Investigation into the circumstances surrounding the death of a man at HMP Bedford on 31 May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is the report of an investigation into the death of a man. The man was serving five months imprisonment, and had been in custody at Bedford for three and half weeks, Prior to this period of imprisonment, he had only ever spent one day in custody . I offer condolences to his family and everyone touched by his death.

An investigator from my office conducted the investigation. Bedfordshire Primary Care Trust (PCT) commissioned a review of the man's medical care, which was completed by a woman from the PCT. I am grateful to the woman for her contribution and report. The Acting Governor of the prison and his staff co-operated fully with the investigation. The report is slightly late, for which I apologise.

The man's sentence was the result of a breach of a non-custodial sentence imposed. On his arrival at the prison, nursing staff assessed him by completing the required health screens and recorded a full medical history. The man raised no concerns during either screen. Unfortunately, apart from the medical records, little else is recorded about the man's interactions with other prisoners or staff at the prison as he did not mix very much.

The man was discovered hanging in his cell. Staff then administered cardio pulmonary resuscitation (CPR) and emergency paramedics continued treatment. The paramedics pronounced him dead..

The investigation has found no deficiencies in the man's care or in the staff response to the emergency when he was found. Therefore, I make no recommendations. I judge that staff at the prison could not have foreseen or prevented his death, although letters subsequently found indicate that his actions were intentional.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2012**

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SUMMARY

1. The man was sentenced to five months in custody at a Magistrates' Court. He had previously only spent one day in custody.

2. On his arrival at the prison, the man went through the usual reception and health screening procedures. He raised no concerns during either. He was then given a cell on the induction wing but as he had arrived on a Friday, his induction did not begin until the following Monday. During his induction, where he was spoken to by staff representing various departments, he said that he had no issues. A secondary health screen was also completed, and indicated that he had no drug or alcohol problems, nor any previous or existing physical or mental health problems. He was not taking any medication.

3. The man moved to a cell on a residential unit, A wing. Officers described him as someone who seldom engaged with staff, kept to himself, and mixed very little with other prisoners. Apart from collecting meals and going to use the shower or telephone, the man spent the majority of his time in his cell. When he first moved to A wing, he was sharing a cell with his co-defendant, who was later released from custody. He then spent four days on his own before a new cellmate was identified to share with him.

4. The man had a visit from his father during the afternoon, and then returned to A wing. During the course of the afternoon, one of the officers on A wing went to speak with the man and his cellmate, as they were not getting along. The cellmate was of a different nationality to the man, and the two were having difficulties communicating and getting on but were not arguing. A cell with a prisoner with the same nationality as the man who died cellmate was available so his cellmate moved there.

5. The man was not subject to any additional monitoring and, apart from routine roll checks, staff had no cause to go to his cell during the evening of the day before he died. At 5.45 am on the day, that he died an officer conducting a count of all prisoners looked into the man's cell and saw him suspended by a ligature hanging from the window. There was also a lot of blood on the floor. The officer immediately called to her colleague on the opposite side of the landing, for assistance. They used their radios to request assistance and entered the cell.

6. The officers cut the ligature and laid the man on the floor. Other staff, including nurses, responded to the emergency call and went to the cell with medical equipment. The staff, as well as paramedics who subsequently attended, carried out cardio pulmonary resuscitation but the man did not respond and was pronounced dead.

7. Staff followed the specified procedures for handling a death in custody. The investigation found no weaknesses in the management of the man in his short time at the Prison and no recommendations are made.

THE INVESTIGATION PROCESS

8. The investigator opened the investigation by telephone and collected the documents when he visited the prison. Notices were issued informing staff and prisoners of the investigation. They asked anyone who had information, pertinent to the investigation, to contact the investigator but no responses were received. Two prisoners provided information to prison staff about the man which was shared with the investigator. The investigator wrote to both prisoners, and one replied.

