Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Coughtrey a prisoner at HMP Bedford on 30 September 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Coughtrey was found hanged in his cell at HMP Bedford on 28 September. He was taken to hospital but died on 30 September. He was 42 years old. I offer my condolences to Mr Coughtrey's family and friends.

Mr Coughtrey had a number of factors which increased his risk of suicide when he arrived at Bedford just five days before his death, including that he was withdrawing from alcohol and he been recalled from a life licence. The staff who assessed him said they were aware of his risks factors, but they did not record their considerations and explain why they had discounted them in favour of his presentation and assurances that he did not intend to harm himself. Shortly before he died, a nurse began Prison Service suicide and self-harm prevention procedures after Mr Coughtrey threatened to cut himself. I am satisfied that the nurse set an appropriate level of observations, as there was little to indicate that Mr Coughtrey was at high and imminent risk of suicide at the time. While there is a need to record risk assessments more carefully, I do not consider that staff at Bedford could have predicted or prevented Mr Coughtrey's actions.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

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Summary

Events

1. On 28 January 2015, Mr Anthony Coughtrey was released on licence after serving 23 years of a life sentence for murder. He was asked to leave two successive placements at rehabilitation hostels in February and March 2015. He went to live first with his sister and then his long-term partner. Mr Coughtrey found employment but struggled with alcohol dependency and drank increasingly heavily.

2. On 23 September, he was charged with assault occasioning actual bodily harm after a fight with his half-brother. He had a fit in police custody and received treatment at hospital for alcohol withdrawal. His licence was revoked and he was sent to HMP Bedford on 24 September 2015. No one at Bedford identified Mr Coughtrey as at risk of suicide when he arrived. A night nurse checked his earlier medical records but did not spot that he had previously tried to hang himself in 2007 and had a history of depression.

3. A prison GP decided that Mr Coughtrey needed the highest level of alcohol detoxification and admitted him to the prison's inpatient unit for monitoring. On 26 September, another GP considered him well enough to move to a wing for prisoners with substance misuse problems, but admitted him to the inpatient unit again on 28 September, after he reported increased withdrawal symptoms.

4. Mr Coughtrey arrived in the inpatient unit at about 3.30pm on 28 September. He pressed his emergency cell bell eight times before 7.41pm, the last four times, because he did not have a television. Just before an officer arrived with a television, shortly before 8.00pm, he told a nurse that he would cut himself with a razor blade. He put the blade under his door when she asked him and said he no longer wanted a television. The nurse began Prison Service suicide and self-harm monitoring, known as ACCT, and set observations at twice an hour. She checked Mr Coughtrey at 8.20pm and 8.50pm, when he was sitting on his bed. At about 9.00pm she discovered him hanged from a sheet attached to the cell window.

5. Nurses began cardiopulmonary resuscitation promptly and paramedics arrived quickly. Mr Coughtrey was taken to hospital but died on 30 September.

Findings

6. Mr Coughtrey had a number of risk factors associated with an increased risk of suicide when he arrived at Bedford, including that he had been recalled to prison for a breach of licence and that he was withdrawing from alcohol. The officers who assessed Mr Coughtrey on his first and second day knew about his main risk factors, but they did not record that they had considered them at the time.

7. The nurse who assessed him in reception based her conclusion that Mr Coughtrey was not at risk of suicide or self-harm on his presentation and because he said he had not previously attempted suicide, which was not the case. A night nurse checked Mr Coughtrey's records, but did not identify that he had previously attempted suicide and had a history of depression.

8. A nurse appropriately began suicide and self-harm monitoring when Mr Coughtrey cut himself and set observations at two an hour. We are satisfied that this was reasonable as there was no indication that Mr Coughtrey was at high and imminent risk of suicide at the time. We do not consider that staff could reasonably have predicted his actions.

9. Although one substance misuse assessment was done through the observation panel in his door, which is not good practice, we are satisfied that Mr Coughtrey's alcohol withdrawal and detoxification was appropriately managed.

