Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marius Lupu a prisoner at HMP Bedford on 18 April 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.

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.

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 Marius Lupu was found hanged in his cell on 13 April 2016 and died in hospital on 18 April. Mr Lupu was 25 years old. I offer my condolences to Mr Lupu's family and friends.

The investigation identified a number of concerns about the way staff managed Mr Lupu's risk at Bedford. They failed to use interpreting services to ensure Mr Lupu could communicate effectively with them. They did not monitor his risk of suicide and self-harm adequately and failed to review his risk as his self-harm escalated. Mr Lupu did not receive a prison induction.

It is not the first time that we make recommendations to address shortcomings in the operation of suicide and self harm prevention procedures at Bedford. I note that similar concerns were raised in the recent Inspection report which also criticised the inadequate support for non-English speaking and foreign national prisoners.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **December 2016**

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Summary

Events

1. On 6 April 2016, Mr Marius Lupu was remanded to HMP Bedford. Mr Lupu was Romanian and did not understand or speak English well. When he arrived at Bedford, staff did not use interpreting services to communicate with him and told him that he could not keep his trainers because they considered the logo inappropriate in prison. Mr Lupu was angry and upset about this, and was verbally abusive to staff. His poor behaviour meant that staff in reception obtained very limited information about him. Mr Lupu did not receive a prison induction.

2. On 12 April, Mr Lupu cut his arms. Prison staff started suicide and self-harm prevention procedures. Mr Lupu's cellmate, who was Romanian, acted as an interpreter for staff. Mr Lupu repeatedly asked for his trainers and refused to take part when staff wanted to assess his risk under suicide and self-harm procedures.

3. That day, Mr Lupu cut his arms three more times but declined medical treatment. Managers did not arrange a multi-disciplinary ACCT case review to review Mr Lupu's risk of suicide and self-harm.

4. On 13 April, Mr Lupu cut his arms, legs and neck five times. Staff did not review his risk. Except for Mr Lupu's second health screen (for which staff used telephone interpreting services), Mr Lupu's cellmate interpreted for staff. Mr Lupu wanted his trainers back. He was verbally aggressive towards staff and refused healthcare treatment. Staff found a note that Mr Lupu had written which said that he intended to end his life. Despite this, no one reviewed his risk.

5. At around 4.00pm on 13 April, a prisoner found Mr Lupu hanged in his cell. He alerted prison officers who responded immediately and radioed an emergency medical code. Staff promptly began cardiopulmonary resuscitation. Paramedics arrived and took Mr Lupu to hospital, where he died on 18 April.

Findings

6. Staff did not use interpreting services during Mr Lupu's reception screen despite knowing that he spoke very little English. Mr Lupu's poor introduction to prison was exacerbated by Bedford's failure to give him a prison induction.

7. We are not satisfied that Bedford fully recognised Mr Lupu's risk of suicide and self-harm. Managers did not hold a multi-disciplinary case review to manage Mr Lupu's risk within 24 hours of starting suicide and self-harm prevention procedures, as they should have done. This meant that staff did not properly review Mr Lupu's risk, complete a caremap or consider how they could reduce his risk.

8. We are particularly concerned that staff did not respond to Mr Lupu's increasing number of self-harm incidents and his heightened risk as the incidents escalated, and that the mental health team failed to intervene. Instead, Mr Lupu's observations remained at half hourly intervals from the outset, and there is no

evidence that staff considered if this was an appropriate level or, indeed, a sufficient response to his risk.

9. Staff failed to identify in Mr Lupu's person escort record that he had a history of schizophrenia, and he was not referred to the mental health team for assessment, as he should have been.

Recommendations

- The Governor and Head of Healthcare should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, including during first night and induction procedures to ensure that they receive information about prison processes in a language they understand.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including ensuring:
    - A multi-disciplinary case review is held within 24 hours of ACCT procedures starting.
    - A multi-disciplinary approach for all case reviews with continuity of case management.
    - Caremap actions are set, which are specific, meaningful, aimed at reducing prisoners' risks and reviewed and updated, as necessary.
    - Risk is reviewed whenever an event occurs which indicates an increase in risk and a case review is held if required, even in the absence of the prisoner.
    - All staff, including healthcare staff, record relevant information about risk, observations and interactions with prisoners in ACCT documents and taking appropriate action.
- The Governor and Head of Healthcare should ensure that:
    - Reception staff examine and record all relevant information about newly arrived prisoners in line with PSI 74/2011.
    - All relevant staff consider person escort records and suicide and self-harm warning forms and ensure there is a clear audit trail.
    - Prisoners identified as at risk of suicide and self-harm have a full mental health assessment.
    - Staff conduct detailed assessments and prioritise prisoners who have not completed their reception screen and induction.
- The Governor should ensure that prisoners' next of kin details are recorded when they arrive at the prison, so that current information is available in an emergency. Where no next of kin is identified, this should be clearly recorded.

