



**Investigation into the circumstances surrounding the
death of a man at hospital, in October 2011,
whilst a prisoner at HMP Bullingdon**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2012

This is a report into the death of a man in October 2011, at hospital whilst he was in the custody of HMP Bullingdon. He was 23 years old when he died. The post mortem result showed that the cause of his death was bronchopneumonia, hypoxic brain injury and hanging. I offer our sincere condolences to his family and friends for their loss.

The investigation was carried out by a senior investigator. I would like to thank the Governor of HMP Bullingdon, and the Governor of HMP Wandsworth, and their staff for their co-operation during the course of our enquiries. I am grateful to the local Primary Care Trust for appointing a clinical reviewer to review the man's clinical care.

Our Senior Family Liaison Officer contacted the man's family to tell them about the investigation and give them the opportunity to raise any issues about the care he received in custody.

The findings of the clinical review play an important part in this report in relation to the man's physical and mental health assessment and care. The review confirms that he received a standard of clinical care which was equitable to that which he could have expected in the community. However, I am concerned that Wandsworth failed to act appropriately regarding his declaration of possible self harm and I am also disappointed with the way the prison dealt with his clothes parcel, which was clearly a source of great distress to him. Recommendations are made regarding these failings. The investigator has also explored allegations made after his death that he had been the subject of bullying and coercion at Bullingdon. While these allegations cannot be discounted, neither can they be substantiated, and we make a recommendation to the Governor at Bullingdon concerning the management of the risk of bullying.

Notwithstanding these concerns, I wish to recognise the speed and professionalism of the staff who responded to the emergency situation and the good practice in family liaison adopted by Bullingdon.

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

CONTENTS

Summary

The investigation process

HMP Bullingdon

HMP Wandsworth

Key events

Issues

Conclusion

SUMMARY

1. The man was born in August 1988. He was single, unemployed and, prior to entering custody, lived in the Slough area. He had been diagnosed as a child of suffering as from attention deficit hyperactivity disorder (ADHD). He also had loss of hearing in his right ear with partial hearing in his left ear, suffered from asthma and he was also a smoker.
2. On 18 July 2011, the man appeared at Crown Court and was remanded into custody until his next court appearance on 9 September and was sent to HMP Bullingdon. On arrival at the prison, he told healthcare staff of his history ADHD, asthma, hearing loss and said that he had no thoughts of self harm. During his time at Bullingdon he had been prescribed inhalers for asthma and had interventions with member of the mental health team concerning his ADHD.
3. On 10 August, the man appeared at Magistrates Court on a separate matter and he remained in custody but was transferred to HMP Wandsworth. Whilst at Wandsworth, he made a complaint that he had not received the clothes parcel sent by his mother and indicated that he could see no point in life – this declaration was not followed up by Wandsworth. He again had interventions with a member of the mental health team but denied any thoughts of self-harm.
4. Following his appearance at Crown Court on 9 September, the man was further remanded into custody, with a trial date of 7 January 2012 and was taken back to Bullingdon. Whilst back at Bullingdon, he continued to be seen by healthcare staff including referral to a specialist psychiatrist, stated he had no thoughts of self harm or taking his own life, and participated in educational classes.
5. At approximately 3.10pm on 11 October, the man was found hanging in his cell and emergency medical assistance was called. Staff began cardio pulmonary resuscitation which was successful in resuscitating him though he remained unconscious. Paramedics arrived and took over his care and transferred him to hospital. He remained in hospital on life support for the next four days and, after discussion between the hospital doctors and his family, the life support was stopped at 2.30pm. He died at 3.28pm.
6. We are satisfied that the care and medical assessment the man received at Bullingdon was equitable to that which he could have expected to receive in the community. We are concerned about the failure to follow up his declaration of potential self harm on his complaint form, and are critical of the way Wandsworth dealt with his clothes parcel. We make three recommendations to the Governor of Wandsworth. We also make one recommendation to the Governor at Bullingdon concerning the management of potential bullying. However we recognise the speed and professionalism of the staff who responded to the emergency situation and the good practice in family liaison.

THE INVESTIGATION PROCESS

7. The investigation was opened on 19 October 2011 when the investigator issued notices announcing the investigation to staff and prisoners and inviting anyone with any information relevant to the investigation to contact him. No one came forward as a result.
8. The investigator visited HMP Bullingdon on 24 October 2011. During his visit he was given copies of all documentation relating to the man and visited where he had lived. During this visit the investigator met the man's mother and explained to her the investigation process and told her that she would be contacted by our Senior Family Liaison Officer after her son's funeral had taken place. The investigator also interviewed the man's cellmate
9. The investigator returned to Bullingdon on 15 and 16 November, 6 and 7 December and interviewed 14 members of staff and two prisoners. Written feedback on the progress of the investigation was sent to the Governor on 8 December.
10. The investigator also visited HMP Wandsworth on 17 and 23 November to obtain copies of documentation and interview three members of staff.
11. The local Primary Care Trust appointed a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of his treatment during his time in custody. We are grateful to him for his timely and considered report.
12. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
13. HM Coroner for Oxfordshire, provided the investigator with a copy of the post mortem report into the man's death on 17 January 2012. The post mortem report, conducted by a Home Office pathologist, gave the cause of death as bronchopneumonia (acute inflammation within the lungs), hypoxic brain injury (inadequate supply of oxygen to the brain) and hanging (with initial resuscitation).
14. The investigator liaised with the police to inform them of the progress of our investigation. Following the suggestion that the man may have been coerced into acting as a witness for the defence in a trial of a prisoner held on remand at Bullingdon, the police provided additional information to our investigator. As a result of these enquiries, he obtained a copy of the transcript of the man's evidence given at Crown Court on 7 September 2011.
15. Our Senior Family Liaison Officer contacted the man's mother to inform her about the investigation and to invite the family to ask any questions or raise any concerns. She asked that our investigation consider the following:
 - Were his mental health needs appropriately addressed?

