

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Purcell a prisoner at HMP Bedford on 29 August 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

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 Paul Purcell died in hospital on 29 August 2016, three days after he was found hanging in his cell at HMP Bedford. He was 37 years old. I offer my condolences to Mr Purcell's family and friends.

Mr Purcell had suffered with mental health problems but initially told the mental health team that he did not require their assistance. He later changed his mind and asked for help, but the mental health team felt unable to offer him any substantive interventions. On the morning of 26 August, while his cellmate staged a protest on the wing, Mr Purcell hanged himself.

I am concerned that Mr Purcell sought assistance from the mental health team on a number of occasions but no practical help was forthcoming. There was, however, nothing that indicated that Mr Purcell had any thoughts of taking his own life and as such his death could not have been foreseen.

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

June 2017

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings	8

Summary

Events

1. In May 2016, Mr Purcell was released from prison on licence. He was recalled to custody on 23 July. On arrival at HMP Bedford, he disclosed that he had been treated for depression and anxiety, and was referred to the mental health team. He was also referred for a detoxification programme.
2. On 10 August, two mental health nurses conducted a mental health assessment. Mr Purcell told them that he had been admitted to a mental health hospital recently but also said that he had no current mental health concerns and no history of mental health problems. He said that he did not want any input from the mental health team but that if he did have any concerns he would contact them.
3. On 17 August, Mr Purcell told a prison officer that he now felt that he needed help from the mental health team, and he was reassessed on 18 August. He denied having any thoughts of self-harm but was paranoid and anxious. The nurse said that there was insufficient time for him to complete the most appropriate programme before his release date so instead he should contact his doctor after release. In the meantime, he could contact the mental health team again if he had further problems.
4. On 23 August, a prison officer telephoned the mental health team and told them that Mr Purcell was suffering from paranoia. A nurse said that he had been assessed the previous week and was not under the care of the mental health team.
5. On 24 August, Mr Purcell told a prison officer that he was concerned about his anger management. A nurse overheard the conversation and notified the mental health team. That afternoon, Mr Purcell and another prisoner held a protest, requesting to see the mental health team. A manager telephoned the team, and a nurse told him that they had already assessed Mr Purcell and if he wanted to see them again he should put in an application.
6. On 25 August, Mr Purcell told a prison officer that he wanted to see the mental health team. The officer telephoned the mental health team, and a nurse said that they had recently seen Mr Purcell and he had been discharged.
7. On 26 August, Mr Purcell's cellmate began a protest on the wing. Prisoners were locked into their cells and an ambulance was called. At 8.49am, an officer noticed she was unable to see into Mr Purcell's cell as he had covered the observation panel. She called for colleagues and they unlocked the door, and found Mr Purcell hanging. They provided medical aid, were soon joined by the ambulance crew, which was already on the wing, and Mr Purcell was transferred to hospital. He died in hospital on 29 August.

Findings

Healthcare

8. Mr Purcell was referred to and assessed by the mental health team on arrival at Bedford. He initially said that he did not need their input but, subsequently, changed his mind and asked for help. Nurses further assessed him but said that he was not in prison long enough for them to undertake any interventions. They advised that, instead, he should speak to his doctor following release. Mr Purcell then asked to see the mental health team on 23 August, twice on 24 August, and again, on 25 August. On none of these occasions did anyone from the mental health team go and see him or make an appointment on his behalf.

Assessment of risk

9. When Mr Purcell arrived in Bedford he applied to be held on the vulnerable prisoner unit, but there were no indications that he was at risk of self-harm. On 24 August, he handed a letter to a prison officer, expressing concerns at his anger management. The officer told a nurse, who relayed the information to the mental health team. There is, however, no reference to the letter outside the note made by the nurse on Mr Purcell's medical record. The prison has been unable to locate the letter or identify the officer.