The Investigation Process

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

11. The investigator visited Bedford on 20 April 2016. He obtained copies of relevant extracts from Mr Lupu's prison and medical records.

12. The investigator interviewed 18 members of staff at Bedford on 24 May, 27 May and 11 July. He also interviewed four prisoners.

13. NHS England commissioned a clinical reviewer to review Mr Lupu's clinical care at the prison. The clinical reviewer joined the investigator for interviews on 27 May.

14. We informed HM Coroner for Bedfordshire of the investigation and have sent the coroner a copy of this report.

15. One of the ombudsman's family liaison officers tried unsuccessfully to contact Mr Lupu's father to explain the purpose of the investigation and ask whether there were any matters he wanted us to consider. We hope that this report addresses any questions they may have, should they receive it in future.

Background Information

HMP Bedford

16. HMP Bedford is a local prison holding about 500 men. South Essex Partnership Trust delivers primary physical and mental health services at Bedford. Northampton Hospital Foundation Trust provides integrated drug treatment services. There is an inpatient unit with nine cells and a four-bed dormitory. There is also a gated cell (for prisoners under constant supervision) and two safer cells (with minimal ligature points to prevent prisoners hanging themselves).

HM Inspectorate of Prisons

17. The most recent inspection of Bedford was in May 2016. Inspectors found self-harm levels had risen significantly since their last inspection in 2014. They found that staff did not manage ACCT procedures well, with poor assessments, insufficient and incomplete care plans, inconsistent case management at reviews, poor attendance by appropriate specialists at reviews and observational contact rather than interaction between staff and prisoners. Inspectors found that support for non-English speaking prisoners was inadequate and foreign national prisoners had no access to a forum or support group, which left them isolated. They said there was no information displayed in reception or available during induction in foreign languages. Inspectors made a recommendation to address inadequate use of professional telephone interpreting services, which they were not sure were used when needed, other than by health services staff.

Independent Monitoring Board

18. 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 there was almost no help on the wings for prisoners with difficulty understanding written or spoken English. The number of prisoners being monitored at risk of suicide and self-harm had increased from the previous year.

Previous deaths at HMP Bedford

19. Mr Lupu was the fourth prisoner to take his life at Bedford since 2013. In two of our investigations (in June 2013 and September 2014), we found staff operated suicide and self-harm prevention procedures ineffectively.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) 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 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

21. On 6 April 2016, Mr Marius Lupu was convicted of theft and failure to provide a sample for drug testing, and was remanded to HMP Bedford. Mr Lupu was Romanian, and had only moved to the United Kingdom in late March 2016. He understood and spoke very little English.

22. Mr Lupu's person escort record (which accompanies prisoners between police stations, courts and prisons) noted a history of schizophrenia and self-harm, with his most recent act of self-harm eight years earlier.

23. An officer assessed Mr Lupu's risk of suicide or self-harm in reception. The officer said there was no need to use Language Line (a telephone interpreting service) because while Mr Lupu's English was limited, he was able to respond to standard questions with 'yes' or 'no'. He considered Mr Lupu's body language and person escort record, but had no immediate concerns about Mr Lupu's risk of suicide and self-harm. He noted Mr Lupu was fit to share a cell with another prisoner.

24. A Supervising Officer (SO) said that staff had to complete next of kin details for new prisoners. Mr Lupu told him that he had no next of kin, family or friends. The SO was aware that Mr Lupu was going to share a cell with a Romanian prisoner, so entered his cellmate's details as Mr Lupu's next of kin. He noted the cellmate's relationship to Mr Lupu as a friend, even though they had never met before.

25. Mr Lupu was wearing trainers that the police had issued him when they had confiscated his own pair, which the SO said had cannabis leaf logos on them. An officer and the SO tried to explain to Mr Lupu that they had to store his trainers because it was against prison policy to allow prisoners to wear clothing which displayed drugs. Mr Lupu responded angrily and appeared to swear at the officers in Romanian, apparently asking for his trainers. The SO said he used an internet translation search engine to look for Romanian words to explain to Mr Lupu why he could not wear his trainers.