10. When Mr Coughtrey was found hanged, no one used an emergency medical code. He was in the healthcare unit and help was immediately at hand. Staff began cardiopulmonary resuscitation immediately and emergency equipment was nearby but this resulted in a small delay before an ambulance was called. We do not consider this affected the outcome for Mr Coughtrey.

Recommendations

- The Governor and Head of Healthcare should ensure that reception, first night staff and others who assess risk, consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, they should record the reasons.
- The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency and the control room calls an ambulance immediately.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator visited Bedford on 8 October 2015. She obtained copies of relevant extracts from Mr Coughtrey's prison and medical records and listened to the emergency radio message of 30 September.

13. NHS England commissioned a clinical reviewer to review Mr Coughtrey's clinical care at the prison.

14. The investigator and clinical reviewer spoke to the Head of Healthcare and the Head of the Integrated Drug Treatment Service, and interviewed four staff together on 4 and 12 November. The clinical reviewer spoke to one member of staff by telephone and the investigator spoke to six others by telephone.

15. We informed HM Coroner for Bedfordshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Coughtrey's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She said she had asked the police to put him on suicide watch and Mr Coughtrey had told her that he would not be able to cope if he were sent back to prison. She asked if Mr Coughtrey had been properly assessed when he arrived at Bedford and whether the prison was aware that he had previously attempted suicide in prison. Mr Coughtrey's sister said she had last spoken to Mr Coughtrey on 27 September, and he had not told her he felt suicidal. She said it was the anniversary of the deaths of his mother and another sister in September, so it was a difficult time of year for him.

17. Mr Coughtrey's family received a copy of the draft report. The solicitor representing his sister wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HM Prison Bedford

18. HMP Bedford is a local prison holding about 500 men over 18. South Essex Partnership Trust is responsible for delivering primary physical and mental health services in the prison. Northampton Hospital Foundation Trust provides integrated drug treatment services (IDTS). There is an inpatient unit with nine cells and a four bed dormitory cell. There is also a gated cell (for prisoners under constant supervision) and two safer cells (specially designed to have minimal ligature points to help prevent prisoners hanging themselves).

HM Inspectorate of Prisons

19. The most recent inspection of Bedford was in June 2014. Inspectors found the prison was overcrowded but was otherwise safe and respectful. Health screening of new arrivals was excellent with careful attention to the individual's immediate risk. Prisoners in the inpatient unit were well supported with good clinical care. Care for prisoners with substance misuse problems was good. Reception screening, first night arrangements, and subsequent clinical care combined with psychosocial support were delivered in line with national guidelines. Prisoners reported a high level of satisfaction with their clinical treatment. Resuscitation kits, including automated defibrillators, were suitably located in the prison and checked weekly.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 October 2015, the IMB reported that the healthcare service appeared to be of a good standard. However, overcrowding had resulted in some beds in the inpatient unit being used for disruptive prisoners. The single officer on the inpatient unit was often called away to cover other duties which meant inpatients had a more restricted regime.

Previous deaths at HMP Bedford

21. There have been two self-inflicted deaths at Bedford since 2011. In both investigations we found that staff in reception did not take full account of all known risk-factors for suicide and self-harm. In the second investigation, officers did not call an emergency code immediately. This resulted in a short delay before an ambulance was called, although the outcome for the prisoner was not affected.

Release on life licence and the recall process

22. Life sentence prisoners who have served the punitive term of their sentence can be released by the Parole Board if it is satisfied that the risk to the public is acceptable. Life sentence prisoners are released on a life licence which remains in force for the rest of their life, although some conditions can be cancelled. The

licence may be revoked and lifers recalled to prison at any time to continue serving their life sentence if it considered necessary to protect the public.

23. There are two types of recall, emergency and standard. Emergency recall is for those who present an immediate risk to public safety and there is not enough time to contact the Parole Board for advice. Once a licence is revoked, the licensee will be arrested and returned to the nearest local prison to continue to serve their life sentence. Prisoners have the right to appeal against recall and further release will be determined by the Parole Board.

