PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 7 November 2013 at HMP Bedford

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the investigation report into the death of a prisoner who was found hanging in his cell at HMP Bedford on 7 November 2013. He was 31 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by a senior investigator. A doctor reviewed the clinical care the man received in prison. HMP Bedford cooperated fully with the investigation.

The man had arrived at Bedford on 28 October 2013. He had been to the prison a number of times before and staff were familiar with him. During some previous stays at Bedford and at HMP Blundeston, he had been managed under suicide and self-harm prevention procedures, but he was not identified as at risk when at Bedford in early October or in the period before he died.

The man asked that his mental health medication should be reviewed. A nurse from the mental health team and another colleague agreed that they should consider raising the dose. The nurse discussed this with the man on the morning of 7 November and gave him some information about the effects of the medication. The nurse made an appointment to discuss this further the next day. The nurse and the officer who accompanied the man to the appointment on 7 November said they had had no concerns about the man and that he gave no signs that he had any thoughts of suicide. That afternoon, the man was found hanged in his cell. Resuscitation attempts were unsuccessful.

Earlier on 7 November, the man had been admonished by an officer and some prisoners later alleged that, in response, the man had said that he would hang himself and the officer had told him to go ahead. Prisoners also said that the man was bullied by another prisoner. The investigation was unable to substantiate any of these allegations.

While I recognise that it would have been difficult to predict the man's actions on 7 November, I am concerned that prison staff did not appear to take full account of all the known risk factors for suicide and self-harm when he arrived at the prison on both 7 and 28 October. The man's GP records should have been requested when he arrived at Bedford, and there is also a need to improve systems for referral to the mental health team for assessment. At the time of the man's death, the prison did not have an up to date emergency code procedure and, while I am satisfied that this did not affect the outcome for the man, all staff need to understand their responsibilities in an emergency.

The 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2014**

CONTENTS

SUMMARY

1. The man was remanded to prison for breach of his bail conditions on 28 October 2013 and arrived at HMP Bedford that day. He had been in prison a number of times before and had been released from Bedford just ten days earlier. He had previously been managed under suicide and self-harm prevention procedures (ACCT) in prison, most recently at HMP Blundeston, until the day he had been released in September 2013.

2. At a reception health screen, a nurse recorded that the man had previously self-harmed and was dependent on alcohol. The nurse referred him to the mental health team and to substance misuse services. The man began an alcohol detoxification programme and was located on the vulnerable prisoners' wing at his request. A member of the mental health in-reach team assessed the man on 29 October and accepted him on the team's caseload. He was added to the waiting list for a mental health assessment, but his name was removed by mistake the next day. The prison had the man's previous mental health records. No one assessed him as at risk of suicide and self-harm.

3. On 4 November, the man told a GP that he needed to increase his dose of olanzapine, an antipsychotic, as it was not having the desired effect and was not in line with what he had been prescribed in the community. The GP said that he would need to discuss this with the mental health in-reach team first. The man saw a nurse from the in-reach team on 6 November and again the next morning. After discussion with another member of the in-reach team, the nurse agreed that the man would benefit from an increased dose. Before this was done, he gave the man some information about olanzapine and its effects and made an appointment for 8 November to discuss this further.

4. Earlier on 7 November, an officer had admonished the man for leaving a workshop to have a cigarette in his cell. After his death, some prisoners alleged that the man said that he would hang himself and the officer told him to go ahead. They also said that another prisoner had bullied the man, which the prisoner denied. We have found insufficient evidence to substantiate these allegations.

5. At around 1.55pm on 7 November, an officer discovered the man hanging by a ligature made from a sheet attached to the window bars of his cell. The officer called for emergency help, but an emergency medical code was not called until another officer arrived shortly afterwards and control room staff called an ambulance. Prison officers and healthcare staff attempted to resuscitate the man until paramedics arrived within ten minutes and took over. Sadly, the resuscitation attempts were unsuccessful and, at 2.35pm, a paramedic pronounced the man dead.

