Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Basalat a prisoner at HMP Woodhill on 11 December 2016

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.

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We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
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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.

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

Mr Jason Basalat hanged himself in his cell at HMP Woodhill on 11 December 2016. He was 52 years old. I offer my condolences to Mr Basalat's family and friends.

Mr Basalat had been at Woodhill for less than 24 hours. Staff described his behaviour as "bizarre" and appropriately identified his mental health issues, prescribed medication and referred him to the mental health team. Despite some deficiencies in Mr Basalat's initial health screen, there was no evidence that he was at imminent risk of suicide or self-harm. I, therefore, consider that staff at Woodhill could not have foreseen Mr Basalat'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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **December 2017**

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Summary

Events

1. On 9 December, Mr Basalat was remanded to HMP Woodhill for dangerous driving. It was not his first time in prison. He had been diagnosed with schizophrenia in 2007, and had last been monitored under suicide and self-harm prevention procedures, known as ACCT, in 2011.

2. Mr Basalat denied thoughts of self-harm or suicide. While he was polite and compliant, staff described his behaviour as “bizarre” and noted that he had defecated in the induction waiting room. At an initial health screen with a mental health nurse, Mr Basalat was abusive and refused to co-operate. The nurse suggested that he should share a cell.

3. That evening, Mr Basalat threatened his cellmate with violence and staff moved his cellmate to another cell. Because of Mr Basalat’s “bizarre” behaviour, officers checked on him around twice an hour. The next morning, an officer spoke to Mr Basalat during the roll check. When he returned around an hour later, he found Mr Basalat hanged in his cell. After resuscitation efforts, Mr Basalat was taken to hospital, where he died that morning.

Findings

4. It was reasonable that staff did not monitor Mr Basalat under ACCT procedures as they saw no information to indicate that he was at risk of suicide or self-harm. Despite this, they increased their routine first night observations of him to twice an hour after his cellmate was moved and because of Mr Basalat’s “bizarre” behaviour. We conclude that staff could not have foreseen the actions that Mr Basalat was to take.

5. Mr Basalat’s behaviour was described by staff as bizarre. His mental health needs were identified; he was prescribed appropriate medication and was referred to the mental health team. However, there were deficiencies in aspects of his initial health screen, including that healthcare staff did not have access to the person escort record or comprehensively record their interactions with Mr Basalat in his medical records.

Recommendations

- The Governor should ensure that all staff, including healthcare staff, in reception and on the first night centre are aware of their responsibility to complete the risk assessment section of the early days in custody booklet.
- The Head of Healthcare should ensure that healthcare staff have access to and consider all relevant information, including the person escort record, before assessing a prisoner.
- The Head of Healthcare should ensure that healthcare staff record all their interactions with prisoners in the medical record.

The Investigation Process

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

7. The investigator obtained copies of relevant extracts from Mr Basalat's prison and medical records.

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

9. The investigator interviewed fourteen members of staff, some jointly with the clinical reviewer.

10. We informed HM Coroner for Milton Keynes of the investigation and have sent him a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Basalat's family to explain the investigation. They did not have any specific questions.

12. Mr Basalat's family received a copy of the initial report. The solicitor representing Mr Basalat's family wrote to us pointing out an omission. The report has been amended accordingly. They also raised 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

HMP Woodhill

13. HMP Woodhill is both a local prison and a high security prison, holding more than 800 men. House Unit 1B houses the first night and induction unit, where prisoners spend their first days in custody. Central and North West London Foundation Trust provide mental health services at Woodhill.

HM Inspectorate of Prisons

14. The most recent inspection of Woodhill was in September 2015. Inspectors reported on the high number of self-inflicted deaths at the prison and that almost a quarter of prisoners said they felt depressed or suicidal when they first arrived. While inspectors reported that reception processes were efficient and that staff were alert to newly arrived prisoners harming themselves, some of their initial checks were not thorough. Inspectors noted the poor quality of some clinical records.

Independent Monitoring Board

15. 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 ending May 2016, the IMB said that, given its role as a high security and local prison the prison was extremely challenging to manage. The IMB reported that healthcare staff continued to deliver a good service.

Previous deaths at HMP Woodhill

16. Mr Basalat was the sixth prisoner to have taken his life at Woodhill since January 2016. There were no significant similarities with previous investigations.

Assessment, Care in Custody and Teamwork (ACCT)

17. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Background

18. Mr Jason Basalat had spent time in prison for minor offences since 1998. In 2006, he was convicted of wounding with intent and sentenced to five years in prison. Mr Basalat had a history of mental health problems and in 2007, was diagnosed with schizophrenia. In August 2011, he was very briefly monitored under suicide and self-harm prevention procedures, known as ACCT.