ACCT

24. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. In 1993, Mr Anthony Coughtrey was sentenced to life imprisonment for a murder he had committed while under the influence of alcohol and amphetamines. Mr Coughtrey had substance misuse problems throughout his life sentence. On 29 June 2007, he tried to hang himself in HMP Peterborough. At the time, Mr Coughtrey said that he was upset the Parole Board had decided not to release him, and his partner had upset him on a visit. On 4 July 2007, he broke his jaw in seven places when he collapsed in his cell. He later said he had accidentally overdosed on heroin. (From that point, he was prescribed medication to relieve the pain.) There are no other prison records of self-harm or attempted suicide.

26. In 2010, at HMP Wayland, Mr Coughtrey began a course of citalopram for depression. He stopped taking citalopram in May 2011 but had weekly sessions with a mental health nurse. Between May 2011 and August 2012, he received individual therapy from a prison psychologist for emotional issues associated with his offence.

27. On 28 January 2015, Mr Coughtrey was released on life licence from HMP Coldingley to a Kenward Trust residential drug and alcohol recovery project in Kent. Two weeks later, Mr Coughtrey was asked to leave because he was aggressive to other residents. He moved to The Ley Community (a therapeutic community for people with addictions) in Oxford but they asked him to leave at the end of May 2015 when he broke the community's rules. Mr Coughtrey then lived with his sister for a short period before moving in with his previous long term partner and her children. Mr Coughtrey's offender manager (probation officer) said Mr Coughtrey made a huge effort to find and remain in employment but began drinking increasingly heavily.

28. On 23 September 2015, the police arrested Mr Coughtrey after he had a fight with his half-brother on a train. He had a fit in police custody, due to alcohol withdrawal and was taken to hospital. He was treated with chlordiazepoxide (a benzodiazepine medication used to manage the symptoms of alcohol withdrawal) and pabrinex (a high potency vitamin solution given by injection and used to treat severe alcoholism).

29. Mr Coughtrey's sister said she told a police inspector that Mr Coughtrey was at risk of suicide and needed monitoring. She said the inspector told her that he would tell the escort service responsible for taking Mr Coughtrey to court and on to prison. Mr Coughtrey's sister said Mr Coughtrey's partner had also spoken to the police because she was concerned he was suicidal.

30. Police noted on Mr Coughtrey's Person Escort Record (PER) which accompanied him from the police station to court and then to the prison, that he was convicted of murder in 1993 and that he was alcohol dependent, suffered withdrawal and had been prescribed medication in custody. Mr Coughtrey's offence/charge was listed as "ABH/recall". There is nothing on the PER reflecting his family's concerns that he was at risk of suicide or that the police had had any concerns about his risk of suicide or self-harm while he was in their custody.

31. On 23 September, the public protection casework section of the National Offender Management Service revoked Mr Coughtrey's life licence and directed he should be returned to custody. Mr Coughtrey appeared at Magistrates Court the next day and was remanded to custody charged with assault occasioning actual bodily harm.

32. Mr Coughtrey arrived in reception at HMP Bedford at 6.35pm. An officer said he spoke to Mr Coughtrey at the front desk. He said he remembered Mr Coughtrey from HMP Wellingborough some years earlier. He said Mr Coughtrey had not changed in the intervening years and did not give him any cause for concern. He said he could not remember whether he was aware that Mr Coughtrey had been recalled to prison from life licence, but said he was not responsible for completing the reception interview or risk assessment that day.

33. An officer said he completed Mr Coughtrey's personal summary sheet in reception (a record of the prisoner's height, weight and other personal characteristics). He said he remembered Mr Coughtrey from when he first came into prison in the 1990s and they had had a general chat. He said he thought he knew that Mr Coughtrey had been recalled from life licence. He said Mr Coughtrey was pleasant and chatty. He was not happy to be back in prison but seemed in good spirits and had not given him any cause for concern.

