Investigation into the circumstances surrounding the death of a man at HMP Bedford on 22 February 2007

Report by the Prisons and Probation Ombudsman for England and Wales

May 2008

This is the report of an investigation into the circumstances of the death of a man on 22 February 2007 at HMP Bedford. The man was found in his cell with a ligature around his neck attached to toilet handrails. He was 37 years old.

I would like to offer my sincere condolences to the man's family and those touched by his death. I apologise for the delay in completing this report.

The investigation was undertaken on my behalf by a colleague. Both she and I would like to thank the then Governor of Bedford, and the appointed Liaison Officer, for their cooperation during the course of our inquiries. I would also like to thank the second Governor at HMP Woodhill for facilitating our investigation.

The man had been in custody at Woodhill between October 2006 and February 2007. He left Woodhill to attend court on 12 February 2006 but, following his appearance, was taken to Bedford because it was closer. The man was only in Bedford for ten days before he died.

Although designated a rule 45 (vulnerable) prisoner, the man was housed in a dedicated cell in a normal wing as there was no room in the vulnerable prisoners unit. The location of the cells allocated to vulnerable prisoners allowed for only poor observation by staff. As a result, the man experienced intimidation and threats from other prisoners, a wholly unacceptable situation. I have been pleased to learn of the Governor's prompt action in response to my investigation in reallocating the cells closest to the wing office for use by vulnerable prisoners.

The man did not eat for five days and his collection of meals and intake of food was poorly monitored. The reasons were not sufficiently probed as staff were unclear as to the procedures when a prisoner refuses food. By the time it was discovered, nurses were concerned about the man's state of health. I make three recommendations in total, including one about dealing with food refusal.

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

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Prisons and Probation Ombudsman
February 2008

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SUMMARY

The man was remanded to HMP Woodhill on 17 October 2006, having been charged with sexual offences. It was noted on reception that he had previously attempted suicide, and for a short period he was supported using the Assessment, Care in Custody and Teamwork (ACCT) document (used to support and monitor those thought to be at risk of self harm).

The man was transferred to HMP Bedford following a court appearance on 12 February 2007. He had been expecting to return to Woodhill and was unhappy about being at Bedford. He applied for rule 45 status (under which prisoners considered to be vulnerable are located away from other prisoners for their own safety). In this man's case, he felt under threat due to the nature of his alleged offences. However, the wing for rule 45 prisoners was full, so he and his cellmate were moved to a normal residential wing (D4 landing).

Over the next five days, the man and his cellmate were subject to abuse and threats from other prisoners which led to them both declining their meals. Healthcare staff were notified on 17 February and the man was found to be dehydrated with low blood sugar levels. He was admitted to the healthcare centre and an ACCT was opened. However, once in the healthcare centre the man began to eat again. Following an assessment and case review on 18 February, the ACCT was closed. It was felt that the man's food refusal had largely been a protest at being in Bedford, and staff were looking into the possibility of a transfer. Whilst the closure of the ACCT was reasonable, the man was still concerned about being housed on D wing. The man mentioned several times about being intimidated on D wing and my investigators found that this had not been fully considered by staff.

During the night of 21/22 February 2007, the man was checked more frequently than was formally required, the last check being at 7.30am when he was in his bed. Just before 8.00am, an officer entered his cell to find the man on the floor with a ligature around his neck attached to the handrails in the toilet area. She summoned assistance, the ligature was cut and nurses attempted to revive the man. The ambulance crew continued attempts, but to no avail.

Following the man's death, all contingency plans were followed and staff and prisoners were well supported.

Two major issues emerged from the investigation. I found the location of the cells for rule 45 prisoners on D4 landing unacceptable as they afforded poor observation from the wing office. The Governor has since changed the cells to be closer to the staff office. Secondly, staff were unclear about how to deal with prisoners refusing food. In the man's case, this was not properly monitored or recorded, nor the reasons for refusal fully explored. Healthcare staff were not informed until it was identified that the man had not eaten for five days. Once this was identified and healthcare staff assessed the man, he was appropriately moved to the healthcare centre and an ACCT was opened.

