PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man while in the custody of HMP Bedford, in December 2011

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

This is a report into the death of a man in December 2011 at HMP Bedford. He was found hanging in his cell by fellow prisoners, the morning after his arrival. I offer condolences to his family and friends for their loss.

The investigation was carried out by one of my investigators. Staff at Bedford co-operated fully with this investigation. NHS Bedfordshire appointed the clinical reviewer to review the man's clinical care.

The clinical review found that the man did not receive an appropriate standard of care at Bedford. The man was placed on an alcohol detoxification programme by the prison doctor and should have been accommodated in a designated detoxification wing with appropriate support. That did not happen. Medical record keeping was also deficient.

During his short time at Bedford, the man denied any thoughts of suicide and self-harm and staff said that he gave then no reason for concern. However, his history indicated a number of significant risk factors known to increase the likelihood of suicide and self harm in prisons, but the man was not being monitored under suicide prevention measures when he died.

Assessing the risk a prisoner poses to himself is not an exact science and involves balancing the prisoner's demeanour and behaviour against known risk factors. However, it is a concern that staff seem to have relied too much on subjective assessments of his personal presentation. On the evidence available, greater weight should have been given to the man's known static risk factors including his history of self-harm, his mental health problems and the circumstances of his offence, particularly at that time of the year. In addition, the man was withdrawing from alcohol which Prison Service guidance emphasises is a particularly risky time.

Lessons need to be learned from the man's sad case and, accordingly, recommendations are made about the need for proper assessment of known risk factors, as well for improvement of the management of prisoners withdrawing from alcohol and of medical record keeping.

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.

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

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SUMMARY

1. The man was born in July was divorced and had three children. He had previously served custodial sentences, the most recent ended when he was released from HMP Woodhill in December 2011.

2. Shortly afterwards the man appeared at West Hertfordshire Magistrates court, and was sentenced to 29 Weeks in custody for a breach of a non-molestation order and sent to HMP Bedford. The man told court staff that he had no thoughts of self-harm at the time, but it was included on his escort record (PER) that he had self-harmed in custody in 2008 and 2009.

3. On arrival at the prison, the man told healthcare staff that this was not his first time in custody, he suffered from schizophrenia and drank alcohol excessively. He denied any thoughts of self harm or suicide and, although he had a number of known risk factors, was not subject to suicide and self harm monitoring. The doctor made an appropriate referral to the prison's mental health team. The man began an alcohol detoxification programme but was located on a standard wing rather than the prison's detoxification unit or in the healthcare centre as would normally be expected.

4. At 9.00am on the day the man died he was found hanging in his cell and emergency medical assistance was called. Staff began cardio pulmonary resuscitation (CPR) until the paramedics arrived and took over his care. After a period of assessment and emergency treatment, at 9.37am the paramedics confirmed that the man had died.

5. There was appropriate initial assessment of the man's physical and mental health and suitable treatment identified. However, the subsequent care that was provided to manage his alcohol detoxification did not follow the standards set out in Bedford's own policy. It is a concern that there was insufficient consideration of his risk of suicide and self harm which took into account all the risk factors involved.

6. We make recommendations about the assessment of known risk factors, the development of a policy for the management and location of prisoners with withdrawal symptoms, and medical record keeping.

THE INVESTIGATION PROCESS

7. This office was informed of the man's death on the day the man died and one of my investigators issued notices on 30 December announcing the investigation to staff and prisoners at Bedford inviting anyone with any information relevant to the investigation to contact him. No one came forward.

8. The investigator visited Bedford on 3 January 2012. He visited the man's cell and obtained copies of relevant documentation. He met the Deputy Governor, and Independent Monitoring Board (IMB) member. My investigator returned to Bedford on 18 and19 January and 8 February to interview 15 members of staff. Written feedback on the progress of the investigation was sent to the Governor on 14 February.

9. NHS Bedfordshire appointed the clinical reviewer to review the man's clinical care. My investigator and the clinical reviewer discussed aspects of the man's treatment during his time at Bedford. The clinical review is annexed to this report.

10. My 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. The investigation report will be sent to the Coroner to assist his enquiries.

11. My investigator liaised with Bedfordshire Police to inform them of the progress of our investigation and to confirm that, following the search of the man's cell, there were no notes or letters found and that the man did not make any telephone calls.