6. The clinical reviewer considered that the standard of mental health care the man received at HMP Bedford was equivalent to that he could have expected to receive in the community. While we recognise that it would have been difficult for prison staff to have anticipated the man's actions on 7 November we consider that he should have been monitored as a risk of suicide and self–harm

when he arrived at Bedford both on 7 October and 28 October. He had a range of risk factors such as recent self-harm, mental health problems, he was withdrawing from alcohol and was on remand. We are not satisfied that these factors were given adequate weight when staff assessed the man's risk of suicide and self-harm. We make four recommendations about mental health referral procedures, assessment of risk, obtaining community GP records and emergency procedures.

THE INVESTIGATION PROCESS

7. The investigator issued notices at HMP Bedford informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. One prisoner responded.

8. NHS England commissioned a doctor to review the man's clinical care in prison.

9. The investigator visited Bedford on 14 November and met the Governor and spoke to staff involved in the man's care. He obtained copies of the man's relevant prison and medical records, and interviewed staff and prisoners at Bedford. The investigator gave the prison initial feedback about the preliminary findings of the investigation and followed this up in writing. At the draft report stage the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations.

10. We notified HM Coroner for Bedfordshire and Luton of the investigation who provided the results of the post-mortem examination. We have sent a copy of this report to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and invite them to raise matters they wished the investigation to consider. They wanted to know:

    - Why the man was in prison.
    - Whether the prison knew about the man's recent stay in a mental health unit and whether they took this into account when assessing his needs.
    - Whether the man was assessed to establish his mental health needs and what assessment took place to decide if he was at risk of suicide.

    The man's family received a copy of the draft report. They did not make any comments.

HMP BEDFORD

12. HMP Bedford is a local prison which holds up to 506 men. The prison takes sentenced and remanded prisoners from Luton Crown Court and Bedford and Luton Magistrates' Courts and sentenced prisoners from other prisons. The vulnerable prisoners' wing (F Wing), where the man lived, holds up to 30 prisoners. South Essex Partnership Trust provides mental health services and Northamptonshire Foundation Health Trust provides general health services including the integrated drug treatment service.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons conducted an unannounced short follow-up inspection in May 2011. Inspectors noted that Bedford was generally a safe prison and that work on preventing self-harm had improved. The healthcare environment was described as poor, but the services were satisfactory. The report of a more recent inspection in January 2014 has not yet been published.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its 2013 annual report, the IMB said that there had been progress in the provision of healthcare services, but some prisoners reported waiting too long to receive prescribed medication and that staff did not take full account of previous medical information. In their previous annual report, the IMB had been concerned about staff bullying prisoners, mainly attributed to a few officers. The IMB noted that the Governor was addressing the problem.

Previous deaths at Bedford

15. We have investigated five self-inflicted deaths at Bedford since 2010. Some of these investigations touched on mental health care and suicide and self-harm procedures, but none raised any issues directly relevant to this investigation.

ACCT - Assessment, Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Support for prisoners includes setting a number of significant interactions with them during the day, supplemented by checks on their well-being during the times they are locked in their cell. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the care-map have been completed, and a review should be held within a week of the ACCT being closed.

KEY EVENTS

17. On 14 February 2013, the man was sentenced to eight weeks imprisonment for theft. He had been in prison before. He arrived at HMP Bedford later that day and was released on 12 March.

18. On 6 May, the man was admitted as an inpatient to a mental health unit at local hospital as a voluntary patient. It was recorded that there was no "definitive evidence" that he was experiencing any psychosis. Before he was discharged, on 28 May, he was diagnosed with mental and behavioural disturbances caused by alcohol use.

19. On 5 July, the man was sentenced to 18 weeks imprisonment for assault. He arrived at Bedford the same day. On 8 July, in a mental health assessment, the man scored 0 for depression and 1 for anxiety on the Personal Health Questionnaire (PHQ-9) Depression Scale (both indicating very low levels of depression and anxiety).

20. The man was managed under suicide and self-harm prevention procedures (ACCT) twice between July and September. Both times he had cut himself and told staff that he was hearing voices. The first ACCT plan was closed on 29 July, after the man seemed to settle and accept his prison sentence. He transferred to HMP Blundeston on 8 August. A second ACCT was opened on 27 August and closed on 5 September, the day the man was released.