THE INVESTIGATION PROCESS

1. I appointed my colleague to lead the investigation on my behalf. She visited HMP Bedford where she met the then Governor. On her initial visit, she was given a tour of Bedford, including the cell where the man had died. She met members of the local committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). Notices were issued to prisoners and staff at both Bedford and Woodhill, inviting anyone who might have information relating to the man to make themselves known to the inquiry.

2. My colleague and one of my family liaison officers, visited the man's parents and partner to discuss the investigation and ascertain any particular family concerns and questions. The man's family said that he had seemed content and settled at Woodhill, and were concerned he had deteriorated in such a short period of time at Bedford. They asked if the man had been taking medication and whether this had been monitored. The man's parents also sought more detail of the checks on prisoners and if anything had happened to him the evening before his death. These issues are explored further in the report.

3. The man's parents also felt that he had friends at Woodhill, with one in particular close and supportive friend. They felt the absence of this friend was a key factor in the man's depression

4. My investigators interviewed staff and prisoners at both Woodhill and Bedford, formally and informally. The team examined the man's prison record, medical records and a series of prison documents.

5. My colleague asked Bedfordshire Primary Care Trust to undertake a clinical review of the man's healthcare in custody. They commissioned an independent healthcare consultant, to undertake the review. Once the investigation was complete, she provided feedback to the Governor regarding her concerns.

HMP BEDFORD

6. HMP Bedford is a local, category B prison, serving the courts of Bedfordshire and adjoining counties. It was built in 1801 and enlarged in 1849. A new gate lodge, houseblock and healthcare centre were added in early 1990s. There is 24 hour medical cover and 12 beds are available in the healthcare centre.

7. HM Chief Inspector of Prisons, last inspected Bedford in April 2006. The inspectors found that the prison was performing reasonably well against the four tests of a healthy prison. The inspectors said the prison was generally safe, providing a well controlled environment. However, more work was needed in supporting victims of bullying and challenging those who bullied.

8. The Chief Inspector reported that a safer custody meeting was held every month, attended by the violence reduction coordinator and suicide prevention coordinator, as well as representatives from other departments such as healthcare, the chaplaincy, CARATS and mental health in-reach staff. All incidents of self-harm and bullying were discussed at this meeting, and any trends identified were analysed. In addition, both the violence reduction and the suicide prevention coordinators highlighted areas where policy or good practice was not being adhered to. A violence reduction survey of both staff and prisoners had been conducted in January/February 2006 and its results indicated that most prisoners felt safe at Bedford, and that incidents of bullying were rare.

9. The inspector said Individual relationships between staff and prisoners were generally good. Prisoners described their treatment by staff as good, and the inspectors saw and heard staff behave only in a professional and respectful manner in their routine dealings with prisoners.

10. Inspectors were concerned that the in-patient regime for prisoners in the healthcare centre was poor. They made a recommendation that the programme to install in-cell electricity be extended to include the healthcare accommodation.

11. F wing holds 30 prisoners and is used solely to house prisoners under rule 45. These are largely, but not exclusively, those charged with sex offences. When F wing is full, prisoners subject to rule 45 are held on D wing for as short a time as possible until a space becomes available on F wing. Rule 45 prisoners on D wing are taken to F wing for exercise and association, but take their meals and showers in D wing. For this, they are unlocked separately from other prisoners. Staff told my investigators that it varied how often D wing needed to be used as an overspill, but the cells were not constantly in use for rule 45 prisoners.

KEY FINDINGS

12. On 17 October 2006, the man was remanded into Woodhill prison, pending trial for alleged sex offences. The man felt depressed. He told staff he had felt suicidal in the past and had not eaten for nine days. When he spoke with clinical staff, he said that he was feeling better. He began to eat and no longer wanted to harm himself.