12. Our Senior Family Liaison officer contacted the man's mother, as his listed next of kin, to explain the purpose of the investigation and invite her to ask any questions or raise any issues for consideration. His family raised no issues at that stage.

HMP BEDFORD

13. HMP Bedford is a local prison which holds up to 506 men. The prison accepts sentenced and remand prisoners from Luton Crown Court, Bedford and Luton Magistrates' Courts, as well as sentenced prisoners sent there because of overcrowding in London prisons.

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

15. Since this office began investigating deaths in custody in April 2004, there have been 14 deaths at Bedford, including that of the man. Recommendations made following these investigations are not repeated in this report. There were three other apparent self inflicted deaths at Bedford in 2011 but there were no significant similarities between those deaths and the man's death.

HM Chief Inspector of Prisons (HMCIP)

16. HMCIP last inspected Bedford in May 2011. The inspection report noted that first night assessments were carried out by reception staff and that first night staff had only limited contact with newly arrived prisoners on their first night. Inspectors also reported that newly arrived prisoners were not given the opportunity to make a telephone call on their first night as staff made calls on their behalf. Inspectors were also concerned that there was no dedicated member of staff on the First Night Centre (FNC) during the night.

17. The report stated that the implementation of the Integrated Drug Treatment System (ITDS) had been successfully managed and general improvements had been made to provide a good quality of service. IDTS awareness training had been delivered to substance use, health services and uniformed staff during the introduction of the service.

Independent Monitoring Board (IMB)

18. Each prison in England and Wales has an IMB, made up of unpaid volunteers from the local community. The IMB is responsible for monitoring day-to-day life in the prison, and to ensure that proper standards of care and decency are maintained. The most recent annual report 2010-2011, published by the IMB at Bedford, made the following comments about reception and the first night centre.

> "Although the size of the Reception area is inadequate, a recent change of layout has improved the speed, efficiency, and to some extent the privacy, of the reception process. All prisoners are seen by Healthcare on their arrival and vulnerable prisoners are separated at all times.
>
> "The First Night Centre is a subterranean space that the Board considers to be an unsuitable location for the most vulnerable group of prisoners, new to prison. Efforts have been made to brighten the unit up but it remains unsatisfactory."

19. The IMB reported that healthcare staff turnover had reduced and as a result the healthcare team had provided a better service. The IMB said that the IDTS service operated well.

Reception

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

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

Suicide and self-harm monitoring

22. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs) and Prison Service Instructions (PSIs). At the time of the man's death PSO 2700 – 'Suicide prevention and self-harm management' detailed prison procedures for looking after prisoners at risk of suicide or self harm (Now replaced by PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others - Safer Custody' with effect from 1 April 2012). Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm.

23. Any member of staff can start the ACCT process, by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training. Once placed on an ACCT, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

Integrated Drug Treatment System (IDTS)

24. IDTS is a Prison Service scheme which aims to increase the amount and quality of substance misuse treatment available to prisoners, with particular emphasis on the early days in custody. It is intended to improve the links between clinical and non-clinical services and reinforce continuity of care from the community into prison, between prisons, and on release into the community. As part of the IDTS programme, prisoners can be prescribed substitute substances to aid detoxification along with integrated clinical and psychological treatments in prison and the community.

KEY EVENTS

25. The man lived in the London area before entering custody. The man was unemployed and had previously served a number of custodial sentences, the last of which ended on 16 December 2011.

26. On 23 December, the man appeared at West Hertfordshire Magistrates Court for breach of a non-molestation order. While at the court the PER document was completed by Serco court custody officers. An officer recorded that the man had previously self harmed when in custody in 2008 and 2009 and asked him if he had any thoughts of self harm. He told the officer that he felt fine and the officer noted that he had an upbeat demeanour.

27. At the magistrates court the man was checked frequently between 10.00am and 2.25pm and no concerns or issues were raised. Following his court appearance the man was sentenced to 29 weeks in custody and was sent to HMP Bedford and left the court at 2.27pm.

28. The man arrived at Bedford at 4.00pm and was seen in reception by Senior Officer (SO) A. At interview, the SO said that he did an initial search of the man and confirmed with him that he had been in custody before. The SO saw the entries made on the PER form about the man's previous self harm and questioned the man who said he had no thoughts of harming himself. The SO recalled that the man's only concern was that he wanted to have a cigarette and he knew he could smoke once he was in his cell.