26. Another officer, who was responsible for prisoner induction, heard Mr Lupu's raised voice. The SO explained to her why Mr Lupu was angry. The officer noted that Mr Lupu removed and threw the police issue trainers. He shouted at a nurse, who was also in reception. The officer said Mr Lupu appeared not to be able to speak or understand much English. She gave him a pair of prison issue shoes. Mr Lupu refused to wear them and continued to ask for his trainers.

27. The first officer said he was not concerned about Mr Lupu because he had calmed down when he told him that he would share a cell with a Romanian prisoner and that he would get his trainers back on release from prison.

28. The nurse in reception told the investigator that she tried to collect Mr Lupu for his reception health screen. She was aware that he did not speak or understand English well and intended to use Language Line in the medical room. However, Mr Lupu refused to go, and was shouting aggressively.

29. As the nurse was unable to examine Mr Lupu, she said she asked him some basic questions to register him on SystmOne (the prison's computerised medical database). The nurse said that, with the use of hand gestures, she found out that Mr Lupu had no concerns about his physical or mental health and had no thoughts of suicide or self-harm. She said that prison staff usually gave her a prisoner's prison escort record and she would sign it to confirm that she had seen and used it as part of the reception screening. The nurse had not signed Mr Lupu's prison escort record, and said that she could not recall seeing it and did not know that it said Mr Lupu had a history of schizophrenia.

30. An officer said she saw Mr Lupu to complete his reception induction. She said Mr Lupu reiterated that he had no next of kin. He used actions to indicate that he wanted a shower. The officer gave Mr Lupu a towel and some prison issue clothing, but Mr Lupu threw them on the floor and said "no". He was angry and started swearing. Because of Mr Lupu's angry behaviour, the officer could not explain to him what to expect from his prison induction.

31. Another SO saw Mr Lupu's behaviour towards the officer. He tried to explain to Mr Lupu using hand gestures that he should use the shower facilities and calm down. He told the investigator that Mr Lupu eventually understood. The SO left the reception and continued with his duties.

32. Mr Lupu was taken to A Wing, and shared a cell with a Romanian prisoner.

33. On 7 April, Mr Lupu did not attend his prison induction, which would have included a secondary health screen, maths and English test, and referral to a course designed for prisoners who could not communicate well in English.

34. The induction officer said she telephoned A Wing to see why Mr Lupu had not attended his induction. Staff told her that Mr Lupu had attended a gym induction. The officer also telephoned gym staff. She suspected that because Mr Lupu's understanding of English was limited, he may have followed his cellmate to the gym. The gym staff told Mr Lupu that he had to attend his induction the next day.

35. Another officer (who worked on the induction wing) was told by A Wing staff that Mr Lupu was a foreign national who did not speak much English. He telephoned a nurse and told her that Mr Lupu had not attended the induction session and so would not be able to complete his secondary health screen that day. He told the nurse that she would need to use Language Line for his health screen.

36. On 8 April, Mr Lupu missed his prison induction session again as he went to the gym. We have seen no evidence to explain why. A nurse rescheduled his second health screen for 11 April, and noted he would need Language Line.

37. On 9 April, Mr Lupu and his cellmate spoke to an officer in the staff office, with the cellmate interpreting for Mr Lupu. Mr Lupu asked basic questions about the prison regime and procedures, which an officer answered. Mr Lupu said he was not happy that he did not have his own trainers. The officer said he would find out about his trainers.

38. On 10 April, an immigration officer told Mr Lupu that he would be deported after he had completed his prison sentence. The immigration officer used the cellmate

as an interpreter. The cellmate said that Mr Lupu was not upset about the decision and had said he was happy to return to Romania.

39. An officer took Mr Lupu's trainers from the prison storeroom, and gave them to Mr Lupu. He did not know that reception staff had previously withheld the trainers from Mr Lupu.

40. On 11 April, an officer noticed that Mr Lupu was wearing his own trainers. She telephoned an SO to find out why he had them. The SO explained that an officer had returned them to him. The SO called an officer to tell him to take Mr Lupu's trainers from him and return them to the storeroom.

41. A nurse saw Mr Lupu for his secondary health screen, and used Language Line to communicate. Mr Lupu told the nurse that he had a history of attempted suicide and self-harm. Mr Lupu said he had not tried to harm himself since 2007 and currently had no thoughts of doing so. He said he did not want to be referred to the mental health team. The screen lasted about 45 minutes, and was the only part of the prison's second day induction that Mr Lupu received.