HMP Woodhill

19. On 9 December 2016, Mr Basalat was charged with dangerous driving and appeared at court the next day. A court document noted that Mr Basalat had told police that he had no mental health issues.

20. At 1.10pm on 10 December, Mr Basalat was transferred to Woodhill. His person escort record noted that he had schizophrenia and was taking antipsychotic medication and antidepressants. It was also noted that he was taking an anticoagulant and had a history of self-harm.

21. A Supervising Officer (SO) interviewed Mr Basalat and completed an early days in custody booklet for him, as was standard practice. He noted that Mr Basalat was taking antidepressants and had told him he had no thoughts of suicide or self-harm. (There was no evidence that staff offered Mr Basalat a first night telephone call, as they should have done.)

22. At 2.50pm, Mr Basalat was taken to the waiting room in the first night and induction unit, where he defecated on the floor. At around 3.30pm, a prison GP assessed Mr Basalat. A nurse was present. The GP noted that Mr Basalat had schizophrenia and depression. He prescribed antipsychotic medication and antidepressants, and referred him to the mental health team. Mr Basalat told the GP he had no thoughts of suicide or self-harm. The nurse said Mr Basalat gave the GP detailed information about his mental health and medications.

23. The nurse told the clinical reviewer that Mr Basalat had asked to use the toilet on several occasions that afternoon and had told the GP that someone had defecated in the waiting room. The nurse said that she asked the GP to prescribe Loperimide, used to treat diarrhoea. (This is not recorded in Mr Basalat's medical records.)

24. At 3.38pm, Mr Basalat was taken back to the waiting room and, ten minutes later, defecated on the floor again. At 4.33pm, he returned to the wing and collected his evening meal. While eating, an Insider spoke to him. (An Insider is a trusted prisoner who provides advice and support to new prisoners.) The nurse told Mr Basalat that she was about to start his initial health screen. He told the nurse he was eating and said, "I'm trying to do so many things." The nurse considered his response reasonable and left him alone. She said Mr Basalat was polite, displayed no signs of aggression and that she asked a mental health nurse and team leader to assess him.

25. Just after 5.00pm, Mr Basalat was taken back to the waiting room and, within ten minutes, again defecated. Officers arrived soon after and just before 5.30pm he and the other prisoners were taken from the waiting room to an area just outside the first night and induction unit. An officer said Mr Basalat did not understand that defecating on the floor was unacceptable and told him that he had needed the toilet.

26. At around 5.48pm, at an initial health screen, a mental health nurse assessed Mr Basalat. An officer was present. The nurse said Mr Basalat was abusive and vague when answering her questions, that his speech was slurred, but that he denied taking any illicit substances. The nurse noted that she had been unable to fully assess Mr Basalat, and noted his behaviour was "bizarre" and that he wanted to go to his cell. The nurse noted that the GP had prescribed Mr Basalat's antipsychotic and other medications. The nurse said Mr Basalat displayed no psychotic symptoms and he denied a history of self-harm or that he had current thoughts of suicide or self-harm. The nurse did not record this information in Mr Basalat's medical record.

27. A SO completed a cell sharing risk assessment, and noted that Mr Basalat had previously been monitored under ACCT procedures in 2011 and had mental health issues. The mental health nurse completed the healthcare section of the risk assessment, and noted that his medical notes had been reviewed and that it had been agreed with officers that he should share a cell.

28. At around 6.00pm, an officer completed a first night induction interview. The officer wrote in the early days in custody booklet (which recorded information for staff about a prisoner's history, needs and risks) that Mr Basalat had refused to engage and was not "compos-mentis". The officer said Mr Basalat was more concerned about what was going on around him than the interview. The officer said the only question that Mr Basalat answered was to confirm that he had no thoughts of suicide or self-harm. The officer noted that the nurse had told him that Mr Basalat should share a cell because of his mental health issues.

29. At around 6.10pm, the officer took Mr Basalat to an empty cell to use the toilet. At around 6.50pm, Mr Basalat moved into a cell with another prisoner. During his final move that evening, the officer said Mr Basalat asked him when they would go to the pub. The officer told Mr Basalat he would not go to the pub as he was in prison. At 7.00pm, the mental health nurse gave Mr Basalat his medication.