34. An officer completed Mr Coughtrey's first night assessment. He said that because Mr Coughtrey had been recalled from licence there was quite a lot of paperwork to read. He said Mr Coughtrey came across as very balanced and was calm, easy-going, co-operative and amenable to answering questions. He said he knew that licence recall was a risk factor for suicide and self-harm. When he asked Mr Coughtrey how he felt and whether he had thoughts of suicide or self-harm, Mr Coughtrey looked bemused and said no. He remembered him laughing with both previous officers. He knew that Mr Coughtrey had an alcohol misuse problem and had medication with him, but said he did not appear to be under the influence of any substance when he assessed him. He said Mr Coughtrey had not given him any cause for concern.

35. At an initial health assessment, Mr Coughtrey told a nurse that he was prescribed gabapentin (a strong painkiller) for a historic injury and chlordiazepoxide for alcohol dependency. Mr Coughtrey reported mild nausea, agitation and mild headache. He said he drank two litres of vodka a day and had last drunk alcohol on 22 September, when he had spent all day drinking. Mr Coughtrey said he had no history or thoughts of suicide and self-harm. She said Mr Coughtrey looked fit and well. She noted he was "on remand for ABH, on recall as well" and referred him to the GP and the substance misuse service.

36. When interviewed, the nurse explained that her role in reception was to triage new prisoners with substance misuse problems. She said she sometimes helped out by completing the initial health assessment if reception nurses were busy. Mr Coughtrey was easily identified as having substance misuse issues because he arrived with letters and medication from hospital. She therefore completed a combined initial health assessment and substance misuse triage.

37. The nurse described Mr Coughtrey as "overpowering". She said he was challenging at the beginning of the assessment when she asked him questions

about his next of kin. He appeared comfortable, self-possessed and did not seem agitated or vulnerable. He said he did not feel depressed or suicidal. The nurse said Mr Coughtrey did not say much and it was hard to establish rapport with him. She said that she did not ask him about the circumstances of his recall to prison. She believed she had had not known that he had been recalled at the time, (although she had noted this in his record). She said that she was unable to see his previous medical record, because he had not yet been booked into the healthcare computer system. However, she said that she would not have read his past record even if it had been available.

38. The GP in reception examined Mr Coughtrey immediately afterwards. He noted that Mr Coughtrey appeared well and relaxed, and had been given intravenous fluids, paracetamol, pabrinex and chlordiazepoxide in hospital the day before. Mr Coughtrey said he usually took gabapentin for face and neck pain. He had a box of gabapentin and some chlordiazepoxide with him from the hospital. The GP concluded that Mr Coughtrey should start his alcohol detoxification at Point A on Bedford's alcohol detoxification chart (the highest level - for patients drinking more than 40 units of alcohol a day). He continued Mr Coughtrey's pabrinex and prescribed a reducing dose of chlordiazepoxide. He admitted him to the inpatient unit, in line with the local alcohol detoxification policy. He did not prescribe gabapentin that night because Mr Coughtrey had fewer tablets with him than expected and he could not be sure whether Mr Coughtrey had been misusing it.

39. At the end of the assessment, Mr Coughtrey took the bottle of chlordiazepoxide he had brought from the hospital from the GP's desk. The nurse noticed it was missing and officers took it back from Mr Coughtrey. She said Mr Coughtrey told her he had taken it because the GP had decided not to give him gabapentin. Mr Coughtrey was given a single cell in the inpatient unit later that day.

40. During the night, the night nurse checked Mr Coughtrey's previous medical record from his time in prison and noted that Mr Coughtrey appeared stable and had no history of mental illness. The nurse did not see entries from 2007 detailing that Mr Coughtrey had attempted suicide by trying to hang himself at Peterborough or those relating to his history of depression and continued substance misuse in prison. The nurse created care plans for alcohol dependence and sleep.

41. During the morning of Friday 25 September, a healthcare assistant carried out the first of two daily alcohol withdrawal assessments required under Bedford's local substance misuse policy. She also completed a mini mental health assessment (a short questionnaire). Mr Coughtrey scored zero on both tests, indicating that he did not have any symptoms of alcohol withdrawal or mental health problems. At 2.06pm, she tried to complete the second alcohol withdrawal assessment but Mr Coughtrey gestured for her to go away.