13. The man's time in Woodhill was unremarkable. At first he was a little nervous, and was supported by other prisoners from the "Insiders" scheme (under which trusted and trained prisoners support others in prison, particularly in the early stages of custody). Generally, the man seemed to settle in well and was described by staff as quiet and pleasant. He made friends easily as people warmed to him, and he associated with a small group of other prisoners.

14. In December 2006, the man became withdrawn. A prison officer remembered that other prisoners spoke to him about their concerns that the man had been discussing self-harm. The prison officer spoke with the man directly. He said that the man was quite tearful and upset as social services had prevented him from having access to his children. The sense of loss was worse leading up to Christmas. The man had lost his appetite and was only eating a small amount of food.

15. The prison officer opened an ACCT form. The man was not thought to be actively suicidal, but was finding things difficult and needed extra support. The man admitted he had previously attempted self-harm by cutting at HMP Bedford, and by overdose and ligature at HMP Wayland, but this was some time ago and he no longer felt suicidal. The prison officer told my investigators that the man then settled quite well, "he became quite sociable within the prison groups, freely spoke to other prisoners, spoke to staff, and joked with staff and prisoners." The ACCT was closed on 29 December 2006.

16. The man worked as a cleaner in the prison and seemed to be progressing well. At the end of January 2007, he visited the prison doctor, complaining of sickness, headaches, depression and poor appetite. He reported that his headaches were worse during the night whilst watching television, and that his last eye test had been seven years previously. The man said he was not eating very much because of nausea and vomiting and that his sleep pattern was poor. The doctor documented that there was no evidence of psychosis and the man denied any thoughts of self-harm or suicide.

17. On 30 January, the doctor prescribed sominex 40 mg at night for insomnia, chlordiazepoxide 20mg twice daily for anxiety, nefopam 60mg three times a day for pain, and metoclopromide 10mg as required for nausea.

18. On 12 February, the man was taken to court where he was further remanded until 21 February. The man was then taken to Bedford prison although he had been expecting to return to Woodhill. There is no evidence in the clinical records that the man had been assessed as medically fit for transfer. Another prisoner was also taken to Bedford rather than returning to Woodhill.

19. On arrival at Bedford, the man had a reception health screen with the reception nurse. The man explained he was prescribed nefopam daily and had been seeing the doctor over the last few months for a head injury and depression. He said he had previously taken anti-depressants and had tried to hang himself about four months before. He made good eye contact during the interview and was calm. The reception nurse told my investigators that the man was quiet and although he answered all questions put to him, he did not "open up". The first night procedures were of a good standard.

20. The reception officer conducted a first night interview with the man. Again, he admitted that he had previously attempted suicide but said he did not feel suicidal at that time. He said he was not concerned about being in custody. He told the reception officer that he had eight children and a supportive family.

21. The following day the man saw the prison doctor. The man had previously suffered a head injury. The prison doctor reported there were no signs of any injury but reviewed his medication and prescribed acupan (nefopam) 60mg three times a day for pain, and fluoxetine20mg once daily for anxiety/depression. The man collected this medication on 14 and 15 February, but not on 16 February.

22. The man and the prisoner that transferred with him successfully applied for rule 45 status (i.e. to be separated from the other prisoners, due to the offences with which they had been charged).

23. As noted, F wing is designated to hold prisoners on rule 45. When the wing is full, several cells in D wing are used to accommodate such prisoners until a space becomes available. There was no room available on F wing, so the man and the other prisoner were located together on the fourth floor of D wing (D4-01). Even if space had become available it would not have been possible for the other prisoner to move to F wing due to potential problems with a different prisoner already located there. The other prisoner told my investigators that the man had been quite protective of him and said he would stay with him as he knew he was vulnerable. The other prisoner said that the man looked after him, for example he went without a blanket to make sure he was warm enough.