Emergency Response

10. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, contains a mandatory instruction that prison staff should use a code blue (or code one) for any emergency where a prisoner is unresponsive, has symptoms including chest pain or difficulty in breathing, and that they should not delay summoning emergency assistance.
11. The prison officer who called the emergency over the radio did not use the correct emergency code. However, when prison officers found Mr Purcell hanging, there was already an ambulance crew on the wing dealing with another incident. While in this case there was no delay in the provision of medical aid, it is important that staff use the correct codes to communicate the nature of emergencies.

Recommendations

- The Head of Healthcare should review the mental health assessment process to ensure that accurate, timely assessments of need take place when there are indications that a prisoner is asking for support.
- The Governor should ensure that when staff become aware of information relating to a prisoner's wellbeing, this is properly recorded and, where necessary, disseminated appropriately.

The Investigation Process

12. 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.
13. The investigator visited Bedford on 12 September. He obtained copies of relevant extracts from Mr Purcell's prison and medical records. He was also given access to police statements from staff and prisoners at Bedford. He interviewed five members of staff and six prisoners. He also requested recordings of Mr Purcell's telephone calls but Bedford did not provide these.
14. NHS England commissioned a clinical reviewer to review Mr Purcell's clinical care at the prison. She and the investigator jointly interviewed members of healthcare staff.
15. We informed HM Coroner for Bedfordshire and Luton of the investigation. He sent us the results of the post-mortem examination and we have given the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted solicitors representing Mr Purcell's family to explain the investigation and to ask whether Mr Purcell's family had any matters that members wanted the investigation to consider. Mr Purcell's family asked about his mental healthcare in prison. Mr Purcell's family were sent a copy of our initial report. They did not offer any comment.

Background Information

HMP Bedford

17. HMP Bedford is a medium security prison that holds approximately 500 men. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

18. The most recent inspection of Bedford was conducted in May 2016. Inspectors found that levels of self-harm had risen significantly since their last inspection in 2014. There were too few psychological interventions for prisoners with mild-to-moderate mental health needs, no therapeutic groups and no access to counselling.

Independent Monitoring Board

19. 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 June 2016, the IMB reported an increase in incidents of self-harm and issues with staff shortages. The board also noted that the mental health team were under intense pressure.

Previous deaths at HMP Bedford

20. Mr Purcell was the sixth prisoner to take his life at Bedford since 2013, and there has since been a further self-inflicted death. We have previously expressed concerns about mental health care.

Assessment, Care in Custody and Teamwork (ACCT)

21. 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 *Management of prisoners at risk of harm to self, to others, and from others (safer custody)*.

Key Events

22. In May 2016, Mr Paul Purcell was released on licence from HMP The Mount but was recalled for breaching the terms of his home detention curfew. He arrived at HMP Bedford on 23 July 2016. In reception, he applied to be held separately from mainstream prisoners for his own protection, as he said that he had been threatened. The vulnerable prisoner unit (VPU) was full, so staff allocated Mr Purcell a cell in the VPU overspill section on C wing.
23. A nurse conducted a reception health screen with Mr Purcell. He told her that he had been treated for depression and anxiety, and she referred him for a mental health assessment. A prison GP saw Mr Purcell to assess his medication. He told her that he was on prescriptions for lorazepam (used to treat anxiety) and mirtazapine (an anti-depressant). She told him that lorazepam would not be prescribed in prison and he would have to switch to diazepam. She referred him for a detoxification programme to help him manage this change. Mr Purcell also had a neurology hospital appointment pending, so she made arrangements to have that appointment rescheduled.
24. On 25 July, a nurse from the mental health team assessed Mr Purcell. She noted that Mr Purcell was not on any prescribed medication. She referred him for further assessment.
25. That day, 25 July, Mr Purcell moved to a cell on the main VPU on F wing. He saw a nurse for a secondary healthcare screening and told her that he sometimes suffered from seizures, most recently in March or April 2016. He said that he was a light user of cannabis but was not suffering any withdrawal symptoms. He said that he had recently separated from his partner, and had been diagnosed with depression but had pulled himself out of it without medication. He said that he had no thoughts of harming himself, and an assessment indicated that he was not suffering from depression. A drug test gave a negative result.
26. On 10 August, two nurses conducted a mental health assessment with Mr Purcell. He said that he did not have any current mental health concerns but agreed to answer some questions. He said that he had been admitted to a mental health hospital three weeks previously but was released after seven hours as they realised that it had been a mistake. (In fact he had been held under Section 136 of the Mental Health Act but not detained following a formal mental health assessment.) He said that he had no other history of mental health problems. He said that he had settled on the wing, he appeared to be in a bright mood, and said that he had no thoughts of harming himself. He said that he did not want any input from the mental health team but that if he did have any concerns he would contact them himself. One of the nurses wrote to the hospital where Mr Purcell said he had recently been, seeking further information. Having detected no signs of mental illness, she did not add Mr Purcell to the mental health team's caseload.
27. A prisoner had known Mr Purcell for some years. He told the investigator that when Mr Purcell arrived on the wing he did not seem himself. They spoke, and Mr Purcell told him that he was hearing voices and having suicidal thoughts, and