- Were his community doctor records obtained?
- Was he ever placed on 24 hour suicide watch?
- What happened to his clothes parcel?
- What happened to his trainers?

16. We trust this report answers these and any other questions the family may have and helps them better understand the treatment he received and the events before and after his death.

HMP BULLINGDON

17. HMP Bullingdon is a large prison in Bicester, Oxfordshire. It holds 1,114 category B and category C prisoners. Category B prisoners are those for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult. Category C prisoners are defined as those who cannot be trusted in open conditions, but who would not have the ability or resources to make a determined escape. Bullingdon accommodates convicted and unconvicted adult male prisoners over six units, and has a mixture of single and shared cells.
18. Healthcare at the prison is provided by the Primary Care Trust (PCT). An inpatient facility can accommodate up to 24 patients. It is staffed throughout the day and has two nurses on duty at night. An outpatient facility delivers a daily assessment system, with prisoners referred to a doctor as necessary. A doctor is available every weekday, and there is an on-call service overnight and at weekends.
19. HM Chief Inspector of Prisons inspected Bullingdon in July 2010. The inspection found that Bullingdon delivered “reasonably good outcomes for prisoners”, had a good standard of accommodation, and positive relationships between staff and prisoners.
20. When considering safety at the prison the report stated:

“Bullingdon remained a reasonably safe prison. There was good dynamic security and additional resources had been allocated to violence reduction since our last visit.

“The management of suicide and self-harm prevention was satisfactory but with evidence of some inconsistency in application. We found one instance, for example, where a prisoner known to be very vulnerable and at risk of self-harm had been allocated to a shared cell with a known bully.”
21. The inspection also considered the accommodation and social backgrounds of prisoners and said:

“Accommodation was generally good – very good in Finmere, the new unit, and on Edgcott unit, which held vulnerable prisoners.

“About a third of the prison’s population were from a black and minority ethnic background, and structures to support race equality were reasonably good and included some meaningful consultation through prisoner diversity representatives. Work on other diversity stands was also being addressed and included, for example, the provision of independent advice for immigration detainees.”
22. Each prison in England and Wales has an Independent Monitoring Board (IMB), made up of unpaid volunteers, appointed by the Secretary of State for Justice, from the community in which the prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and

they report to the Justice Secretary annually. At the time of writing, the most recently published report for Bullingdon covered the period August 2009 to July 2010. The IMB was “generally satisfied with the overall standard of the prison management, treatment of prisoners and facilities provided”. However, the “poor provision of ... healthcare” was “deeply worrying”.

23. Since this office took over responsibility for investigating deaths in custody in 2004, there have been 14 deaths at Bullingdon before the man’s death. The last apparent self inflicted death was in May 2010 and there are no similarities between that death and the death of the man.

HMP WANDSWORTH

24. Wandsworth is the largest prison in England and Wales, holding up to 1,665 convicted and remanded adult men. Its catchment area includes courts in central and south west London and neighbouring Home Counties. Wandsworth is a category B local prison. (Category B prisoners are those who do not require maximum security, but for whom escape needs to be made very difficult.) Some prisoners will serve the whole of their sentence at Wandsworth, while others will be moved to other prisons, including lower category ones, as appropriate.

25. HM Chief Inspector of Prisons last inspected Wandsworth in March 2011. Among other matters, the Chief Inspector found that:

“Prisoners consistently reported frustration at getting things done, obtaining information and receiving help, even with simple matters. The lack of information during induction and a weak personal officer scheme compounded these problems and prisoners appeared to have low expectations of what they could expect from staff, with many describing staff as confused, and in some cases evasive.

“Rules about clothing being brought or sent in were clear but many prisoners told us that they had not received this information on arrival. No written information about access to property, or the sending in of clothing, was given out during induction. There were also problems in accessing stored property.

“Each wing had an identified day for prisoners to go to the property store but this process was not widely understood or known by prisoners we spoke to.”

26. In respect of prisoner complaints at Wandsworth the Chief Inspector said that:

“Although there was a published policy and a series of instructions to staff about the management of prisoner applications, practice continued to vary across the residential units. On the whole, management of the system was inconsistent and its implementation across the prison was disorganised, with no way of checking the existence, nature or timeliness of responses.”

27. The most recently published IMB report for Wandsworth covered the period June 2010 to May 2011. In their report the IMB comment on the relationship between staff and prisoners as follows:

“It is of great concern that there has been little improvement in prisoner-staff relationships. While the Board has observed some good interaction between prisoners and staff, too often prisoners tell us that officers do not help them with the most basic enquiries. Instead they are frequently told to wait or try later.

“Since the most basic questions are not answered in person, the Application System is overloaded. Applications go missing or are lost, and responses are almost always late, if they arrive at all. The Prison acknowledges that this system does not work and during the year a new process has been identified, piloted and was launched in June (on this we will report next year).

28. With regard to prisoners’ property the report specifically states that although there had been some improvement in the management of property the IMB noted that “Wing staff continue to be unwilling or unable to leave their positions in order to sort out problems with property”. The IMB also comment on the receipt of incoming mail as follows:

“The post room team has been reduced in number from eight to four. As a result priority has been given to registered and legal mail. At the end of the year there were considerable delays in the sorting of normal mail and the prisoners have been informed to expect late deliveries.”

29. In 2011, the Ombudsman received 16 complaints from prisoners regarding their property whilst in custody at Wandsworth. Of these five complaints are currently under investigation and two complaints have been upheld. Where cases have been upheld the prison service is responsible for compensating the prisoner by either providing replacement items or the cash equivalent.

