Investigation into the circumstances surrounding the death of a man at HMP Bedford on 1 May 2006

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the death of a man on 1 May 2006 while in the custody of HMP Bedford. The 43 year old man was suffering from depression and was located in the healthcare centre for closer supervision. It was there that he took his own life, using a bed sheet attached to a window. The man was transferred to a local hospital, where he died at three minutes past midnight on 1 May 2006.

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

I must express my sincere condolences to the man's family, who shared in his happiness and supported him through his more desperate times. I know that his death has caused much grief. I only hope that this report goes some way to answering the questions they have surrounding his death.

I appointed two of my fatal incidents investigators to carry out this investigation on my behalf. Bedfordshire Primary Care Trust appointed a clinical reviewer to complete an independent clinical review into the man's medical care during his time at Bedford. I would like to thank the clinical reviewer for his comprehensive review. In addition, I would like to thank the pharmacy technician who reviewed the man's medication and made two recommendations in an additional report, attached to the clinical review.

This report focuses on the approach to the man's detoxification from alcohol and upon the regime in Bedford's healthcare centre. He was in prison for just over two months. He had no previous experience of custody.

I make nine recommendations in addition to the eight made by the clinical review team.

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

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SUMMARY

The man was struggling with alcoholism and depression when he was arrested and remanded into the custody of HMP Woodhill on 25 February 2006. He remained at Woodhill for only six days. On 3 March, following a court appearance, he was remanded to the custody of HMP Bedford.

At Woodhill, the man was felt to be at risk of self-harm or suicide and was placed on the special support and monitoring arrangements known as ACCT (Assessment, Care in Custody and Teamwork). He continued to be subject to ACCT procedures for a short time after his transfer to Bedford. He also underwent a detoxification process for two weeks and received medication for his depression.

At Bedford, he seemed to settle on the wing and got on well with staff and prisoners. In consultation with the man, staff agreed that his ACCT file could be closed in mid-March because the risk of self-harm had reduced. On 8 April, the ACCT was reopened after he self-harmed. He was also made subject to an hourly special watch.

The man obtained the sought-after job of Stores Orderly which afforded him much time out of his cell in the fresh air. Unfortunately, due to his depression he found it harder and harder to get out of bed in the morning. Staff were concerned about him and, in line with Bedford's suicide prevention strategy, transferred him to the healthcare centre. The ratio of staff to prisoners is higher in the healthcare centre and it was hoped that he might receive an enhanced level of care.

The man was in the healthcare centre for the last nine days of his life. He shared a dormitory cell for the majority of those nine days. The limited regime meant that he spent most of his day alone with another prisoner whose also exhibited self-harming behaviour, and I have little doubt that this will have affected his already depressed mental state.

The man asked to be moved to another cell in the healthcare centre (there is only one dormitory cell in the healthcare centre and the rest are single cells). On the evening of 30 April, he was moved to a single cell. His observation levels were not increased and no note was written by the member of staff who authorised the transfer.

The nurse and the healthcare assistant on duty that night started their shift on 30 April at 8.30pm. The healthcare assistant noticed that the man seemed much more down than usual and spoke to him for a considerable length of time about his problems. Together, they planned the steps that he could take to improve his situation. Following this conversation, the healthcare assistant, in agreement with the nurse, increased the man's observation levels to half-hourly. However, within an hour the man was discovered hanging in his single cell at 11.05pm.

Resuscitation efforts were started by prison officers who were helped by the nurse. An ambulance was called and the man was taken to the local hospital, where he was pronounced dead at three minutes past midnight on 1 May 2006.

THE INVESTIGATION PROCESS

1. I appointed two colleagues to conduct the investigation into the man's death on my behalf. On 8 May 2006, the investigation team went to Bedford to gather his prison records. They met with the governing Governor, with union representatives and with a member of the prison's Independent Monitoring Board. They were briefed about the prison and its staff.

2. The investigation team issued notices of their investigation and invited staff and prisoners to contact them with any information that they felt might be relevant to the investigation. One prisoner contacted my office and he was interviewed.

3. The investigation team attended the prison in May and June to interview staff and prisoners. On 6 June, one of the investigators and one of my family liaison officers met the man's family to give them an opportunity to voice their concerns. These have been considered in the investigation and are explored in further detail in this report. During the meeting, the family requested copies of the man's prison records which they were sent in July 2006.

4. Bedfordshire Primary Care Trust (PCT) expressed concern about conducting the clinical review into the man's death. From April 2004, Bedfordshire PCT has delivered healthcare services in HMP Bedford, and the PCT was worried that they would not be in a position to review the quality of clinical care delivered by their colleagues with sufficient independence. With this in mind, the PCT sought to appoint an independent clinical reviewer from a neighbouring county. After some delay, the head of healthcare at in a neighbouring PCT was appointed as clinical reviewer. One of my investigators met with the clinical reviewer on 5 July to outline the preliminary findings and discuss the direction of his clinical review. I would like to thank the clinical reviewer for his excellent clinical review, which has made a substantial contribution to the effectiveness of this investigation.

5. In November 2006, the man's family was asked whether any additional concerns had been raised by the prison documentation they had been sent. A number of additional issues have been explored.

HMP BEDFORD

6. HMP Bedford is a medium-size local prison, most of which was constructed in the nineteenth century. Although it has a couple of modern extensions, further expansion of the prison's facilities is made difficult by its location in the centre of the town. As a local prison, Bedford serves a number of courts in the area. There are comparatively few sentenced prisoners. With a large number of prisoners being remanded directly from court, there are significant demands on the detoxification programme. The large numbers of remand prisoners mean that the population is ever-changing.

7. Her Majesty's Chief Inspector of Prisons last made a full announced inspection of Bedford in January 2004. A follow-up unannounced inspection took place in April 2006, just over two weeks before the man, who is the subject of this investigation report, died. In her reports, the Chief Inspector recognises the challenges faced by busy local prisons such as Bedford. It is within this context that she acknowledges that Bedford "has begun to travel towards becoming a healthy local prison".

8. In January 2004, the Chief Inspector recommended that "in-patients should be provided with a therapeutic regime". During the follow-up inspection, the inspection team found that this recommendation had still not been achieved and noted:

   "Prisoners on the in-patient unit told us that they had very little time out of cell. Their cells did not have electricity, so they were unable to watch television in them. When they were unlocked there was no structured therapeutic regime. They were sometimes offered exercise, but not every day, and there was little for them to do."

9. Since I became responsible for the investigation of deaths in prisons in April 2004, there have been three other apparently self-inflicted deaths at Bedford. I have considered these investigations during the course of completing this report. In particular, I am pleased to note that, following the death of the man who is the subject of this investigation, the support available to staff was much improved in accordance with a previous recommendation.