9. NHS Bedfordshire conducted a review of the medical care provided to the man, while in custody. The woman from Bedfordshire PCT completed the review on their behalf.

10. The investigator wrote to the Coroner, to inform him of the investigation and to request a copy of the post mortem report.

11. A family liaison officer (FLO), telephoned the man's family. She explained the purpose of the investigation and followed this up in writing. The family telephoned her. Whilst his father was his allocated next of kin, due to a language barrier, the family liaison officer contacted the man's Cousin. He confirmed that he had received the Prisons and Probation Ombudsman information and would discuss this with the man's father. The family liaison officer spoke to the man's' cousin on two further occasions and he informed her that they did not require a visit and had no issues to raise at this stage. The draft report was made available to the family.

12. Sadly, there was limited information available about the man and his time at the Prison. The investigator visited the Prison and spent time on the wing where he had lived to understand how the regime worked. He also spoke informally to staff who worked regularly on A wing, but they were unable to provide much information about the man.

HMP BEDFORD

13. HMP Bedford is a local prison for male offenders. The prison accepts sentenced and remand prisoners from all local courts, and out of area courts due to overcrowding. It has an operational capacity of 506 prisoners. The prison has been on its present town centre site since 1801. In the early 1990s, a new gate lodge, house block, and healthcare centre were added to the earlier Victorian wings. In addition, the prison accommodates young adults.

14. The National Health Service (NHS), through Bedfordshire Primary Care NHS Trust (NHS Bedfordshire), commissions healthcare services at Bedford. The provider arm of NHS Bedfordshire is Bedfordshire Community Health Services (BCHS). BCHS provides a healthcare team of doctors, nurses and nurse managers, based in the prison. The team provides diagnostics including blood services, in-patient care, and an integrated drug treatment service (IDTS), as well as other primary care services. The South Essex Partnership Foundation University NHS Trust provides a mental health in-reach team. However, there is currently no primary mental healthcare provision. Bedford's healthcare unit can accommodate up to 13 in-patients.

15. Since this office began investigating deaths in custody in April 2004, there have been 12 deaths at Bedford, including that of the man. Recommendations made following these investigations are not repeated in this report.

Her Majesty's Chief Inspector of Prisons (HMCIP)

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

Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board, responsible for monitoring day-to-day life in the prison, and to ensure that proper standards of care and decency are maintained. The most recent annual report 2009-2010, published by the IMB at Bedford, contains no issues that are relevant to the man's care.

Critical incident and hot debriefs

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

Cut-down tools

19. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must be provided with and carry, when on duty, their own personal issue tool

Emergency response codes

20. Staff use emergency codes to summon assistance to deal with a particular situation. In most prisons, the common coding system is 'Blue' to indicate a prisoner with respiratory problems, or who is unconscious, and 'Red' to indicate a prisoner who is bleeding. The benefit of such codes is to allow medical staff to attend the emergency with the correct equipment, and to minimise delays to treatment.

Listeners

21. Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.

Reception and induction

22. A Cell Sharing Risk Assessment (CSRA) is completed for every prisoner on his or her reception into custody. The document has recently changed and now requires all decisions to be evidence-based. This requires staff to check prisoners' previous convictions to identify potential risks to them sharing a cell. The CSRA assesses a prisoner as either a standard or high level of risk. If high risk and considered unsuitable to share, a multi-disciplinary team must review the risk frequently.

23. Reception staff do not routinely have access to a prisoner's past records, so at this point the prisoner is the main source of information. All prisoners will also have a Person Escort Record (PER). This document is used when escorting a prisoner between prisons, courts, and police stations. It includes pertinent information, such as a prisoner's risk to others or themselves.

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

25. All new prisoners are housed on the induction wing. If staff considers a prisoner is vulnerable, they will be given a cell on another more appropriate wing where they will receive their induction. During induction, staff asks about any immediate concerns, such as disability, their offence, and general well-being. In addition, there is a further assessment, medical screening, and input from the education, and offender management units. Staff ensures that prisoners have a new reception pack, pin numbers to access the prisoner telephone system, and explain visiting arrangements.

