Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Liam Bentley, a prisoner at HMP Swaleside, on 6 June 2022

## A report by the Prisons and Probation Ombudsman

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# Our vision

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

# Our values

**We are:**

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity

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

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

Mr Liam Bentley was found hanged in his cell on 6 June 2022 at HMP Swaleside. He was 25 years old. I offer my condolences to his family and friends.

Mr Bentley was a troubled man who appeared to struggle with being in prison. He isolated himself in his cell, seemingly out of fear of threat or assault from other prisoners, and chose not to collect his mental health medication as a result. I am concerned that several opportunities were missed to identify and consider his risk of suicide and self-harm properly. It is particularly worrying that, despite his many risk factors, staff chose not to start suicide and self-harm prevention procedures when Mr Bentley harmed himself and said that he would take his life.

Prison staff did not monitor Mr Bentley's self-seclusion in line with local expectations. They said that this was a direct result of ongoing staff shortages at Swaleside. Several other aspects of the expected prison regime were not initiated for Mr Bentley. I am extremely concerned about ongoing staff shortages at Swaleside and how these affected the level of support and monitoring that Mr Bentley received.

On the morning of his death, a roll check was not completed as it should have been. While proper completion would have identified earlier that Mr Bentley had hanged himself, I cannot say that it would have led to a different outcome.

Liaison with Mr Bentley's family following his death was extremely poor. No one from Swaleside contacted them for over two months after staff from a neighbouring prison had broken the news. This is unacceptable and reflects badly on the prison.

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

**Kimberley Bingham**
**Acting Prisons and Probation Ombudsman** **July 2023**

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# Summary

## Events

1. In December 2016, Mr Liam Bentley was sentenced to seven years in prison for robbery. Mr Bentley had a diagnosis of attention deficit hyperactive disorder (ADHD) and autism, and often did not take his medication. He had a history of challenging behaviour: he often isolated himself and, on several occasions, he was monitored under suicide and self-harm monitoring procedures, known as ACCT.

2. On 25 March 2022, Mr Bentley was transferred to HMP Swaleside. On 16 April, Mr Bentley harmed himself and told prison staff that he wanted to kill himself. Several days later, he headbutted his cell door. Staff did not start ACCT procedures.

3. On 19 April, staff started self-seclusion monitoring procedures after Mr Bentley said that he felt threatened by other prisoners and did not want to leave his cell. On 2 May, he assaulted a member of staff while being restrained, following his refusal to return to his cell.

4. Over the following weeks, Mr Bentley frequently refused to collect his medication. He told staff that he did not feel safe collecting it with other prisoners. However, on some occasions, he left his cell to collect it.

5. Mr Bentley was discussed regularly at Safety Intervention Meetings, at which he was referred to other support agencies within Swaleside.

6. At around 8.20am on 6 June, a prison officer found that Mr Bentley had blocked his cell door observation panel. Officers went into the cell and found him hanging from a ligature attached to his bed. Prison staff initially began cardiopulmonary resuscitation (CPR) but stopped soon afterwards when it became apparent that Mr Bentley had been dead for some time.

## Findings

### Identifying the risk of suicide and self-harm

7. We are concerned that there were some missed opportunities to identify that Mr Bentley was at risk of suicide and self-harm. When he harmed himself and said that he wanted to take his life, staff did not start ACCT procedures as they should have. His wider range of risk factors, including self-seclusion, fear of assault and the effects of stopping medication on his mental health, were not considered holistically and there were a number of missed opportunities for staff to consider Mr Bentley's risk and start ACCT procedures.

### Self-seclusion

8. Swaleside has good processes to monitor prisoners isolating themselves. However, we are concerned that these were not properly managed: Mr Bentley's self-seclusion monitoring document was poorly completed, and there was no management plan to encourage his re-engagement with the regime.

### Staff shortages

9. Swaleside has been operating considerably below its expected staffing complement for some time. We are concerned about the impact that this had on Mr Bentley: a wing manager said that a lack of staff directly affected their ability to manage Mr Bentley's self-seclusion in line with local policy and numerous other expected aspects of his prison regime were incomplete.

### Mr Bentley's concerns for his safety

10. Mr Bentley frequently told staff that he felt threatened by other prisoners. Although we found no evidence that this was the case, we are concerned that staff did not carry out sufficient investigation into his allegations to establish if he was being bullied or threatened. This is particularly important given that it was the reason for his self-seclusion and is a risk factor for suicide and self-harm.

### Roll checks

11. On the morning of Mr Bentley's death, a roll check was not completed as it should have been.

### Family liaison

12. We are very concerned about the quality of family liaison offered to Mr Bentley's family after his death. After a family liaison officer from another prison told Mr Bentley's family of his death, over two months passed before anyone from Swaleside made contact with them.

### Clinical care

13. When Mr Bentley stopped taking his medication, there was no follow up from the mental health team, despite a marked change in his behaviour that prompted several referrals to the team.