21. The man spent time at HMP Bedford again between 7 and 18 October after he was convicted of theft and sentenced to 28 days imprisonment. Dr A, a prison doctor, observed that the man was withdrawing from alcohol and referred him to the Integrated Drug Treatment Service (IDTS) and the mental health team. The man said that he had no thoughts of self-harm, but that he had cut himself while in the community. Dr A noted that the man had harmed himself during his last period in prison and had a history of depression. The IDTS team reviewed the man each day. On 8 October, the man scored 7 for depression and 1 for anxiety on PHQ-9 scale, both within normal range. There is no record of any further concerns about the man during this period of custody.

22. On 28 October, the man was remanded to prison charged with theft. He was due to reappear at a local magistrates' court on 18 November. He arrived at HMP Bedford at around 4.00pm. It was noted in the Person Escort Record (PER) form which accompanied him that, in January 2013, the man had said that he "wanted to end it all".

23. At a routine health screen interview, Nurse B, who knew him from earlier sentences, recorded that the man had previously harmed himself. (A health screen takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, any substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.) The man said that he drank up to six bottles of wine a day and 12 cans of special brew. Nurse B referred the man to the drug and alcohol team and the mental health

in-reach team as he was prescribed olanzapine (antipsychotic medication) and because of his previous mental health problems. Nurse B told the investigator that the man had appeared calm and stable and that he had no concerns about the man's presentation or risk of self-harm or suicide.

24. Dr C, a prison doctor, saw the man and recorded that he drank more than 240 units of alcohol a week. Dr C prescribed an alcohol detoxification programme of chlordiazepoxide (10 mgs), olanzapine (10 mgs), thiamine (100mgs) and vitamin B. As the man had a slight tremor he was given 40 mgs of librium (used to treat anxiety and alcohol withdrawal). Mrs E, the clinical lead nurse for alcohol and drug services then assessed the man.

25. At his request, the man was located on the vulnerable prisoners' wing (F wing) where he shared a cell with another prisoner, Mr F. At around 1.15am on 29 October, an operational support grade, Mr G, recorded in the wing observation book that the man had told him that he was going to get beaten up in the morning by other prisoners. There is no record that the man mentioned any other threats.

26. At 3.40am, Mr G recorded that Mr F had complained about the man talking to himself and making noises. When interviewed, Mr G said that he calmed both prisoners down, but did not think that he needed to separate them. He said that he did not think that the man was at risk of harming himself.

27. At 9.30am on 29 October, Ms H, from the mental health in-reach team, saw the man following Nurse B's referral. She recorded that the man had previously harmed himself, but now appeared to be calm and stable. Ms H accepted the man onto the in-reach team caseload and added him to the waiting list for a mental health assessment. She had no concerns about his risk of suicide or self-harm.

28. At around 10.55am, a supervising officer (SO) spoke to the man and Mr F about what had happened during the night. The man told the SO that his medication had not taken effect and he had felt paranoid. He said that no one had threatened him and he thought that he had been hearing voices. Mr F told the SO that he would injure the man if he had to continue sharing with him.

29. The SO arranged for Mr F to move to another cell. When interviewed, the SO said he did not think that the man was at risk of suicide or self-harm and that he did not have any concerns about his medication.

30. On the afternoon of 29 October, at 3.45pm, a member of the safer custody team notified the mental health in-reach team, wing staff and healthcare that the records showed that the man had a history of suicidal thoughts and mental health issues. Ms H told the investigator that this risk alert had already been noted by reception staff when the man had arrived at the prison. The in-reach team checked their records and found that the man was already on their waiting list for a mental health assessment. The SO said that he had already seen the man when he received the risk alert and did not have any concerns

about him. When she received the risk alert, Mrs E checked to ensure a referral had been made to the in-reach team.

31. Members of the drug and alcohol team monitored the man for the next few days. They did not observe any signs of withdrawal symptoms and stopped assessing him on 2 November.