Counselling Assessment Referral Advice and Throughcare service (CARATs)

26. The Counselling Assessment Referral Advice and Throughcare service (CARATs) team provide a substance misuse service for prisoners with serious drug and alcohol problems. The team works in partnership with the healthcare service, and officers, to provide a service within the prison, and as a referral agency for ongoing support to prisoners on their release.

Suicide and self-harm monitoring

27. Assessment, Care in Custody and Teamwork has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

KEY EVENTS

28. The man had been convicted of theft, and his sentence was suspended for two years. He committed a further offence. This resulted in his local Magistrates imposing a sentence of five months imprisonment. He had only ever spent one day in custody prior to this.

29. When the man arrived at HMP Bedford a reception Officer completed the initial procedures with him, including recording his personal details. Although asked, he did not give reception staff the name of his next of kin. The reception officer told the investigator that her recollection of the man was that he was a 'cheeky chap' and was quite young. When asked whether the man's nationality caused any communication problems, the Officer said that he was able to understand the questions and provide clear answers. The Officer said that reception staffs have access to 'The Big Word' interpreting service if they have any difficulties.

30. The Big Word is a global company that provides translation and interpreting services. The company is able to provide a telephone interpreting service for most languages and dialects. Prison staff can use the service to assist communication with prisoners who speak little or no English.

31. A cell sharing risk assessment (CSRA) was also completed in reception to assess his suitability to share a cell. The assessment uses a series of questions about previous behaviour in custody and offending to assign a level of risk of either 'high' or 'standard'. Recent changes to the CSRA require that information provided is checked against a prisoner's previous convictions. The man was considered a 'standard' risk and suitable to share a cell.

32. Once staff had completed all the reception paperwork, a Staff Nurse completed an initial health screen. The initial health screen aims to get a brief medical history and identify any current medical problems or medication. In addition, prisoners are also asked about previous or current thoughts of self-harm, as well as drug or alcohol use.

33. The man did not mention any current or previous health conditions. He said that he had never used drugs and had no thoughts of harming himself. A Nurse recorded that he appeared fit and well and, in terms of his mental state, appeared stable.

34. When all the reception procedures had been completed, the man was taken to C wing, the first night and induction wing. That day, was a Friday. A prisoner would normally begin their induction the day after arriving into custody. However, as it was a weekend his induction did not take place until Monday 9 May.

35. Over the weekend, the man's categorisation was completed. There are four security categories used to classify every adult male prisoner. The categories are based on the severity of the crime and risk posed to the public should an individual escape. Category A prisoners are those whose escape would be highly dangerous to the public or national security. Category B prisoners do not

require the highest levels of security, but escape must be made difficult. Category C cannot be trusted in open conditions, but they are unlikely to escape. Category D can be reasonably trusted not to escape and are normally in open prisons. Some are in closed prisons but work out in the community or outside the prison.

36. The man was initially categorised as D, based on his offence and previous history. However, as he had previously breached community sentences, the category was changed to C. As he was a foreign national, staff also had to establish whether he would be subject to deportation. Administration staff sought confirmation of his immigration status from the UK Border Agency and on 13 May, a response was received indicating that he was a European national, and was not to be deported.

37. The reception Officer was working on C wing on 9 May and interviewed the man as part of the induction process. She asked him whether he had any concerns about being in custody, and he said that he had none, and that he did not feel at risk. He also indicated that he was likely to receive visits. The answers recorded indicate that the man answered positively to all the questions he was asked. The reception Officer also said that he had been quite relaxed during their conversation.

38. A member of staff from the prison's CARATs team also spoke with the man as part of his induction. (The team meet all prisoners as part of their induction, not only those with a history of drugs and alcohol, to tell them about their services.) Following the induction, the man had no further contact with the CARATs team.