42. An officer visited Mr Lupu and took Mr Lupu's trainers from him. He told him that he would have to wear the prison issue shoes. Mr Lupu was unhappy with the decision.

43. Later that morning, Mr Lupu damaged the television and chair in his cell, as well as the observation panel on his cell door. The cellmate was in the cell at the time. An officer tried to talk to Mr Lupu but found it difficult because of the language barrier. Staff removed the broken television and other broken items from the cell, and decided Mr Lupu should have a disciplinary hearing.

44. Mr Lupu collected his lunch barefoot. When an officer asked why he was not wearing shoes, Mr Lupu did not respond, but looked angry and spat on the floor.

45. On 12 April, Mr Lupu attended a disciplinary hearing, but did not take part. His cellmate acted as an interpreter. Mr Lupu was found guilty of damaging prison property and received a fine. Before leaving the hearing room, Mr Lupu removed his shoes and asked for his trainers.

46. When Mr Lupu collected his lunch, an officer said he called her "all the names he could think of in Romanian, obviously swearing". She gave him a formal warning about his negative behaviour.

47. That afternoon, an officer responded to Mr Lupu's cell bell. Through the observation panel, he saw Mr Lupu sitting in a chair, cutting his forearm with a razor blade. There was a pool of blood on the floor and the officer said Mr Lupu repeated the words, "No shoes" in English. A nurse responded to the officer's radio call for immediate healthcare assistance. Mr Lupu eventually allowed the nurse to treat his cuts, with his cellmate interpreting.

48. While the nurse treated Mr Lupu, a prisoner biohazard cleaner cleaned the blood on the cell floor. The cleaner tried to talk to Mr Lupu but he did not respond, and only spoke to his cellmate in Romanian. The cleaner saw Mr Lupu hide a razor blade in his bedding and told prison staff about this after he had finished cleaning the cell. Staff removed the blade.

49. An officer began ACCT suicide and self-harm prevention procedures for Mr Lupu. A custodial manager decided that Mr Lupu should stay in his cell and staff should check him every half an hour until they could assess him. She said Mr Lupu was angry, and was shouting and swearing in Romanian, with a few English words.

50. At 2.00pm, an officer tried to assess Mr Lupu under ACCT procedures. The cellmate interpreted for Mr Lupu. The officer noted that Mr Lupu's main issue was that he wanted his trainers, but said he could not complete the assessment because Mr Lupu did not want to take part and swore at him.

51. At 2.05pm, an officer checked Mr Lupu and found that he had cut his forearm again. She radioed the healthcare team. An SO attended the cell and spoke to Mr Lupu. His cellmate interpreted for him. The nurse arrived. Mr Lupu declined treatment, but asked for tobacco. The SO removed a razor blade from his cell.

52. At 2.25pm, Mr Lupu cut his forearm. An officer noted in Mr Lupu's ACCT record that Mr Lupu had again declined medical treatment.

53. That afternoon, the custodial manager went to the prison's storeroom to see Mr Lupu's trainers. She agreed that they were inappropriate and tried to explain why to Mr Lupu, but he refused to respond.

54. At 3.35pm, Mr Lupu cut his forearm again. A nurse went to his cell and noted that Mr Lupu had removed his wound dressings. Mr Lupu declined medical treatment and threatened to cut his throat if staff did not give him tobacco. An officer said that he had checked Mr Lupu's cell for sharp instruments but found none. He said when he told the duty governor (who was unavailable for us to interview) that it was becoming difficult to manage Mr Lupu, the duty governor told him Mr Lupu must stay on the wing.

55. Afterwards, the custodial manager again tried unsuccessfully to speak to Mr Lupu to understand why he was harming himself. At 4.30pm, the biohazard cleaner went to Mr Lupu's cell and cleaned the blood on the floor. That evening, staff put another television in the cell.

56. National instructions say that the first ACCT case review must he held within 24 hours of monitoring procedures starting and ideally, after the assessment interview. Staff did not hold a first case review.

57. An SO attended the 7.45am briefing meeting at the start of his shift. Staff discussed Mr Lupu's behaviour the previous day. The SO said that as the wing supervisor, he intended to hold a case review with Mr Lupu that morning.

58. That morning, the cellmate had gone to work in the prison workshop.

59. At 9.20am, an officer checked Mr Lupu. He was sitting in his chair, with his arms covered in blood. The officer radioed a code red medical emergency (which indicated blood loss) and asked for the healthcare team to attend. A nurse arrived and noted that Mr Lupu had multiple laceration wounds to his wrists. He was unable to treat Mr Lupu because he was verbally aggressive and declined medical treatment. Staff checked Mr Lupu's cell again for sharp instruments but found none.