KEY EVENTS

30. The man was born in August 1988 in Middlesex. He was single, unemployed and lived in the Slough area prior to entering prison. He had been diagnosed with ADHD (This is a neurobiological disorder that interferes with an individual's functional capacity, primarily characterised by the individual being hyperactive, impulsive and unable to sustain attention and concentration. Symptoms often start before seven years of age and for many individuals they continue into adulthood) at the age of six and had received treatment for this condition into his adolescence.
31. On 18 July 2011, the man appeared at Magistrates Court and was remanded into custody at HMP Bullingdon on a charge of grievous bodily harm, which appeared racially motivated. He was scheduled to reappear at Crown Court on 20 July.
32. The documentation that accompanied the man from the court to Bullingdon included the Person Escort Form (PER), Warrant of sending to Crown Court for trial, and the MG4 Form Charge documents (completed by the court, police and custodial transfer staff).
33. The PER detailed the time the man arrived at Magistrates Court, the number of cell checks, how often he was offered and accepted food and drink, the time he spent with his legal representative and the time he left the court for Bullingdon. There is room on the PER to record details of potential risk such as self harm, at risk of abuse, drug or alcohol issues. He was not identified as being at risk, but it was stated that he had mental health issues.
34. On the man's arrival at Bullingdon, an officer completed the Prisoner Passport and First Night Information Form. This form is completed to obtain some initial information from him. This included his next of kin contact details of his father. He told the officer that he had been in custody before and he had never had thoughts of self harm or suicide.
35. Later that evening, the man saw a nurse who conducted a reception health screen (A first reception healthscreen takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.). He told the nurse that he was prescribed an inhaler due to wheeziness and was registered with a community medical practice in Slough. He said that he had been in custody before and he had not used drugs and did not drink. He told the nurse that he was deaf in his right ear and only had partial hearing in his left ear. The nurse recorded that he had no thoughts of harming himself. His blood pressure was recorded as 124/67, within normal range. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.). The nurse recorded his weight as 67kg (10 stone 8lb) and his height as 1.85m (6' 1").

36. An officer completed a cell sharing risk assessment (CSRA) (the risk assessment considers the risk posed to others by the individual) and assessed that the risk was standard (no apparent risk to others) and there were no concerns. It was recorded that the man was a smoker and could be allocated to a double cell provided that it was not with a fellow prisoner who was from black or ethnic minority groups due to previously recorded racially aggravated incident.
37. The next morning a nurse saw the man for a second healthscreen (A second healthscreen takes place on the second day a prisoner has been in custody to conduct an in depth assessment of physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.). The nurse recorded his blood pressure as 105/69 (within normal range) and confirmed his height and weight as the previous day. He told the nurse that he had occasionally used cannabis in the past, but not in the previous month, and was an occasional smoker, smoking two to three cigarettes a day. He said he had been prescribed inhalers for his asthma by his doctor. He also said that he had been diagnosed with ADHD at the age of six and had previously taken medication but was not prescribed any at present. He explained to the nurse that, due to his hearing loss, he had been to hospital four weeks before entering prison. He said he had been given a magnetic resonance imaging (MRI) scan (a medical imaging technique used to visualise detailed internal structures) and was waiting for a further appointment for him to have a hearing aid. The nurse recorded that he had no thoughts of harming himself or thoughts of suicide. She referred him to be seen by the prison doctor for a prescription of inhalers and to the mental health team because of his history of ADHD.
38. Later that morning, the man saw a prison doctor, as arranged by the nurse. The doctor recorded that he was a mild smoker, had a history of asthma but had no other medical problems. He told the doctor that he was due in court and expected to be released from remand in two days. The doctor prescribed salbutamol (inhaler for asthma) and Clenil Modulite (inhaler for asthma).
39. The man appeared at Crown Court the next day and was further remanded into custody. The completed PER did not raise any concerns about him.
40. On 28 July, the man saw a member of the mental health team as a result of the referral made by the nurse. He told the nurse that, as a teenager, he had been prescribed Ritalin (a medication for ADHD) until he was 14 and then Concerta xl (a medication for ADHD), which he stopped taking at the age of 16. He said that he had been under the care of a doctor a Hounslow Community Mental Health Trust (CMHT). The nurse told him that he would be seen in a week's time. The nurse also recorded that the CMHT and his surgery had been contacted by fax to obtain information about his treatment.
41. The following day the healthcare team at Bullingdon received detailed responses from the surgery and the CMHT. This included that the man had been prescribed inhalers by his community doctor, and that he had been diagnosed with ADHD when aged six and was prescribed medication for that condition into his teenage years.