42. At 2.55pm, a nurse completed a more detailed substance misuse assessment to follow her triage assessment the previous day. Mr Coughtrey said he had started misusing alcohol and cannabis when he was 11, and that alcohol had been a problem for a long time. He said he had coped poorly since his release in January 2015, and had turned to alcohol again. He said he had no history or current thoughts of suicide or self-harm and no mental health problems. He

became emotional when speaking about the death of his mother (who had died in 2007). She offered to refer him to the chaplaincy team for bereavement counselling, but Mr Coughtrey said he did not want this.

43. The nurse told the investigator that Mr Coughtrey was not allowed out of his cell because there were not enough officers on duty, so she had conducted the assessment through the hatch in the cell door. She said Mr Coughtrey was pacing his cell while they spoke but he became more amicable as the assessment progressed. She said that she spoke to him for about 30 minutes. He appeared physically well but seemed to be fighting back tears when talking about his mother. She said she knew that Mr Coughtrey had spent 23 years in prison and had been recalled after a short period on licence. She said she did not want to provoke him by exploring how he felt about that. She said she did not consider that he was at risk of suicide or self-harm.

44. Also on 25 September, a Supervising Officer (SO) completed a basic custody screening (which is completed within 72 hours of the prisoner's arrival and is designed to assess their immediate needs). Mr Coughtrey said that he had no housing issues and would go back to working as a plumber when he was released. He said he had a problem with alcohol and was detoxifying. He said that he did not have any mental health problems. The SO said that he did not have any concerns that Mr Coughtrey was at risk of suicide and self-harm. He knew that he had been recalled from life licence and that this was a significant risk factor. However, he considered that Mr Coughtrey appeared calm and relaxed. The SO said he was also reassured because Mr Coughtrey was an inpatient in the healthcare centre and so he thought he would be getting appropriate care.

45. A GP re-prescribed Mr Coughtrey's gabapentin and he received his normal dose that evening.

46. On 26 September, Mr Coughtrey again scored zero for symptoms of alcohol withdrawal at his first assessment. A GP agreed he could move to D Wing (for prisoners with substance misuse issues) because he appeared stable, had finished his course of pabrinex and was managing on the reducing dose of chlordiazepoxide. Mr Coughtrey reported a mild headache at his second assessment. He moved to a single cell on D Wing later that day.

47. On Sunday 27 September, the healthcare assistant assessed Mr Coughtrey in the morning and afternoon and he reported mild headache, mild nausea and mild tremor at both.

48. At 10.47am on 28 September, a caseworker with St Giles Trust (a charity working to help prisoners resettle into the community), completed a resettlement plan (the second part of the basic custody screening). She noted that Mr Coughtrey's primary problem was alcohol misuse. He told her he was still having withdrawal symptoms and would like to see a doctor. She sent a request for a GP to see Mr Coughtrey.

49. At 11.42am, a GP saw Mr Coughtrey, who said he had tremors, headache and sweating. She noted that his blood pressure was high and he was shaking and red faced. Mr Coughtrey said he was not having hallucinations and had not

taken any illicit substances. She decided to increase the chlordiazepoxide dose to the highest level and admit Mr Coughtrey to the healthcare centre as an inpatient again.

50. The GP told the investigator that Mr Coughtrey was very reasonable when she assessed him and she had not been concerned about his mental state. However, she said it was unusual for a patient to have a worsening of withdrawal symptoms after an initial improvement. She therefore felt it was important that Mr Coughtrey should resume his detoxification at the highest point and return to the inpatient unit for closer monitoring.

51. The healthcare assistant had completed Mr Coughtrey's two daily assessments on D Wing. She said that Mr Coughtrey was polite, but only ever responded to her questions with a yes or no. She said she completed all of her assessments with him in the wing office so they could have some privacy. Mr Coughtrey had the opportunity to raise any issues with her but had not. The last time she saw him was when he was on his way back to the inpatient unit on the afternoon of 28 September. She told him he would be better off there than on the wing. She said nothing in Mr Coughtrey's behaviour or presentation had given her cause for concern.