60. At 9.40am, another officer noted that Mr Lupu's wound was still bleeding. When the first officer checked Mr Lupu at 10.05am, he had cut his neck. Staff radioed for immediate help from the healthcare team. A nurse arrived within minutes, and saw that Mr Lupu had made further cuts to arms and superficial lacerations to the right side of his neck. Mr Lupu allowed the nurse to examine his neck but refused further treatment. The nurse recorded in Mr Lupu's medical record and told the SO and an officer that he was concerned about Mr Lupu's safety. He recommended that Mr Lupu should be moved to a safer cell (a cell with fewer ligature points) and his level of observations should be increased, including considering whether to place him under constant observation.

61. At 10.25pm, a mental health nurse went to A Wing, expecting to attend ACCT reviews, including for Mr Lupu. She was aware of Mr Lupu's self-harm. She noted in Mr Lupu's ACCT record that she had tried to see him, but the SO had said that it was inappropriate at that time because Mr Lupu had just cut his forearm and staff were attending to him. A nurse said that the SO believed that Mr Lupu understood his behaviour and was trying to persuade the officers to return his trainers to him. The nurse decided that Mr Lupu did not need immediate mental health intervention and told staff that the healthcare team would support Mr Lupu through the ACCT process or at the request of wing staff.

62. The SO said that he telephoned a custodial manager about increasing the frequency of Mr Lupu's ACCT observations and asked him to attend the wing. The custodial manager arranged for the cellmate to return from his workshop to the wing to translate and help calm Mr Lupu.

63. At 10.27am, Mr Lupu harmed himself again. Another nurse could not see where Mr Lupu had cut himself because he declined medical treatment and was acting aggressively. The nurse said he suggested again to the SO that staff should increase the frequency of Mr Lupu's observations.

64. The custodial manager, cellmate and SO arrived at Mr Lupu's cell. Mr Lupu was standing up, and was upset and angry. The custodial manager tried to explain to Mr Lupu (with his cellmate interpreting) that staff were trying to help him and if he continued to harm himself, he would be placed under constant observation in the healthcare unit. The custodial manager apologised to Mr Lupu that his trainers were mistakenly returned to him and then taken away again. He encouraged Mr Lupu to allow the nurse to treat his cuts. The custodial manager told the cellmate that the staff would leave him to talk to Mr Lupu in private to see whether he could calm him.

65. When the custodial manager returned to the cell, Mr Lupu appeared calmer, and was talking to his cellmate. He declined medical treatment. The custodial manager said he told the SO and an officer that placing Mr Lupu on constant observation in a gated cell in the healthcare unit was an option. However, he felt that if the cellmate remained with Mr Lupu that afternoon, it would reduce his risk of self-harm. The custodial manager authorised the cellmate to be absent from work for the afternoon. He asked a biohazard cleaner to clean Mr Lupu's cell.

66. Just before 12.10pm, the custodial manager spoke to the duty governor. He discussed whether Mr Lupu needed constant observation. The custodial manager told the duty governor that Mr Lupu had calmed down and there had

been no further incidents of self-harm for nearly an hour and a half. He said that he had tentatively arranged for a member of staff to be available in the afternoon to observe him constantly, should Mr Lupu harm himself further.

67. At 12.10pm, the duty governor's duty ended. He said he gave a handover to a custodial manager, about Mr Lupu and his trainers. He explained their plan for Mr Lupu and that a member of staff was available if constant observation was needed. The custodial manager said that he was told that Mr Lupu had harmed himself and that a decision had not yet been taken about whether constant observation was needed. He said that the duty governor had to authorise constant observation. The custodial manager was unaware that Mr Lupu had not had an ACCT review. He said he had been told that Mr Lupu had refused medical treatment or to move to the healthcare unit because he smoked.

68. Shortly after 12.10pm, staff radioed a medical emergency code red, asking for the healthcare team to attend Mr Lupu's cell. An officer noted that Mr Lupu had cut his right leg. A nurse went to Mr Lupu's cell but he again declined medical treatment. The nurse said that he reiterated to wing staff, including the same SO as before, that Mr Lupu should be placed under constant observation. The custodial manager said he tried to talk to Mr Lupu but he swore at him, refused help or to be moved to the healthcare centre.