wanted to speak to someone from the mental health team. He told the investigator that he approached Officer A and told her his fears about Mr Purcell. When the investigator asked her about this, she said she had no memory of this prisoner, or any other prisoner, expressing fears about Mr Purcell's wellbeing.

28. On 17 August, Mr Purcell told Officer A that during his mental health assessment the previous week he had not disclosed all relevant information, and he felt that he did now need the support of the mental health team. She telephoned a nurse, and the nurse and a colleague saw Mr Purcell the following day. He said that he needed to talk to people rather than keeping his problems to himself. He denied having any thoughts of harming himself but said he was due to be released at the end of September, and had become paranoid and anxious. The nurse said that if he began an Improving Access to Psychological Therapies (IAPT, a treatment for people with anxiety and depression) programme, he would not be able to complete it before being released. He should therefore contact his doctor following release but, if he felt he needed help in the meantime, he should again contact the mental health team.
29. On 23 August, an officer telephoned a nurse. He said that Mr Purcell was struggling with increasing paranoia. The nurse said that Mr Purcell had had a thorough assessment the previous week and had been discharged from the care of the mental health team.
30. On 24 August, Mr Purcell handed a letter to a prison officer. A nurse was in the room and the officer told him that Mr Purcell's letter had expressed concerns at his own anger management. The nurse referred Mr Purcell back to the mental health team. The prison has been unable to identify this officer or locate the letter, and there is no entry on his electronic prison record in relation to the letter.
31. Later that day, Mr Purcell and another prisoner were involved in a protest. Mr Purcell said that he had asked to see a community psychiatric nurse but this had not happened. One of the prison's managers telephoned a nurse. She said that the mental health team had assessed Mr Purcell and he had not submitted any applications. The manager asked how Mr Purcell could see the team, and the nurse said that he should put in an application. When Mr Purcell ended his protest staff took him to the segregation unit, where he remained overnight. The following day he was allocated a cell in the VPU overspill section of C wing, sharing a double cell with another prisoner.
32. On 25 August, Mr Purcell told an officer that he wanted help from the mental health team. The officer telephoned a nurse. She explained that Mr Purcell had been in recent contact with the mental health team and had been discharged, but he would be referred for counselling after release. The officer asked officers on C wing to pass this information on to Mr Purcell.
33. Mr Purcell's cellmate told the investigator that some other prisoners verbally abused Mr Purcell when they came back onto C wing. On the evening of 25 August, he and Mr Purcell were discussing his problems, and Mr Purcell said that he felt like taking his own life. He talked it through with him and, having done so, said that he did not think Mr Purcell had any serious intent.