KEY EVENTS

10. The man was taken into police custody on 24 February 2006. While at a local police station, he attempted to cut his left forearm in an act of deliberate self-harm. The next day, he appeared at a Magistrates' Court and was remanded to HMP Woodhill in Milton Keynes. He was facing a charge of assault causing actual bodily harm. This was his first time in custody.

11. Upon arrival at a prison for the first time, all prisoners must have a First Reception Health Screening. This is an interview with a member of healthcare staff to discuss any medical issues that need to be addressed. The prisoner is also risk-assessed to identify how likely they are to self-harm or attempt suicide. If the prisoner is thought to be at risk of self-harm, an ACCT file is opened so that staff can effectively monitor and record how the prisoner is feeling, and offer appropriate support.

12. The man underwent his First Reception Health Screen on 25 February at Woodhill. He was recorded as suffering from depression and seeking referral for a medical appointment. In the substance use section of the form, the man admitted that he drank ten to twelve pints per day and two bottles of wine. The man told the interviewer that he did not feel like harming himself. An ACCT file was not opened at that time. The man was referred to the detoxification unit and to a doctor in connection with his physical and mental health.

13. Just two days after the First Reception Health Screening, a medical officer at Woodhill, raised a Concern and Keep Safe form. Any member of staff can raise such a form. The Concern and Keep Safe form is the first stage of the suicide prevention strategy known as Assessment and Care in Custody and Teamwork (ACCT). The medical officer listed six factors for placing the man on an ACCT: his withdrawal from alcohol, personal problems, treatment for depression, reported suicidal feelings, the man's own request and because he had been observed crying.

14. On the same day (28 February), the man was admitted to the healthcare centre because he was "expressing ideas of self harm and suicide". He was interviewed at 3.00pm in accordance with the ACCT procedure. The interview assesses the level of risk that an individual poses to himself, and if there are any factors that would help to reduce that risk. He told staff that he was feeling low for numerous reasons: namely his alcohol dependency, difficulties in his personal life and being remanded into custody. He had attempted suicide at home in 2005 and subsequently spent ten weeks in a psychiatric unit to treat his depression. He told staff that he wanted to sort his life out and that he saw a "light at the end of the tunnel". His 'Coping Resources' were listed as his many friends, his boat, and finding an adult son that he had never met. The man was put on a low observation level: three

observations during a day shift and five observations at night. (Observations require that staff try to talk with the prisoner and gain an impression of their mood. This would not apply if the prisoner was asleep.)

15. A telephone call that the man made to his father at 4.30pm on 28 February was cut off half way through due to difficulties with the telephone line. He told staff that he would try again in the morning.

16. The man rang his cell bell at 6.40pm that evening. He had made cuts to both forearms. Although the wounds were bleeding, they were not severe enough to require dressing. The man agreed that he would ring the cell bell if he self-harmed again. He was offered the opportunity to call the Samaritans but declined.

17. At just after 10.00pm that evening, the man tried to suffocate himself with a black plastic bin liner in his cell. He rang the cell bell as agreed. A staff nurse on duty that evening convinced the man to hand over the black bag and shoelace that he was using. He was relocated to another cell in the healthcare centre. He asked to see a Listener. (A Listener is a prisoner who has been trained by the Samaritans to help other prisoners who are struggling to cope. They listen to a prisoner's problems in confidence and can stay with a prisoner for any length of time.) The Listener stayed with the man for two hours that night. The next day, staff observed that he appeared to be a little brighter. He had also spoken to his father again on the telephone.

18. On 3 March 2006, the man appeared at another Magistrates' Court. His case was committed to the Crown Court. On his way to court, he asked staff to ring his parents to let them know that he would not be able to attend the visit they had arranged because of his court appearance. My investigators met with the man's family during the course of the investigation. They expressed concern and frustration about the last minute cancellation of visits so early on in his remand period.

19. The man was remanded to Bedford prison following this court appearance. He went through another General Health Screen which identified the same issues as that completed at Woodhill. When asked about his acts of self-harm, the man said that he had no further thoughts of harming himself. He said that he had self-harmed for domestic reasons which had been addressed in the meantime.

20. The ACCT documentation was transferred to Bedford with him and he continued to be monitored by staff. By this time, the man's observations level was hourly. While he was on the first night centre, he was recorded as being "in good spirits" and getting on well with his cell mate. A senior officer completed a case review and CAREMAP. The man told staff at Bedford that he was sleeping and eating well. He said he did not feel like self-harming. On the CAREMAP, the senior

officer recorded only one issue: “feelings of isolation”. To reduce the risk, the senior officer suggested that the man should share a cell with someone else. The man also recommended that he contact his family.

21. The man was moved to C wing on 6 March and again recorded as mixing well with other prisoners. He told an officer on the wing that his depression was particularly bad in the mornings. On 7 March, the man was still in bed at 10.35 am, two and a half hours after being woken for breakfast. He told the same officer on the wing that he was “fine”.

22. The man was escorted to the Magistrates’ Court again on 9 March. Hourly observations were made by staff who escorted him and at the court. He was again remanded to Bedford and returned to C wing.

23. An ACCT review took place on 9 March to assess whether the man’s risk of self-harm had changed. The man told the two officers who attended the meeting that he felt “more settled” and that he got on with his cellmate. He was particularly looking forward to his parents visiting him at the weekend. The man was still considered to be a low level of risk, but hourly observations continued.

24. On 13 March, the man complained that he felt low in mood. He did not feel up to collecting his medication and refused exercise. Over the few days prior to this, he had repeatedly told staff that he was having difficulty sleeping because he was sharing a cell with someone who was going through a detoxification programme. At this time, the man was frequently recorded sleeping well into the afternoon. Another officer on the wing spoke to the man for about 40 minutes about his depression. The officer offered him the chance to speak to a Listener or to the Samaritans, but the man said that he would prefer to talk things through with the officer. When the conversation ended, he thanked the officer, who then made a clear entry in the man’s ongoing self-harm monitoring record.

25. The man was due to take a basic skills test on 14 March. (Prisoners take this test so that staff can determine what kind of job will best suit them.) When he was unlocked for the test, the man told the officer that he did not feel up to taking it as he was depressed. The officer referred the man to a Community Psychiatric Nurse (CPN).

26. The man refused to leave his cell even to collect his medication. The doctor visited him at 3.00pm that afternoon. He recorded that the man was still low in mood and changed the medication to “something stronger”.

27. The next day, the man kept his appointment with the prison’s CARATs team. (CARATs is a national programme that supports prisoners who have substance misuse problems; it stands for Counselling, Assessment, Referral, Advice and Throughcare.) The man admitted to drinking ten to twelve pints a day and up to two bottles of wine. In

clinical terms, he was an alcoholic. The CARATs team told my investigators that resources to support alcoholics are limited. As an identified alcoholic, the team at Bedford met with him and suggested that he attend an Alcoholics Anonymous group for support. He was referred to the AA group on 15 March. During his meeting with the CARATs worker, the man asked to be transferred to D wing. Prisoners located on D wing are subject to Voluntary Drug Testing and it is expected that the wing is drug-free.