42. On 1 August, the man appeared again at Crown Court. A PER was completed that confirmed there were no issues or concerns regarding him. At this court appearance it was ordered that he was to remain remanded in custody until his next appearance at the court on 9 September.
43. The next day the man saw a prison doctor, as he said the amount of hearing in his left ear was reducing. The doctor made a referral to the ear, nose and throat (ENT) consultant at the local hospital. Healthcare confirmed with the hospital that he was under the care of a consultant ENT surgeon and he would receive an appointment in due course.
44. A nurse next saw him on 6 August as previously arranged. He told the nurse that he wanted to be prescribed Concerta xl (for treatment of ADHD). The nurse recorded that he fidgeted and continually shook his leg through out their conversation and that, due to his hearing loss, things had to be repeated.
45. He was required to appear at Magistrates' Court on 10 August for charges of dangerous driving. A PER Form was completed and it was recorded that he had been seen by the mental health team but there were no concerns about his welfare.
46. When the man arrived at court, a PCO recorded that he had arrived from Bullingdon, noted his date of birth and that he had mental health issues. Following his court appearance he was returned to custody and scheduled to reappear at court on 25 October. A PCO recorded that he was taken from court to HMP Wandsworth.
47. On arrival at Wandsworth, an officer made an entry into the man's prison computer records that he had been transferred to Wandsworth from Bullingdon via his appearance at court. A CSRA was completed and a governor assessed that the risk was standard and he was allocated to a double cell. Throughout his remaining time at Wandsworth there were no further entries made in his computerised record.
48. The man then saw a nurse for an initial healthscreen. The nurse recorded that he appeared mentally stable, that he was on prescribed inhalers and had no thought of self harm or suicide. He told the nurse that he wanted to see a member of the mental health team as he had ADHD and wanted to be prescribed Concerta xl. The nurse referred him to be seen by the doctor.
49. Later that evening, the man saw a prison doctor, who recorded that he had transferred from Bullingdon and was requesting medication for ADHD. The doctor made a referral for him to be seen by the mental health team.
50. The next morning at 9.40am, a nurse attempted to conduct a second healthscreen, however he refused. Some 40 minutes later he agreed that a nurse could conduct the second healthscreen. He told the nurse that he smoked about five cigarettes a day and enjoyed light exercise. The nurse recorded his height, weight and his blood pressure was 103/76 (within normal limits).

51. Later that afternoon a mental health nurse saw the man as a result of the referral made the previous day. He told the nurse that he had been prescribed Ritalin and Concerta xl until he was about 18 years old. He said that his ADHD had got worse since being in prison. He also said that he was next due to appear in court on 9 September. The nurse recorded that he appeared mildly agitated, had difficulty in keeping to the point and that his case would be discussed with the mental health team.
52. On 18 August, the man made an official complaint on Prisoner's Formal Complaint Form COMP 1 Form concerning not receiving his property. In his complaint he wrote:

"I did speak with my wing but they are not helping me at all. It seems to me as if I am a ghost. I'm mentally unstable and on the verge of thinking the worst. No one is listening to me so what's the point in LIFE?"
53. A prison governor explained at interview that when prisoners complete a complaint form they are put in a sealed box on the wing and these are collected by the complaints clerk. This is so that the complaints forms are not openly read by staff. The governor said that it was the expectation that once a comment, like that made by the man, had been made on a request complaint it should be referred to one of the residential managers or one of the senior officers who would go and speak to him about his wellbeing and his frustration and complaints. The governor said that his complaint form had not been referred to a residential manager and had only been processed by the complaints clerk who provided an interim response to him on 30 August to inform him his complaint had been received and was being looked into.
54. Between the 12 and 22 August, the man had no interventions with healthcare staff and there were no entries made by discipline staff in his prison computer record.
55. The next day, a nurse saw the man to undertake a follow up assessment. He told the nurse that he felt much more relaxed and settled. Although he was keen to recommence being prescribed Concerta xl he said he felt it more appropriate to do this once he was back at Bullingdon. The nurse recorded that he agreed that the mental health team would not have any further interventions with him unless he wished. The nurse said at interview that he did not tell her that he was in low mood, did not say anything about his submitted complaint and gave no indication that he had thoughts of self harm or suicide.
56. On the 6 and 7 September, the man appeared at Crown Court as a defence witness in an unrelated trial of fellow prisoner. On each occasion a PER Form was completed which recorded that there were no concerns regarding his welfare.
57. Two days later the man again appeared at Crown Court for his own offences. A PER was completed that raised no concerns. Following his court appearance, he was further remanded in custody, with a trial date set for 7 January 2012, and he was sent to Bullingdon.

58. Following being received in reception, a nurse saw the man for an initial healthscreen assessment. The nurse recorded that he had no concerns about his physical or mental health, his blood pressure was 105/67 (within normal limits) and had no thoughts of harming himself or taking his own life. The nurse also noted that he appeared “cheerful and relaxed”.
59. An officer conducted the CSRA who recorded that there were no concerns or issues. At 10.55pm, a nurse conducted night time observations on new reception prisoners and recorded that there were no concerns and he was observed lying on his bed listening to music.
60. The next morning, a nurse saw him for the second healthscreen assessment. The nurse recorded that he suffered from asthma, ADHD and that his blood pressure was 110/60 (within normal limits). He told the nurse that he had an outstanding appointment at the hospital for an assessment for a hearing aid. He also told the nurse that he had used cocaine some two months ago but did not want to be referred to the drug detoxification team. The nurse noted that he had no thoughts of self harm or thoughts of taking his own life but did feel stressed about being in prison.
61. On the 14 September, the man saw the visiting dentist, as he complained of a cracked tooth. She recorded that he had dental caries (tooth decay), poor oral hygiene, was a smoker and was on prescribed medication of salbutamol and clenil modulate. He said that he only brushed his teeth once a day in the mornings and requested private treatment. He told the dentist that if he was sentenced and in Bullingdon he would make an appointment to have the dentistry work done. She recorded that he was given oral hygiene, diet, and smoking cessation advice.
62. The next day the man completed another complaint form (Comp 1 Form) to ask about the whereabouts of the clothes parcel that had been sent to him. In this occasion he wrote:

“I feel this prison is discriminating me for some sad reason. I just want my clothes. Thank you”

“I would like the property department to be fully investigated and to stop this corruption and for my clothes to be issued to out to me since I have been in custody for 6 weeks now”

He received a response to his complaint on the 20 September, which said that a thorough search had been undertaken but there was no record of his clothes parcel at Bullingdon.

63. In the days that followed, he had no further interventions with healthcare staff and there were no concerns recorded by discipline staff. He did attend education classes and had become friends with a fellow prisoner who attended the same class. The prisoner told the investigator that the man would speak about the reason why he was in prison and that he realised that he had made a mistake.

