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 at HMP The Mount in December 2014

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 the man who was found hanged in his cell at HMP The Mount in December 2014. The man was 23 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. The clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with the investigation.

The man was remanded to HMP Bedford on 30 October 2014 and sentenced to six years imprisonment in November. On 12 December, the man was transferred to HMP The Mount. He was Polish and spoke little English. During his time at The Mount, prison staff had little interaction with the man and never used a professional interpreting service, but relied on his cellmate to communicate with him.

I do not consider that reception and healthcare staff at The Mount could have made a fully informed decision about The man's risk of suicide and self-harm or his healthcare needs, without using an interpretation service. Staff relied too heavily on another prisoner interpreting for him, including for confidential matters. I am also concerned that there is no record of any meaningful staff interaction with the man during his time in prison, either at Bedford or the Mount. Finally, although it was too late to save the man, there were deficiencies in the emergency response which The Mount needs to put right.

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 **July 2015**

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SUMMARY

1. The man was remanded to HMP Bedford on 30 October 2014, and was convicted of aggravated burglary on 18 November. He was moved to HMP The Mount on 12 December. The man was Polish and spoke and understood very little English. Despite this, no one at The Mount used a telephone interpreting service to communicate with him.

2. There is no written evidence in the prison records of any staff interaction with the man for the ten days he spent at The Mount. The man's personal officer and the foreign national officer said they spoke to him using his cellmate as an interpreter. However, there is no record of these conversations.

3. At 3.00am on 22 December, the man's cellmate woke and found that the man had hanged himself using a torn blanket attached to the curtain rail around the cell toilet area. The man's cellmate raised the alarm. It took staff more than a minute to go into the cell, and no one radioed an emergency medical code, which caused a delay in calling an ambulance. Officers and healthcare staff tried to resuscitate the man. Shortly after paramedics arrived, they pronounced him dead.

4. We are concerned that staff at The Mount did not use a telephone interpreting service to speak to the man, but relied on another prisoner for confidential and potentially sensitive discussions. We cannot therefore be certain that staff properly assessed his risk of suicide and self-harm. There was little evidence of supportive interaction with him after he arrived at the prison. There were also weaknesses in the emergency response. We make three recommendations.

THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at The Mount informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

6. The investigator obtained all relevant documents relating to The man's time in prison. He interviewed 12 members of staff at The Mount and spoke to four prisoners.

7. NHS England appointed Dr Frank Voeten to review the clinical care the man received at The Mount.

8. We informed HM Coroner for Hertfordshire of the investigation and we have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted the man's mother to inform her of the investigation and to invite her to identify any relevant issues that she wanted the investigation to consider. The man's mother did not have any specific issues for the investigation to consider.

HMP THE MOUNT

10. HMP The Mount is a medium security prison, which holds 770 convicted adult men.

11. The healthcare provider is Hertfordshire Community Services Trust and GP services are commissioned from Pathfinder Practice, South West Hertfordshire Health Centre.

Her Majesty's Inspectorate of Prisons

12. The report of the most recent inspection of The Mount, in April 2015, has not yet been published. At the time of the previous inspection, in October 2011, inspectors reported that prisoners were sometimes used inappropriately as interpreters for confidential matters and that the telephone interpreting service had only been used four times, in the nine months before the inspection. They repeated a recommendation from the previous inspection in 2009, that interpreting services should be used in all cases where confidentiality was required. We understand that at the recent inspection in April 2015, inspectors were still concerned that prison staff did not use interpretation services to communicate with prisoners who did not speak and understand English.

Previous deaths at The Mount

13. The man's death is the third self-inflicted death at the prison since 2007. In our report into the death of a man at the prison in May 2013, we were critical of the emergency response and we found similar failings in this investigation.

KEY EVENTS

14. The man was a citizen of Poland. It is unclear how long he had been living in the United Kingdom, but he spoke very little English. In June 2014, the man was cautioned for the possession of a controlled drug and, in October, was given a community sentence for burglary.

15. On 29 October, the man was arrested for aggravated burglary. Police records noted that he could not read or write English. On 30 October, the court refused him bail and he was remanded to HMP Bedford.

16. Police and court custody staff completed the man's Person Escort Record (PER), a document that accompanies all prisoners when they move between police stations, courts and prisons. They wrote that he had been charged with burglary and that they had used a Polish interpreter to speak to the man, who had not identified any concerns about his welfare.