## Recommendations

- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and, in particular, the need to record, share and consider relevant information about risk, and start ACCT procedures when indicated.

- The Governor and Head of Healthcare should ensure that prisoners who are self-secluding are managed in line with local guidelines, including that:

    - pre-assessments are completed within 24 hours;

    - the first review and management plan are completed within 25 hours; and

    - healthcare staff and other support services are invited and contribute to all reviews, where their support is relevant.

- The Director General of Operations for HM Prison and Probation Service (HMPPS) should ensure that clear measures are implemented as a matter of urgency to recruit and retain sufficient operational and specialist staff at HMP Swaleside to reinstate purposeful activity and support prisoners' progression.

- The Head of Healthcare should ensure that all prisoners, who are not taken to hospital as advised, receive appropriate follow-up care.

- The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

- The Governor should ensure that staff complete roll checks as required, by looking carefully through the cell door observation panel and taking appropriate action if there are any immediate concerns for the wellbeing of a prisoner.

- The Governor should ensure that prisoners who block their cell door observation panels are challenged, blockages are removed, and frequent offenders receive appropriate disciplinary action or support.

- The Governor should ensure that prison staff liaise with families following a death in custody in line with national instructions, including that:

    - a family liaison officer is appointed as soon as possible;

    - the family liaison officer maintains contact with the bereaved family and provides appropriate information and support; and

    - funeral expenses are offered and the deceased's property returned to their family within appropriate timeframes.

- The Head of Healthcare should ensure that all patients who are prescribed medication licenced for ADHD have physical health checks and ongoing monitoring in line with National Institute for Health and Care Excellence (NICE) guidelines.

- The Head of Healthcare should ensure that prisoners who do not collect their medication are monitored and reviewed in line with local policy.

- The Head of Healthcare should ensure that all prisoners with a history of substance misuse are referred to the prison's substance misuse team when they arrive.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

# The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. No one responded. The investigator obtained copies of relevant extracts from Mr Bentley's prison and medical records.

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

16. The investigator visited Swaleside and interviewed fourteen members of staff and spoke to two prisoners, some jointly with the clinical reviewer. Some of the interviews were conducted remotely.

17. We informed HM Coroner for Kent Mid and Medway of the investigation. The Coroner provided us with a copy of the post-mortem and toxicology report. We have sent her a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Bentley's next of kin, to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Bentley's family told us that another prisoner had tried to stab Mr Bentley at Swaleside and that he was too frightened to leave his cell to collect his medication. They said that prison staff had opened Mr Bentley's legal correspondence and had assaulted him around four weeks before he died. Mr Bentley's family told us that his telephone calls to them often disconnected, that he was unable to access the Samaritans and that he was unable to have or clean his own clothes. They also told us that communication from the prison's family liaison officer was poor. They asked the following questions:

    - Why was Mr Bentley transferred to Swaleside?
    - Was Mr Bentley assaulted by staff and why did this happen?
    - Why was Mr Bentley unable to speak to a Listener, despite asking to do so?
    - Why was Mr Bentley's parole hearing cancelled?
    - What medication was Mr Bentley prescribed, why was it changed and why was more not done to ensure that he received it?
    - When was Mr Bentley last checked by staff before he died?
    - Did Mr Bentley make any complaints during his time at Swaleside?

19. Mr Bentley's family received a copy of the initial report. They pointed out some factual inaccuracies. This report has been amended accordingly. Mr Bentley's family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

# Background Information

## HMP Swaleside

20. HMP Swaleside, on the Isle of Sheppey, is part of the long-term high security estate. It holds up to 1,090 men serving sentences of at least four years. Until April 2022, Integrated Care 24 (IC24) provided physical healthcare services at Swaleside and Oxleas NHS Foundation Trust provided mental healthcare services. From April, Oxleas has provided both physical and mental healthcare, which includes 24-hour nursing cover.

## HM Inspectorate of Prisons (HMIP)

21. The most recent inspection of HMP Swaleside was in October 2021. Inspectors reported that outcomes for prisoners remained disappointing, particularly in safety and purposeful activity.

22. Inspectors reported that incidents of self-harm had almost doubled since the last inspection. They reported that that they had spoken to prisoners who were self-secluding who said that they spent most of their time locked in their cell and did not receive regular meaningful contact from staff to check on their wellbeing. Inspectors found that more than a third of prisoners felt unsafe and that some low-level poor behaviour went unchallenged.

23. Inspectors reported that the delivery of services was hindered by significant shortages of staff. They reported that having only three quarters of staff available limited the ability to reinstate purposeful activities for prisoners. They found that the offender management unit (OMU) continued to be under-staffed, and that the amount of meaningful in-person contact that prisoners had with their prison offender manager was insufficient and among the worst they had seen. Although inspectors noted that staff shortages were beyond the ability of prison managers to influence directly, it was nevertheless a fundamental strategic risk and priority, which needed HMPPS's intervention and support.