64. On 1 October, the man saw a nurse and he told the nurse that he felt more settled than when they last met on 6 August. He said to the nurse that he was next due to appear in court on 25 October and may be transferred out of Bullingdon, however he wanted to see a psychiatrist regarding being prescribed Concerta xl. Five days later a visiting psychologist recorded in the medical record that he had been referred to be seen by specialist psychiatrist.
65. In the days that followed, the man continued to attend his education classes and there were no concerns recorded by staff. Prison records show that he telephoned his father on 8 and 10 October and his mother on 8 October. The investigator obtained transcripts of these telephone calls which gave no indication that he was in low mood or gave any indication to his parents that he had intentions to harm himself.
66. On the 10 October, the man submitted his canteen order (a weekly request made by prisoners to purchase personal consumable items) which he would have been due to receive three days later. His order included £6 of telephone credit, 37.5g of tobacco and other consumable items such as milk, tea bags, sugar, oats, shampoo, mouthwash, a latte mug, pen and playing cards.

Events of 11 October

67. The man had attended his morning educational class as usual. Following lunch, he told an officer that he felt unwell and was not going to his class that afternoon. The officer told him that he needed to go and see a nurse if he felt unwell, but he said he wanted to stay in his cell. The man's cellmate asked if he wanted to go to the gym with him but he said "no". He went to the gym and the man remained in the cell and the door was locked by discipline staff, in line with the normal prison routine.
68. Later that afternoon at approximately 3.10 pm, the cellmate returned from the gym and was let into the cell by discipline staff. Within seconds he was banging on the cell door. Officer A responded and was told by him that the man was hanging from the bed. The officer shouted for assistance and went into the cell and found him hanging from the upper bunk by a belt with the privacy toilet curtain pulled around him so he could not be seen from the observation hatch.
69. He supported the body whilst Officer B cut the ligature. Officer A and another officer started CPR (a combination of rescue breaths and compressions which manually circulate blood and oxygen around the body) whilst another officer made a level 1 response call (meaning someone found not breathing) on the radio to summon urgent medical assistance.
70. At 3.13pm a nurse was the first member of healthcare to arrive at the man's cell, quickly followed by another nurse and a doctor. The healthcare staff took over the CPR and used an automated external defibrillator (AED) (which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) which advised that there was no

shockable rhythm. A nurse put a cervical collar around his neck for support. An emergency ambulance was requested at 3.21pm.

71. CPR continued and the doctor administered adrenaline and shortly afterwards staff felt a pulse and the man began breathing on his own but remained unconscious. CPR was stopped but he continued to be given oxygen. The paramedics arrived at 3.31pm and took over his care, supported by the doctor, and ensuring his condition was stabilised he was taken to hospital, where he was placed in an induced coma and put on life support.
72. A bed watch risk assessment was completed which authorised the man to be accompanied by two officers and that restraints were only to be used when he was conscious and mobile. A governor contacted the man's nominated next of kin, his father, at 4.30pm to inform him of the incident and that his son had been taken to hospital.
73. Immediately having found the man, staff took the cellmate to the healthcare where he remained overnight so that he could be monitored by staff, as he was understandably upset following his discovery of the man. Staff also ensured that support was made available to other prisoners affected by the incident and a debrief for staff was held with support available for those who wished it.
74. The next day a governor was appointed as prison family liaison officer who met with the man's family when they visited him in hospital. Healthcare staff maintained in contact with the hospital for updates on his condition. Hospital staff said that the prognosis for his recovery was poor and that the doctors would review the next steps on 15 October.
75. The hospital doctors, having consulted the family, turned off the life support at 2.30pm and the man died at 3.28pm. In the days that followed the prison family liaison officer maintained contact with the man's mother to offer support and financial assistance towards funeral expenses in accordance with Prison Service Order (PSO) 2710 'Follow up to death in custody'.
76. Following the man's death anonymous information from prisoners was given to staff that alleged that he had been bullied for tobacco by Prisoners 1 and 2. It is a regular occurrence in prisons that prisoner exchange and barter their canteen items. The prisoners have their own repayment system known as "double bubble" (pay back twice the amount borrowed). This has the opportunity to be used as a means of bullying if one prisoner becomes in debt to another. When interviewed by the investigator the man's cellmate said that he was not aware that he was being bullied by any prisoners.
77. When interviewed, Prisoner 1's personal officer confirmed to the investigator that the allegations that the man was being bullied by Prisoner 1 only surfaced after he had died. The officer said that he was an aggressive prisoner who had received several warnings about his behaviour. The officer went on to say that the prisoner did not openly associate with other prisoners and tended to keep himself to himself. The officer explained that it was his understanding of the nature of the allegation made against him was that he was giving out tobacco to fellow prisoners and then charged excessively more tobacco in return as

payment, and if he did not receive the charged amount would take other prisoner's property as payment.