69. At 12.45pm, 1.03pm and 1.29pm, an officer completed ACCT checks for Mr Lupu. He noted Mr Lupu sat in his cell, smoking.

70. At 1.45pm, staff held a briefing meeting, and discussed Mr Lupu. An officer said staff were told that Mr Lupu had harmed himself many times, had refused medical treatment and his risk of suicide and self-harm was being monitored. After the meeting, an SO said he asked the custodial manager if Mr Lupu would be placed under constant observation. They said that Mr Lupu would continue to be managed on the wing and not under constant observation. The custodial manager said no one suggested to him that Mr Lupu should be under constant observation. He believed that Mr Lupu's acts of self-harm were not sufficiently severe to warrant constant observation; his cuts were mainly superficial; and Mr Lupu had refused to move to the healthcare unit as he could not smoke there. We saw no evidence that Mr Lupu had refused to go to the healthcare unit.

71. Shortly afterwards, Mr Lupu's cellmate left the cell to attend a visit and two minutes later, Mr Lupu cut his legs. An officer called the healthcare team and a nurse (who was unavailable for us to interview) attended. Mr Lupu declined treatment. The officer said it was difficult to manage Mr Lupu and he believed he would have been managed better under constant observation.

72. At around 2.10pm, an officer arrived at Mr Lupu's cell. He looked calm, was smoking a cigarette and had many superficial cuts. Unaware that prison and healthcare staff had already attended Mr Lupu's cell, the officer radioed the healthcare team to report Mr Lupu's cuts to his neck and legs. A second officer, who was on the landing below, heard the request and shouted to the first officer that the nurse had already tried to treat Mr Lupu's wounds. The first officer said he would wait for the nurse to arrive.

73. The officer tried to talk to and support Mr Lupu. Another Romanian prisoner on the landing interpreted for him. Mr Lupu was unhappy and pointed to a note he had written in Romanian on the table in front of him. The officer looked at the note and asked the prisoner to translate it. The prisoner told the officer that Mr Lupu had written that he had had enough, was going to end his life and blamed others for everything that had happened to him.

74. At 2.43pm, a nurse and the custodial manager went to Mr Lupu's cell. Mr Lupu declined medical treatment. The officer said that he recalled that he or another member of staff had put the letter in the ACCT record. He said he had told the custodial manager what the note said. (The custodial manager however said he first heard about the note after Mr Lupu was taken to hospital.) The officer said that as Mr Lupu had refused medical treatment, the custodial manager said Mr Lupu's ACCT monitoring would continue in his cell.

75. At 3.30pm, two officers checked on Mr Lupu. An officer looked through the observation panel and saw Mr Lupu standing up, his legs appeared cut and there was blood on the floor. She radioed a medical emergency code red for the healthcare team to attend. She unlocked his cell door. While one officer tried to speak to Mr Lupu, the other officer left the cell and returned with another Romanian prisoner to interpret for them. Mr Lupu said he had cut himself because he wanted his trainers. A nurse responded to the emergency call and spent around ten minutes in the cell. She noted that Mr Lupu had wounds on his legs, arms and wrist. He declined medical treatment. The officers searched Mr Lupu's cell but could not find a cutting instrument. Mr Lupu did not say what he had used to cut his body, but asked for the biohazard cleaner to clean the blood on the floor.

76. The biohazard cleaner said that an officer asked him to clean Mr Lupu's cell at 4.00pm. He said that when he arrived, the cell was locked and he looked through the observation panel in the door. He found Mr Lupu hanging from a bed sheet tied to the window. Mr Lupu appeared grey and lifeless. The biohazard cleaner alerted an officer who was on the other side of the landing.

77. The officer immediately looked through the observation panel and saw Mr Lupu hanging from a blanket attached to the window. While he unlocked the cell door, he shouted across the landing to a second officer. He called a medical emergency code blue (which indicates a life-threatening medical emergency such as when a person is found hanging, unconscious or not breathing). The control room immediately called an ambulance. Both officers went into the cell.

78. One officer supported Mr Lupu's weight, while the other officer cut the ligature, and placed Mr Lupu on the cell floor. They checked for signs of life but found none. Another two officers then arrived at the cell. None of the four responding officers had had recent first aid refresher training.

79. One officer started cardiopulmonary resuscitation and another officer helped him. At 4.05pm, a nurse and a doctor arrived at the cell with medical equipment. The nurse attached the defibrillator, but it did not find a shockable heart rhythm. Two officers continued trying to resuscitate Mr Lupu until paramedics arrived at 4.10pm. Paramedics continued emergency treatment, a pulse was found and Mr Lupu was taken to hospital at 5.25pm. He died in hospital at 11.55am on 18 April.