24. That evening (13 February) the man declined his evening meal, saying he was not hungry. The landing officer recorded this in the man's wing record. The prisoner that transferred with the man told my

investigators that other prisoners were shouting through the door, and the man told them to go away. On 14 February, the landing officer recorded that the man declined lunch, again saying he was not hungry. However, he did have a shower and cleaned his cell. The following day, the man said he did not want to come out to take a shower or clean his cell as he had done so the day before. He asked if he could have a tea pack (this contained tea bags, milk and sugar).

25. The other prisoner told my investigators that, during the evening of 15 February, a group of prisoners had been shouting things through the door like, "Nonces, we're going to cut you open, going to kick you." The man had shouted back at them, and they then pushed burning paper into the cell. The night Officer checked prisoners on D wing. The man and the other prisoner said they were spending a lot of time in their cell and asked if they could have some tea bags. They also asked for an application form to see the Independent Monitoring Board (IMB). (The IMB is made up of independent volunteers who monitor the treatment of prisoners.) The night officer provided both the tea bags and the form.

26. On 16 February, the other prisoner completed the IMB application form. He wrote that he and the man had been in their cells since they arrived. They were being bullied and had burning paper pushed under their door. The other prisoner was also upset at being in Bedford, and felt he had been lied to as he had been told he would be returning to Woodhill. (By the time the IMB received the application and went to see the other prisoner, he had already been moved back to Woodhill.)

27. That evening (16 February), the night officer was on duty. One of his tasks was to check that all prisoners were in their cells. When he approached cell D4 01 he noticed that someone had written "nonce" on the door. As it was in non-permanent ink, the night officer was able to rub it off. He asked the man and the other prisoner if they were okay. The other prisoner replied that at about 7.45pm someone had pushed burning paper under their door. The night officer could see there was a mark on the floor. He then submitted a security information report (SIR) to alert others to the problem. The night officer told my investigators that the other prisoner had been quite upset and difficult to talk to, whereas the man had been rational and explained what had happened.

28. The SIR was followed up the next day. The other prisoner was unable to move to F wing, as there were likely to be problems with another prisoner residing there and he was due to move to Woodhill as soon as there was space. The man was not mentioned. The Senior Officer (SO) on duty suggested the mark on the floor was some distance from the door, and said she thought the mark had been made by a previous prisoner. It was noted in the wing observation book that staff should be alert to the situation.

29. On 17 February, the man and the other prisoner again declined to have a shower, go out to exercise, or use the phone. It was the landing officer's first day at work since 14 February. He noticed that the man and the other prisoner declined their lunch again and notified healthcare staff. The other prisoner told my investigator they had not collected their meals because they were too scared to leave the cell.

30. Two nurses visited the man and the other prisoner in their cell. The first nurse said that, at first, both men were lying on their beds. The other prisoner was very vocal, and angry about being in Bedford. He said that the nurses were the first to listen to them and was grateful to see them. The first nurse asked if they had reported their issues to the appropriate staff, and listened to them for between 30 and 40 minutes. The other prisoner said that they were not going to eat unless they were moved to Woodhill. The nurse explained the potential consequences of not eating. The man and the other prisoner said that they were not comfortable leaving their cell for any reason, including collecting food, and that staff had not helped them with this.

31. The first nurse assessed the man's physical state. He was much quieter than the other prisoner but seemed to agree with what the other prisoner was saying. He said that it was easier for his family to visit him at Woodhill and he had not even phoned them whilst at Bedford. The man was dehydrated, had dry skin, poor skin colour and low blood sugar. The nurse told my investigators that she was concerned about the man's physical health.

32. The nurses explained to the man and the other prisoner that they could not immediately help with the request to move to Woodhill as it was a Saturday, but it would be followed up on the coming Monday. They asked the men if they would start eating again if they were moved to the healthcare centre. The first nurse told my investigators that she knew this could be viewed as blackmail, but was concerned about the man and felt that he in particular needed to start eating and drinking again.