17. At Bedford, a nurse completed an initial health screen, using a telephone interpreting service. The man told the nurse that he had not been in prison before and he had no thoughts of suicide or self-harm. The nurse recorded no concerns about the man's physical or mental health. The nurse did not consider that he was at risk of suicide or self-harm and noted that no immediate action was required.

18. The officer noted in the man's record that he had explained the prison's induction process and safer custody policy to the man. He also noted that the man declined the offer of a telephone call to a family member or friend. There is no record that he used an interpreter.

19. On 31 October, the nurse completed the man's secondary health screen. The nurse used the telephone interpretation service. She recorded that the man denied any thoughts of self-harm and noted no other health concerns.

20. Little information is recorded about the man's time at Bedford. There were no meaningful entries in his case history, and no evidence that a personal officer spoke to him.

21. On 18 November, at Luton Crown Court, the man pleaded guilty to aggravated burglary. He was sentenced to six years.

HMP The Mount

22. On 12 December, the man moved to The Mount. Officers at Bedford recorded no concerns on his escort record. The man went to the prison's induction unit.

23. The nurse completed an initial health screen at 3.30pm. She used another Polish prisoner, as an interpreter. The prisoner had transferred from Bedford at the same time as the man, but did not know him. The

nurse told the investigator that she used an online translation tool to establish that the man was happy for the prisoner to interpret for him. She explained that there was no telephone in the room where she carried out healthcare assessments, so she could not use the telephone interpretation service. The man told the nurse he had no thoughts of self-harm, or any physical or mental health issues. The nurse noted that the man appeared calm and well.

24. An induction officer noted in his case history that the man was not at risk of self-harm, had no mental health issues and had declined to speak to the unit's supervising officer. The officer said he could not remember speaking to the man personally, and thought he might have just written up what another member of staff had told him.

25. An induction orderly, (a prisoner who assists officers to deliver the induction process), told the man that his prison induction would take place the next day at 10.30am. The man signed a number of induction compacts, but there is no evidence that the man understood the contents. A member of staff did not sign them. The investigator could not establish who gave the man the compacts, but it is appears to have been an Insider, (a prisoner who gives advice to prisoners in the first night centre). All of the information was in English.

26. At 10.30am on 13 December, the induction orderly gave an induction talk for new prisoners. The induction orderly said he went through the induction process slowly so that the prisoner, who was also there, could interpret for the man. The induction orderly said the man and the prisoner stayed behind after the induction, and he checked with the prisoner, that the man had understood. The man signed copies of The Mount's information for prisoners and employment policy, both in English, to say that he agreed to the terms and conditions laid out in them. (The Mount now has copies of these policies in Polish.)

27. A Polish prisoner in the induction unit, told the investigator he had a brief conversation with the man, but he did not speak very much, even though they were talking in Polish. The polish prisoner said he thought that the man might have been depressed, or he might just have been sad about being in prison.

28. On 15 December, the man was moved, with the prisoner, to Ellis Wing. One of the Insiders in the induction unit told the Officer that the two prisoners were happy to share a cell together. The officer said he asked the prisoner to interpret for him to confirm that the man was willing to share a cell and the man agreed. The officer told the investigator he later asked the man, as best he could without speaking Polish, if he understood what was happening and if he was happy to move. The man again said he was. After taking the two prisoners to Ellis Wing, Officer Copcutt had no further contact with the man.

29. The man had a personal officer. Personal officers should get to know the prisoners they are responsible for, act as a first point of contact for any problems and help with resettlement issues. The personal officer told the investigator he spoke with the man twice in December, but could not recall exactly when. The personal officer said that he first spoke to the man and the prisoner shortly after they arrived on Ellis Wing, and they had asked for a television and kettle for the cell. The second time, several days later, was when he was unlocking his cell and greeted him. The personal officer said the man did not raise any issues at the time. The personal officer told the investigator that the man was quiet, polite, and spent a lot of time in his cell. The officer said that he did not have time to record his interactions with the man in his prison records.