30. At the end of his shift, the officer briefed another officer who was starting the night shift. He told him that he should "keep an eye" on Mr Basalat as he had earlier defecated in the waiting room and his behaviour had been described as "bizarre". At around 9.00pm, an operational support grade (OSG) arrived on the unit.

31. At around 9.05pm, Mr Basalat's cellmate asked to speak to a Listener, a prisoner trained by the Samaritans. The OSG said the cellmate was very distressed, was scared and physically shaking. He told the OSG that he had suicidal thoughts and that Mr Basalat was "crazy". He said Mr Basalat had tried to light a fire (although the officer saw no evidence of this), and had threatened to rape him.

The cellmate was moved from the cell to speak to a Listener (a prisoner trained by the Samaritans) and was monitored under ACCT procedures.

32. At around 9.50pm, the OSG investigated a banging noise from Mr Basalat's cell. Mr Basalat was covering the area at the bottom of his bunk bed with towels. The officer asked Mr Basalat to remove the towels and Mr Basalat apologised.

33. At around 11.30pm, the night duty manager arranged for Mr Basalat's cellmate to move to a single cell. A custodial manager asked Mr Basalat if he was okay and told him to get some sleep as it was getting late. He said that Mr Basalat asked if his cellmate was okay and seemed concerned for his welfare. He said Mr Basalat's behaviour had not concerned him.

34. The night duty manager and the custodial manager agreed that the risk Mr Basalat posed to others was greater than the risk he posed to himself, and they did not consider it necessary for him to be monitored under ACCT procedures. Because of the concerns raised by staff and the mental health nurse about Mr Basalat's "bizarre" behaviour and need to share a cell, the night duty manager told the officers on the wing to increase his checks to twice an hour. (As with all newly arrived prisoners, Mr Basalat was already being checked frequently at night.) She asked the OSG to refer Mr Basalat to the mental health team and noted that they would review him the next morning during his second day induction interview. She told the day manager that Mr Basalat's cell sharing risk assessment needed to be reviewed the next morning.

35. An officer said that Mr Basalat spoke to him that night. He said Mr Basalat told him all was well, responded clearly when spoken to and was confident in his speech. The OSG said that at one point Mr Basalat told him he could not find his phone and had lost his coat. He told him that his property was safe and Mr Basalat thanked him. During the night, Mr Basalat asked for his cell door to be left open as he needed his coat and had to go for a walk. Mr Basalat slept fully clothed through the night.

36. At 6.25am on 11 December, Mr Basalat was confused and told the OSG he had to leave for work at 9.00am, and needed to buy an alarm clock. The OSG told him that the day staff would help him. Mr Basalat thanked him.

37. At around 7.05am, Officer A arrived for work. The night officer told him that Mr Basalat had had a troubled night and his cellmate had been moved, but that Mr Basalat had eventually settled and had slept through the night.

38. At 7.15am, Officer A checked on Mr Basalat during his roll check. He spoke to him for two and a half minutes during which Mr Basalat said he thought he was going to be kidnapped by other prisoners. The officer reassured him that this was not the case and that he was safe. Mr Basalat told the officer not to lie to him, as he had been in the army and knew they were coming for him. The officer asked Mr Basalat if he was going to do anything silly. He said he would not and said he was okay. The officer said Mr Basalat's behaviour had not changed from the night before. The officer told Mr Basalat that he would visit him after he had completed his roll check.

39. Just after 8.00am, Officer A told Officer B that he had a bad feeling about Mr Basalat and asked her to go with him to check on him. At around 8.09am, he looked through the observation panel and saw Mr Basalat hanging from the top rail of his bunk bed. He radioed a medical emergency code blue and the control room called an ambulance immediately. (A code blue indicates a life-threatening situation such as when a prisoner is unconscious or not breathing.)

40. Officer A went into the cell, followed by Officer B. He untied the ligature and lowered Mr Basalat to the floor. Officer B checked for signs of life, but found none. Officer A started cardiopulmonary resuscitation until healthcare staff arrived and took over.

41. At 8.11am, a nurse arrived at the cell. He said that when he arrived officers were trying to resuscitate Mr Basalat. Other members of the healthcare team, including another nurse and a prison GP, helped him to attach the defibrillator which advised to continue with chest compressions.

42. At 8.22am, paramedics arrived and continued resuscitation efforts. At 9.05am, Mr Basalat was taken to hospital, where doctors pronounced him dead at 9.35am.

Contact with Mr Basalat's family

43. Two prison staff were appointed as Woodhill's family liaison officers. Mr Basalat had named his ex-partner as his next of kin and initially. After some initial difficulty in making contact with her, a family liaison officer from HMP Wandsworth contacted her, with police assistance, on 14 February. It was later established that Mr Basalat's brother would be the main family contact.