29. Officer A took down the man's personal details. He named his mother as his next of kin. The officer also recorded that the man said that he needed help with reading and writing. The man said that he had been in prison before, was a smoker and was happy to share a cell. He also said that he had no thoughts of harming himself or taking his own life and did not want the prison to contact anyone on his behalf.

30. The man then saw Nurse A for a reception health screen at 4.29pm. He told the nurse that he usually drank up to four bottles of vodka a day but had not had a drink for three days. He said that he suffered from schizophrenia for which he was prescribed olanzepine and had been admitted to St Clement's Psychiatric Hospital in the past. He told the nurse that he had no thoughts of harming himself or suicide. The nurse recorded that the man's community doctor was at Stevenage Health Centre and he was to be seen by the prison doctor.

31. At 5.06pm the prison doctor, Dr A saw the man who told the doctor about the amount of alcohol he usually consumed and that he had suffered from seizures in the past. As a result of this the doctor prescribed chlordiazepoxide (for alcohol detoxification) at 40mg for the first night, followed by four days of this medication in decreasing daily amounts from 40 mg to 10mg. In addition, the doctor also prescribed thiamine (for alcohol detoxification) and Vitamin B (for alcohol detoxification). The doctor also recorded that the man had been prescribed olanzepine in the past and this was to be confirmed with his

community doctor. Due to the man's mental health history the doctor referred him to be seen by a member of the mental health team.

32. When interviewed by the investigator Dr A said that he had briefly read the man's computerised medical record which detailed that he had been on alcohol detoxification programmes in the past and had a mental health history. The doctor went on explain that it was his expectation that, as he had placed the man on a detoxification programme, the man should have been allocated to a cell on the detoxification wing, D wing, so that he could be monitored by the nursing staff during the night.

33. Nurse A confirmed at interview that prisoners placed on a detoxification programme are allocated to D wing unless there are no available places at the time.

34. At 5.14pm, Nurse B gave the man his first dose of chlordiapoxide as prescribed by Dr A. At interview, the nurse said that she was not fully aware of the policies and procedures for dealing with prisoners on detoxification programmes. The nurse also explained that she wrote the notes of her interventions with prisoners in a notebook and transferred them onto the computerised system later. However, on the 23 December she left the prison and was not on duty again until 29 December and had not updated the records.

35. Officer B 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 also completed the man's Induction Sheet. The man told the officer he had no concerns about being in prison and had no thoughts of self harm or suicide. Nurse A also endorsed the assessment to confirm that there were no concerns.

36. SO A was the officer in charge of reception and the man was allocated to cell 1 on level one, on the First Night Centre (FNC). This cell was a double cell which the man occupied by himself and it was immediately opposite the wing office. The investigator checked the prison records for the number of spaces available on the detoxification unit on the 23 December and found that there were five spaces. There is no record of the reason why the man was not allocated to the detoxification unit (D wing).

37. Officer C recorded in the man's prison computer record at 7.11pm that he had been allocated to his cell on the FNC, that the induction programme had been explained to him and that there were no concerns of self harm or suicide.

38. Operational Support Grade (OSG) conducted the night roll checks (a physical check of all cells to observe, via the observation hatch in the cell door, that each prisoner was present and there are no issues or concerns that need to be raised) at approximately 9.00pm on 23 December and 6.30am the next morning and there were no concerns. At interview, the OSG said that on checking the man's cell everything was in order as he recalled that at 9.00pm the man was sitting on his bed and at 6.30am he was under the bed covers and appeared asleep.

39. At approximately 7.15am on 24 December, Christmas Eve, Officer D conducted the handover roll check from night staff to the day staff. On reaching the man's cell, the officer saw him sitting on the bed and he was dressed. The officer told the investigator that he said good morning to the man who acknowledged him with a shake of the head.

40. In the mornings on the First Night Centre, a wing orderly (a trusted prisoner who is employed to do duties on the wing) goes to each prisoner's cell to collect their menu request for lunch and evening meal for that day. Wing orderly A and wing orderly B, came to the man's cell at approximately 9.00am and opened the observation hatch to ask for the menu list but saw him hanging from the cell window and immediately alerted Officer E who was in the wing office.