78. Bullingdon acted on this information and staff searched Prisoner 1's cell and found unauthorised items in his possession along with a book that contained the first names of prisoners with amounts of tobacco written next to their name, and one of these names was "the man". He was moved initially to the care and separation unit and then to D wing and placed on violence reduction monitoring.
79. Violence Reduction Officer explained at interview that the purpose of violence reduction monitoring was to monitor Prisoner 1 (without his knowledge) for a period of 28 days to observe his behaviour. Following three separate assessments there was no evidence found to suggest that he bullied other prisoners and the violence reduction monitoring process was closed and he remained on D wing.
80. Prisoner 1 confirmed, when interviewed by the investigator, that the name in his book did refer to the man. He went on to explain that he used to let people have tobacco and keep a record until it was repaid back to him. He said that this was usually "double bubble", however, because he knew him from living in the Slough area, he only had to repay the amount that was borrowed. He went on to say that the man was a bubbly character who did tell other prisoners the reason he was in custody. He also said that he was not aware of anyone bullying him and would have expected him to have mentioned it to him if bullying had taken place.
81. In respect of Prisoner 2, Bullingdon initially moved him to A wing. However he became threatening and abusive towards staff so he was taken to the care and separation unit. Prisoner 2's personal officer told the investigator that this prisoner was an intimidating character, who only mixed with prisoners from the same ethnic background, but there had been no indication that he was bullying the man prior to 11 October. The investigator has found that there is no obvious connection between Prisoners 1 and 2.
82. The Violence Reduction Officer also interviewed Prisoner 2 about being an alleged bully which he denied. The officer went to B wing to speak to prisoners who said that he was a bully but none were prepared to have their names formally recorded so the matter could not be taken any further. He continued to be uncooperative with staff and he was subsequently transferred to HMP Gloucester. It was not possible for the investigator to interview him.
83. The investigator obtained the canteen requests that the man made in the three weeks immediately prior to his death. These show that he placed an order on each Monday and would have received his items on the Thursday of that same week. The amount of tobacco that he purchased was shown to the officers interviewed who agreed that the amount was far in excess of what a casual smoker such as he would use in a week. It is likely that the order was to repay a tobacco loan.
84. In addition to the allegations made about Prisoners 1 and 2, information was also given that suggested fellow prisoner bullied prisoners for canteen items on

B wing and used other prisoners, including the prisoner the man had befriended, as debt collectors. As mentioned earlier in the report the man appeared as a defence witness in this prisoner's trial. Prison records show that they were on the same wing at Bullingdon from 18 July to 10 August and at one point were only two cells apart.

85. By the time the man returned to Bullingdon from Wandsworth on 9 September, the fellow prisoner had been moved to the care and separation unit as he said he had become fearful of his own safety due to the nature of his offence. The investigator attempted to interview him but he refused.
86. The prisoner the man had befriended, however, did agree to be interviewed by the investigator. At interview he said that he was in the same English and maths group as the man and had been with him in the morning before he was found hanging. He said that the man was an easy person to get along with and that there was nothing that seemed to be bothering him and he did not appear down. On that morning, he said that the man had told him about the reason that he was in prison and that he had "done something stupid". He went on to say that after the man had died he had heard rumours that he had been bullied but he did not know who by or what for.
87. Following the man's death, as part of her role as prison family liaison officer, the governor contacted Wandsworth to locate his clothes that had been sent there in a parcel upon his transfer from Bullingdon on 10 August, so that the items could be returned to his mother. After a protracted search his clothes parcel was found unopened in the mail room at Wandsworth and it was returned to the governor who ensured it was given to his mother.
88. The investigator interviewed a governor and the Developing Prison Service Manager (DPSM) at Wandsworth. Both explained the process that is followed when a prisoner transfers into the prison and the time taken deal with a prisoner's property and monies. As a result of the delay in forwarding the man's clothes parcel, the mail room at Wandsworth had been reorganised by the time the investigator visited the prison on 23 November.

ISSUES

Clinical care

89. The man's mother was concerned that her son had not been appropriately assessed for his mental health needs and that the prison had not obtained his community medical records. The clinical reviewer has carefully considered the overall clinical care given to the man and concludes:

"In my opinion, there is no evidence in the records that he received inappropriate or inadequate physical or mental health care.

"In my opinion the medical records, presented as paper printouts of electronic entries, include all the basic medical information one might expect for effective primary care. The admission details are comprehensive and referrals to specialist teams were appropriate. In particular the notes on the resuscitation procedure were very thorough."

"I would commend the health care team in HMP Bullingdon for their thorough approach to medical records which by implication suggests a thorough approach to clinical care and in particular for their prompt and effective response to this incident."

90. The man was appropriately referred to the mental health team regarding his history of ADHD when he came into prison. He had documented interventions with members of the mental health team throughout his time in custody. The healthcare team ensured that the full details of his mental health history, treatment and medication were obtained from his doctor in the community and hospital specialist.
91. In respect of the mental health care that he received the clinical reviewer made the following comment:
- "Mental Health needs were addressed. Suicidal risk assessment was included in the records of the mental health examinations and each of the admission examinations. There is no suggestion in the records that he was experiencing suicidal ideation [thoughts] at any point while in prison."
92. We are satisfied that the level of intervention between the mental health team and the man was appropriate to meet his needs. We accept that he gave no sign to staff that he was contemplating taking his own life during his time in custody.

Prison computer records

93. The man was at Wandsworth from 10 August to 9 September and throughout that period there was only one case note entry made on his record, which was the day of his arrival. There are no entries to indicate that the prison induction process had been completed, nor from any wing officer to confirm that he had settled into the prison regime.

94. Documenting a prisoner's progress in prison is an important part of the role of discipline staff and provides a chronology of events, issues and concerns. In interrogating the documentation for this investigation it is not known whether there were any issues or concern regarding the man during his time at Wandsworth.

The Governor of Wandsworth should ensure that all staff correctly maintain prisoners' records so that there is an effective record of events, issues, concerns and action taken.

