ordered 'normal' observations and recorded it on page 5 together with a note that she had 'discussed (it) with MO' (meaning the doctor). No mention was made about the intermediate option of increasing the man's watch to 'frequent' (randomly every two hours).

61. With the exception of some of the language used about him 'playing mind games' and 'making silly comments about self harming', the entries in the F2052SH are of a high standard, demonstrating quality interaction with him and showing evidence of staff taking care of his wellbeing. Prison Service policy requires regular case reviews and in the man's case these occurred on six occasions. The records of the case reviews show that the majority had a satisfactory multi-disciplinary attendance although there was minimal continuity of members of the review panel. The summaries of each review were comprehensive although most of the support plans were fairly generalised and did not identify individual accountability.

62. The Prison Service Order says:

> "Special consideration should be given to prisoners on an open F2052SH who are .... subject to an adjudication ... Adjudicators should consider the implications of the punishment they may impose on a prisoner who is found guilty at an adjudication and who is subject to F2052SH procedures, such as removal from association, loss of canteen and cellular confinement ..."

63. The man was adjudicated upon on 19 August and, in apparent compliance with the order quoted above, an unscheduled case review was held later that day. The adjudicating governor chaired the case review. There was other evidence that this governor was aware of the link between the event of the adjudication and the man's ongoing self harm management. On 22 August, however, the man was given a day's cellular confinement as an adjudication punishment without having been examined by a doctor and passed fit for such punishment (as was required at that time). At a case review held later that day, the reviewers arranged for his immediate admission to the healthcare centre.

64. On 26 August the man was again brought before a governor for adjudication, this time there were two separate charges. One related to damaging his cell furniture and the other to throwing a book at an officer. Both incidents occurred in the healthcare centre. When the man made his counter allegation that he had been assaulted by a wing officer, the adjudicator and acting governing Governor adjourned the hearing pending an investigation of his allegation. On the other charge, the acting governor found him guilty and punished him with five days cellular confinement. Later that day a case review was held. The man aired his anger about the alleged assault and also asked for his medication to be reviewed. This was ordered by the chair of the review who allocated the responsibility to a community psychiatric nurse who was party to the review. A further review was booked for 5 September.

<u>Communication between departments</u>

65. Multi-disciplinary attendance at F2052SH reviews at Bedford was of a good standard. However, there was no action ordered by the acting governor on 28 August to implement his decision that the man's next location must be given careful consideration following his threats to climb on the beams as reported in the SIR on 26 August. The man was moved from the SSU to a cell in the FNC on 27 August. Records showed that the move was prompted by the need to find a cell in the SSU for another prisoner. There is no evidence that the move was given special consideration. There is no evidence that any link was made between the man's written statements describing a past history of sexual assault in a young offenders institution and his reluctance to share a cell.

Follow-up to deaths in custody

66. PSO 2710 gives instructions on action to be taken following a death in custody, including the support arrangements for staff and prisoners. The PSO says that priority must be given to communicating the facts about the death to prisoners and staff. It says it may be useful to issue a written statement to prisoners to defuse rumour and myth but that this will depend on local judgement. Any prisoner who may have been particularly affected by the death should be offered support. The management at Bedford acted more than appropriately with regard to prisoners. They not only issued a timely notice to prisoners about his death but took extra measures to identify his friends and offer individual support from the chaplain and other staff. In addition, after his mother and her daughter visited the prison on 28 October the Governor circulated to prisoners a typewritten version of a most thoughtful thank you letter the man's mother had written to the prisoners and given to him during her visit.

67. On the issue about supporting staff, there was an immediate 'hot debrief' of some of the staff involved, but no contemporaneous note was made. Healthcare staff and control room staff were overlooked. The clinical reviewer established that the lack of support to at least one member of healthcare staff, a pharmacy technician with no previous experience of a traumatic death, led to distress and a period of illness. The OSG from the control room told my investigators that no–one had checked on her wellbeing on the day. She just went on working. She was later offered counselling and the FNC manager had offered to take the OSG with her to counselling but she felt it was too late. Two weeks after the man's death the deputy governor had told her they were having a critical incident debrief and invited her but she had declined saying she had needed the hot debrief. She had seen a member of the Post Incident Care Team but only after he had learned informally that she was upset.