32. On 4 November, the man told Dr C that he wanted to increase his dose of olanzapine from 10 to 20mgs. The doctor noted that the man had been on 20mgs when he had been in the prison in August, but this had stopped when he had lost his prescription. Dr C referred him to the mental health in-reach team to review his prescription which would be necessary before any increase. It was then noted that Ms H's referral for a mental health assessment had mistakenly been cancelled on 30 October.

33. On the afternoon of 6 November, the man asked Officer G if he could see someone from the in-reach team. Nurse H, a mental health nurse from the team, was on the wing at the time and went to see the man. He recorded that the man said he was unable to sleep and was losing control of his emotions because he was not getting the right dose of olanzapine of 20mgs, which his community GP had prescribed. The man reported hearing voices and feared he might harm himself. Nurse H told the clinical reviewer that the man had said that, when he was in the community, he had felt like harming himself when he was not taking olanzapine.

34. Nurse H knew the man from his previous stays at Bedford. In a statement to the investigator, he said his clinical impression from this assessment was that The man did not show any signs of psychotic or depressive symptoms, was not at risk of self-harm and did not seem agitated or aggressive. Nurse H recorded that he would discuss the case with his colleagues in the in-reach team and see the man again on Friday 8 November.

35. Officer G said that he had not previously come across the man at Bedford. He said the man was very quiet, polite and laid-back. He had had no concerns about him.

7 November 2013

36. On 7 November, Officer I was supervising prisoners in the F wing workshop. He told the investigator that prisoners are unlocked at around 8.00am and should be in the workshop shortly after 8.15am. He said that, sometime before the first official tea break, which is at 10.00am, the man said he needed to go to the toilet and left the workshop. He went back to his cell and Officer I was sure that he had smoked a cigarette. Officer I said he had reminded the man that there was a toilet on the same floor as the workshop and that he should not go back to his cell.

37. Nurse H spoke about the man to his colleague, Nurse J, that morning. They agreed that they needed to consider raising the dose of olanzapine. To expedite this, Officer K brought the man from the workshop to see Nurse H at

10.30am that morning. They discussed his self-harm, substance misuse and the effects of olanzapine. The man said he was unable to stop drinking, which caused him to commit offences. Nurse H noted that the man was focussed and positive and had no thoughts of self-harm. He told the man that he would give him some more information about olanzapine and arranged another appointment for the next day to make a decision about his medication.

38. The man then returned to F wing and was locked in his cell. Officer K dropped off the information about olanzapine from Nurse N. Officer K told the investigator that he thought that the man looked well and had interacted well with Nurse H. He said that he had had no concerns about him when he saw him in his cell.

39. Mr L, a prisoner on F wing, told the investigator that, at around 11.40am, the man came to see his cellmate, Mr M, after prisoners were unlocked for lunch. The man exchanged some of his milk for tobacco and then went back to his cell. Mr L said that the man often swapped food, drink and medication for tobacco.

40. Officer G saw the man collect his lunch and take it back to his cell. After all the prisoners had collected their lunch, the officers locked them in their cells. Officer G conducted a roll check, at around 12.10pm, and said he saw the man sitting at the table in his cell at that time.

41. At around 1.45pm Officer I and Officer G started to unlock prisoners. Officer I unlocked the cells on the landing below the man's cell (known as the 2s landing) and was nearly finished before Officer G started to unlock the cells on the man's landing (the 3s). Officer I was directing prisoners into the workshop when he noticed that the man was missing and called up for him. Officer G had not yet got to the man's cell (F3-8) and, when he did so, he found the man hanging from a ligature made of a bed sheet, attached to the window bars of his cell.

42. Officer G supported the man's body, to relieve the pressure on his neck and called to Officer I for help. Officer I radioed for urgent assistance giving his location and asked for the emergency response nurse to attend. Records show the call was made at 1.55pm. Officer I did not use a designated emergency code. Officer I then helped Officer G cut the ligature and lower the man to the floor. They started cardiopulmonary resuscitation (CPR) as the man was not breathing. Officer N arrived soon after and, at 1.57pm, radioed a code blue (an emergency code indicating that someone is not breathing or is unconscious). An ambulance was called at 1.58pm.