The man's property complaint

95. The man's mother had sent to him a clothes parcel in the period after he initially arrived at Bullingdon. The investigator has not been able to establish the date that this was received. However, he was transferred to Wandsworth on 10 August and at that point he had not received the clothes. This was a cause of distress to him, who made a complaint on 18 August to establish what had happened to his belongings. He did receive an interim response from staff at Wandsworth on 30 August to say that the matter was being looked into. He had an additional response on 9 September, the day he attended court and was returned to Bullingdon, stating it would take time as staff at Wandsworth needed to liaise with Bullingdon.
96. In this complaint, the man wrote that he did not see the point in life. This declaration made by him potentially indicated that he may have considered self harm or suicide. At interview, a governor said that it was his expectation that such declarations made by prisoners should be immediately brought to the attention of wing staff so that a prisoner's wellbeing could be checked and appropriately monitored by staff. In this instance, the complaints clerk did not bring his declaration to anyone's attention and staff were not aware of the need to check on his well being. Just two months later he took his own life. This omission meant that an opportunity to put appropriate support in place for him was missed, and important information concerning his state of mind was not passed on to Bullingdon. This is a significant failing.

The Governor at Wandsworth should ensure that any declaration of potential self harm or suicide is appropriately investigated, assessed, recorded, and action taken as necessary to provide support to the prisoner concerned.

97. Once back at Bullingdon, the man completed two further complaint forms on 15 September and 21 September asking about his belongings. These were answered on the 20 and 26 September respectively which informed him that Bullingdon had no record of his clothes parcel.
98. From the evidence gathered during this investigation, it is clear that the parcel was received at Bullingdon and then correctly forwarded to Wandsworth because of the man's transfer. However, the parcel remained in the mail room at Wandsworth unopened and not processed. The prison's family liaison officer gathered his property together following his death to return it to his family and

persisted in asking Wandsworth to conduct a thorough check and only at that point was the parcel found.

99. As a direct result of the issue surrounding the man's property, Wandsworth has reorganised the mail room and the investigator was shown the new system when he visited the prison on 23 November. During 2011, the Ombudsman received 16 complaints from prisoners regarding their property whilst in custody at Wandsworth. Of these five complaints are currently under investigation and two complaints have been upheld, this indicates that there have been considerable problems regarding prisoners property at Wandsworth. Whilst we recognise that changes have now been made it is our opinion that Wandsworth failed him in not appropriately dealing with his property and that his complaint was justified.

The Governor of Wandsworth should keep the new mail system under review, to ensure it works effectively to keep any delays relating to prisoners property to a minimum.

100. We also recognise the additional stress caused to the man's family due to the delay in his property being returned to Bullingdon by Wandsworth. Had it not been for the persistence of the prison's family liaison officer we are confident that the delay would have been far greater than it actually was.
101. The man's mother is also concerned that a pair of his trainers had not been returned. A prisoner's personal property is logged on individual property cards (F2056C and F2056D). Upon review of his property cards, the investigator found no entries relating to trainers only what were described as "flip flops". Therefore we are unable to provide any further information concerning the location of any trainers he may have had.

Allegations of bullying and coercion

102. Following the man's death prisoners anonymously gave staff information that alleged that he had been bullied for tobacco by two fellow prisoners and the investigation has carefully explored these allegations by interrogating documentation and conducting interviews. His canteen records for the three weeks prior to his death did include a significantly higher purchase of tobacco than would be expected for a light smoker.
103. The evidence gathered does indicate the potential for bullying existed. In particular Prisoner 1 confirmed that he was owed tobacco by him, and he had ordered significantly more tobacco than a casual light smoker would consume in a week. This does, therefore, suggest that he may have been repaying the prisoner considerably more tobacco than he suggested at interview.
104. On receiving the allegations of bullying on B Wing, Bullingdon appropriately followed the Violence Reduction policy by immediately responding to the allegations by moving the alleged perpetrators from their existing location and putting in place a monitoring programme to monitor and, where necessary, address any bullying behaviour.

105. From the evidence gathered during the investigation, the potential for the man to have been bullied certainly existed, however, we are unable to say definitively that he had been the subject of bullying or that this caused him to take his life. Sadly, the allegations of bullying only came to light following his death and were dealt with appropriately by Bullingdon. However, many of the indications uncovered by the investigator should also have been apparent to wing staff and should have prompted earlier intervention.

The Governor of Bullingdon should ensure that the local Violence Reduction Policy is consistently and effectively followed by staff, and risks are appropriately identified and managed.

106. The additional suggestion that the man was coerced into acting as a defence witness for a fellow prisoner, a known bully, has also been addressed by the investigation. Prison records confirm he was on the same wing but a different spur to the prisoner from 27 July until 10 August. He gave, as a witness, evidence at Crown Court on 7 September 2011 and the investigator obtained a copy of the transcript of the evidence. In his evidence, he confirmed that he had initially met the prisoner in the community and then again when at Bullingdon.

107. Prison records also confirm they were on the same prison transport vehicle when the man returned to Bullingdon on 9 September, after he appeared at Crown Court for his own offence. At this time, the prisoner was not on the same wing as him. The prisoner was subsequently found guilty on 14 September and was sentenced on 14 October to seven years in custody. We have not found any evidence to substantiate that the man was coerced to act as a witness for him, although it must remain a possibility.

108. It is however, noteworthy that the investigation has established that all but one of the alleged perpetrators of the bullying and coercion lived within a two mile radius of the man's pre-custody address in the Slough area. Whilst this information in itself does not evidence the allegations, it does indicate the potential for these individuals to have been known to him prior to entering custody.

Emergency response

109. The staff response to the man's ally's need for assistance was swift and professional. Staff, with the assistance of the doctor, commenced CPR and the AED was attached and intravenous access to his arm was gained. Due to him not having any cardiac rhythm there was no instructions to shock him during the CPR.

110. Staff were successful in resuscitating him, though he remained unconscious and was supported with oxygen. Paramedics took over his care and he was transferred to hospital.

111. In his review, the clinical reviewer comments on the emergency response as follows:

“The nursing and medical response including the prompt starting of life support measures by the prison officers was both efficient and effective. The effectiveness of this resuscitation is a fitting reminder to any organisation to train and retrain staff in basic life support procedures.”