28. The man's ACCT document was closed on 17 March. He attended the review with two members of discipline staff and two CPNs. He was recorded as being "very settled". It was noted that he had been placed on the waiting list for relaxation classes. Otherwise, the record of the case review determined that "there were no further issues or problems". According to his records, the man only attended Alcoholics Anonymous on one occasion (28 March).

29. In the early hours of 8 April, the man cut his right wrist with a razor blade. He was sharing a cell with another prisoner at that time. The cellmate told my investigators that they would often sit up together throughout the night. He said that the man was particularly worried about the outcome of his offence. He said that they got on well and it seemed that the man often felt better after talking things through. The cellmate remembered waking up to discover that the man had cut himself. He immediately called for assistance. At that time, it was his impression that the man was not trying to take his own life. The cellmate remembered that the man was embarrassed about having cut himself.

30. An orderly officer responds to any calls for assistance from staff during the shift. The senior officer who did the man's original ACCT CAREMAP was the orderly officer in charge of the prison that night. The senior officer remembered being called to D wing during his shift. When he got there, he took the man to the wing office and spoke to him about why he had harmed himself. Healthcare staff attended and used a large bandage to dress the cut. The senior officer said that the wound was superficial, but the large bandage was used because that was all that was available at the time. The man was concerned about the effect that seeing such a large bandage would have on his family who were scheduled to visit the next day. The senior officer advised him that, if he wanted to stop his family from worrying, all he had to do was wear a long-sleeved shirt. During the investigation, the man's wife expressed concern at the advice that the senior officer gave following this episode of self-harm. The senior officer assured my investigator that he thought he was acting in the man's best interests to reduce his anxiety during this crisis period.

31. The man told an officer on the wing that he cut his wrist, "as a way of relieving his frustration at not being able to sleep and the waiting for his trial". That officer assessed the man's level of risk to suicide and self-

harm and opened an ACCT document that instructed staff to observe the him regularly during the night. Another review was arranged for 11 April.

32. As previously arranged, the man's parents visited him on 8 April. His mother was concerned about his appearance and, when prompted, he showed the bandage under his long-sleeved shirt. The man's parents also told my investigators they were concerned that the man had been advised to hide the cuts on his arm.

33. On the morning of 10 April, the man was referred to a doctor after a long chat with an officer on D wing. In the afternoon, he saw the doctor and told staff that he was happy with the appointment. No clinical record was made of this medical appointment, although a note was made in the wing history file.

34. The man attended a relaxation class on 11 April. The officer that ran the relaxation class recalled that the man attended two of them altogether. He said that the man did not benefit from the sessions, so halfway through the second of his sessions he left the course. The relaxation classes are referred to in the record of an ACCT review that took place on the same day. The man said that he felt more confident to approach staff when he felt depressed. Another officer was helping the man to secure employment in the prison.

35. On 12 April, an officer on D wing was doing his lunchtime checks when he discovered the man in his cell. He appeared very low in mood. The officer took him to the wing office and spoke to him. The man told the officer that he felt like he was having a nervous breakdown. Following this conversation, the officer requested that a doctor should review the man's medication. No note is made of the man being seen by a doctor following this referral.

36. The man slowly began to adjust to life on D wing. On 16 April, he is noted as having had his hair cut and being out on association. He appeared to be in "in good spirits". He collected his medication regularly and repeatedly told staff that he was feeling fine.

37. A review of the man's self-harm support plan was held on 18 April. The man told staff that he was still feeling down, although he was enjoying working in the stores. He said he still had thoughts of self-harm, but was coping by occupying himself in his cell. He got on well with his cellmate and thought that talking to him helped him cope. A further review was recommended for 26 April. All those who attended the review agreed that the man should remain subject to the enhanced levels of support.

38. The man spent the morning of 20 April awaiting the decision of the court whether or not to grant him bail. The court did not grant bail and he was recorded as being "understandably" low. He did not go to work

the following morning because he “did not feel like it”. Later that day, the man told an officer that he had no energy and that he wanted to be left on his own in a dark room. Following this conversation, that officer spoke with a senior officer and they agreed that the man’s observation levels had to be increased to one observation per hour.

39. The man was admitted to the healthcare centre on 21 April 2006. As he was leaving his cell on D wing, his cellmate warned staff that the man was low in mood. This was noted in his ACCT document.

40. An agency nurse completed the man’s healthcare admission assessment. The record of this assessment does not include his past medical history, the medication that he was taking at the time of his admission or any medical observations (for example, blood pressure). The admission form simply shows that he was being admitted to the healthcare centre because he was “low in mood”.

41. Bedford’s healthcare centre has ten single cells, one gated cell for prisoners who need constant observation, and one cell with three beds, known by staff as the dormitory cell. The man was located in the dormitory cell. When he arrived on healthcare, he was sharing it with two other prisoners. One was interviewed by my investigators but could not remember the man at all. He was only in the cell with the man for the first night. The second prisoner shared the dormitory cell with the man for nine days.

42. The man’s ACCT document was transferred with him at the same time to the healthcare centre. There is no time lapse in the entries which continued to be made approximately every hour. This was in line with the agreed observation level from the last case review. The man was recorded as reading his newspapers or talking to his cellmate for a lot of his first evening in healthcare.

43. The following night, staff noted that the man and his cellmate sang Elvis songs together. The man was considered as “much brighter and in good humour”. However, the next day he complained to staff of feeling depressed again.

44. The officer who ran the relaxation class told my investigators that he would go and speak to the prisoners in the healthcare centre once or twice a day, as a matter of routine, because his office was near there. He recorded visiting the man in the healthcare centre on 24 April. He told the officer that he continued to have fleeting thoughts of self-harm, although no more than when he was first transferred to the healthcare centre. The man was hopeful that he would be released on 26 April. Despite this, he still felt despair and hopelessness which the officer noted as “normal for depression”.

45. All prisoners who go to court must pass through the prison’s reception area. The man’s ACCT file accompanied him to reception on 26 April.

A note was made by an officer in reception that the man was very tired. He told staff that he was "not getting any sleep due to his cellmate". This is the first record in his paperwork of this complaint.

46. The man was not granted bail on 26 April. He returned to the prison's healthcare centre, awaiting a further court appearance scheduled for 5 May. No note was made in his ACCT file until the morning of 27 April when he appeared to be in a "good mood". The man told another officer that he had slept for most of 27 April because he had not got much sleep the previous night.

47. The man saw a psychiatrist on 28 April. He told the psychiatrist that his medication was not working and that he was still anxious. Following the meeting, the psychiatrist wrote:

    "No feeling. Just going through every minute/every hour. Intermittent/fleeting suicidal thoughts. Manages them without any self-harm."

    During this interview, the man denied that he was having any "current" or active thoughts of suicide or self-harm.