41. Officer E told wing orderly A to press the alarm bell to summon urgent assistance while the officer ran straight to the man's cell, went in and supported his body. Several staff immediately followed including SO B, Officer F and Officer G. SO C used the radio to request an emergency ambulance. Officer F cut the ligature, made from torn bedding, that was around the man's neck and the officers placed the man on the floor and immediately started cardiopulmonary resuscitation (CPR - a mix of rescue breaths and chest compressions performed in an effort to circulate oxygen around the body).

42. The officers were quickly joined by healthcare staff who 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). The defibrilaltor advised that there was no shockable rhythm.

43. The staff continued with CPR until the paramedics arrived at 9.12am and took over the man's care. After a period of treatment and assessment at 9.37 am the paramedics pronounced that the man had died.

44. Later that morning a hot debrief, chaired by the Deputy Governor A and Governor B, was held with staff involved in the incident at which support was made available to all staff (Hot debriefs should be led by a senior member of prison staff and are intended to offer staff involved the opportunity to discuss the incident. The purpose is to offer reassurance, information and support.). Prisoners were offered support from the chaplaincy, IMB and the Samaritans and those on ACCT were checked. At their request, wing orderly A and B were subsequently given other duties in the prison.

45. SO D was appointed as the prison's family liaison officer by Governor B and left in the early afternoon, accompanied by the reverend, to go to break the news to the man's mother. When they arrived at approximately 2.30pm, the man's mother was not at home but there were other relatives present who contacted her to return. The SO and the Governor waited until the man's mother arrived, when they broke the news of her son's death and offered condolences and support, including the offer of financial assistance towards the cost of funeral

expenses. The man's mother said she would let his children know of their father's death.

46. In the days that followed, SO D maintained regular contact with the man's family and the prison again offered financial support towards the cost of funeral expenses in line with Prison Service guidance.

ISSUES

Assessment of risk

47. As the man was at Bedford only a very short time before his death, there were few entries made in his prison record. At the time of his reception, SO A was aware of the man's history of self harm from the PER. When questioned about this, the man said he had no thoughts of self harm or suicide. Officer B carried out both the CSRA and first night assessment. Elements of the latter assessment include issues of self harm or suicide. Again, the man denied any current thoughts of self harm or suicide. All those who met him described him as seeming calm and the man said he was "fine".

48. The man's mental state and risk of self harm or suicide were assessed twice by healthcare staff on his arrival at the prison – once by Nurse A and once by Dr A. Both were aware of his history but neither thought that he showed any signs of vulnerability. But because of his mental health history the doctor referred him to be seen by a member of the mental health team.

49. The clinical reviewer, made the following comments concerning the man's mental heath:

> "In the community the man had extensive involvement with mental health services, including several admissions to a mental health unit. During his spells in prison he had received care from the primary and secondary mental health services. However there remained some uncertainty about his diagnosis in relation to his mental health, although he told healthcare staff at HMP Bedford he suffered from schizophrenia."

50. We have considered whether staff should have opened an ACCT plan on the man's arrival. Previous reports have been critical when prison staff place too much reliance on what the prisoner tells them and ignore the weight of other risk related information. The PER that accompanied him to prison made reference to his history of self harm behaviour. He also had a history of alcohol misuse and mental health problems, both of which increase the risk of suicide. In addition, he had been convicted of an offence against a family member just two days before Christmas and placed on an alcohol detoxification programme. All of these factors are significant indicators of risk of self harm and suicide. Set against these, as outlined in the report, he consistently denied any thoughts of self harm or suicide when asked directly about this. His behaviour and demeanour gave no indications otherwise.

51. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, it is concerning that staff relied so heavily on the man's presentation, when he had a large number of known risk factors when he arrived at Bedford. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence

used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to his presentation.

The governor should implement robust first night procedures which ensure that all the known risk factors of a newly arrived prisoner are fully considered.

Alcohol Detoxification and Integrated Drug Treatment System (IDTS)

52. The clinical reviewer has carefully considered the care given to the man for his alcohol detoxification and made the following comments:

> "The objective of IDTS is to expand the quantity and quality of drug treatments within prisons by increasing the range of treatment options available. Most notably this is achieved by substitute prescribing but also by integrating clinical and psychological treatments in prison and prison and community treatments in order to prevent fatalities either on reception into custody or on release into the community.
>
> "On 23rd December 2011 there was cell space on D wing and it remains unclear why the man was subsequently accommodated onto C wing from reception."