43. A custodial manager who is also a first aid instructor, arrived at the cell and took over chest compressions from Officer G. A defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) had been brought from the wing office. Officer N applied the defibrillator. Resuscitation attempts continued, assisted by Nurse O and Nurse P who arrived shortly afterwards and gave the man oxygen. A rapid response vehicle and an ambulance arrived at the prison gate at around 2.05pm. (According to

Ambulance Service records the emergency request was received at 1.57pm, the ambulance arrived at the prison at 2.03pm and the paramedics were with The man at 2.05pm.) Paramedics continued to attempt resuscitation, but at 2.35pm pronounced that the man had died.

Contact with the man's family

44. A prison manager acted as the prison's family liaison officer and at 6.00pm went to the man's father's home and informed him of his son's death. The prison manager maintained contact with the man's family and offered support. In line with national policy, the prison offered financial assistance towards the cost of the man's funeral, which took place on 21 November 2013.

Support for staff and prisoners

45. A debrief was held later that day for the staff involved in the emergency who were offered the support of the prison's care team.

46. Notices were issued to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy were available to support prisoners and those identified as at risk of suicide and self-harm monitoring were reviewed in case they had been adversely affected by the man's death.

Events after the man's death

47. On 8 November, the day after the man's death, Mr L told Officer Q that he believed that another prisoner, Mr R might have bullied the man in exchange for food. He told the investigator that one of the man's problems was that he was short of tobacco and offered his food and medication to other prisoners in exchange. He thought that Mr R was trying to arrange for the man to give him his medication in exchange for tobacco. Mr L said that Mr R had said that he was fed up with the man constantly asking for tobacco and that he drew officers' attention to the fact that the man took lots of unscheduled breaks from the workshop.

48. On 10 November, Mr S claimed that, on the morning of 7 November, the man had had an argument with Officer I about taking a break from the workshop. He said that Officer I was angry with the man for taking too long on a break and had sworn at him. In response, Mr S had said that the man had told Officer I he was "going to hang himself". He alleged that Officer I had told him to go ahead. Mr L and Mr S repeated their claims to a member of the Independent Monitoring Board.

49. On 18 November, Mr M, Mr L's cellmate, and Mr R were involved in a confrontation and were subsequently both locked in their cells. Mr M later gave a statement to staff about Officer I's conduct towards the man.

50. When interviewed by the investigator, Mr S described the man as a quiet person. Both he and Mr L said that the man had threatened to kill himself and Officer I had told him to go ahead. Mr L said that Officer I had been a good

officer up until that day, but he had appeared to be in a very bad mood on the morning of 7 November.

ISSUES

Clinical care

51. The clinical reviewer considered the management of the man's mental and physical health at the prison. He concluded that the man's care was equivalent to that which he could have expected to receive in the community.

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52. The clinical reviewer found that the man had a long history of alcohol abuse and associated mental health issues. The man had episodes of feeling paranoid, expressing suicidal thoughts and hearing voices. However, there was no evidence that the man had previously acted on his suicidal thoughts either in prison or in the community. Although he had previously harmed himself, these incidents do not appear to have been attempts to kill himself.

53. The man arrived at Bedford on 28 October. He was well-known to staff at Bedford and, as soon as he arrived, appropriate referrals were made to the mental health in-reach team and the drugs and alcohol service. The clinical reviewer found that the man's alcohol detoxification programme was appropriately managed.

54. The man's name appears to have been removed from the in-reach team waiting list by mistake on 30 October, although he was subsequently referred again by the prison doctor on 4 November for a review of his medication. The man had been on the waiting list for a standard mental health assessment. While we are satisfied that the cancellation did not lead to any undue delay in him being seen by members of the mental health in-reach team or in receiving appropriate mental health support it does not appear that a full mental health assessment was carried out. There was nothing to indicate that the man was suffering from any acute mental health crisis which required urgent intervention, but it is important that prisoners should not be removed from waiting lists until assessments have been completed. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners are not removed from the waiting list for health services until checks have been made that the required actions have been completed.