48. The man's suicide prevention case review was due to take place on 26 April. He was not able to attend the review because he was in court. The duty governor drew staff's attention to this after a standard audit check of suicide prevention documentation. An officer and psychiatric nurse undertook the man's case review two days later. It was agreed that his level of risk remained low, but the observations should remain hourly. The man denied having suicidal thoughts during this meeting. No mention was made of his cellmate, lack of sleep or medication in the record of the case review. Despite this, the man requested that a move from the dormitory, "as fellow inmate's annoying him".

49. The man spent the next day (29 April) in "very good spirits" according to his ACCT file. He had a good visit and was seen talking to a prisoner whom he had known for a number of years before coming into prison. On 29 April, it was recorded that he was, "getting annoyed. Wants to be in single cell."

50. During the exercise period on 30 April, the man asked an officer about the opportunity to work as an orderly in the healthcare centre. The officer discussed this with nurses who agreed that the job would be "beneficial and therapeutic". The officer then spoke to the man when he returned to the dormitory cell a couple of hours later. The officer recorded him as being "more upbeat and positive than of late". Just one hour later, a healthcare assistant made the following entry in his ACCT file:

"Feeling low in mood owing to pad mate attempts to self harm. I spoke with the man at length and is hoping for permission to relocate him. Oscar 1 informed."

51. The senior officer who wrote the man's ACCT CAREMAP was again the orderly officer for the evening shift on 30 April. During interview, the senior officer described the shift as "a really, really busy evening". He had supervised the transfer of a volatile prisoner, who regularly self-harmed, to the gated cell in the healthcare centre. It was during this difficult transfer that the senior officer got a call from the healthcare centre. He was told that a noose had been discovered in the dormitory cell. Healthcare staff wanted to discuss what action could be taken. The senior officer ensured that the prisoner who was being transferred had settled and that the appropriate paperwork was in place. He then asked healthcare staff about the situation in the dormitory cell.

52. The senior officer was told by nurses that the man's cellmate had made two nooses during the course of the day. The cellmate talked to the man about his own thoughts of suicide. Nurses briefed the senior officer that the man had told them he was finding it difficult share a cell when his cellmate was talking about killing himself. When the senior officer asked the nurses what action they recommended, he was told that the man and his cellmate should be split up. There was a single cell available and the nurses recommended that the man be located there. As orderly officer in charge of the operational matters of the prison during a shift, it was ultimately the senior officer's decision whether to move a prisoner. He considered the information that the nurses had given him and agreed to their recommendation. He did not look at the suicide prevention documentation for the man or for his cellmate that was available in the healthcare office. He asked the nurse to make a note of the transfer in the man's ACCT file.

53. The senior officer entered the dormitory cell to speak to the man. He noticed that he had already packed up his belongings. He told him that he was going to move to a single cell. They discussed the fact that this would mean he could get more sleep before his first day as health care orderly the next morning. The man moved to cell 7 in the healthcare centre. During interview, the senior officer said that he considered increasing the man's observation level but did not think it would be necessary. He did not record this decision and personally made no entry in the man's ACCT document.

54. The health care assistant for the evening shift checked the man at 6.50pm and recorded that he was "settled". Prisoners in healthcare have access to small portable black and white televisions. He was given hot water and a television at 7.10pm. The healthcare assistant noted that the man was watching his television at 8.00pm and again that he appeared to be "settled".

55. The night shift for healthcare at Bedford are made up of one healthcare assistant and one qualified nurse, who start their shift at around 8.30pm. The healthcare assistant described the handover from the previous shift as being "a verbal briefing". The evening staff discuss each prisoner, any significant issues and how their day has been. The healthcare assistant told my investigators that a written record is also made in the medical records. Healthcare staff will refer to this during their shift if there is anything not made clear during the handover.

56. On 30 April, the healthcare assistant recalled that, during handover, staff mentioned that the man had been transferred to a single cell. The reason that she cited for the move was because of his "awkward, upsetting, infuriating cell mate". She went on to describe the cellmate as someone who regularly self-harmed using broken glass or broken forks. She said that the cellmate had handed in "two or three nooses" in the week before. The healthcare assistant said that, in her opinion, the nurse and healthcare assistant on the evening shift had moved the man to a single cell, "with the best of intentions … giving this guy some space and peace and quiet away from [his cellmate]."

57. Following her handover, the healthcare assistant's routine is to walk around the healthcare centre to each of the cells and gives the prisoners hot water for a cup of tea. When she got to the man's cell that night, she stopped to have a brief chat with him. During interview, she recalled that he "looked awful, looked dreadful". She described him as "always well kept, clean shaven, tidy". That night she noticed that he had not bothered to shave for a couple of days and said that "he just looked really rough". When the healthcare assistant asked the man what was wrong, he said that he had had a "rotten day". The healthcare assistant asked him if he would like to speak to a Listener or to discuss his problems with her. He said that he would like to speak to her. They had spoken at length on a couple of occasions and she said that they enjoyed a "good rapport". She explained that she had a couple of jobs to do first, but that she would come back to speak with him about ten minutes later.

58. The healthcare assistant went to check with the nurse that she could spend some time with the man, because the nurse was running healthcare that night. The nurse agreed that the healthcare assistant should talk to the man. During her medication round, the nurse had noticed that the man was lying on his bed writing. She did not speak with him at the time, but had recorded her observation in his ACCT file. The healthcare assistant finished off her water round, wrote some observations in the open ACCT logs and then returned to the man's cell to speak with him.

59. During a night shift, all prisoners are locked in their cell. Only the orderly officer can routinely open a prisoner's cell. Healthcare staff have a sealed pouch with an emergency key that they may use in urgent situations to enter a prisoner's cell. They have been advised to

use this key only in the presence of the orderly officer. The healthcare assistant spoke to the man through the open observation panel on his cell door.

60. They talked for nearly half an hour. The healthcare assistant said that the man was pleased to be away from his cellmate, but that this was not a "major concern" for him during their discussion. Instead, he told her that he was concerned that he was going to spend ten to fifteen years in prison. She reminded him of legal advice which suggested that he was likely to receive a shorter sentence, but she told my investigators that nothing she said would reassure him. The man told the healthcare assistant that he was sorry for having hurt his family through his drinking. He said he did not think he could ever give up drinking completely and that he still craved it. She discussed his anxiety and asked about his medication. Between the two of them, they wrote a list of things that the man could do to make himself feel better, including getting his medication reviewed and building bridges with his wife. The healthcare assistant said that she would write the detail of this conversation in the man's medical record. She said that she would request an urgent review with the mental health team to stop him from slipping further into depression.