30. The prison's foreign national officer told the investigator that he did not speak to the man until 17 December. The officer interviewed the man and the prisoner for 15 minutes. The foreign national officer said the two prisoners seemed to be friends. The officer said he asked the prisoner to interpret for him. The foreign national officer said that he thought the man's body language indicated that he was happy and understood everything that was said to him. The foreign national officer described the man as a cheerful chap. He said he did not use the interpretation service as he said it would have been time consuming, and he made no note of the conversation in the man's prison records.

31. The prisoner told the investigator that the man did not speak English, was very quiet and did not complain about anything. He said he helped the man to communicate with prison staff by interpreting for him. The prisoner said the man never talked about suicide or harming himself and he did not think he was being bullied.

32. On 17 December, the man asked for his sister's telephone number to be added to his list of telephone contacts. After his death, it was established that this was the prisoner's girlfriend's number. The prisoner called this number once, on 19 December. He did not mention the man in the call. (It is possible that the man, who had not used his prison phone account, had allowed the prisoner to use it to call his girlfriend, so it did not his affect his own telephone credit for calls home.)

33. Nothing further is documented about the man during his time at The Mount. The investigator could not identify any officers who knew the man or had more than passing contact with him.

34. The prisoner who lived in the cell next to the man, told the investigator that The man did not mix with other prisoners on the wing and would only say hello or goodbye. The prisoner said that the man spent a lot of time in bed. .

35. On 21 December, the prisoner said the man seemed fine. He said that officers locked him and the man in their cell at about 5.00pm, and they had spent the evening watching television. The prisoner said he went to

sleep at around midnight and thought that the man was still awake at the time.

22 December 2014

36. The prisoner said that, at around 3.00am on 22 December, he was watching television in his cell, when he heard a 'throaty noise' coming from the man's cell. He said about 20 minutes later he heard a female officer expressing shock.

37. The prisoner said he woke in the early hours to use the toilet. He told the investigator he found the man hanging from the privacy curtain rail, wrapped in a blanket. (The prisoner and the man had been using the blanket as a curtain around the toilet.)

38. At 3.15am, the prisoner pressed the cell bell to call staff. A minute later an officer arrived. She looked through the door observation panel and saw the man hanging with the blanket wrapped around him. The officer went to get another officer who was in the wing office a short distance away. The officer did not radio an emergency medical code blue. (Code blue is an emergency call sign, which signifies a life-threatening medical emergency, such as when a person is found hanging, unconscious or not breathing.)

39. Two officers went back to the cell 30 seconds later, followed by a custodial manager. The custodial manager looked into the cell and saw the man hanging. The custodial manager walked away from the cell to radio for help, but did not call a code blue. A support officer in the prison's control room, relayed the call to other officers. Two officers remained at the cell door.

40. The custodial manager returned to the cell and looked in again for ten seconds, then stood back for another 20 seconds. At 3.17am, over a minute after first arriving at the cell and two minutes after the prisoner first rang the cell bell, the custodial manager unlocked the cell door and went in, followed by the two officers. The custodial manager supported the man's weight, while an officer cut the ligature, which was made of a thin strip of torn blanket and placed the man on the cell floor. Two other officers then arrived at the cell.

41. The custodial manager and one officer checked for signs of life, but could find none. Two officers started cardiopulmonary resuscitation and the custodial manager radioed for an ambulance. The control room called an ambulance at 3.18am. The custodial manager brought a defibrillator from the wing office. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.) At 3.21am, the prisoner left the cell and two other officers looked after him. Another officer took over cardiopulmonary resuscitation from the officer. The officers attached the defibrillator, but it did not find a shockable heart rhythm. Two officers, who were both first aid trained, continued the

resuscitation effort until paramedics arrived at 3.35am. Paramedics continued emergency treatment, but pronounced the man dead at 4.00am.

42. After the man's death, staff submitted several intelligence reports, because some prisoners had alleged that the man had either been bullied or sexually assaulted. The investigator interviewed officers and prisoners about the allegations, but could find no evidence to support the claims, which appeared to be based on rumours and hearsay among prisoners after the event, many of whom had been on other wings and had not had any contact with the man. The prison did not investigate the allegations.

Family Liaison

43. The man had not given any details of his next of kin and had not made any phone calls, sent any letters or received any visits, while he was in prison. The prison's family liaison officer, sought help from the Polish Consulate to identify the man's family in Poland and inform them of his death. Polish police told the man's mother the sad news the next day. She had not known that her son was in prison. In line with Prison Service guidance, The Mount paid for the man's body to be repatriated to Poland and contributed to his funeral expenses.