24. Inspectors also reported that the healthcare team was overstretched, again due to longstanding staff shortages. They found that many prisoners missed external healthcare appointments due to the lack of staff available for escorts.

## Independent Monitoring Board

25. 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 April 2022, the IMB reported that efforts to implement a worthwhile regime for prisoners had been made difficult by staff shortages, with just 160 staff available out of an agreed complement of 261. They found that this was exacerbated by a large proportion of staff having less than two years' experience.

26. The IMB reported that the almost total withdrawal of the key worker scheme due to staff shortages had led to further frustration and worry for prisoners and may have

been a factor in the recent increase in deaths at the prison. The IMB also reported that although staffing of the safer custody team had increased, cross-deployment to other areas meant that they had not been in a position to provide as much support to prisoners as they would have liked.

27. The IMB reported that the prison could do more to avoid prisoners isolating themselves and that CSIP should receive more attention from custodial managers. They reported that prisoner on prisoner incidents of violence had risen.

28. The IMB reported that it was too early to comment on the transfer of healthcare services to Oxleas NHS Trust, although early indications were encouraging. However, staff shortages in healthcare continued. The IMB reported that missed hospital appointments were an issue and were most often caused by a lack of escort staff.

## Previous deaths at HMP Swaleside

29. Mr Bentley was the sixth prisoner to take his life at Swaleside since January 2021. In our report into the death of a prisoner in December 2021, we raised issues about prisoners receiving medication, that staff should consider all risk factors when assessing a prisoner's risk of self-harm, and that allegations of bullying should be promptly investigated.

30. There were also six deaths from natural causes at Swaleside during this period. There were no significant similarities between our findings in these investigations and our findings in this report. There have also been three drug-related deaths at the prison. In our report into the death of a prisoner in October 2021, we found that healthcare staff should ensure that prisoners received their prescribed medication.

## Assessment, Care in Custody and Teamwork (ACCT)

31. 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. As part of the process a support plan (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

# Key Events

32. On 22 December 2016, Mr Liam Bentley was sentenced to seven years in prison for robbery. It was not his first time in prison. He had a history of violent behaviour in custody, including assaulting officers for which he received five further sentences to run concurrently.

33. Mr Bentley had diagnoses of attention deficit hyperactivity disorder (ADHD) and autism and a history of substance misuse. On 18 occasions between 2016 and November 2020, Mr Bentley was subject to ACCT procedures. These were often started because he isolated himself as a result of feeling threatened by other prisoners or during periods when he refused to take his medication.

34. On 12 January 2021, Mr Bentley was released on licence. On 30 March, he was recalled to HMP Bristol and he was transferred to HMP Channings Wood in October. Mr Bentley harmed himself soon after his arrival at Channings Wood. Staff started ACCT procedures as a result.

35. On 12 January 2022, Mr Bentley was sentenced to a further eight months in prison for assaulting an officer in July 2021. Days later, he harmed himself by making superficial cuts to his hand. Staff started ACCT procedures, which they stopped two weeks later.

36. On 5 February, Mr Bentley harmed himself by making cuts to his arm. Prison staff re-started ACCT procedures. Mr Bentley said that he found his emotions challenging and struggled to communicate with staff. Staff ended ACCT procedures on 10 February.

37. On 15 February, Mr Bentley assaulted a member of staff who had told him to return to his cell. Mr Bentley said that he would “kill himself” and staff started ACCT procedures. They also started monitoring him under a Challenge, Support and Intervention Plan (CSIP, a multidisciplinary approach which focuses on those who pose a raised risk of violence to others and works to change their behaviour). Staff ended ACCT procedures on 18 February.

38. On 1 March, Mr Bentley was transferred to Bristol. Because his ACCT post-closure review had not been completed, staff started a further seven-day period of ACCT monitoring. Over the following weeks, it was noted that he raised no concerns, he was polite and pleasant and said that he felt safe at Bristol.

39. On 16 March, a date for Mr Bentley’s parole hearing was set for 25 May. (This date was adjourned from a previous hearing as he had received a new sentence and was not therefore eligible for parole at the time.)

40. On 18 March, Mr Bentley was told that he would be transferred to HMP Swaleside as part of his sentence progression and because of his Category B status. Prison staff noted that he said that he was happy about the transfer and that he wanted to keep his head down and focus on his parole hearing. However, five days later, Mr Bentley said that he did not want to transfer to Swaleside because he would be threatened by other prisoners. He later said that he accepted the need for the transfer but did not view it as being progressive. Staff noted that any transfer or wing move was difficult for Mr Bentley because he did not like change.

## HMP Swaleside

41. On 25 March, Mr Bentley arrived at Swaleside, having been prescribed an antidepressant and ADHD medication. At a reception healthcare assessment, a prison nurse identified that he had ADHD and a history of self-harm. The nurse referred Mr Bentley to the prison's mental health team. However, Mr Bentley did not receive a prison induction and no referral was made to the substance misuse team.