Clinical review

68. The Director of Care at Bedford Primary Care Trust carried out a clinical review and he concluded that, overall, policies and procedures appeared to have been adhered to and the man received care equitable to other prisoners, and no worse than he might have expected in the wider community. His more detailed findings and conclusions have been drawn together in the paragraphs below.

    a. The man was well known at Bedford Prison and was reported by those interviewed to be different on this admission. Previously he had presented as a cheeky, likable rogue. During this sentence he was angry, venting his frustration on furniture, windows, and staff. At times he appeared confused and frightened, making repeated threats to kill himself in a variety of ways but never actually carrying out any of the threats.

b. The man was haunted by his past and chose either to seek help from prison listeners, CPN's and others or to turn it down, refusing to share any problems with officers and others, turning to 'childish tantrums' and failing to mix well with other prisoners at times.

c. Additional counselling may have helped him cope with the loss of his girlfriend and other historic issues.

d. The man was not deemed to require in-patient health care assistance towards the end of his life but had been in the in-patient unit for a period during this sentence. He had regular access to CPNs and medical staff throughout his sentence.

e. The psychiatrist not seeing him as planned, due to an administrative mix up, could have contributed to the final outcome, but the health care team reassured the clinical reviewer that the care plan, clinical diagnosis and management plan would not have been different had the consultant seen him. He was seen by an SHO (senior house officer) and regularly by the CPNs

f. The 'assault incident' played a role in the man's belief in himself and the system. He was not allowed a photograph as evidence and there is no evidence that he was seen by a doctor other than the F213, signed two days later.

g. The man was alone in a double cell the night he died; the records clearly indicate his wish not to share a cell and his delight at the location. Fellow prisoners state the he wanted to share and should not have been alone, as his behaviour was going down hill. He had been advised of the impending transfer from this cell the night before he died. This may have been a factor in his state of mind, but calls on the cell bell seem to have been answered and available support offered

h. Qualified nurses responded to the first call for assistance, but the second call required assistance by a nurse and a pharmacy technician. This technician, who was involved was very disturbed by the events, but refused the option of attending the 'Hot debrief' taking extended sick leave immediately following interview by the author.

i. The radio call for assistance to B1 landing rather than C1 caused confusion, but not an undue delay. CPR had been started by the prison officers and was rotated to health care staff as they arrived. The confusion was unfortunate, but not a contributory factor in the man's death.

j. The two calls for an Ambulance were confused and vague. The first in respect of what had happened exactly, the second in the specific requirements. A paramedic crew would not have been able to act differently, as nursing staff had administered medication. However they may have been able to make a decision regarding continued CPR

in the light that the man was not responding to treatment, as indicated by his general observations and the resuscitation machine reading. These issues were not contributory to his death.

k. Members of staff were genuinely disturbed and deeply upset by the man's death. From written and verbal accounts given, clinical and prison staff seemed in need of formal post-incident support.

l. There was little doubt in the clinical reviewer's mind that the prison was under a significant amount of pressure at the time leading up to the man's death. Several staff reported three particularly difficult prisoners that were taking up considerable resources.

m. Where an incident occurs on a Saturday (e.g. the man smashing a window in the visiting area) prisoners are not seen by the prison doctor until the following Monday morning if the injuries are considered minor or appear non-existent. In his case the incident took place on a Saturday. The medical paperwork was completed on the Monday but the doctor dated his report on the Wednesday. The doctor has since left the establishment and so this could not be clarified but the clinical reviewer concluded that attention should be given to an audit of such delays and follow up actions agreed

n. Algorithms used in the SSU (Segregation and Support Unit) were not always completed.

o. Abbreviations and undistinguishable signatures should be addressed in all records, by ensuring summary sheets and signature lists are in every file.