52. Prison records show Mr Coughtrey moved from D Wing to the inpatient unit at 3.41pm. The nurse manager remembered he was there when she came on duty at about 4.00pm. She said all she knew about him was that he was on an alcohol detoxification and had returned from D Wing to be observed:

53. The cell call record for Mr Coughtrey's cell shows he pressed his emergency bell eight times between 3.50pm and 7.41pm. We do not know why he pressed his bell on the first four occasions or who answered it.

54. An operational manager was duty governor on 28 September. She said she answered Mr Coughtrey's cell bell when she was in the inpatient unit at about 6.30pm. She said Mr Coughtrey asked her for a television. She told him that she did not know if there were any spare ones available (but does not appear to have checked). Mr Coughtrey told her he was going mad and she offered him some jigsaw puzzles but he said he did not want them.

55. Mr Coughtrey was not wearing a top and the operational manager told him to put one on if he rang his bell because he needed to be dressed properly. She said Mr Coughtrey was annoyed about not having a television and being told to put a top on. He told her he had served a lot of time in prison and knew what was what. She said he was a bit rude but did not seem distressed. He did not appear to be under the influence of any substances as far as she could tell from talking to him through the observation panel. He rang his bell a second time and asked for a radio. She wrote in the wing observation book, "TV is broken, please look into replacement or a radio".

56. The nurse manager said she answered Mr Coughtrey's cell bell around 7.00pm and he asked her for a television. She said he was quite upset and was shouting. She rang D Wing and asked them to bring a spare television. Just before the officer arrived with the television, Mr Coughtrey pressed his cell bell again. When she responded, Mr Coughtrey was holding a razor blade and threatening

to cut himself. She said she told him that no one was going to go into the cell to give him a television while he had a razor blade and he passed the blade to her under his cell door. The officer arrived with the television but Mr Coughtrey said he did not want it, so she told the officer to leave it outside his cell in case he changed his mind.

57. As Mr Coughtrey had threatened to cut himself, the nurse manager began Prison Service suicide and self-harm monitoring procedures (known as ACCT) at 7.55pm and set observations at two an hour. She said she thought this was appropriate because Mr Coughtrey had given her the razor blade immediately, which suggested he was not at high risk of harming himself. She checked Mr Coughtrey at 8.20pm and 8.50pm. Each time she recorded that he was sitting on his bed and looked at her but did not reply when she asked him if he was OK and if he needed anything.

58. About ten minutes later, as she was leaving the unit to go home, the nurse manager looked into Mr Coughtrey's cell again. At first she thought he was standing with his back to the window. Then she noticed that his face was an odd colour and saw part of a green sheet around his neck. She shouted to Nurse A for help and then pressed the general alarm button. Prison logs record the general alarm at 9.02pm. Nurse A and the two night nurses were just a few feet away and responded immediately. All four nurses went into Mr Coughtrey's cell and found he had tied part of the sheet around his neck and attached it to the window frame. They cut the sheet and Nurse A started cardiopulmonary resuscitation. None of the nurses radioed a code blue medical emergency (indicating circumstances such as when a prisoner is unconscious or has breathing difficulty), which would have prompted the control room to call an ambulance in line with Bedford's local emergency protocol.

59. Nurse B brought an emergency response bag containing oxygen and a defibrillator. The nurses attached the defibrillator but this found no shockable heart rhythm and the nurses continued chest compressions, in rotation. Nurse B said Mr Coughtrey showed no signs of life.

60. The night manager said she responded immediately to the general alarm, as it was unusual to hear one at that time of night. She radioed for two officers to join her immediately. When she arrived at Mr Coughtrey's cell the nurse manager and Nurse A were performing cardiopulmonary resuscitation. According to prison logs, at 9.04pm, she radioed the control room and asked an officer to call an ambulance, which he did immediately.