42. On 6 April, a mental health nurse assessed Mr Bentley. The nurse noted that his mood could rapidly fluctuate but that he appeared stable. The outcome of the assessment was for the ongoing management of Mr Bentley's ADHD to be discussed at the next mental health multidisciplinary team (MDT) and for his medication to be reviewed.

43. On 13 April, the MDT meeting discussed Mr Bentley. They agreed that he would remain on the mental health team's caseload and that a psychiatrist would review him in June.

44. On 14 April, Mr Bentley spoke to his community offender manager (COM). He told her that he had not got on well at previous prisons but was settling at Swaleside. They discussed his parole hearing on 25 May.

45. In the early hours of 16 April, Mr Bentley told an Operational Support Grade (OSG) that he was frightened of being stabbed and that he wanted to "kill himself before anyone else could". The OSG noted that Mr Bentley had been pacing his cell, had "severe paranoia" and had harmed himself by making a superficial cut to his hand. A Custodial Manager (CM) who was the night manager, noted that Mr Bentley was "very paranoid" and feared for his safety. No one started ACCT procedures.

46. Mr Bentley blocked his observation panel during the morning roll count. A CM checked on his welfare. Mr Bentley told him that a prisoner had tried to attack him with a weapon. The CM noted that there was no evidence to corroborate the allegations made and that Mr Bentley was defensive and presented with "elevated paranoia and anxiety". Mr Bentley told the CM that he would resort to violence if he was not moved to the segregation unit. Later that day, Mr Bentley was moved to A Wing to mitigate any immediate risk that he posed to himself. Staff referred him to the mental health team and to the Swaleside Outreach Service (SOS, a partnership service between HMPPS and Oxleas, run by prison staff, psychologists and clinicians to help prisoners whose behaviour is complex, challenging, violent and/or disruptive).

47. From 16 April, Mr Bentley began collecting his medication far less frequently. There were prolonged periods of non-compliance, with the longest period of compliance being for just four days from 27 May. The longest period of non-compliance was for 32 days during April and May.

48. On 19 April, a Supervising Officer (SO) also referred Mr Bentley to the mental health team as he appeared unstable and had not collected his medication for several days. The mental health referral was triaged that day, and an earlier appointment with the psychiatrist was arranged for 21 April.

49. That day, an officer started self-seclusion monitoring procedures because Mr Bentley refused to leave his cell and said that he was being targeted by other prisoners. (Swaleside's self-secluding procedures are based on ACCT procedures and are used to manage and engage with prisoners who choose to isolate themselves. The process aims to help them re-integrate fully into prison life using multidisciplinary reviews and care plans to offer support.)

50. On 20 April, an officer noted during a welfare check that Mr Bentley had engaged well, wanted to remain in his cell but continued to express concerns about his safety. A SO, Mr Bentley's prison offender manager, met him and noted that he appeared "mentally unstable" and continued to claim that he was being threatened.

51. On 21 April, a consultant psychiatrist, assessed Mr Bentley. He noted that Mr Bentley had said that he was under threat but was not willing to disclose further information. Mr Bentley told the psychiatrist that he found his ADHD medication helpful and that his ADHD symptoms had been in remission. He discussed with him other medication options and it was agreed that he could not keep and administer his ADHD medication because it was a controlled drug but that he could change his medication to atomoxetine which was also used to manage ADHD and which he could administer himself. Mr Bentley denied any thoughts of self-harm and he planned to review him again in one to two months.

52. That evening, an officer noted that Mr Bentley had been aggressive and threatening, and had headbutted and punched his cell door. The officer noted that Mr Bentley's behaviour was "odd" and "very strange". An officer told the mental health team about the incident.

53. On 22 April, a SO a told his COM about his concerns for Mr Bentley's deteriorating mental health. He also explained that it would not be possible to arrange a video link for Mr Bentley's parole hearing because there was no equipment available to facilitate it but he said that attempts would be made to arrange a telephone conference. The COM asked the SO to check if Mr Bentley was taking his medication as he had previously felt unsafe when collecting it, and that his risks increased when he was not compliant. The SO said that he reported the issue to healthcare staff who told him that they would investigate the matter. The SO said that he did not chase the matter due to other work pressures. (It is not clear if any enquiries were made to check if Mr Bentley was taking his medication, and there is no evidence that the mental health team was aware of concerns about his medication compliance.)

54. On 26 April, an officer noted that Mr Bentley had threatened staff, claiming that he had not been given food or his canteen (purchases from the prison shop). The officer referred him to the mental health team because of his "odd behaviour".

55. On 30 April, Mr Bentley damaged and flooded his cell. He was moved to another cell and staff started disciplinary proceedings against him.

56. While being escorted to his disciplinary hearing on 2 May, Mr Bentley told staff that he would not return to A Wing after the hearing. When staff told Mr Bentley to return to his cell, he refused and became abusive and aggressive. Fearing for the safety of his staff, a CM initiated the use of force, during which Mr Bentley assaulted the CM.