34. On 26 August, CCTV footage shows Mr Purcell coming out of his cell at 7.54am. Shortly after this, upstairs on the wing, his cellmate climbed onto a beam and threatened to jump. Prisoners on the wing were locked back into their cells and an ambulance was called. CCTV shows Mr Purcell going back into his cell at 7.55am and an officer locking the door. At 7.59am, a prison manager, two officers and a prison pharmacy technician went into Mr Purcell's cell to collect an item belonging to his cellmate. An officer locked the door again at 8.02am.
35. At 8.20am, the ambulance crew arrived. They left their equipment trolley at the foot of the stairs outside Mr Purcell's cell while they went up to the next landing where his cellmate was protesting.
36. At 8.49am, an officer went to Mr Purcell's cell door, but was unable to see into the cell as he had covered the observation panel. She returned one minute later with two managers and a supervising officer (SO). They unlocked the cell door and found Mr Purcell hanging from the window frame by a ligature he had made from his bedclothes. While the SO radioed for assistance, the others entered the cell. An officer used her anti-ligature knife to cut Mr Purcell down, while another supported his weight. They lowered him to the floor and began to provide cardiopulmonary resuscitation (CPR). One minute later, a nurse arrived, followed less than a minute after that by the paramedics, who had been called to the prison when Mr Purcell's cellmate began his protest. They provided medical aid in the cell until 9.18am, when they transferred Mr Purcell to hospital.

Contact with Mr Purcell's family

37. When Mr Purcell was taken to hospital, prison staff contacted his family. They went to the hospital and stayed with him until he died. A SO was appointed as family liaison officer, and offered support to Mr Purcell's family. In line with prison service guidance, Bedford offered to contribute to the costs of Mr Purcell's funeral.

Support for prisoners and staff

38. After Mr Purcell's death, the prison's acting Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
39. The prison posted notices informing other prisoners of Mr Purcell's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Purcell's death.

Post-mortem report

41. The post-mortem report showed that Mr Purcell died from hypoxic brain injury, cardiac arrest and hanging. No toxicology tests were carried out.

Findings

Healthcare

40. The clinical reviewer noted that the prison dealt properly with Mr Purcell's outstanding neurology appointment. He was appropriately referred for mental health triage in reception, and the triage carried out two days later referred him on for assessment.
41. On 10 August, two nurses assessed Mr Purcell and decided not to place him under the care of the mental health team. The clinical reviewer noted that the decision not to explore Mr Purcell's recent admission to a mental health hospital for paranoia was an insufficient response. Nor did the nurses explore the prescriptions from Mr Purcell's doctor to treat anxiety and depression, or his outstanding psychiatric appointment. They did not ask why Mr Purcell was on the vulnerable prisoner unit and were therefore unaware that he had expressed the potentially paranoid belief that he was under threat. While one nurse later contacted the hospital for confirmation of the circumstances, records do not show that anyone considered the reply.
42. On 17 August, Mr Purcell said that he wanted the support of the mental health team and two nurses saw him the following day. He expressed anxiety about his forthcoming release from prison, but the nurses said that there were no interventions he could do in the short time before he was to be released. They did not refer him to a doctor to review his previous medication prescription for anxiety and depression nor did they offer a follow-up appointment, which the clinical reviewer noted would have been appropriate.
43. On 23 August, an officer told a nurse that Mr Purcell was struggling with increasing paranoia. The nurse said that he had already been assessed and discharged from the mental health team. The clinical reviewer's opinion was that this should have been seen as a trigger to revisit the decision made on 18 August.
44. On 24 August, a nurse referred Mr Purcell to the mental health team once again after he indicated that he was struggling with anger management. Later that afternoon, an officer telephoned a nurse to ask about Mr Purcell's interaction with the mental health team. He was involved in a protest because he said he had asked to see the mental health team but had not been able to do so. The nurse told him how Mr Purcell should make an application. She did not arrange to see him. The clinical reviewer noted that this should have been cause to reconsider whether Mr Purcell needed further assessment.
45. On 25 August, an officer telephoned a nurse and asked whether Mr Purcell was under the care of the mental health team, as he had said that he needed their help. She told the officer that Mr Purcell had agreed to see his doctor in the community, following release.
46. Between 18 and 25 August, Mr Purcell made four separate attempts to get some help from the mental health team. None of these prompted anyone from the team to go and see him, or schedule him for further assessment. This was despite him having been told when he was not put under the team's care that he