61. When the healthcare assistant left the man, she had convinced him to have his cup of tea and a cigarette on his bed to calm himself down. He agreed to try to calm down by doing some breathing exercises. As she was leaving his cell door, he said to the healthcare assistant, "Do you know what I have done in the past?" She replied that she did not, because she had not had the opportunity to read his notes in any detail. During interview, the healthcare assistant told my investigators that, in hindsight, the man may have been referring to his previous suicide attempts. After his death, she had reflected that he might have been trying to warn her that he was contemplating taking his own life. At the time, she thought he might have been referring to previous offences. The man thanked her for everything she had done for him and she left him at around 10.00pm.

62. After their lengthy conversation, the healthcare assistant spoke to the nurse about her concerns for the man. She said that she did not think that he was going to harm himself. She was concerned that they would have a long night with him being up and out of bed and feeling anxious. She suggested that the number of checks made on him during the night should be increased from one an hour to "at least one every half an hour … just to keep an eye on the guy."

63. The healthcare assistant said that changing a prisoner's level of observations is usually done following a formal review of the prisoner's risk factors. During a night shift, there are not enough people to conduct a formal review and changing someone's level of observations is more a matter of "initiative". She explained that the night orderly officer would be told of such a change. In this case, the night orderly

officer was on his way to healthcare to access the emergency medication cupboard on the lower level for another prisoner's medication. As part of his duties, at the beginning of a shift the night orderly officer visits the healthcare centre to check each of the prisoners and the quality of the ACCT documents. The healthcare assistant did not specifically tell the night orderly officer that she had increased the man's observation levels because she knew that he would be made aware of the change on his imminent visit to healthcare.

64. In line with the agreed increased observations, the healthcare assistant checked the man at 10.30pm and noted that he was asleep under his bed sheets. She said that she was relieved to see him like that, because she thought it meant that he was "okay". The staff toilet on the healthcare wing is just adjacent to the man's cell. The healthcare assistant looked in at him again as she was on her way to the toilet at around 10.40pm. He was still in his bed at that time.

65. At 11.00pm, the healthcare assistant went to check the prisoners on her half hourly round. She went to the man's cell first because it was located at the far end of the healthcare centre. To record the check, she carried a small device to plug into an electronic socket (a process called 'pegging'). As she pegged his cell, she turned to her left. She could see directly into the cell through the open observation panel. The healthcare assistant saw the man hanging from the window.

66. Just at that moment, the nurse, the orderly officer and an officer who was assisting the orderly officer with his duties during his night shift arrived back on the landing from the emergency medication cupboard on the lower floor of the healthcare centre. They were standing together outside the staff office, about ten metres away from the man's cell. The healthcare assistant shouted to them that the man was hanging in his cell. The orderly officer and the officer assisting him immediately ran to the cell. The orderly officer unlocked and opened the door. The orderly officer supported the man's weight, the officer assisting him used an anti-ligature knife to cut the man down. (All officers at Bedford carry an anti-ligature knife in a pouch on their belts.) The two officers took the man's weight and gently laid him on the floor. The nurse instructed the healthcare assistant to go to the staff office and fetch the emergency bag. The orderly office took the ligature from the man's neck and tried, unsuccessfully, to find a pulse. He asked the nurse to try and find a pulse, but she could not. The orderly officer used a torch that he carried with him to check the man's eyes. He described them as being "fixed". Although he had no vital signs of life, staff agreed to commence cardiopulmonary resuscitation (CPR).

67. The healthcare staff were standing at the door and the officers commenced CPR. The officer who was assisting the orderly officer requested a resusi-aid, a plastic device which prevents infection through any possible bodily fluid exchange during resuscitation. Staff

do not carry these as a matter of course and one was not available in the emergency response bag. The officer commenced mouth-to-mouth with no protection for himself or for the man. The orderly officer was performing chest compressions.

68. While performing chest compressions, the orderly officer radioed for assistance. In his radio request, he asked for an emergency ambulance and for another officer to come to the healthcare centre from D wing, where he was carrying out his night shift, immediately. The orderly officer knew that staff performing CPR would become tired and it was his priority to get as many people to help as he could. At the time, the door between D wing and the healthcare centre was kept open. This meant that the officer from D wing could move freely to get to the emergency and assist the orderly officer. When the D wing officer arrived, he took over mouth-to-mouth. By this time, the nurse had located a mask in the emergency bag.

69. The orderly officer left the cell and the officer assisting him took over chest compressions. He made his way to the gate so that he could let the ambulance through to the healthcare centre. On his way to the gate, the orderly officer had gone to A and B wings, larger wings which have no locked gates between them. He asked that someone go and relieve the D wing officer because he needed to return to the wing where he was the only officer on duty.

70. In the meantime, the nurse had taken over mouth-to-mouth. An officer arrived from A wing with instruction to take over from the D wing officer. The healthcare assistant was awaiting further instruction from the man's cell, but also continued checking on other prisoners in the healthcare centre.

71. The orderly officer met the first ambulance five minutes after the emergency call. He took the paramedics to the healthcare centre. He then went back to the gate to meet a second ambulance. The A wing officer asked the officer performing chest compressions to get a piece of paper and write down the names of all those who had entered the man's cell. The officer understood that he was given this job to take him away from the emergency and keep him busy. It was the first time that he had come across such an emergency, and he said he was upset by it. The paramedics took over the CPR. They administered medication and put a tube down the man's throat. At that point, the staff left the man's cell and went to the staff office.

72. Paramedics attempted to resuscitate the man in his cell. For the best chance of survival, they decided to transport him to the local hospital only five minutes away. The A wing officer was asked by the orderly officer to escort the man to the hospital. An emergency response team (known as a 'crash' team) was waiting at the hospital when the ambulance arrived at 11.50pm. Emergency resuscitation attempts

were continued, but these were unsuccessful and the man was pronounced dead at 00.03am on 1 May 2006.

73. The A wing officer, who had escorted the man to the hospital, rang the prison from the hospital to notify them of the his death. He waited until the police attended the hospital and handed them an item of the man's personal property. He returned to the prison at around 12.45am.

Staff Support

74. All of the staff, apart from the officer assisting the orderly officer, continued to work the rest of their shift. That officer was given the opportunity to go home. Instead, he elected to go and sit with the D wing officer in the wing office. He said that this was helpful for both of them, and meant they could discuss what had happened with each other. He did not want to go home to a house where his family would be sleeping.

75. All staff involved in the incident attended the hot debrief at the end of their night shift, at about 8.00am. (A hot debrief is an opportunity for staff to discuss the details of what has happened and share any immediate concerns.) As there were no administrative support staff available to minute the meeting, the Governor recorded the hot debrief on cassette tape.

76. A critical debrief was held on 16 May 2006. This lengthier session encouraged staff to analyse what had happened and to share any concerns. All staff interviewed by my investigators at Bedford felt well supported by the prison. One member of staff expressed concern that the hot debrief was tape recorded as he felt that staff may have been inhibited by the tape machine.

77. At the time that my investigators attended the prison, the Governor had already begun to address shortcomings he had identified as part of the debriefing process. I commend this prompt action. I am also pleased to note that there has been a marked improvement in the staff support available at Bedford since a previous investigation mounted by this office.