33. Both men were taken to the healthcare centre at about 4.45pm. They were placed in single cells rather than the dormitory, partly because staff were not sure how much the two men were encouraging each other not to eat. The first nurse said as soon as the man arrived in healthcare he seemed happier. It was meal time when they arrived and the man went to the servery and returned with a plate of chips. The nurse returned later to check if the man had had enough to eat and drink. He replied that he had. The nurse completed the admission paperwork. She noted he was receiving treatment for a head injury and depression. She recorded the reason for admission as food refusal, dehydration, low mood, and low blood sugar (3.9).

34. An ACCT form was opened on both men by a prison officer and senior officer, the reason given as "due to not eating since 13.2.07". An

immediate plan was made - moving them to healthcare, regular checks and interaction. Staff also made them aware of the support they could access through the Listeners (prisoners trained by Samaritans).

35. The nurse from reception carried out a complete physical and psychological needs assessment of the man. She noted that he had good speech and eye contact. The man said he felt low, but not suicidal. He was alert and aware of the situation, but felt slightly faint and had not been sleeping well. His skin was dry. Healthcare staff started a fluid balance chart to monitor the man's fluid intake. This is good practice when someone has not been eating.

36. On 17 and 18 February, the man was checked regularly. Staff said he was polite and friendly but did not easily engage in conversation. The man ate and drank normally, and said he was feeling better. He came out of his cell, and chatted to the other prisoner. A prison officer said the man responded to her encouragement to eat. She said that she gave him a fresh set of clothes and shower gel. He had a bath and a shave and immediately looked much fresher. He also came out of his cell, and went to watch football in the television room with other prisoners.

37. In the afternoon of 18 February, a full ACCT assessment was completed by another officer. The man said he had stopped eating as a protest at being at Bedford. He said he felt unsafe on D wing, but was more comfortable in healthcare, was coping, and did not feel suicidal. This officer said that the man did not present as someone with problems. His manner and demeanour were fine and relaxed. He maintained eye contact and answered all her questions.

38. Following the assessment, an ACCT review took place with the man, a senior officer, the second nurse and a second prison officer. They agreed they would explore the possibilities for transfer. They all decided to close the ACCT as the man's food refusal had not been a protest and had ended. The man had no thoughts of self-harm, and most of his problems had been dealt with in the previous 24 hours. It was agreed that he would be visited on 25 February as a follow up to the closure of the ACCT.

39. A second doctor saw the man the next day. The man explained he had experienced chronic head pains following an assault in 1986. The doctor noted that the man was taking Prozac for depression. The man engaged well and maintained good eye contact. There were no longer signs of dehydration. The doctor assessed that the man was fit to move from healthcare to a normal wing. However, there were still no places available on F wing, and he was assured he could stay in the healthcare centre until a place became available.

40. The second prison officer made enquiries about the man and the other prisoner moving to Woodhill. It was agreed that the other prisoner

would be transferred that afternoon, but as the man's next court appearance was at Luton he needed to stay in Bedford. The court appearance after that would be at St Albans, and he would then return to Woodhill. The second prison officer said that the man was still very concerned about returning to D wing. She reassured him that he would not be moved to D wing. She said she could make arrangements for the man to go to F wing at exercise times and association and to integrate slowly into the wing. They expected cells on F wing to become available later that week.

41. Although the man did not have in depth conversations, the officer felt he was comfortable and he did chat to other prisoners in healthcare. He was also looking into education courses and had been reading books.

42. The healthcare assistant was on night duty in the healthcare centre from Monday 19 February. He described the man as quiet, and as someone who liked to keep himself to himself. The healthcare assistant said that he would ask the man if he wanted anything, but he rarely did and, as a consequence, they did not have much opportunity for conversation.