Support for prisoners and staff

44. Two governors debriefed the staff involved in the emergency response and offered support. Woodhill notified other prisoners of Mr Basalat's death and offered them support. Officers checked on prisoners assessed as at risk of suicide and self-harm, in case they had been affected by the news of Mr Basalat's death.

Post-mortem report

45. The post-mortem examination established the cause of Mr Basalat's death as asphyxia by hanging. Toxicology tests detected levels of Mr Basalat's prescription drugs which were consistent with therapeutic use.

Findings

Identifying risk of suicide and self-harm

46. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires that all staff, who have contact with prisoners, are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures. Mr Basalat had two risk factors: he had schizophrenia and he had just arrived in prison.

47. PSI 64/2011 advises staff to be aware of the presentations of schizophrenia, including hallucinations, delusions, muddled thoughts and changes in behaviour, and to monitor closely prisoners taking anti-psychotic medication for distress and other side effects. Staff appropriately identified Mr Basalat's mental health issues, prescribed medication and referred him to the mental health team.

48. Mr Basalat repeatedly denied thoughts of suicide and self-harm and never self-harmed or expressed thoughts of suicide or self-harm during the very short period of time that he was in prison. Despite this, staff increased Mr Basalat's first night checks to twice an hour because of his unusual behaviour. Although he had significant mental health issues and his behaviour was unusual, we are satisfied that there was nothing to indicate to staff that Mr Basalat was at risk of suicide or self-harm or that he should be monitored under ACCT procedures.

Early days in custody booklet

49. In light of the series of deaths in custody, many within the first few days of custody, Woodhill designed an early days in custody booklet to reinforce the requirements already set out in PSI 64/2011. The purpose was to ensure that staff considered risk factors during the reception and first night screening process for newly arrived prisoners and to improve the sharing of information between organisations and departments within Woodhill.

50. The booklet included a risk and triggers checklist for staff to complete for each newly arrived prisoner. Staff at Woodhill are required to use the booklet from when a prisoner arrives in reception, and it should note all the information listed in the documents they arrive with. These generally include as the person escort record, a suicide and self-harm warning form (where applicable), a police medical record and police detention records, where available. Each staff member, including healthcare staff, who are interviewing prisoners, should confirm that they have seen and considered all the documents received about that prisoner.

51. In Mr Basalat's early days in custody booklet, the checklist in the risk assessment section was not completed, as required. Despite having access to Mr Basalat's person escort record, reception officers and others, including healthcare staff, did not record his risk factors, such as context of his custody, clinical history or risk triggers in the booklet. Some of the staff interviewed, including the mental health nurse, were unsure about when the checklist should be completed and who should complete it.

52. In our investigation into the death of a prisoner at Woodhill in August 2016, we identified concerns about staff not completing the checklist risk assessment but Woodhill told us that changes to the risk assessment process had been satisfactorily implemented. While we do not consider it likely that the failure of staff to complete the risk assessment for Mr Basalat would have changed their judgement and therefore the outcome for Mr Basalat, in light of the significant number of deaths at Woodhill recently, many during their early days in custody, it is particularly important that staff complete all relevant sections of the early days in custody booklet. We make the following recommendation:

The Governor should ensure that all staff, including healthcare staff, in reception and on the first night centre are aware of their responsibility to complete the risk assessment section of the early days in custody booklet.

Initial health screen

53. Mr Basalat did not interact with the mental health nurse during the initial health screen. Although the nurse had access to the early days in custody booklet, Mr Basalat's cell sharing risk assessment and his medical notes, she did not have access to his person escort record which contained relevant information about his history of self-harm, alcohol problems and schizophrenia. We consider that nurses should have and consider all relevant information before assessing newly arrived prisoners to ensure that their review is as detailed and thorough as possible. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff have access to and consider all relevant information, including the person escort record, before assessing a prisoner.

54. The mental health nurse told the investigator that Mr Basalat had denied harming himself in the past or having current thoughts of self-harm during his initial health screen. The nurse said that Mr Basalat had not displayed psychotic symptoms during the assessment. We are concerned that none of this information was recorded in Mr Basalat's medical records, as it should have been. Similarly, another nurse did not note her discussion with Mr Basalat, or that she had asked the GP to prescribe medication to alleviate symptoms of Mr Basalat's diarrhoea. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff should record all their interactions with prisoners in the medical record.

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