Family contact

78. The man had listed his parents as his next of kin. His family were a constant source of support throughout his time in prison. Their frequent visits are well-recorded as lifting his mood. He also corresponded with his wife. On the night that he died, the man's parents were away on an overnight trip. The prison notified the local police. The police tried to locate the man's parents for some time. Eventually, the police obtained an address for his brother and visited him at lunchtime on Monday 1 May to break the sad news. The man's

father then got in touch with his parents and wife to tell them what had happened.

79. The prison's family liaison officer and chaplain went to the man's parents' house on the afternoon of 1 May. Both the family and the man's wife visited Bedford prison, although on separate occasions.

80. A family liaison officer from my office, arranged to meet with the man's parents and brother and separately with his wife. In these meetings, the family officer, accompanied by my investigator, explained the investigation process and asked if there were any concerns. Both parties raised issues to be considered during the investigation.

81. It is my policy to disclose all relevant documents to relatives and interested persons as soon as possible during an investigation if this is their wish. The man's parents and his wife asked for copies of all his prison files. Both parties received all of the documents (subject to minor redaction in line with data protection requirements).

ISSUES

Was the man in the safest place in the prison?

82. The man was moved to the healthcare centre on 21 April. The reason for admission was recorded as “low in mood, see to take medication”. His cellmate on D wing told my investigators that he did not think the man should have been moved to the healthcare centre. He told my investigators that the officers on D wing were ”supportive” and that he had a good relationship with him. He was concerned that it was only about one week after leaving D wing that he died.

83. Bedford’s Suicide Prevention Strategy was last reviewed in September 2005. The Governor and Area Manager signed off the document. There is a section entitled ‘Location Residential Unit or Healthcare Centre’ on page 14 of the document. This section encourages officers to consider the degree of risk and the level of support when deciding where to locate prisoners subject to suicide prevention procedures. The document recognises that a prisoner who remains on the residential unit will stay in contact with a familiar environment and people, and that staff can support the prisoner to deal with the demands of the normal regime. The document goes on to suggest that a prisoner located on the healthcare centre will receive “more intensive supportive care and safe environment”.

84. The officers who recommended that the man should be transferred to the healthcare centre did so because they thought it would enhance his care. According to the suicide prevention strategy, he would receive more support and the healthcare centre would provide a “sanctuary from the normal regime”. The man had received increasing contact with a psychiatric nurse leading up to the transfer from the residential unit.

    The Governor should review the Suicide Prevention Strategy to emphasise that each prisoner must be assessed individually as to whether a transfer to the healthcare centre is in their best interests.

85. The ratio of staff to prisoners is indeed higher on the healthcare centre. The man received individual care and attention from many of the nurses and from the healthcare assistant on the night he died. However, the regime in the healthcare centre was much reduced as compared with that on ordinary location. The man spent a good deal of his day in his cell. While on D wing he had been a Stores Orderly, a coveted position, which meant that he could walk around the prison in the fresh air. The man had got on well with his cellmate on D wing who had provided him with support throughout his depressive episodes. By contrast, the prisoner sharing the healthcare dormitory with the man was self-harming and was described by the healthcare assistant as an “awkward, upsetting, infuriating cell mate”. The man spent a prolonged

amount of time in the dormitory with this prisoner. He did not sleep well and eventually requested a transfer to another cell.

The Governor and the Head of Healthcare should improve the regime in healthcare to ensure that prisoners have more to occupy their time and more time out of their cells.

86. Prison Service Orders (PSOs) provide detailed instructions on the management of prisons. PSO 2700 relates to suicide and self-harm prevention and instructs that:

"Two at-risk prisoners should not share a double cell. If it is not advisable or practical to place a prisoner on an open F2052SH in a shared cell, the reason for the allocation to a single cell should be recorded in the F2052SH, and additional protective measures put in place to compensate for the added risk."

87. The presumption in PSO 2700 is that prisoners at risk should be in shared accommodation. This is reinforced in Bedford's own Suicide Prevention Strategy:

"All prisoners subject to an open ACCT Plan will normally be located in shared accommodation. If left on their own, at risk prisoners must be seen by staff at intervals no longer than 30 minutes or as a support plan in ACCT Plan indicates."

The Governor should remind staff that prisoners who are subject to ACCT procedures and are transferred to a single cell should be subject to checks at least every 30 minutes in accordance with HMP Bedford's Suicide Prevention Strategy.

88. The prisoner sharing the dormitory cell was an at-risk prisoner who was self-harming while in the cell with the man. The healthcare assistant told my investigators that the cellmate:

> "… was very awkward in the respect of he was always handing in bits of broken glass, bits of broken fork because they have plastic cutlery, bits of broken fork where he had perhaps been self harming he had scratched or gouged his arms with it".

During interview, the cellmate told my investigators that he spoke with the man about self-harming and suicide, although his recollection was that it was the man, and not him, who seemed the more preoccupied with harming himself. There is no doubt that the man and his cellmate were 'two at-risk prisoners' and therefore that they should not have been sharing a double cell.

89. The day after the man was transferred to Bedford, the senior officer completed a Case Review and CAREMAP. He identified that the man was suffering from "feelings of isolation" and suggested that he should

aim to share accommodation and contact his family to reduce his risk. Throughout his time at Bedford, the man had not been located in a cell by himself. When the same senior officer authorised the transfer to the single cell, he said that he checked the man's ACCT file and there was nothing that concerned him in the most recent entries. He told my investigators that he took the advice of the nurses, who thought that the cellmate was having a bad effect on the man and that it would be in his interest to move to his own cell. During interview, the senior officer said:

"To be honest with you, my main concern at that stage was [the cellmate] because of the threats and his actions that he'd taken that night. So I went back in and dealt with [the cellmate]."

90. The senior officer agreed with my investigators that he should have formally reviewed and recorded any changes to the man's circumstances in his ACCT file. Instead, he spoke with him as he walked to his new cell at the end of the healthcare centre and he reassured him that he was much better for the transfer. The two men spoke about him starting a job as the Healthcare Centre Orderly the following morning. The senior officer said that when he left the man, he "appeared to be that relieved to be on his own and have some peace and quiet". With this in mind, the senior officer, "did not feel that it was needed" to increase his observations at that time. This decision was in contravention of Bedford's own suicide prevention policy which states that at-risk prisoners who have been transferred from shared accommodation "must be seen by staff at intervals no longer than 30 minutes". The senior officer was trained in ACCT procedures one month after he had been transferred to Bedford on promotion in January 2006.

The Governor should remind staff that every decision affecting a prisoner on an open ACCT must be made after checking the prisoner's documentation and must be recorded personally by the member of staff responsible for making that decision.