39. The initial health screen is designed to be completed in two parts, with a more in-depth medical assessment carried out a few days after a prisoner has been in custody. It is an expectation that when a prisoner goes into prison, the healthcare department will make a request to their community general practitioner (GP) and their medical notes would then be available for the secondary screen. The man said that he had not seen a doctor in the community and provided no contact details to the prison.

40. A nurse completed the secondary health assessment with the man on 9 May. This included an alcohol screen. The screen asks the patient a series of questions about their alcohol consumption to ascertain whether there is a need for them to undergo detoxification. The man indicated to the nurse that he had never had any problems with alcohol. A PHQ9 score was also completed. (A PHQ9 uses a series of questions, much like the alcohol screen, to gauge whether a prisoner is depressed and how severe this may be.) The man answered all the questions put to him positively and indicated that he had no current or previous symptoms of depression.

41. Due to the histories and previous lifestyles of many prisoners, risks of blood borne viruses are increased in a prison setting, and it is normal practice for vaccinations to be offered. There is currently no vaccination available for hepatitis C, which is a disease affecting the liver. Hepatitis B also affects the liver, but unlike hepatitis C a vaccine is available.

42. As well as the above screens, the nurse also advised him about blood borne viruses such as hepatitis C, human immunodeficiency virus (HIV), and hepatitis B. He was also tested for tuberculosis which, due to the close living conditions, can be more prevalent in prisons. He accepted a test for hepatitis C and a vaccination for hepatitis B. He had his first vaccination for hepatitis B later that day and a second on 17 May. Apart from attending for his second injection, he had no further contact with healthcare staff at Bedford.

43. The man remained on C wing until 10 May. He moved to A wing, a residential wing which can accommodate around 130 prisoners. He was given a cell, which he shared with his co-defendant who had arrived at Bedford on the same day as him. Both men had completed their induction together and moved to A wing at the same time. There is very little recorded about him while he was on A wing, and he appeared to have socialised with other prisoners very little.

44. The investigator spoke with an officer, who works regularly on A wing. The Officer explained that the man kept very much to himself and did not appear to socialise on the wing. He said that this was not unusual and, as prisoners had access to television in their cells, it was common for them to stay in their cells rather than come out onto the landing during association periods. (Association is the term given to the time that prisoners have out of their cells to socialise with their peers, use the telephone or shower.) The officer recalled that the man would collect his meals along with other prisoners and would use the shower and telephone as he required. It was not the case that he did not come out of his cell at all.

45. A wing's regime allows association on Monday and Wednesday afternoons, as well as Tuesday and Thursday mornings and evenings. Work or education is provided Monday to Friday both mornings and afternoons. However, due to the shortage of available spaces, half of prisoners attend the morning sessions and the other half in the afternoon.

46. As a sentenced prisoner, the man would have been required to work or attend education if required to do so, as part of the prison rules. The investigator asked whether he would have been allocated work on A wing. He was told that Bedford struggles to provide employment for all prisoners, due to the high population and it was likely that he had yet to be given a job.

47. Documentation provided to the investigator shows that if suitable, the man was to be released on home detention curfew (HDC). (HDC allows prisoners serving between three months and under four years early release from prison to serve a maximum of 90 days in the community wearing an electronic tag, which must not be removed, and subject to a curfew. To be released a prisoner must be able to provide a suitable address that has been approved by the Probation Service.) The man was told that his eligibility date for HDC was 14 June, and he completed documentation that recorded the address he would live at, if released. If he was not granted HDC, he would have been released on 21 July.

48. The man's co-defendant was released from custody on Thursday, 19 May. Documents show that over the next four days he remained in the same cell on his own. On 23 May, another prisoner was placed to share with him.