Support for staff and prisoners

44. At 7.00am, managers debriefed the staff involved in the emergency response. The staff said they found it helpful and that the prison's care and welfare team had given them good support.

45. The custodial manager asked other officers to review prisoners identified as at risk of suicide and self-harm, in case they had been affected by the news of the man's death. The prisoner had been very shocked and said that staff had supported him well.

Post-mortem report

46. A post-mortem examination concluded that the man's death was caused by hanging. Toxicology tests found that there were no drugs or alcohol in his blood when he died.

ISSUES

Communication with prisoners who speak little or no English

47. Prison Service Instruction (PSI) 64/2011 about safer custody states:

> "All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and / or during the risk management process."

48. It was evident that the man spoke and understood very little English. It was noted on his police record and his PER that an interpreter had been used.

49. The Mount's foreign national policy requires staff to use a telephone interpreting service to communicate with prisoners who cannot speak English. Staff at the prison were aware of the service, but said they relied on other prisoners to interpret for them. Neither the nurse who carried out the initial health screen, nor officers in reception and the first night centre used the interpreting service.

50. We do not consider that the man would have been able to understand staff sufficiently for them to have reliably established his immediate needs, risk of suicide and self-harm, or health issues, without the use of a qualified interpreter. Using the telephone interpreting service would have protected the man's privacy and allowed staff to be more confident about establishing whether he had any personal concerns or worries that he might have been unwilling to disclose in front of another prisoner, especially someone he did not know. It might have helped them identify any risk of suicide or self-harm. Officers would also have been able to establish if he had any concerns about sharing a cell with the prisoner.

51. The clinical reviewer commented that the nurse would have been unable to make a reliable assessment of the man's health by using another prisoner as an interpreter. Even if the nurse had wanted to use the telephone interpreting service, this was not available in the room used for health screens. Many prisoners would be inhibited from disclosing sensitive and personal information about their health or other matters that might be distressing them, in front of another prisoner. This arrangement did not adequately protect the man's right to medical confidentially.

52. The prison told the investigator that staff had used the telephone interpreting service only 13 times in the previous year. This reinforces the Inspectorate's concerns that the telephone interpreting service was not used by staff sufficiently to support prisoners who did not speak English.

53. At the time of the man's death, the prison's information for prisoners and employment policy were not translated into Polish. We understand that these documents have now been translated into Polish and other relevant

languages.

54. We recognise that in many circumstances it is appropriate and pragmatic to use other prisoners to interpret day-to-day matters, including some aspects of induction. However, prisoners must be confident that they have the freedom to communicate with staff in a safe environment and not be reliant on other prisoners to speak on their behalf. It would be helpful for the prison to inform prisoners of the telephone interpreting service, so that they can request its use, if they are feeling vulnerable. Staff should also be reminded of the prison's own policy, that the telephone interpreting service is the most reliable way to have confidential or sensitive conversations with prisoners who do not speak or understand English well. We make the following recommendation:

The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

Contact with staff

55. When the man arrived at The Mount, he was assessed in reception, and no one identified him as at risk of suicide and self-harm. (As noted, we are concerned that the lack of professional interpretation made this difficult) After that, there is little evidence of contact with prison staff. Officers appeared to have relied on Insiders for most first night procedures, including signing compacts, which are usually the responsibility of prison officers. Records show, in line with standard arrangement at The Mount, that the man was offered an interview with the supervising officer in the induction unit on his first night, but declined. (Although the officer who recorded this, believed it was information from someone else.) He attended induction sessions, which the prisoner interpreted for him. The man moved to Ellis Wing, three days after he arrived at the prison.

56. The man's personal officer told the investigator he recalled speaking to him twice during his time at The Mount. The first time was about cell facilities and he thought that the prisoner had interpreted. The second was just a greeting, when he unlocked his cell one morning.

57. The Mount's personal officer scheme is outlined in a policy document dated July 2014. It sets out a number of requirements, including meeting a prisoner to explain the role within seven days, and to update case history notes regularly. There were no personal officer entries in the man's case history notes, and no entries from any other officers to indicate that they had checked on his wellbeing during his short time at the prison. He had no allocated activity and it appears he rarely left his cell.