91. According to his ACCT CAREMAP, the man was lonely in the prison environment. He had gained support from his cellmates in the past on C and D wings, during times of difficulty. He had spent nine days in the dormitory cell in the healthcare centre, with less time out of his cell and little to occupy him. At his own request, the man was moved to a single cell, away from another troubled prisoner, because staff thought it was in his best interests. Had he been sharing his cell on the evening of 30 April, he may not have had the opportunity to take his life. The senior officer should have personally recorded that he did not think it necessary to increase the observations at the time of transferring him to the cell.

92. The man was subject to half hourly observations at the time that he died. The healthcare assistant and the nurse appropriately agreed to

increase the number of observations following the healthcare assistant's lengthy conversation with him. During interview, the healthcare assistant said that she had not read his suicide prevention documentation before their discussion. She did not read the documentation before suggesting the increase in observations. The healthcare assistant told my investigators that, as she concluded her lengthy conversation with him, he said to her:

"… do you know what I have done in the past, and I said, no I haven't really had a chance to read your notes in depth. So he was oh right ok, but then afterwards when I did have chance to read his notes I saw that he had attempted to take his life on a couple of occasions before and I think in a round about way he was trying to warn me."

While I commend the healthcare assistant for taking time to speak with the man at length about what was on his mind, this is a stark reminder of the importance of staff reading a prisoner's records in a timely fashion and using the information to inform their care.

93. The man's family was extremely worried about the design of his cell when he died. They told my investigators that they were particularly concerned by the pipes that ran under the window in his cell. They felt that these pipes, combined with the bars on the window of the cell in healthcare, afforded the man the opportunity to attempt suicide. I realise that it is not possible for all risk to be eliminated. However, it is embedded in Bedford's suicide prevention policy that prisoners who are deemed to be at particular risk of attempting self-harm or suicide should be transferred to the healthcare centre. It seems sensible, then, that cells should be assessed for ligature points and, where possible, such points should be eliminated.

The Governor and the Head of Healthcare should assess the cells in the healthcare centre for ligature points, taking action to reduce these where possible.

Did the man receive effective treatment for his alcoholism? Did this affect his mental state before he died?

94. Before entering custody, the man's lifestyle had become chaotic because of his severe depression and abuse of alcohol. His alcoholism was identified at Woodhill, and when he arrived at Bedford he was put on the alcohol detoxification programme immediately.

95. The detoxification nurse administered his alcohol detoxification programme. In April 2006, there was only one detoxification nurse working at Bedford due to staff illness. As Bedford is a local prison, significant numbers of prisoners arrive who are suffering from alcohol or drug withdrawal and the detoxification nurse's task was unenviable. She gave the man Librium, a drug routinely used for prisoners withdrawing from alcohol. The detoxification course lasted nine days.

When questioned during interview, healthcare staff did not seem aware that he had undergone the alcohol detoxification programme.

The Head of Healthcare and the Governor should ensure that alcohol detoxification is delivered as part of mainstream healthcare, rather than in isolation from other healthcare services.

96. When asked what work they had undertaken with the man, the CARATs team recognised that resources for prisoners withdrawing from alcohol are limited. They suggest that, regrettable as this is, it is a national issue and not within their control.

The Governor should ensure, as far as possible, that there is a full complement of staff to deliver the detoxification programme.

97. In June 2006, the month after the man's death, the Department of Health, in conjunction with the National Health Service, published a document entitled, 'Models of Care for alcohol misusers', known as MoCAM. MoCAM provides guidance as to how best to treat adults affected by alcoholism. It suggests that there should be a central care plan for patients which combines all the strands of their treatment in a structured approach to their care. With the prioritisation of primary care resources for alcohol services that this document recommends, structured holistic care should become the norm for prisoners suffering from alcohol withdrawal, rather than the exception. Alcohol withdrawal is dangerous and, coupled with depression, might be crucial to the mental balance of prisoners.

98. During his last conversation with the healthcare assistant, the man reflected that he could never successfully give up alcohol. He said that he had no control over his life. There can be little doubt that he did not feel he had effectively addressed his problems with alcohol and that this was on his mind on the evening that he died.

Was there an appropriate response when the man was discovered?

99. The man was discovered in his cell by the healthcare assistant. Despite being in the healthcare centre, with the only nurse on duty for the night shift present, it was prison officers who commenced and continued Cardio-Pulmonary Resuscitation(CPR). There is a defibrillator available in the healthcare office. Although the nurse had experience of working in the Accident and Emergency Department of the local hospital, she was not trained in the use of a defibrillator.

Healthcare staff should be trained in the use of a defibrillator and there should be a member of staff who has been trained in its usage on duty at any time.

100. I must commend the resuscitation efforts of the orderly officer and the officer assisting him. However, I am surprised that the skilled

healthcare staff on duty at that time did not immediately take control of the resuscitation efforts. I am concerned that the officer assisting the orderly officer did not have access to a face guard to protect himself during mouth to mouth resuscitation efforts.

Response staff should carry protective equipment, such as a pocket mask, at all times.

101. A critical debrief was held on the morning following the man's death. In general, staff felt that it was useful to talk about his death at that early stage. One member of staff suggested the fact the debrief was taped was unhelpful. My investigators were told by the Governor that this was not ideal, but had been unavoidable given a shortfall in administration staff that morning. I agree that taping such a sensitive meeting should be avoided in future and commend this for the consideration of the Governor as a matter of housekeeping.

The Clinical Review

102. Primary Care Trusts (PCTs) are responsible for undertaking a clinical review following all deaths of prisoners in Prison Service establishments. When my investigator initially contacted Bedfordshire PCT, they expressed concern that the clinical review would not be sufficiently independent. Since April 2005, the PCT has provided and managed healthcare services in HMP Bedford. In light of their concerns, they appointed the clinical reviewer from a neighbouring PCT, to conduct the review on their behalf. The man's wife was concerned about the independence of the clinical reviewer because the clinical reviewer was a Prison Service employee at the time he conducted the clinical review. The clinical review was thorough and balanced to provide an assessment of clinical care sufficient for the purposes of this investigation. However, I can understand that the appointment of a Prison Service employee could be also be criticised as being insufficiently independent. On receipt of this report, the Bedfordshire PCT may care to seek further central advice on the matter from the Department of Health.

103. There was a slight delay in appointing the clinical review. By the time the appointment had been made, healthcare staff had been interviewed by investigators from my office, the police and their own senior management team. The Human Resources department of Bedfordshire PCT requested that staff should not be interviewed a further time. For this reason, the clinical reviewer did not visit the prison or speak to staff directly. He liaised with the Head of Healthcare at Bedford during the course of his paper-based review. He was given full access to all records and transcripts of staff interviews previously conducted by my investigators.

104. The clinical reviewer considered the available paperwork and makes the following six recommendations:

- This report recommends that healthcare professionals are trained in the use of an Automated External Defibrillator (AED) on an annual basis with intermittent refreshers and that several AEDs are placed strategically throughout the establishment.

- This report recommends that front line staff carry protective equipment such as a pocket mask or face shield.