49. On 30 May, the man had a social visit from his family in the afternoon. Information from another prisoner on A wing at that time indicated that during this visit he had an argument with his father. The investigator wrote to the prisoner who had moved to another prison to request further information. He responded that somebody else had told him the information and he was unable to provide anything further. The investigator also made enquiries with staff that had been working in the visits that day, but was told that nothing had been recorded and they could not recall the man having any problems.

50. Between 3.00pm and 5.15pm that afternoon, prisoners on A wing were unlocked for association. The officer, who works regularly on A wing told the investigator that during this time he had gone to the man's cell, as he was not getting along with his cellmate. The officer said that the man's cellmate was of a different nationality, and they were having difficulties communicating. Both prisoners had told him that they were not getting along. He said that they both appeared to be all right, but at the time another prisoner of the same nationality as the man's cellmate was in a cell on his own on the opposite side of the landing, and it was logical for him to move his cellmate to share with that prisoner.

51. A prisoner who wrote to the investigator said that he had heard rumours that the man threatened his cellmate to get him to move out of their cell. The officer, who works regularly on A wing, was asked whether he had any indication of this when he had spoken to them. He said that although both prisoners were telling him that they were not getting along, the situation was very calm. The man's cellmate did not appear threatened and, in his opinion, was keen to share with his fellow national.

52. After collecting their evening meals at 4.30pm, prisoners were then locked in their cells for the remainder of the evening from 5.15pm. The man was now in his cell on his own. During the evening, staff would have carried out at least two roll checks, one at 7.00pm and another by night staff at around 9.00pm. There is nothing recorded that suggests any problems with the man. (A roll check is when officers account for every prisoner on a residential unit, by looking into each cell and counting each person. Staff report their totals to the officer in charge who will collate all the figures to ensure that the roll matches the number of prisoners that are known to be in custody.) The officer, who was on duty on A wing on the night of 30 May, said that A wing was particularly noisy that night, with prisoners kicking cell doors and shouting until around midnight.

53. Between 8.30pm and 7.30am, the prison has minimum staffing levels and night staff are on duty. During the night, staff patrol the residential units and carry out observations on those prisoners subject to additional monitoring. For security reasons, officers on the residential units do not carry keys at night, and the officer in charge is the only person with a full set of keys. However, patrol

staff are each provided with a sealed pouch with a single cell key, which can be opened in an emergency when immediate access to a cell is required.

54. At 5.45am on 31 May, the officer, who was on duty on A wing on the night of 30 May, was conducting a count of all prisoners on A wing with another officer. When she arrived at the man's cell she looked in and saw him at the back of his cell. He was hanging from the window, by a ligature around his neck, his feet around six inches off the floor. She also noticed a lot of blood on the floor of the cell. She immediately called to the officer, who was on duty on A wing on the night of 30 May, who was on the opposite side of the landing, for assistance. The officer used his radio to call for emergency assistance, the officer, who was on duty on A wing on the night of 30 May, broke her sealed pouch and the two officers entered the cell.

55. The officer who used his radio to call for emergency assistance held the man to support him while the officer, who was on duty on A wing on the night of 30 May, loosened the ligature and used her cut-down tool to cut it from the window. The officer said that when the ligature was loosened she could see that the man had blood around his neck, but she could not see a wound. Once the ligature had been released, the staff laid the man onto the floor. By this time other staff, including the orderly officer, a Senior Officer (SO) and another nurse had arrived at the cell.

56. The Senior Officer and the Nurse were together in the healthcare wing when they heard the call for assistance from the officer who used his radio to call for emergency assistance and went to A wing together. When they arrived at A wing, the nurse with the senior officer collected the emergency medical bag from the treatment room, which contained a defibrillator and other medical equipment. (A defibrillator delivers a controlled electric shock to the heart if there is an irregular rhythm. The defibrillator will not deliver a shock unless there is heart activity detected and cannot restart a heart that has no output.)