57. Staff returned Mr Bentley to his cell and the CM and a SO successfully de-escalated the situation. Mr Bentley later apologised for his behaviour and said that he had been under threat from the Muslim community. The officers reassured Mr Bentley that his safety was paramount and that they would investigate moving him to the vulnerable prisoners' (VP) unit. Prison staff started disciplinary proceedings against Mr Bentley for assaulting the CM.

58. A nurse assessed Mr Bentley for any injuries sustained during the use of force. She noted that he had an injury to his left eye and that he should attend hospital for further tests. An officer asked the nurse if Mr Bentley could be taken to hospital later that afternoon or the next day as the prison could not provide an escort. The nurse told the officer that Mr Bentley should be taken to hospital that day and should not wait twenty-four hours. (Mr Bentley was not taken to hospital.)

59. On 3 May, a SO completed Mr Bentley's self-seclusion assessment. The SO noted that Mr Bentley was self-secluding because he felt threatened by Muslim prisoners, that he had not collected his medication as a result, and that he wanted to move wings. The SO noted that a move to the VP wing might be a possibility, that support could be provided by SOS and that a referral to Swaleside's Pathways Unit, a psychologically informed, planned environment (PIPE) could be made. (The Pathways Unit aims to address offenders' behaviour to help them progress in completing sentence plans. The aim is for prisoners to maintain their own and others' safety while improving their psychological, social and physical wellbeing.) Staff later told Mr Bentley that he could not move to the VP wing as he did not fit the criteria of a vulnerable prisoner.

60. That day, the Safety Intervention Meeting (SIM, a weekly multiagency meeting, where the most complex prisoners are discussed) discussed Mr Bentley. The Head of Safety and Equalities, a CM and representatives from healthcare and the mental health team attended. It was noted that Mr Bentley was a "complicated individual" who had recently been restrained, did not want to collect his medication with other prisoners, was subject to CSIP procedures and needed to be referred to both the SOS and PIPE. (There were no healthcare interventions as a result of the information discussed at the meeting, including with regard to Mr Bentley's compliance with his medication.)

61. On 4 May, Mr Bentley's disciplinary hearing about his assault of a CM, was adjourned and referred to the police for further investigation.

62. On 6 May, staff started further CSIP procedures following Mr Bentley's assault of a CM. It was noted that triggers for his negative behaviour included not being able to recognise other people's body language, not trusting others and seeing others as a threat. It was noted that the SOS team should intervene to support Mr Bentley with his behaviour as he struggled to communicate.

63. On 11 May, Mr Bentley told his COM that he was unhappy at Swaleside, had been assaulted by staff for no apparent reason, that there was a staff conspiracy against him and that prisoners "were out to get him". (Mr Bentley did not mention any specific events involving staff and it is likely that he was referring to the use of force on 2 May.) Mr Bentley told Ms Smith that he had not collected his medication as he felt unsafe, and that staff would not bring it to him. She noted that Mr Bentley's anxiety levels appeared high. She told him that she was concerned that when he

did not take his medication, he might misinterpret events, which might result in an increased risk of aggressive behaviour.

64. On 12 May, the COM discussed with a SO her concerns about Mr Bentley's behaviour. She said that his behaviour deteriorated when he did not take his medication and discussed with the SO the possibility of Mr Bentley's medication being taken to him. The SO told her that he had spoken to healthcare staff about the matter and had been told that this would not be possible as it would be a case of "secondary dispensing", which was not permitted, and that Mr Bentley would have to collect the medication from healthcare. (There is no evidence that this concern about Mr Bentley's compliance was either noted to have been passed to or received by healthcare staff.) The COM noted that she had discussed the possibility of Mr Bentley moving to the PIPE unit but given his recent behaviour, the likeliness of the move was "remote".

65. At a CSIP review chaired by a SO and attended by a CM, Mr Bentley said that he would continue to self-seclude as he feared for his safety. He said that he felt uncomfortable around Muslim prisoners, not because they might harm him, but because he feared saying something inappropriate to them which would result in him getting into trouble. The SO told us that there was no identifiable or credible threat to Mr Bentley and no intelligence to suggest that there was. Mr Bentley acknowledged that his behaviour was due to his paranoia and agreed to work with officers. The SO noted that referrals had been made to the SOS and psychology team and that a further review was scheduled for 30 May.

66. On 17 May, Mr Bentley was discussed at a SIM which the Head of Safety and Equalities, a SO and a healthcare representative attended. It was noted that he had "trust" issues but had been working with officers. Actions to be taken included a referral to the SOS and psychology team, both of which had already happened.

67. On 19 May, Mr Bentley missed a planned GP appointment because the wing was locked down. A further appointment was made for 6 June but Mr Bentley died before this took place.