55. According to Nurse H, the man displayed no symptoms of mental health issues which required a change in medication. The clinical reviewer found Nurse H's decision not to recommend an immediate increase in olanzapine on 6 and 7 November appropriate.

56. The man's family asked if the prison had been aware that he had been in a mental health unit, if they had taken this into account when assessing his mental health and if they had accessed the man's community medical records. Information about the man's stay in the mental health unit was recorded in his prison medical records but we have seen no evidence that they received his GP records.

57. Prison Service Order (PSO) 3050 - Continuity of Healthcare states that efforts should be made to retrieve any information required from the prison's GP or other relevant service. The prison did not request the man's community GP records so his full medical history was not considered while he was at Bedford. We make the following recommendation:

The Head of Healthcare should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health problems.

Assessment of risk of suicide or self-harm

58. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". A list of potential triggers includes previous deliberate self-harm, mental illness and early days in custody.

59. The man had a history of self-harm and had been managed under ACCT procedures several times in the past. He had been released from HMP Blundeston on 5 September and an ACCT was closed that day. This information was in the man's medical record and we believe that this should have been considered when he arrived at Bedford on 7 October. During the time he was in the community after his release from Blundeston, he had cut himself and he was withdrawing from alcohol when he arrived. These are factors which are known to increase the risk of self-harm. As the man had been on an ACCT on the day of his release from Blundeston, we are surprised that an ACCT was not opened on 7 October.

60. When the man returned to Bedford again on 28 October, he was on remand (another factor which increases risk of self-harm and suicide) as well as withdrawing from alcohol. His mental health problems and his history of self-harm were also noted, but he was again not assessed as at risk of suicide and self-harm.

61. It is clear that both healthcare and reception staff knew the man and remembered him from previous sentences. It is possible that this familiarity outweighed all the other information available about the man when assessing his risk, including that he had been managed under ACCT procedures until the day of release on his previous sentence a month earlier. There was little to suggest his risk had reduced in the meantime and evidence, including recent self-harm, would suggest that it had increased. On 6 November, he had told Nurse H that he feared he might harm himself. The man had never previously harmed himself by ligature and we accept that the man's actions on 7 November would have been difficult to predict, but with the range of risk factors, we consider it would have been prudent to open an ACCT on both occasions he arrived at Bedford in October and to have continued to monitor

him until staff were satisfied that he was stable and settled on his medication. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

The emergency response

62. Officer H discovered the man hanging in his cell at around 1.55pm and immediately asked Officer I to assist. Officer I initially radioed a general request for emergency assistance and then helped Officer H to cut the man down. When another officer joined them two minutes later he radioed an emergency code blue which led to the control room calling an ambulance automatically. The control room logged the emergency code as being received at 1.57pm and an ambulance was called at 1.58pm. Paramedics arrived at the cell at around 2.05pm, seven minutes after being called.

63. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, issued in February 2013, contains mandatory instructions for prisons to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.

64. The officers who found the man did not use a medical emergency response code. This meant that the other staff who responded were not immediately alerted to the nature of the emergency and that there was a slight delay before an ambulance was called.

65. A notice was issued at Bedford in October 2012, setting out guidance for staff when responding to a medical emergency. The notice preceded the issue of PSI 03/2013 and did not cover all aspects required. After feedback during the investigation, we understand that a new protocol has been issued. It is important that all staff at the prison are aware the new requirements. We therefore make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical

emergencies and that Bedford has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Conduct of staff and allegations of bullying

66. Information received by the prison after the man's death suggested that he might have been bullied for his food and medication. A separate allegation was made that an officer had made inappropriate comments to the man.

67. Three prisoners told the investigator that, after Officer I warned the man about leaving the workshop for an informal break, the man told Officer I that he intended to kill himself. The prisoners alleged that Officer I told him to go ahead. Officer I acknowledged that he had spoken to the man about leaving the workshop, but denied making such a comment.

68. The Governor investigated the allegations against Officer I and wrote in the Governor's journal that he thought that the prisoners were lying and were trying to implicate an officer who they did not like as he had taken a tougher stance on the wing. He concluded that Officer I had done nothing wrong. Neither the investigator nor the police found any other evidence to support the prisoners' allegations. We also note that Nurse H and Officer K saw the man very shortly after this alleged incident and he did not indicate any upset or mention any concern to either of them about his treatment by the officer.