57. When the Senior Officer and the nurse with her arrived at the cell, the officer who used his radio to call for emergency assistance and the officer, who was on duty on A wing on the night of 30 May, had only just placed the man on the floor. The nurse who was with the senior officer loosened the ligature from around his neck and checked for a pulse, before starting cardio pulmonary resuscitation (CPR). The nurse asked staff to pass the emergency equipment and to take over CPR while she attached the defibrillator to the man. The defibrillator indicated that there was no heart activity, so no shock was delivered, and CPR continued at a rate of two breaths for every 30 chest compressions, the universal standard ratio. The officer who used his radio to call for emergency assistance assisted the nurse. An ambulance had been requested at 5.47am and treatment continued until the arrival of paramedics just before 6.00am.

58. Paramedics continued to treat the man, administering medication to try to restart the heart and continuing CPR for around 15 minutes. However, despite their best efforts, he did not respond to treatment and was pronounced dead at approximately 6.15am.

Actions following the man's death

59. Prison Service Order (PSO) 2710 provides instructions to prison governors on the actions that should be taken following a death in custody. This includes family liaison. The PSO instructs that the prison must appoint a family liaison officer and a deputy to cover any absence. They must also arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible and in a suitable manner, giving an accurate factual account of what has happened.

60. The safer custody team at Bedford ensured that all prisoners who were subject to ACCT monitoring were reviewed immediately after the man's death. Those prisoners who were located on A wing were offered the support of the chaplaincy department.

61. Bedford appointed a Senior Officer (SO) as their family liaison officer and a Reverend as her deputy. The SO appointed as a family liaison officer established from visits records that the man's father was his next of kin as he had not provided a name on his reception at Bedford. The Man's family were notified in person by The SO appointed as a family liaison officer, who remained in contact with the family. Bedford arranged for financial assistance with funeral expenses and assisted with arranging the repatriation of the man to his country for burial.

62. The investigator was satisfied that all staff involved on 31 May were adequately supported and the debrief process took place in accordance with National Offender Management Service (NOMS) guidelines.

ISSUES

Clinical care

63. The woman from PCT carried out the review of the medical care given to the man at Prison. As part of the review, she looked at all medical documentation that had been completed and reviewed the actions taken by nursing staff. She concluded that there was nothing to suggest that the man should have been offered any other healthcare input, other than that which he received. She made no recommendations.

Custodial care

64. The investigation found that in the relatively short time that the man was at Bedford all the required actions were taken by the prison. He was given a full induction and the prison had in place systems to ensure that foreign national prisoners received equal treatment and were given additional support if required. A personal officer scheme was in place. Staff on the residential unit were aware of the man, but he gave no indication of any problems or reasons for them to consider additional monitoring.

Emergency response

65. Many prisons use codes, such as ‘blue’ or ‘red’, in emergency situations which allow staff to respond with emergency equipment. At Bedford, emergency codes are not used to define medical emergencies. The opinion of the management team at Bedford is that all emergencies should be treated with the same urgency, and all medical equipment should be available. Therefore, medical bags are located on every residential wing and contain all equipment required to enable medical staff to treat all types of medical emergency. This policy does not appear to have delayed or hampered treatment of the man.

CONCLUSION

66. In the relatively short time that he was in prison, he engaged very little with either staff or other prisoners. He was other national but spoke some English and was said by staff to be able to communicate his needs. Sadly, little is documented about him due to his limited contact with others. Therefore much of the investigation is based on the few completed documents and informal discussions with staff.

67. Although he chose not to interact a great deal with his peers, he did not isolate himself and would leave his cell to collect his meals, use the telephone, and use the shower. He gave staff no reason to believe that he may be a risk to himself or that he required additional monitoring. His death came as a complete shock to staff who knew him.

68. Following his death, the police translated letters that he had written to his family in his country which indicate that he intended to take his own life. However, there is no evidence to suggest that his death was either preventable or foreseeable by staff at Bedford.