Staff and prisoner support

80. The Head of Residential and Services debriefed the staff involved in the emergency response and offered his support and that of the staff care team. Staff reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been affected by Mr Lupu's actions. A further debrief was carried out on 18 April, after Mr Lupu's death had been confirmed.

Family Liaison

81. In the absence of details from Mr Lupu, staff had recorded his cellmate as his next of kin. The prison's family liaison officer contacted the Romanian Embassy (in Romania and London) to help identify Mr Lupu's family in Romania and inform them of his death. Despite the Romanian Embassy identifying a telephone number for his family in Romania, neither the Romanian Embassy, Bedford nor our family liaison officer has been able to make meaningful contact with Mr Lupu's family. Bedford has referred the matter to the Romanian Embassy and police.

Events after Mr Lupu's admission to hospital

82. After Mr Lupu's death, an officer told the investigator that another prisoner had told him that other prisoners had been bullying Mr Lupu for tobacco. We saw no evidence to support this allegation.

Cause of death (need input from clinical reviewer)

83. The post-mortem examination concluded that Mr Lupu's died as a result of hanging.

Findings

Communication with foreign national prisoners

84. The National Offender Management Service's guidance to prisons about managing foreign national prisoners says:

> 'Language barriers … can exacerbate all other problems. As professional staff, we have a responsibility to ensure that prisoners understand what is being said to them and what is expected of them. Staff should not assume that prisoners with 'some' command of the English language, fully understand what is being said or the implications. Staff need to understand and be equipped to respond to requests … '

85. PSI 64/2011 says that staff must consider using interpreting services when dealing with prisoners whose first language is not English, particularly when assessing or managing prisoners' risk. Mr Lupu was Romanian, and his English was poor. Staff should have asked him if he wanted to use Language Line to make sure they could communicate with him in a meaningful way. While staff were aware of the Language Line service, they failed to use it, but over relied on Mr Lupu's cellmate to translate. Reception staff said that Mr Lupu appeared to understand them because he responded 'yes' or 'no' appropriately. They considered he was not at risk of suicide or self-harm when he arrived, taking into account the information in his person escort record. We are not persuaded that staff had enough information about Mr Lupu to assess his risk effectively We are also concerned that as his incidents of self-harm and his risk increased, staff failed to consider using Language Line.

86. PSI 07/2015 says that prisons should provide induction information in a range of languages. Mr Lupu did not have a prison induction (and it is not clear that without staff using the interpreting service, Mr Lupu understood that he was meant to have one). This meant that he never received induction information in Romanian, and in any case, as HM Inspectorate of Prisons found in their inspection report such information was not available at Bedford.

87. In a PPO review of self-inflicted deaths in 2013-14, which we published in March 2015, we noted that a number of prisoners in the study had not received a proper induction, and were not aware of basic prison procedures. We highlighted in our review the need for all prisoners to receive a basic induction. We are concerned that this never happened in this case. HM Inspectorate of Prisons recommended after their inspection in May 2016 that staff make greater use of the telephone interpreting service to communicate with foreign national prisoners with little English and make prison information freely available in relevant languages. We make the following recommendation:

The Governor and Head of Healthcare should ensure that accredited interpreting services are used for prisoners who do not understand English well, whenever matters of accuracy or confidentiality are a factor, including during first night and induction procedures to ensure that they receive information about prison processes in a language they understand.

Management of ACCT

88. In line with Prison Service Instruction (PSI) 64/2011 on safer custody, an officer completed the initial ACCT assessment as best as he could despite Mr Lupu's behaviour and refusal to be interviewed. The officer used an interpreter to explain the ACCT process and recorded that the reason that Mr Lupu had harmed himself was that he did not have his trainers. However, we had a number of concerns with the way ACCT procedures operated.

89. The PSI requires a multi-disciplinary approach for case reviews with relevant people involved in the prisoner's care. It says that a case manager should hold a first ACCT case review within 24 hours of starting ACCT monitoring, ideally immediately after the assessment interview. The first SO should have held a case review. He said that because Mr Lupu kept harming himself, it was difficult to hold the review. A nurse said she went to the wing to participate in the ACCT review, but was told it was an inappropriate time to engage with Mr Lupu. While we recognise that it was an inappropriate time to conduct an ACCT review, no one rescheduled it, and it is unacceptable that Mr Lupu's risk was not reviewed before he died.