43. The first nurse saw the man on 20 February. The man said that some of the prisoners from D wing had been shouting out of their windows and he felt threatened by them. The first nurse said that the man often seemed deep in thought and kept himself to himself. The next day she noticed that he chose to stay in his cell during association.

44. It is noted that the man had a legal visit via video link on 20 February. (There is no further detail.) It is also recorded that he was due to appear before Luton Magistrates' Court again the following day via video link. A third nurse was on duty in the healthcare centre when a member of staff collected the man for his legal visit. The man had not mentioned the visit beforehand, and did not speak about it on his return. The third nurse described the man as very quiet, polite and unassuming.

45. The man's mother received a letter from him. She said there was nothing to indicate that he was not coping. The man's parents had been trying to arrange a visit at Bedford, but had found the bookings system difficult in comparison to that of Woodhill.

46. That evening (20 February), the healthcare assistant and the healthcare officer came on duty at about 8.30pm. The healthcare officer performed the roll check to check everyone was in their cells. There is no requirement to check on prisoners throughout the night, unless there is a medical reason, or they are subject to an ACCT. Staff also perform "pegging" (certain points on the landing have to be electronically pegged to show that staff are patrolling the landing and the prison is secure).

47. The healthcare assistant explained that in practice, he checked prisoners frequently:

> "We have to do pegging at each end of the ward, so we're doing that every half an hour. So as I come round, usually I carry a torch and I check everybody. Sometimes there might be people awake, sometimes they might ask for hot water, which I get for them, and just generally make sure everybody's OK. But because of the ACCT documents, plus the pegging, I mean we're going to be coming round every 20-30 minutes anyway."

48. The night of 21-22 February was no different:

> "I'd asked him [the man] earlier on before everybody started settling down if he wanted anything, if he wanted any hot water. He replied no and that was it really. He went to bed and that was it really. I checked him through the night, he was in his bed. I think once he got up maybe to use the toilet. He came back and the next time I came round he was back in bed again and that carried on all the way through the night."

49. A separate prisoner, told a governor that he had spoken to the man at about 10.00pm and had given him some tobacco. This separate prisoner said that the man appeared optimistic. He said he had a legal visit and was only expected to be sentenced for one of the charges he faced. This prisoner said he had trouble sleeping, but did not speak to the man again or hear him moving around during the night.

50. At around 6.00am on 22 February, the healthcare assistant conducted another roll check of all prisoners and found nothing unusual. Just before he finished his shift at 7.30am, he checked all the prisoners again and saw that the man was in bed.

51. The second prison officer came on duty at this time. Healthcare staff were conducting a handover of the patients, and she began to check the prisoners on ACCTs and collect hot water for prisoners who requested it.

52. Just before 8.00am, she reached the man's cell (number 6). She could not see the man and thought he might be on the toilet so called his name. When she did not hear a response, she looked more closely and could see the man's legs on the floor. The officer opened the cell door and could see that the man had a ligature around his neck, attached to the handrails in the toilet area of the cell. She shouted for help and supported his weight. At that time, a governor came onto the landing. He heard the shouts and went to the cell. He saw that the man was unconscious so used his radio to call for urgent assistance and request an ambulance.

53. Nurses ran to the cell, cut the ligature and began cardio pulmonary resuscitation (CPR). The man was warm to touch and they felt he had only recently used the ligature.

54. The automatic defibrillator machines are designed for easy use. Once attached to the patient, the machine instructs the user either to stand back while it administers a shock or, if it cannot detect any electrical activity in the heart, to continue CPR. When the nurses attached the defibrillator, it instructed them to continue CPR. Two nurses continued CPR until paramedics arrived at 8.08am. Sadly, the resuscitation efforts were unsuccessful.

55. Following the man's death, a note was found that he had written to staff. It said that he was expecting to go to court before canteen supplies arrived, and asked whether he would be allowed to have his canteen early or have a smokers pack to take with him.

56. Contingency plans for dealing with a death in custody were activated, and the various tasks were allocated and carried out by staff. This has been well documented.