69. The clinical reviewer made the following recommendations which I endorse:

A. A review of the need for counselling, psychological support and a consideration of the need for CBT (Cognitive behaviour therapy) should be undertaken.

B. All allegations of assault should allow the prisoner access to a photographer and a doctor.

C. The administrative oversight that resulted in the man not seeing the consultant psychiatrist should be addressed in order to prevent similar occurrences in the future.

D. Communications, specifically around the request for ambulances should be reviewed and a proforma or similar developed.

E. All notes should contain signature lists and an abbreviation summary. Continuous chronological records, whilst difficult to operate on a daily basis, would make the investigation process and other review systems simpler.

RECOMMENDATIONS

1. **I recommend the Governor of Bedford reminds staff that prisoners who self harm (or make serious threats to do so) as a means of gaining something should be taken seriously, and helped to find constructive ways of meeting their needs. Staff should also be reminded that the use of judgemental or derogatory language is unprofessional and should be discouraged in verbal and written communication.**

A Notice to Staff has been issued regarding the use of language in communications, both written and verbal. The ACCT training also reinforces to staff that self-harm must be taken seriously.

2. **I recommend that the Governor of Bedford seeks to ensure that staff are fully conversant with the range of observation levels for F2052SH / ACCT forms, particularly the difference between normal and frequent observations.**

The local ACCT training is addressing this point.

3. **I recommend that the Governor of Bedford seeks to ensure that communication between security and other departments in the prison is timely and accurate.**

Safer Custody is now a standing agenda item on the Security Committee. Residential Principle Officer's cross check Security Information Reports relating to injuries and bullying.

4. **I recommend that the Governor of Bedford reminds staff of the content of Prison Service Order 1700 (Segregation) and the revised Discipline Manual, particularly in regard to the completion of Segregation Safety Algorithms and the requirement for a medically qualified person to authorise cellular confinement.**

A notice to staff has been drafted reminding staff of the requirements of PSO 1700.

5. **I recommend that the Governor of Bedford reviews the local arrangements for supporting all staff after a death in custody to ensure that proper records are kept and that no staff are omitted from the support available.**

The contingency plans are to be updated.

6. **A review of the need for counselling, psychological support and a consideration of the need for CBT (Cognitive Behaviour Therapy) should be undertaken.**

CPNs can now refer offenders into a 'Beat the Blues' programme. Psychological support services and relaxation therapy are now available.

7. All allegations of assault should allow the prisoner access to a photographer and a doctor.

This procedure has been introduced at Bedford.

8. The administrative oversight that resulted in the man not seeing the consultant psychiatrist should be addressed in order to prevent similar occurrences in the future.

Revised procedures are now in place to prevent any similar occurrence.

9. Communications, specifically around the request for ambulances should be reviewed and a proforma or similar developed.

Prison Service procedures as set out in PSO 1400 and the National Security Framework provide the necessary structure and format for this to be implemented in Bedford's local policies and procedures. The national audit system undertaken by the Prison Service Standards Audit Unit will monitor its implementation.

10. All notes should contain signature lists and an abbreviation summary. Continuous chronological records, whilst difficult to operate on a daily basis, would make the investigation process and other review systems simpler.

This is being addressed through training. In addition, those undertaking the role of log keepers will take notes, avoid abbreviations and sign appropriately.

GOOD PRACTICE

I acknowledge the good practice identified by the clinical reviewer in his report and repeat them below:

- **There was evidence of good care and concern for the man, by specific prison officers and healthcare staff. The man had been able to develop good relationships with named individuals who were clearly offering him support and assistance.**

- **The actions surrounding the call for assistance are noted as good practice, especially the rotating of the CPR at the scene of his death, between prison staff, healthcare staff and the ambulance staff, who clearly worked as one team.**

- **The high level of upset and concern expressed by many NHS and Prison staff is indicative of a caring and professional staff team, who supported each other well in the time immediately after the man's death.**

- **There is a general wish to learn from the events described. At interview several staff have sought to learn from the events surrounding the man's death, such that care is improved for future prisoners.**