53. Prison Service Instruction (PSI) 45/2010 'Integrated Drug Treatment System' details the mandatory requirements for prisons to support and facilitate the delivery of IDTS. In respect of the location of prisoners placed on detoxification programmes the PSI states:

> "Local prisons must be able to offer immediate access to clinical services as described in the Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006) whenever there is a clinical need. This means that all drug or alcohol dependent prisoners arriving in Reception must always be offered immediate admission to a stabilisation unit."

54. In the man's case, when he arrived at Bedford the investigation has established that there were five available spaces on the detoxification unit. It was Dr A's understanding that, having placed the man on an alcohol detoxification programme he should have been allocated to the detoxification wing for ongoing assessment. Indeed Bedford's "Alcohol Detoxification policy" states:

> "In accordance with DH Guidelines (1999) detoxification for concurrent 'significant polydrug' use or 'benzodiazepine use' should be undertaken in the IDTS stabilisation wing. All clients undergoing alcohol detoxification must therefore remain on the IDTS stabilisation wing until their alcohol detoxification is complete. (If a patient refuses location on the stabilisation unit treatment cannot be refused, but he must sign a disclaimer which should detail the risks of not being properly observed and supported)."

55. We have been unable to establish why the man was allocated to the FNC rather than the detoxification wing. There is no record of the man refusing to be allocated to a cell on the detoxification wing nor a signed disclaimer. We consider the failure to accommodate the man in a supported location in the detoxification wing was a serious omission by staff at Bedford.

56. PSI 45/2010 also specifies the mandatory requirement for a local policy on how to manage prisoners known to be suffering from withdrawal as follows:

> "Establishments must have a policy, agreed between the Residential Manager, the Substance Misuse Service Manager and Healthcare Manager, for how prisoners known to be suffering from withdrawal, (including alcohol withdrawal), should be managed in order to reduce the associated risk of suicide and /or self harm. The policy must cover all units where prisoners known to be withdrawing are located, both dedicated units and ordinary wings."

57. At the time of the investigation there was no local policy in place to meet the requirements of PSI 45/2010.

58. Specifically concerning the assessment of the man's alcohol withdrawal, the clinical reviewer, in her report, states:

> "There was no assessment of his alcohol withdrawal state made in reception by either the reception nurse or the IDTS nurse. This does not comply with IDTS policy which states that
>
> "An alcohol dependency scale must be completed on all patients who are to be clinically assessed with possible alcohol dependency problems"
>
> "The IDTS nurse we spoke to describes undertaking assessments as part of the duties in reception, however, nothing is recorded in the clinical record to suggest this happened when she saw the man on 23 December."

59. The clinical reviewer and the investigator were very concerned about this lack of understanding of the role of the IDTS nurse and raised their concerns with the Head of Healthcare.

60. There were no follow up checks of the man after he had been seen by Dr A. Bedford's "Alcohol Detoxification policy" details the routine nursing observations for a prisoner placed on alcohol detoxification as: "Temperature, pulse and blood pressure to be recorded twice daily for the first 5 days of detoxification" and clinical monitoring requirements of: "six hourly throughout the detoxification".

61. The man saw Nurse B at 5.14pm on 23 December and this was the last clinical intervention with him until the nurses responded to the emergency incident at 9.00am the next morning. We make the following recommendation:

The Governor and Head of Healthcare should produce a local policy for managing prisoners withdrawing from drugs and alcohol to meet the requirements specified in PSI 45/2010 'Integrated Drug Treatment System' and ensure that all relevant staff understand it and are trained and competent in their roles.

Medical record keeping

62. The importance of maintaining accurate and contemporaneous medical records is a frequent issue in our reports. In her report, the clinical reviewer makes the following comments:

> "The IDTS nurse who saw the man in reception on 23rd December did not make an entry in his clinical record. She told the review she had a notebook she recorded her observations in. Any meaningful clinical contact should be recorded in line with Nursing and Midwifery Council professional standards for record keeping.
>
> "A member of the healthcare staff reported they did not always have sufficient time to complete entries in clinical records due to the time pressures and constraints of evening receptions. This did result in clinical information not being recorded."

63. Maintaining accurate and contemporaneous medical records is an essential part of a patient's ongoing care, and it is evident that procedures at Bedford did not meet the required professional standards. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions in clinical records, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Emergency response

64. The staff response to the man's need for assistance was swift and professional. Staff correctly commenced CPR and an automatic external defibrillator was used. As the man did not have any cardiac rhythm, there were no instructions to shock him during the CPR.