68. On 20 May, a SO spoke to Mr Bentley about his parole hearing. They discussed the PIPE unit at Swaleside, which Mr Bentley said he might struggle with but agreed that it should be considered. The SO noted that Mr Bentley appeared a "bit erratic" but that it was "nothing out of the ordinary" given his mental health diagnosis. He noted that Mr Bentley did not want to talk much.

69. On 22 May, staff noted that Mr Bentley was feeling positive and coping well with his self-seclusion regime.

70. On 23 May, two SOs chaired a self-seclusion review. They noted that over the previous weeks, Mr Bentley had engaged well with staff, had taken his medication and had said that he wanted to stay out of trouble and remain behind his cell door. A SO said that he recalled that there were no issues about Mr Bentley collecting his medication at this time. Mr Bentley was set targets of continuing to engage with staff and to take his medication. A further review was scheduled for 6 June.

71. At a SIM, staff noted that Mr Bentley continued to self-seclude and that a SO had referred him to PIPE.

72. On 24 May, Mr Bentley told a prison offender manager, that he had a parole hearing the following day. Mr Bentley raised concerns about his parole dossier and she said that she would make enquiries with a SO. She later noted that Mr Bentley's parole hearing had not been booked in the video link and that they would have to wait for a revised date for it to be re-arranged.

73. Mr Bentley's parole hearing did not therefore take place on 25 May. He telephoned his COM that afternoon, told her that he was "still smiling" and was positive. Ms Smith noted that Mr Bentley sounded "surprisingly stable" and had accepted the reasons why his parole hearing had not taken place. Mr Bentley told her that his solicitor had assured him that he would attend the next parole hearing. (Mr Bentley's family said that he told them that he had been devastated that his parole hearing had been cancelled.)

74. The COM asked Mr Bentley if he was taking his medication. He told her that staff had brought it to his cell for two days, as he had not felt comfortable collecting it. He said that they had not been back since and he was unsure why. Mr Bentley told her that he still felt threatened by prisoners but did not provide any specific information. She told him that she would raise his concerns with a SO, which she said she did.

75. That afternoon, Mr Bentley telephoned his sister from his in-cell telephone. He told her that his parole hearing had been cancelled but might take place in August. He told his sister that he believed that staff were "deceitful". Mr Bentley said that prisoners on the wing wanted to "stab" him but that they "could not break a man who has been broken".

76. On 28 May, Mr Bentley asked an officer to help him complete an application for the PIPE unit. The following day, he went to the prison chapel but declined the opportunity to shower or take exercise.

77. On 30 May, two SOs chaired a CSIP review. Mr Bentley said that he still had concerns about interacting with Muslim prisoners. He said that he had no issues about other prisoners intimidating him or going to his cell door, but he still wanted to self-seclude. Mr Bentley said that he recognised that his paranoia played a part in how he felt and that with staff support, he had been able to collect his medication, which he said had made a real difference. It was noted that Mr Bentley continued to engage and build relationships with staff and a further review was scheduled for 14 June.

78. A trainee forensic psychologist with the SOS team, contacted the Head of Safety and Equalities, as support Mr Bentley might receive from them had been discussed at a SIM earlier that day. She asked for a referral to be made.

79. On 31 May, Mr Bentley accepted the opportunity to shower and exercise, but there was no further record of staff's interaction with him. The SOS contacted the Head of Safety and Equalities and asked again for Mr Bentley's referral to be made if required.

80. On 1 June, a prisoner on the wing died which resulted in the wing being locked down. Mr Bentley was unable to have a shower or take exercise.

81. At 9.31am, Mr Bentley spoke to his mother by telephone. They talked about domestic issues and about his parole hearing being cancelled. Mr Bentley said that the Parole Board had wanted him to return to Channings Wood. (We found no record that this was the case.) Mr Bentley told his mother that he would rather be stabbed and would resort to violence if moved, but that there were some staff at the prison with whom he got on well.

82. On 2 June, A Wing was locked down following the death of the prisoner the previous day. An officer noted that Mr Bentley appeared to be "getting worked up" about his property from a previous prison and had threatened to assault "anyone and everyone".

83. That afternoon, the officer from the prison's safer custody team checked on Mr Bentley because he was self-secluding. The officer said that another officer had told him that Mr Bentley had been aggressive and that he should not open his cell door. The officer said that Mr Bentley, who did not appear aggressive, told him that everything was okay and asked him about an interview with the police which he thought he was to have. (The police interview was likely about Mr Bentley's assault of a CM on 2 May.) The officer told Mr Bentley that he would be unable to find out about the matter as it was a bank holiday weekend, but that he would check for him the following Monday. The officer said that Mr Bentley expressed no thoughts of self-harm. Mr Bentley later joked with another officer about his interview with the police, who noted that he raised no concerns. Mr Bentley accepted the offer of a shower and exercise.