could always contact them again if he felt he needed help. He did so, and received none. The clinical reviewer noted that, at the very least, someone should have reassessed Mr Purcell's needs. She concluded that indications that he was in need of further mental health assessment were not acted upon, and the mental health care Mr Purcell received was below that he could have expected in the community.

47. The clinical reviewer made five recommendations, which the head of healthcare should address individually. We make the following recommendation:

The Head of Healthcare should review the mental health assessment process to ensure that accurate, timely assessments of need take place when there are indications that a prisoner is asking for support.

Assessment of risk

48. When Mr Purcell arrived in Bedford he applied to be held on the VPU. He was identified as having had mental health problems and correctly referred to the mental health team. There were no indications that he was at risk of self-harm.

49. A prisoner told the investigator that he had alerted an officer to his concerns about Mr Purcell. She however said in interview that she had no recollection of this. We are therefore unable to comment on this any further.

50. A nurse was in the room when Mr Purcell handed a letter to a prison officer on 24 August. The nurse did not see the letter but the officer told him that Mr Purcell said he was concerned about managing his anger. The nurse contacted the mental health team. Bedford has been unable to locate the letter, and there is no mention of it on Mr Purcell's electronic record, nor is it recorded in the F wing observation book. We have been unable to check whether there was any mention in the segregation unit observation book as it was destroyed during disturbances in Bedford in early November. However, the lack of information about this is worrying. We make the following recommendation:

The Governor should ensure that when staff become aware of information relating to a prisoner's wellbeing, this is properly recorded and, where necessary, disseminated appropriately.

51. Mr Purcell's cellmate told the investigator that he had not discussed the actions he had planned on the morning of 26 August with Mr Purcell. There is no evidence to suggest that they planned anything together or that he deliberately created a diversion for Mr Purcell.

52. Mr Purcell had written to his family from Bedford. They said that some references in his letters indicated that he might be feeling anxious. Mr Purcell was not, however, subject to any postal monitoring restrictions, and there was no reason for the prison to have been aware of this

Bullying

53. When Mr Purcell arrived in prison, he asked to be put on the vulnerable prisoners' unit. He said he was under threat and with no way of assessing this at the time prison staff rightly took the precaution of treating his fears as potentially

valid. There is, though, almost no other indication that Mr Purcell was under any specific threat in Bedford. A prisoner was a friend of Mr Purcell's and spoke to him during his time in Bedford. He told the investigator that Mr Purcell did not have any problems in the prison. He was confident that Mr Purcell did not take any drugs while in Bedford and that he had no problems with debt or bullying. Mr Purcell's cellmate said apart from some verbal insinuation, Mr Purcell was not bullied or under specific threat from other prisoners

Emergency response

54. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, contains a mandatory instruction that prison staff should use a code blue (or code one) for any emergency where a prisoner is unresponsive, has symptoms including chest pain or difficulty in breathing and that they should not delay summoning emergency assistance.
55. When prison officers found Mr Purcell hanging, the SO radioed for assistance but did not use the recognised emergency code. A prison manager however did so and, because there were ambulance staff already on the wing, there was no need for the control room to request an ambulance as would normally be the case. In this instance there was no delay in providing medical care to Mr Purcell, and the clinical reviewer noted that the emergency response was good. We make no recommendation, but would point out that in emergency situations time can be crucial, and it is important that staff acting under stressful conditions are aware of their responsibilities.

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