61. A rapid response paramedic arrived at the prison at 9.10pm and both officers took him to Mr Coughtrey. An ambulance arrived at 9.15am and the officers took the crew to the cell. The paramedics attached their own defibrillator and gave Mr Coughtrey adrenaline. A Helimedix team (a team of doctors and paramedics run by a medical emergency charity) arrived after the second ambulance and took over the resuscitation attempt. They managed to establish a pulse and, at 10.30pm, Mr Coughtrey was taken to hospital by ambulance.

Contact with Mr Coughtrey's family

62. The duty governor telephoned Mr Coughtrey's partner to let her know what had happened and offered to send a taxi to take her to the hospital. The Head of Healthcare had arrived at the prison at the same time as the Helimedix team. She and the duty governor went to the hospital and met Mr Coughtrey's partner when she arrived. Mr Coughtrey's partner contacted Mr Coughtrey's siblings and they joined her. The Head of Healthcare stayed at the hospital with Mr Coughtrey's family for most of the night. A custodial manager was appointed as family liaison officer the next day and met Mr Coughtrey's family at the hospital.

63. Mr Coughtrey did not recover and died at the hospital at 4.05pm on 30 September. The custodial manager kept in contact with Mr Coughtrey's family and arranged for his property to be returned to them. The prison contributed towards the costs of Mr Coughtrey's funeral in line with national guidance.

Support for prisoners and staff

64. After Mr Coughtrey was taken to hospital, senior managers debriefed the staff involved in the emergency response to discuss any issues arising and offered support and that of the staff care team. The Head of Healthcare spoke to the nurses individually the next day.

65. The prison posted notices informing other prisoners of Mr Coughtrey's death, and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm, in case they had been adversely affected by Mr Coughtrey's death.

Post-mortem report

66. The post-mortem examination concluded that Mr Coughtrey died as a result of hanging. Toxicology tests for non-prescribed drugs and alcohol were negative. The toxicologist noted that, because Mr Coughtrey had died two days after being found hanged, he could not say definitively that there were no other substances in Mr Coughtrey's system on 28 September.

Findings

Assessment of risk of suicide and self-harm on arrival

67. Prison Service Instruction (PSI) 64/2011, (Safer Custody) lists a number of risk factors and potential triggers for suicide and self-harm. Mr Coughtrey had a number of these risks:

- previous attempted suicide;
- licence recall;
- early days in custody;
- substance misuse;
- alcohol detoxification;
- violent offence against a family member; and
- history of depression.

68. PSI 07/2015 (Early Days In Custody) requires staff to be alert to the increased risk of suicide and self-harm among new prisoners. They are required to interview new prisoners to assess the risk of suicide and self-harm and act appropriately to address any concerns, including opening an ACCT if necessary.

69. None of the officers who spoke to Mr Coughtrey when he arrived at Bedford thought he appeared at risk of suicide or self-harm. They all commented that was relaxed, calm and had joked with officers who remembered him from previous prisons. The officer and the SO who completed first and second day risk assessments said they were aware that recall to prison from licence and detoxification from alcohol are risk factors for suicide and self-harm but did not think Mr Coughtrey appeared at risk. The SO said he was also reassured that Mr Coughtrey was being monitored more closely as an inpatient.

70. The nurse said that she did not establish a rapport with Mr Coughtrey at his initial health assessment was unable to elicit much personal information from him and had not been able to read his previous medical record. Mr Coughtrey said he had no thoughts of suicide or self-harm and did not disclose his past history of suicide attempts. She knew little about his circumstances or the risk factors relevant to him. She said she had based her conclusion that Mr Coughtrey was not at risk of suicide or self-harm on his presentation and his declaration that he had not previously attempted suicide.

71. The Head of Healthcare told us that, at the time, they had recently introduced a new procedure for the night staff to check through the past medical records of new prisoners on their first night to identify any significant history. This is a good initiative, as this information is often not accessible at the initial health assessment. However, the night nurse who checked Mr Coughtrey's medical record did not note that he had tried to kill himself by hanging in 2007, his history of depression and the continual thread of substance misuse problems throughout his past medical history. The clinical reviewer considered that these should have been included as significant historical risk factors.