84. On Friday 3 June, the wing's normal regime resumed. However, during the day, there were several altercations involving prisoners and staff which were due to the death of the prisoner two days earlier. (There is no evidence that Mr Bentley was involved in any of these incidents.) This led to the wing being locked down again. An SO, the Head of Safety and Equalities, said that a restricted regime over the weekend remained in place while staff investigated and established the reasons for the disturbance. He said that this meant that prisoners were only allowed out of their cells for around half an hour. During the day, Mr Bentley declined to exercise or shower.

85. The Head of Safety and Equalities, sent an email to the SOS, enquiring further about Mr Bentley's referral as she had not been at the SIM when it was discussed.

86. On 4 June, an officer spoke to Mr Bentley. He told us that Mr Bentley appeared well and talked about getting his Category C status as he wanted to be closer to home. The officer said that Mr Bentley was in good spirits and gave no indication that his risk of self-harm had increased. Mr Bentley declined the offer to take a shower or exercise.

87. On 5 June, Mr Bentley told staff that he did not want lunch and only wanted a cold food pack during the day. (The cold food pack is served as well as the lunchtime hot meal and is given for prisoners' evening meal and breakfast the following day.) During the day, the SOS team asked the Head of Safety and Equalities, again about Mr Bentley's referral.

88. That afternoon, Mr Bentley rang his cell bell twice. We have been unable to confirm what this was for and do not know which officer answered the bell. At around

4.00pm, a food bag was hung on Mr Bentley's cell door and soon afterwards, he returned to his cell, having taken a shower.

89. An officer, who had been working on the wing, said that he had been told that Mr Bentley was self-secluding and was not to be unlocked. The officer said that he had no interaction with Mr Bentley, other than a roll check which he completed at around 4.55pm. He said that he asked Mr Bentley if he was okay and that Mr Bentley said he was and gave him the thumbs up.

90. At 5.14pm, Mr Bentley rang his cell bell. An officer answered the bell at 5.53pm. (The officer said that he likely answered the cell bell during a further roll check of the wing.) The officer remained at the cell for around 40 seconds but could not recall why Mr Bentley had rung his cell bell or the conversation he had with him.

91. At around 7.30pm, a OSG started his duty as the night officer and received a handover from the officer. At around 7.45pm, the OSG carried out his roll and welfare checks and the officer left the wing. The OSG said that Mr Bentley was sitting on his bed and when he asked how he was, he replied that he was okay and gave the thumbs up. The OSG said that he had no concerns about Mr Bentley's welfare and did not check on him again that night. This was the last time that Mr Bentley was seen alive.

## Events of 6 June 2022

92. On 6 June, the early start officer, who was due to relieve the OSG, did not arrive for work. An officer was therefore asked to relieve the OSG and arrived on the wing at around 7.40am. He received a handover from the OSG, during which Mr Bentley was not discussed. The officer did not then carry out a roll check as he should have. (It is the responsibility of the early start officer to complete the roll check rather than the night officer.) He said that this was because prisoners on the wing had blocked their observation panels and he felt under pressure to confirm the roll, due to his late arrival on the wing, and because he knew that the day staff who were about to start work would shortly complete a welfare check of all prisoners. At 8.09am, the roll was recorded as being correct.

93. At around 8.20am, two officers carried out a welfare check of Mr Bentley and found that he had blocked his observation panel. The officers turned the cell light on but there was no response. An officer asked the other officer to tell a CM, who attended immediately.

94. When the CM arrived, he opened the cell door. The officers found Mr Bentley hanging from a ligature made from a bed sheet, which he had tied to the bed frame. The CM took Mr Bentley's weight and an officer tried to cut the ligature, but due to its thickness she was unable to. The CM also had difficulty in cutting the ligature.

95. At around 8.22am, an officer called a medical emergency code blue (used when a prisoner is not breathing and which triggers an automatic request for an ambulance and for healthcare staff to attend). Soon after, the CM radioed for all available healthcare to attend. The control room called for an ambulance at 8.23am. A SO responded soon afterwards and also tried to cut the ligature which, when assisted by an officer, he was able to cut from around Mr Bentley's neck around two minutes

later. The SO, the Head of Safety and Equalities, described Mr Bentley as being "rigid" and an officer said that Mr Bentley was "extremely cold and stiff".

96. A nurse arrived with the medical emergency response bag, directly followed by, the Head of Healthcare. The Head of Healthcare. asked for Mr Bentley to be brought out on to the landing and she briefly checked for signs of life, found none and immediately started CPR. The nurse further assessed Mr Bentley and told us that he was very cold and that his jaw had locked. It was established that rigor mortis was present. At around 8.25am, healthcare staff stopped CPR. At 8.39am, paramedics arrived and confirmed that Mr Bentley had died.

## Contact with Mr Bentley's family

97. No family liaison officer (FLO) was available at Swaleside after Mr Bentley died. At around 3.45pm, a Father from HMP Elmley was appointed as the FLO. The FLO, an operational manager, and a second Father visited Mr Bentley's mother at her home and told her that her son had died.