57. Prisoners and staff were told of the man's death and offered support. Staff contacted Woodhill so the news could be broken to staff and prisoners who knew him there, including the other prisoner.

58. The prison's family liaison officer offered the man's family an opportunity to visit HMP Bedford. This was accepted.

ISSUES

Response to bullying allegations and Rule 45 prisoners on D wing

59. My investigators found that staff were aware that intimidation of rule 45 was likely on D wing. On the whole, when issues were identified they were dealt with appropriately.

60. When the night officer saw the writing on the man's cell door and was told of burning paper being pushed under the door, he acted appropriately by submitting a SIR. Staff felt that the mark left on the floor from the paper had been present before the incident. The senior officer spoke to the man and the other prison officer about the problems they were having. They told her that water had been poured, and burning paper pushed, under the door, and that various prisoners had shouted abuse.

61. The senior officer told my investigators that she had tried to find out who was responsible. The man and the other prisoner did not know but one of the wing cleaners suggested two names. There was no evidence that these two prisoners were responsible, but the senior officer warned them what would happen if she found them intimidating other prisoners. She also noted the details in the wing observation book, warning staff to be alert.

62. The other prison officer told my investigators he thought staff knew that he and the man were being bullied. No staff member remembered actually witnessing any bullying; they said they were aware of their responsibilities in addressing bullying.

63. The location of the cell occupied by the man and the other prisoner - on the fourth floor, in the far corner - afforded poor observation from the wing office. Staff acknowledged that, due to the low number of staff and their various duties, as well as the location of the cells, there were many opportunities for bullying to take place around these cells without their knowledge.

64. I accept that prison overcrowding leads to many difficulties when allocating prisoners. However, holding vulnerable prisoners on landing 4 in D wing led to unacceptable abuse at the hands of other prisoners.

65. My investigators found that the man had been subject to bullying and harassment in D wing. This was examined in depth, and my investigators spoke to a number of prisoners. All rule 45 prisoners who were spoken to and who had been held on D wing said they had been subject to bullying from other prisoners. Many, like the man, had been frightened to leave their cell, and had foregone showers, association, and using the phone. Most prisoners said that staff had offered these services, but they did not feel comfortable leaving the cell.

66. Some prisoners said that staff had explained the regime and encouraged them to press their cell bell if they had any problems. However, in practice, they felt forgotten about on the fourth landing.

67. I understand that rule 45 prisoners are held on D wing for as short a time as possible. However, by definition these prisoners are vulnerable – all the more so since they are either in prison for the first time or have recently transferred from elsewhere.

68. I also understand that D4 had the advantage of a stairwell leading to easy access to F wing, as well as being locked off from the rest of the wing. However, against this must be counted the fact that most residents on D4 were normal location prisoners, many of whom would be unsympathetic to those on rule 45.

69. Use of D4 also meant there was little interaction between staff and prisoners on rule 45. This was discussed with the Governor at the time of the investigation. As a consequence, a bid was submitted to have another wing changed to hold rule 45 prisoners but this had consequences for the type of population Bedford would hold. The cells for holding rule 45 prisoners on D wing have now been moved near the staff office. This seems the most practical short-term solution in difficult circumstances.

70. When my investigators discussed the issues with other prisoners who had been held on D wing, they felt more concerned about staff being unaware of intimidation than about access to any service or facility.

The Governor should review arrangements for monitoring how frequently D wing cells are used to hold rule 45 prisoners, and any incidents involving those prisoners.

Food refusal

71. When staff first found the man was not eating his meals, the landing officer explained to him that all other prisoners were locked up and those prisoners working on the servery had been warned to be courteous. Many staff felt that the food refusal was a protest at being in Bedford. There appears to have been some truth in this. However, the other prisoner told my investigators that he and the man had received comments from other prisoners like "enjoy your food" and that one member of staff had said he could not guarantee their safety. When the man moved to the healthcare centre he immediately began eating again. This would indicate that the motivation for refusing food was not only in protest at being in HMP Bedford.