112. We recognise and commend the actions and professionalism of all the staff who responded the emergency situation, being successful in resuscitating the man, giving him the best possible chance of a positive outcome.

Restraints, security and bedwatch arrangements

113. On each occasion a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.
114. Unfortunately, there have been too many reports in which we have criticised the level of restraints used when prisoners are taken to outside hospital. It is pleasing to recognise the good practice adopted by Bullingdon in not authorising the use of restraints whilst the man was unconscious, which ensured that he was treated with dignity and respect on his admission to hospital and the days before his death.

Appointment of Family Liaison Officer

115. We wish to recognise the good practice adopted by Bullingdon in the early appointment and intervention of the prison family liaison officer. This compassionate and sensitive approach taken by Bullingdon ensured the man's family had support available during the days leading up to his death and this continued the days that followed and included the offer of financial assistance towards funeral expenses in accordance with PSO 2710.

The Governor at Bullingdon appointed the family liaison officer immediately after the man had been admitted to hospital. This is good practice and should be shared with other establishments.

CONCLUSION

116. When the man was found hanging, staff responded swiftly and with professionalism. As a result of the swift actions of all the staff who responded that afternoon, they were successful in resuscitating him and transferring him to the care of the hospital.
117. It is clear from the documentation considered during this investigation that the issue of the man's clothes parcel from his mother caused him significant stress. This was further compounded by the delay to his family in the returning of his clothes following his death. It is our opinion he, and his family, have been let down by Wandsworth in their failure to handle the receipt and the subsequent return of his clothes parcel. Indeed, we recognise the persistence of the prison's family liaison officer in finally securing the return of the parcel from Wandsworth.
118. Wandsworth's failure to appropriately follow up the man's declaration on his complaint form and provide assessment and support is a significant failing. As is the failure to pass this information on to Bullingdon. However we are satisfied that he gave no indication to staff at Bullingdon, his fellow prisoners or his family that he intended to take his own life. Following his death we are satisfied that Bullingdon appropriately followed the guidance given in PSO 2710, 'Follow up to death in custody'.
119. The investigator followed up the allegations made that the man had been the subject of bullying and the suggestion he had been coerced into acting as a defence witness. Both must remain a possibility, however, the investigation has not been able to substantiate any of the allegations.
120. We make four recommendations, and are critical of the way Wandsworth handled the issue concerning the man's ally's clothes parcel and declaration of potential self-harm. We do recognise the professionalism of the staff who responded to the emergency incident and the good practice in family liaison.
121. We judge that there was appropriate assessment made of the man's physical and mental health needs and the standard of clinical care he received at Bullingdon was equitable to that he could have expected to receive in the community.

The man's mother and her legal representative received a copy of the draft report as part of the consultation process. Written representations were provided on her behalf in response to the findings of the investigation, some of which fall outside the remit of our investigation. A number of areas of concern were raised including his access to a belt, the issue of alleged bullying and the inadequacy of the response and emergency treatment when he was found. His family were 'highly dissatisfied' with the Prison Family Liaison and feel that the officers had no knowledge of his personal circumstances.

We are grateful to the family for the time they have taken to consider the report and for the feedback they have felt able to share. The Ombudsman has considered the issues raised and has, where appropriate, amended the report

to reflect their comments. It was felt, however, that some of the issues raised would be more appropriately addressed outside of this report in separate correspondence to the man's mother and legal representative.

RECOMMENDATIONS

1. The Governor at Wandsworth should ensure that all staff correctly maintain prisoners' records, so that there is an effective record of events, issues, concerns and action taken.

Accepted

The Personal Officer Scheme has been reviewed and the policy stipulates that Personal Officers should make two entries per month into the Nomis Files of their prisoners.

Management checks are in place to monitor this and every prisoner now has the name of their personal officer noted on the door of his cell.

Progress to date: Month on month improvements have been noted by sample checks. At present most prisoners are receiving at least 1 entry per month which is an improvement to build upon.

The induction process has also been reviewed: It is now the procedure that on a prisoner's first night in custody, a personal officer (for the duration of the induction period) is assigned. They introduce themselves to the prisoner and makes an entry on the prisoner's case notes. At the end of the induction a note is also made on the prisoner's case notes that they have completed the induction.

2. The Governor at Wandsworth should ensure that any declaration of potential self harm or suicide is appropriately investigated, assessed, recorded, and action taken as necessary to provide support to the prisoner concerned.

Accepted

All staff will be reminded (via a Governor's order) the procedures and actions to take if any concerns are raised (including in writing via complaints) regarding potential suicide and self-harm.

3. The Governor of Wandsworth should keep the new mail system under review, to ensure it works effectively to keep any delays relating to prisoners property to a minimum.

Accepted

The mail system has been reviewed. HMP Wandsworth still does not have the capacity to accept items through the post. All items therefore received will be returned to sender or an address provided by the prisoner. Following the review it has been agreed to double the resources in this area to ensure turnaround of parcels received is as timely as possible. An annual review will continue to be conducted.

4. The Governor of Bullingdon should ensure that the local Violence Reduction Policy is consistently and effectively followed by staff, and risks are appropriately identified and managed.

Accepted

A notice to staff will be issued reminding them to be vigilant with regard to prisoners' canteen orders to monitor for signs of bullying or patterns of unusual expenditure. We will also remind our prisoners' clerk to monitor and report any unusual patterns or expenditure.

5. The Governor at Bullingdon appointed the family liaison officer immediately after the man had been admitted to hospital. This is good practice and should be shared with other establishments.

Accepted

This recommendation has been brought to the attention of OSRR Group within headquarters and they will disseminate this identified good practice through minuted regional safer custody meetings.