69. In relation to the allegations that Mr R had bullied the man, none of the staff were aware of any such suggestion before his death. Any form of negative behaviour, including bullying, can be reported by staff using a 'Tackling Antisocial Behaviour' (TAB) referral form. No TAB forms about the man were submitted while he was at Bedford.

70. When interviewed, Mr R said that he did not consider that any prisoners had bullied the man, but freely admitted that he had found the man's habit of continually asking for tobacco annoying so he said he had avoided him. There are no contemporaneous records to indicate that Mr R bullied the man and, as with the allegations against the officer, without further evidence to it is not possible to establish whether of not the man was bullied. There is no evidence from shortly before his death that he had been coerced for medication or food or had traded it for tobacco and the post-mortem report indicated that the man had been taking his medication as prescribed. He had also put on weight during his time at the prison.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners are not removed from the waiting list for health services until checks have been made that the required actions have been completed.

2. The Head of Healthcare should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health problems.

3. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
    - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

4. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Bedford has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

ACTION PLAN: The man HMP Bedford – 7 November 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners are not removed from the waiting list for health services until checks have been made that the required actions have been completed.	Accepted	Training will be provided for all new healthcare staff on the use of SystmOne (the clinical IT system) as part of their induction programme and their induction pack signed to say they have received it Feedback from South Essex Partnership Trust regarding System One states this is a TPP software issue which they are aware of. They have been contacted and due to the company about to enter into a tendering process they have no plans to change this however should a new system be put in place prior, then training will be disseminated by TPP In order to mitigate this risk the referral waiting lists (held on SystmOne) are audited weekly via caseload meetings to ensure that all actions for prisoners are achieved prior to closing the referral. Additionally an electronic referral is made via email to the In Reach Team which they triage and action as appropriate.	Head of Healthcare July 2014 This action in place from 9th June 2014	
2	The Head of Healthcare should ensure that GP records are requested for newly arrived prisoners, particularly those	Accepted	It is standard medical practice for all GPs to request a patients medical records on their arrival in reception by the patient completing a consent form which is faxed to	Head of Healthcare September 2014	

	with ongoing health problems.		the GP surgery the next working day Additionally work is in progress to amend the first night reception health screen template to demonstrate that the newly received prisoner has been asked for consent to obtain their GP record.		
3	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff: a)Have a clear understanding of responsibilities and the need to share all relevant information about risk. b)Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. c)Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.	Accepted	Refresher training is to take place every 2 years in "Introduction to Safer Custody", procedures for identifying prisoners at risk of self-harm, and for managing and supporting them in accordance with the ACCT Management process. This will be provided to all staff including all Reception, Induction & HCC services (Clinical, Substance misuse & Mental Health staff) Full staff briefing before a multi disciplinary audience, will be held quarterly. A notice to staff was issued to support the briefings on the 7th May, to remind staff of the need to share all relevant information about risk. To issue a reminder to ensure all known risk related information warnings and Alerts are considered and remind staff to record known risk factors and update C-NOMIS. A notice to staff will be issued explaining the actions required in terms of opening an ACCT document whenever a prisoner has recently self harmed or expressed suicidal intent.	Governor July 2014 Governor July 2014 Governor July 2014 Governor July 2014	

4	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Bedford has a Medical Emergency Response Code protocol which: a)Provides guidance to staff on efficiently communicating the nature of a medical emergency; b)Ensures staff called to the scene bring the relevant equipment; and c)Ensures there are no delays in calling, directing or discharging ambulances.	Accepted	Governors Order 53/2014 has been issued in line with PSI 03/2012 to provide guidance to staff on efficiently communicating the nature of a medical emergency The new emergency response codes have been discussed at healthcare team meetings to ensure they understand the codes and the corresponding equipment they are required to attend the emergency with. An agenda point has been added on the monthly Safer Custody meeting to discuss and review all emergency incidents.	Governor Monthly	Completed 30 April.2014