72. My investigators asked if, as an exception, staff would consider taking meals to those who were scared. Staff had mixed views about this. However, a Governor felt that staff should do this as a temporary measure. It was never fully recognised by staff that the man was both

apprehensive of collecting his meals on D wing, and upset at being in Bedford. It appears that no staff had in depth conversations with the man regarding his concerns.

73. Staff and managers did not seem to be clear about the process to deal with food refusal and varied in their understanding. Whilst some recorded that the man was not collecting his meals, five days of refusals had elapsed before he was assessed by healthcare, by which time the nurses were concerned for his health. Staff could not provide the investigation team with a coherent explanation of the actions that should be taken when someone refuses food.

74. The clinical reviewer has expressed concern that healthcare staff were not informed that a prisoner had been refusing food for five days. I share that concern.

The Governor should implement a clear and coherent procedure for prisoners who refuse food. This must include notifying and involving healthcare staff at an early stage.

ACCT

75. It was appropriate that staff opened an ACCT when they found the man had been refusing food. He was also low in mood. When someone is unsure whether to open an ACCT, it is right to err on the side of caution. Opening the ACCT means a full assessment by a trained professional will occur within 24 hours, and the decision whether to keep the document open can be taken. The ACCT was closed by a multi-disciplinary team including the man. This decision was reasonable, and ACCT policies and procedures were properly followed.

76. However, I am concerned that staff felt the food refusal had only been a protest at being in Bedford. The man was certainly unhappy with his transfer from Woodhill and refusing food had been, in part, a protest. However, there was also evidence that he was fearful of coming out of the cell, and taking the food. Other prisoners had commented on the food, leading the man to be suspicious. Whilst in healthcare, the man also experienced shouting from prisoners in D wing and on several occasions sought reassurance that he would not be housed there.

Healthcare

77. The man's treatment in the healthcare centre was good. Healthcare staff and the second prison officer made efforts to engage with the man and to help address the problems he was facing. However, I concur with the clinical reviewer's finding that it was very difficult to identify those staff due to illegible signatures in the paperwork. Other healthcare staff could not identify some signatures either.

The Governor and Head of Healthcare should consider the clinical review and its findings.

78. The man's father was concerned that the handrail in the cell was an obvious ligature point. For a physically able man the rail is unnecessary, but of course many of those located in the healthcare centre will need such a support. However, while I make no formal recommendation, the Governor will wish to consider whether the rails should be removed from some cells in the healthcare centre. Many of the prisoners located there may have a past or current history of self-harm (I acknowledge there may be many other possible ligature points).

Crisis management

79. When staff found the man hanging, they acted appropriately, sensitively and speedily. Considerable efforts were made to save the man, and the Governor will also wish to consider if any members of staff should be recognised formally.

80. Once the man had been pronounced dead, all contingency plans were carried out professionally and thoroughly. The investigation team found that a good level of support was demonstrated and offered to staff.

81. The manner in which the sad news of the man's death was broken to his family, and the subsequent family liaison, was also handled well.

Conclusion

82. This man had some history of suicidal ideation, had been transferred from a prison where he had settled, and was subject to some bullying and abuse from other prisoners. However, he had moved to the healthcare centre – where the evidence suggests he felt much safer – some five days before his death, and had given neither staff nor fellow prisoners any reason he was planning to hang himself. I do not think his actions on the morning of 22 February 2007 could reasonably have been anticipated by those responsible for his care.

RECOMMENDATIONS

The Governor should review arrangements for monitoring how frequently D wing cells are used to hold rule 45 prisoners, and any incidents involving those prisoners.

The Governor should implement a clear and coherent procedure for prisoners who refuse food. This must include notifying and involving healthcare staff at an early stage.

The Governor and Head of Healthcare should consider the clinical review and its findings.