90. Mr Lupu's risk was never fully assessed and staff never identified caremap actions to help reduce his risk. No one reviewed the frequency of ACCT checks, which remained at two per hour, despite Mr Lupu repeatedly harming himself over a short period. Record keeping was poor. Prison and healthcare staff raised serious concerns about Mr Lupu's level of self-harm to prison managers (supervising officer, custodial manager and duty governor). Yet, there was no effective interaction or discussion about Mr Lupu's heightened risk or how staff should manage it, even after staff found a note an hour and a half before Mr Lupu was found hanged, in which he said that he wanted to end his life.

91. The PSI says that staff must hold an ACCT review whenever there is a clear sign or concerns that a prisoner's risk of suicide and self-harm has changed. This never happened. Although managers had discussed placing Mr Lupu under constant supervision, we have seen no evidence that they considered Mr Lupu's risk holistically or that anyone took responsibility for escalating his risk and subsequent care. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including ensuring:

- **A multi-disciplinary case review is held within 24 hours of ACCT procedures starting.**
- **A multi-disciplinary approach for all case reviews with continuity of case management.**
- **Caremap actions are set, which are specific, meaningful, aimed at reducing prisoners' risks and reviewed and updated, as necessary.**
- **Risk is reviewed whenever an event occurs which indicates an increase in risk and a case review is held if required, even in the absence of the prisoner.**

- **All staff, including healthcare staff, record relevant information about risk, observations and interactions with prisoners in ACCT documents and taking appropriate action.**

Clinical care

92. The clinical reviewer concluded that the clinical care Mr Lupu received was not equivalent to what he could have expected in the community, particularly Mr Lupu's health screens. She made a number of recommendations, which the Head of Healthcare will need to address.

93. Reception staff should provide the nurse with the person escort record. A nurse said that she would normally sign the prison escort record to confirm she had seen it, but Mr Lupu's person escort record was unsigned which suggested she had not. PSI 74/2011 on early days in custody including reception processes, is clear that staff should examine all information, including person escort records. It requires that staff note all relevant information in the appropriate record, and that they inform other staff and act on the information identified, where necessary. We are concerned that staff failed to identify that Mr Lupu's prison escort record highlighted a history of schizophrenia and to explore its relevance to his situation.

94. Despite staff being unable to complete Mr Lupu's first health screen, they failed to carry out his secondary screen (which would routinely have taken place the next day) until five days later. While we recognise that healthcare staff conducted Mr Lupu's secondary health screen within the 5 day timescale required by Prison Service Order 3050, they should have prioritised it because the information they gathered about Mr Lupu was limited at the first health screen.

95. A nurse referred Mr Lupu to the mental health team on the day he hanged himself after he had harmed himself several times. A mental health nurse tried to assess Mr Lupu but staff said this was not possible due to Mr Lupu's ongoing incidents of self-harm. The first nurse should have arranged to return to Mr Lupu's wing to assess him later. Instead, she relied on an SO's comment that Mr Lupu was not displaying mental health concerns. The same nurse noted that Mr Lupu did not need to see the mental health team at that time, but could see them at staff's request at a later date. Prison officers are not trained to diagnose mental health issues, and we are concerned that the nurse decided on Mr Lupu's needs without assessing him herself. While a mental health assessment at that time may not have changed the outcome for Mr Lupu, it is possible that it might have uncovered any underlying mental health issues. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **Reception staff examine and record all relevant information about newly arrived prisoners in line with PSI 74/2011.**
- **All relevant staff consider person escort records and suicide and self-harm warning forms and ensure there is a clear audit trail.**
- **Prisoners identified as at risk of suicide and self-harm have a full mental health assessment.**

- **Staff conduct detailed assessments and prioritise prisoners who have not completed their reception screening and induction.**

Next of kin details

96. PSI 64/2011, which gives guidance on safer custody, managing prisoners at risk of suicide and self-harm, says that prisons must record a prisoner's next of kin or nominated person during the reception process. When Mr Lupu told reception staff that he had no next-of kin, staff should have recorded that he had no next of kin. Instead, they noted his cellmate as his next of kin despite Mr Lupu not nominating him and not knowing him. This was inappropriate. We make the following recommendation:

The Governor should ensure that prisoners' next of kin details are recorded when they arrive at the prison, so that up to date information is available in an emergency. Where no next of kin is identified, this should be clearly recorded.

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