72. On 25 September, the nurse managed to gain more information about Mr Coughtrey at his second day substance misuse assessment. However, she did not explore with Mr Coughtrey how he felt about being back in prison.

73. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. None of the staff who had contact with Mr Coughtrey during his first days in prison considered him to be at risk of suicide, despite the range of his risk factors.

74. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm and document their decision.

75. There is little evidence that anyone fully considered the implications of recall to prison for a life sentenced prisoner who had recently been released after serving 23 years and might now be facing many more years in prison. Mr Coughtrey was particularly vulnerable at the time, as he was withdrawing from alcohol. Although the officers who assessed Mr Coughtrey knew about his main risk factors, they did not record their exploration of them at the time or why they decided to discount them. Ultimately, all of the staff relied on his presentation and assertion he did not intend to harm himself. We make the following recommendation:

The Governor and Head of Healthcare should ensure that reception, first night staff and others who assess risk, consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm. When they decide not to begin ACCT procedures for prisoners with significant risk factors, they should record the reasons.

Subsequent management of risk

76. Mr Coughtrey was not feeling well on 28 September and seems to have been frustrated and agitated that he did not have a working television when he arrived back in the inpatient unit. (Although he later refused one). When he threatened to harm himself with a razor, the nurse manager began ACCT suicide and self-harm prevention procedures. She set the level of observations at two an hour until Mr Coughtrey could be assessed and have his first ACCT case review.

77. Although the nurse manager knew little about Mr Coughtrey's circumstances, other than that he was withdrawing from alcohol, we do not think that his behaviour at the time was so concerning that she should have considered his risk of suicide as high, or set more frequent observations. In any event, she found Mr Coughtrey hanging ten minutes after she had last checked him. There was little to indicate that Mr Coughtrey was at imminent risk of suicide at the time and his actions appear to have been sudden and impulsive. We do not think that staff could reasonably have predicted or prevented Mr Coughtrey's actions.

Clinical care

78. The clinical reviewer was satisfied that Mr Coughtrey's alcohol withdrawal and detoxification was well managed. When he arrived at Bedford he was appropriately placed on the highest point of the alcohol detoxification scale and admitted to the inpatient unit as a precautionary measure. A GP's decisions to move Mr Coughtrey to D wing on 26 September, and then back to the inpatient unit when he felt unwell on 28 September, were sound and based on the evidence at the time.

79. However, the clinical reviewer was concerned that a nurse completed a follow up substance misuse assessment on 25 September through the hatch in his cell door. She said it was not unusual for her to have to assess prisoners through the cell door hatch because officers were often unable to unlock prisoners for various reasons. This is not good practice and does not provide suitable patient confidentiality. The clinical reviewer has made a recommendation about this which the Head of Healthcare will need to address. We do not repeat it here as we do not consider it affected Mr Coughtrey's overall standard of clinical care.

Emergency response

80. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol that ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. As is usual, Bedford uses code blue to indicate an emergency such as 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.

81. The nurse manager did not call a code blue when she discovered Mr Coughtrey hanging but pressed the general alarm bell. She said that a general alarm at 9.00pm at night would indicate to the night officers that they should respond immediately, which they did. Nurses on the inpatient unit at Bedford are usually expected to wait for officers to arrive before opening a cell but nurses opened the door immediately to help Mr Coughtrey. Cardiopulmonary resuscitation with the appropriate equipment was provided without delay.

82. The night manager arrived within two minutes of the general alarm and radioed the control room officer to call an ambulance. Paramedics were very quickly at the scene. It is highly unlikely that the short delay in calling an ambulance for Mr Coughtrey made a difference, as Mr Coughtrey was in the healthcare centre and healthcare staff were on hand immediately to administer emergency treatment. However, it is important that all staff working in prisons, including healthcare staff, are familiar with the emergency code system and use the appropriate code to prompt the control room to call an ambulance immediately. In other cases, any delay in calling an ambulance could be critical. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that staff use the appropriate code to communicate a medical emergency and the control room calls an ambulance immediately.

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