65. Staff continued with CPR until the paramedics arrived and took over the man's care. Sadly following their assessment and treatment, they confirmed that he had died.

66. Even though the man could not be revived, we believe that the response by staff at Bedford helped to ensure that everything possible was done for him.

CONCLUSION

67. The man was in prison for less than 24 hours before taking his life. He gave no indication to staff that he was thinking of doing so. Staff at the prison acted essentially only on what the man told them. There were, however, other static risk factors which should have been taken into consideration and we therefore judge that there was insufficient consideration and assessment of whether he was a risk to himself.

68. After a mostly satisfactory initial health assessment, the care that was provided did not meet the standards set out both by the Prison Service and in Bedford's own detoxification treatment policy. The man was unsupported at a critical time during detoxification. We agree with the opinion of the clinical reviewer that the standard of health care he received at Bedford did not meet the standard required by the prison's own policy.

69. When the man was found hanging, staff responded swiftly and professionally.

The man's family and their legal representative received a copy of the draft report as part of the consultation process and written representations were provided on behalf of his family, in response to the findings of the investigation. The man's family are still concerned that he was not allocated a place in the detoxification unit at Bedford. However as highlighted in the report the investigation was unable to establish the reason why this occurred however the Ombudsman considers the failure to accommodate the man in a supported location as a serious omission by staff at Bedford.

The man's family also expressed their concern that as a member of the Irish travelling community and a previous prisoner at Bedford, staff should have been aware of his vulnerabilities and they have questioned whether there were any underlying prejudices. This investigation has not discovered any such prejudices towards the man however the investigator did consider if all risks, including history of self harm, alcohol misuse, mental health issues and the offence for which he was convicted were considered by staff as significant indicators of risk of self harm and suicide. The man consistently denied any thoughts of self harm, when asked directly, and did not display any behaviour to suggest he was suicidal. However the PPO has recommended that more importance should be applied to known risk factors and should not just rely on a prisoner's presentation.

We also note the man's family's further concern in relation to the time of his death and the timings provided by staff. However the nurses who responded to the emergency situation correctly commenced CPR and acted appropriately. Certification of death was made by the attending paramedics, as the nursing staff at the prison are not qualified to make that decision. We are grateful to the man's family for the time they have taken to consider the report and for their comments.

RECOMMENDATIONS

1. The Governor should implement robust first night procedures which ensure that all the known risk factors of a newly arrived prisoner are fully considered.

   Accepted
   HMP Bedford provides a first night procedures in line with PSI 74/2011 Early Days in Custody.

   A notice will be issued to all staff working in reception advising the Reception Manager will ensure that once they have checked the PER for identified risks at the front desk for a new prisoner, the PER is then passed onto the Reception Nurse, so that they are able to refer to the PER when they carry out the First Night Screening with the new prisoner. Any Suicide & Self Harm Warning Forms received from the PECS contractor, will be passed onto the Reception Nurse for consideration.

   When the Reception Officer is completing the First Night Centre Interview form, they refer to the prisoner's PER.

   When the Reception Nurse completes the HCC section of the CSRA, they will identify on the CSRA form that the prisoner is required to be located on D Wing in order to receive the necessary IDTS First Night Prescribing support. The Reception Officer locating prisoners on C Nomis will have this requirement in writing.

2. The Governor and Head of Healthcare should produce a local policy for managing prisoners withdrawing from drugs and alcohol to meet the requirements specified in PSI 45/2010 'Integrated Drug Treatment System' and ensure that all relevant staff understand it and are trained and competent in their roles.

   Accepted
   The local IDTS Policy is currently being reviewed by Head of Drug Strategy to ensure that all mandatory actions of PSI 45/2010 are adhered too.
   The reviewed policy will reflect training needs for both operational and clinical staff; this includes IDTS, reception and First night centre staff.

3. The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions in clinical records, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Accepted
   All healthcare staff are aware of the need to promptly and accurately record information in the clinical records, to ensure continuous and appropriate care. This is re-enforced through the completion of mandatory record keeping and information governance training.

The facilities for Healthcare screening of prisoners in reception are currently being upgraded to enable both the GMS and IDTS nurses to have access to System One computers which will result in an improvement in the documentation process.