- This report recommends all First Responders undertake initial training and subsequent refreshers in First Aid/CPR in accordance with national guidance.

- It is recommended that healthcare professionals are empowered to take charge at a medical emergency and that this is embedded in a written framework.

- It is recommended that [improving the quality of ACCT recording and ensuring timely reviews when a prisoner's circumstances change significantly] is reinforced through the Safer Custody Manager and Head of Healthcare.

- It is recommended, from reading the Inmate Medical Record (IMR), that policy and practices are developed to ensure greater collaborative working and interaction between the different strands of healthcare delivery – healthcare, mental health in-reach and detoxification. In particular, a standard patient group directive should be followed by all clinicians when prisoners undertake an alcohol detoxification programme.

105. The clinical reviewer's expert recommendations reinforce crucial areas in the care of any prisoners, particularly those suffering from mental health problems and alcohol dependency. I agree with all of his recommendations and fully endorse them.

106. An independent report was commissioned by the Coroner as part of the inquest proceedings and received in my office during the consultation period. The report was carried out be a Consultant Psychiatrist, who was asked to compare the treatment that the man received in Bedford prison, compared to his treatment in the community. The Consultant Psychiatrist concluded that:

> "I would judge the management of his withdrawal from alcohol and benzodiazepines, the recognition of his need for ongoing treatment of his addiction, assessment of his mood n an ongoing manner and attempts with pharmacology, i.e. anti-depressants, to attenuate his mood to have been appropriate interventions."

The independent report makes no recommendations.

107. In his analysis of the man's clinical records, the clinical reviewer identified the following areas of good practice:

- The interaction between the man and the healthcare assistant and subsequent documentation in the [medical record] is to be commended.

- The action of the officers who attended the incident is to be commended. They exercised a clear duty of care, to the best of their ability.

- The support mechanisms offered by HMP Bedford and the PCT to the staff are clearly robust and to be applauded.

108. As part of the clinical review process, a colleague of the clinical reviewer, reviewed the dosage of medication that the man was prescribed and found it to be higher than he would expect, but within clinical guidelines. However, he made the following recommendations:

    - The most important issue is to ensure that all staff who prescribe/issue chlordiazepoxide for alcohol detoxification are following a robust (pre-agreed) standard operating procedure or policy with clear dosage guidelines in response to severity of symptoms with the possibility for regular review if the patient or staff involved raise concerns.

    - The standardised detoxification policy should encourage the recording of any possible side effects.

The man's family's concerns

109. During the course of the investigation, the man's family expressed several concerns about his care. I have endeavoured to respond to all of these concerns in the body of the report.

110. In addition, the man's wife raised a concern about the manner in which the prison dealt with her when she visited. She felt that prison staff were dismissive of her and, just prior to the visit, she was told that "if there was trouble" she "would be escorted off the premises".

111. His wife was also concerned about the return of his property as she is his legal next of kin. She had written to the prison to notify them of this. However, she received no response to her letter and her general impression of the prison was that issues were "not followed up". She asked to whom the property had been returned and it was not until my investigators asked the prison on her behalf that she discovered that the property had been returned to other family members. I recognise that it can be difficult to identify a prisoner's next of kin. In good faith,

the prison had returned the man's property to his parents whom he had identified as his next of kin upon his reception at Bedford.

112. There is a Prison Service family liaison toolkit for staff nominated as the family liaison officer following a death in custody. The duties of a family liaison officer are listed in the toolkit and include:

> "To offer support, practical help and advice to the family (before and after the inquest)."

The man's parents also expressed concern that, as at December, they had not received acknowledgment of a letter that they sent to the prison, copied to the Governor, in October.

113. I conclude from this that the family liaison function may properly extend beyond the few days following a prisoner's death. Furthermore, where there is some confusion about who is the prisoner's next of kin, prisons should deal with any requests for information transparently and swiftly.

RECOMMENDATIONS

I have made nine recommendations:

The Governor should review the Suicide Prevention Strategy to emphasise that each prisoner must be assessed individually as to whether a transfer to the healthcare centre is in their best interests.

The Governor and the Head of Healthcare should improve the regime in healthcare to ensure that prisoners have more to occupy their time and more time out of their cells.

The Governor should remind staff that prisoners who are subject to ACCT procedures and are transferred to a single cell should be subject to checks at least every 30 minutes in accordance with HMP Bedford's Suicide Prevention Strategy.

The Governor should remind staff that every decision affecting a prisoner on an open ACCT must be made after checking the prisoner's documentation and must be recorded personally by the member of staff responsible for making that decision.

The Governor and the Head of Healthcare should assess the cells in the healthcare centre for ligature points, taking action to reduce these where possible.

The Head of Healthcare and the Governor should ensure that alcohol detoxification is delivered as part of mainstream healthcare, rather than in isolation from other healthcare services.

The Governor should ensure, as far as possible, that there is a full complement of staff to deliver the detoxification programme.

Healthcare staff should be trained in the use of a defibrillator and there should be a member of staff who has been trained in its usage on duty at any time.

Response staff should carry protective equipment, such as a pocket mask, at all times.

The Clinical Reviewer, makes a further six recommendations which I endorse:

This report recommends that healthcare professionals are trained in the use of an Automated External Defibrillator (AED) on an annual basis with intermittent refreshers and that several AEDs are placed strategically throughout the establishment.

This report recommends that front line staff carry protective equipment such as a pocket mask or face shield.

This report recommends all First Responders undertake initial training and subsequent refreshers in First Aid/CPR in accordance with national guidance.

It is recommended that healthcare professionals are empowered to take charge at a medical emergency and that this is embedded in a written framework.

It is recommended that [improving the quality of ACCT recording and ensuring timely reviews when a prisoner's circumstances change significantly] is reinforced through the Safer Custody Manager and Head of Healthcare.

It is recommended, from reading the Inmate Medical Record (IMR), that policy and practices are developed to ensure greater collaborative working and interaction between the different strands of healthcare delivery – healthcare; mental health in-reach and detoxification. In particular, a standard patient group directive should be followed by all clinicians when prisoners undertake an alcohol detoxification programme.

The pharmacy technician, in his analysis of the man's medication, made the following two recommendations:

The most important issue is to ensure that all staff who prescribe/issue chlordiazepoxide for alcohol detoxification are following a robust (pre-agreed) standard operating procedure or policy with clear dosage guidelines in response to severity of symptoms with the possibility for regular review if the patient or staff involved raise concerns.

The standardised detoxification policy should encourage the recording of any possible side effects.

Good practice

I strongly agree with the commendations of the clinical reviewer:

The interaction between the man and the healthcare assistant and subsequent documentation in the [medical record] is to be commended.

The action of the officers who attended the incident is to be commended. They exercised a clear duty of care, to the best of their ability.

The support mechanisms offered by HMP Bedford and the PCT to the staff are clearly robust and to be applauded.