58. We are concerned about the lack of staff interaction with the man on his first night in the prison and later when he moved to Ellis Wing. In a recently published review of all self-inflicted deaths in prison in 2013/14, we noted that there had been an increase in deaths of prisoners at an early stage in a new prison. Most of the prisoners who died had spent less than three months in their final prison. The very early days in prison are often recognised as a high-risk time, but there is also a need to ensure that staff are vigilant for signs of vulnerability in the weeks that follow, and after a prison move. This requires appropriate interaction with prisoners. We make the following recommendation:

The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.

Emergency response

59. The Mount's night patrol procedures says that cells can be opened during the night with only one member of staff present if there is an immediate danger to life, the alarm has been raised and the control room has been informed.

60. There was a delay of nearly two minutes between staff finding the man hanging and going into his cell. It was a further minute before anyone asked the control room to call an ambulance. Although it is likely the man had already died, in other circumstances this delay could have been critical.

61. We are concerned that the officer who found the man hanging did not immediately radio an emergency medical code and did not go into the cell. When the custodial manager and other officers arrived at the cell, they also did not act with sufficient urgency and go into the cell immediately to cut the man down. When the custodial manager radioed for help, he also did not use an emergency medical code, but just asked for staff assistance.

62. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, specifies that all Governors must have a Medical Emergency Response Code protocol based on the PSI. The PSI states that staff should use a code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

63. The Mount's most recent Staff Information Notice 41/13, about calling an ambulance in an emergency was issued on 4 April 2013. The notice states that staff should call a code blue for prisoners who are unconscious

or experiencing breathing difficulties but staff did not do this. The notice does not clearly state that the control room should call an ambulance immediately a medical emergency code is received, in line with the national instruction. We do not therefore consider that the local instruction accurately reflects the intended purpose of PSI 03/2013. We make the following recommendation:

The Governor should ensure that local emergency procedures are in line with PSI 03/2013, that staff call the appropriate emergency code immediately in an emergency, enter a cell quickly, and that the control room calls an ambulance as soon as an emergency code is broadcast.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.

2. The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.

3. The Governor should ensure that local emergency procedures are in line with PSI 03/2013, that staff call the appropriate emergency code immediately in an emergency, enter a cell quickly, and that the control room calls an ambulance as soon as an emergency code is broadcast.

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that foreign national prisoners are informed of the availability of the telephone interpreting service and that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor.	Accepted	A notice to prisoners has been displayed on all wings informing prisoners of the availability of the interpretation services. A notice to staff has also been issued and this is currently available on the intranet. Information for staff detailing the use of the translation services and how to use it will be displayed in all wing offices This will be the responsibility of the wing managers under the direction of the CM of Safer Custody The translation service can be contacted using any wing phone. In addition to this, a new phone line and translation service phone has been ordered so this can be used when prisoners do not speak English or understand it well arrive in reception. This will be located in the reception Health screening room. As a temporary measure a conference phone has been made available and	Phone line Deputy Governor Translation Service Phone Head of Operations 31/07/15	

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			translation services are available within the prison obtained from UKBA.		
2	The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs, who they can approach for help and who will make regular checks on their wellbeing, backed up by good quality entries in their case notes.	Accepted	A personal officer scheme is already in place and staff are expected to make a weekly entry on PNomis. This will be management checked by the Wing manager on a monthly basis and challenged by the wing CM's if not adhered to. The Foreign National Officer will be tasked with regularly meeting those prisoners who cannot speak English over the first month. They will be seen at the earliest opportunity following reception. The prisoner's personal officer and wing staff will be made aware of any specific needs and will be encouraged to use the translation services if this is appropriate. These prisoners will be discussed at the monthly Safer custody meetings but the main support after the first month will be through the personal officer scheme.	Foreign Nationals Officer 31/07/15	

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
3	The Governor should ensure that local emergency procedures are in line with PSI 03/2013, that staff call the appropriate emergency code immediately in an emergency, enter a cell quickly, and that the control room calls an ambulance as soon as an emergency code is broadcast.	Accepted	Local instructions have been reviewed and amended to reflect that an ambulance should be called by the control room after a medical emergency code has been received. Staff have been reminded of the procedures by way of notices being displayed on the wing. Staff have also been issued a card to explain what a code blue and code red is. Ambulances are now called immediately by Communications on receipt of either code.	Completed	