98. On 9 June, Mr Bentley's sister contacted the COM to ask several questions about her brother's death. The COM spoke to a SO about her contact with Mr Bentley's sister and he told her that a family liaison officer had broken the news of Mr Bentley's death. The COM emailed the correspondence unit at Swaleside to establish the name and contact details of the family liaison officer so that she could provide their contact details to Mr Bentley's family. She received an automated response, saying that the prison would respond within twenty days.

99. On 13 June, Mr Bentley's sister contacted the COM again to say that she was disappointed that neither she nor her mother had had any further contact from Swaleside's family liaison officer. She raised several further questions, including about funeral arrangements.

100. On 17 June, the COM contacted Mr Bentley's sister to confirm that a CM had replaced the Father as the FLO.

101. On 20 June, a CM, who had just returned from a period of leave, responded to an email from the COM in which she had explained that Mr Bentley's sister was acting on his mother's behalf. The CM told the COM that he would now be the family liaison officer for Mr Bentley. The COM contacted Mr Bentley's sister and provided her with a CM's contact details.

102. The CM said that he heard nothing from Mr Bentley's family. As he was about to start a set of night duties, which would then be followed by a period of rest days and which would mean that he would be absent from the prison for several days, he told another CM and another FLO at the prison that he would not be able to carry out the family liaison duties. No further contact was made with Mr Bentley's family.

103. Mr Bentley's funeral took place on 29 June. As the prison had made no contact with Mr Bentley's family, no representative from the prison attended and at the time no funeral expenses were offered in line with national instructions.

104. On 16 August, in response to the PPO contacting Swaleside seeking clarification about the prison's contact with Mr Bentley's family, the CM contacted Mr Bentley's

family. The CM apologised that the prison had not made contact sooner and invited Mr Bentley's family to visit Swaleside and meet the prison's Governor. Mr Bentley's family declined the offer.

105. Mr Bentley's family had initially paid for his funeral themselves. Swaleside subsequently offered to reimburse them for the expenses, which Mr Bentley's family accepted. We understand that they have now been reimbursed for the costs and that Mr Bentleys property was eventually returned to them after our initial report was issued in December 2022.

## Support for prisoners and staff

106. After Mr Bentley's death, the Head of Recovery and Service Improvement, 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. The prison posted notices informing other prisoners of Mr Bentley's death and offered support.

## Post-mortem report

107. The post-mortem examination established that Mr Bentley died from suspension by ligature. Toxicology tests showed that nothing of significance was detected in Mr Bentley's blood or urine.

# Findings

## Identifying the risk of suicide and self-harm

108. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase their risk of suicide and self-harm and take appropriate action, including starting ACCT procedures when a prisoner is identified as at risk.

109. Mr Bentley had several significant risk factors for suicide and self-harm. He had been monitored under ACCT procedures many times in the past and had harmed himself several times. Mr Bentley often failed to take his prescribed ADHD medication, and this affected his behaviour. He isolated himself, seemingly due to a fear of being attacked, and he spent little time out of his cell or with his peers. Mr Bentley was managed under CSIP procedures and staff referred him several times to the mental health team.

110. Mr Bentley harmed himself twice at Swaleside. After he cut his hand and told an OSG that he would kill himself on 16 April, a CM concluded that Mr Bentley did not need to be monitored under ACCT procedures because Mr Bentley had subsequently assured him that he had no intention of taking his life. We are concerned that this gave too much weight to Mr Bentley's comments and failed to consider sufficiently his actions, threats and risk factors. This was a missed opportunity to start ACCT procedures.

111. Five days later, Mr Bentley headbutted and punched his cell door. Staff described his behaviour as "very strange" and were sufficiently concerned as to refer him to the mental health team. However, they did not recognise or report Mr Bentley's actions as self-harm and therefore did not assess his risk adequately and did not consider starting ACCT procedures.

112. In the days before his death, Mr Bentley's risk factors increased. His parole hearing had been cancelled, his regime had become more restricted, and he was expecting police to interview him about assaulting an officer which might have led to further charges.

113. In the weeks leading to his death, Mr Bentley had only periodically taken his medication. While staff highlighted that this affected his anxiety and behaviour, they should also have considered its impact on his risk of suicide and self-harm.

114. While Mr Bentley received some good support from officers at Swaleside, which he acknowledged, we are concerned that many of his actions and risk factors were treated in isolation. There is no evidence that prison or healthcare staff considered Mr Bentley's risks holistically or whether he should have been monitored under ACCT procedures.

115. Mr Bentley was subject to self-seclusion and CSIP monitoring. While these were important measures to take, they did not offer the same level of protection as ACCT monitoring. We consider that there were many missed opportunities for staff to consider Mr Bentley's risk and to start ACCT procedures, particularly as he had harmed himself, threatened to take his life and was discussed at a SIM.

116. Had they done so, they might have identified and addressed Mr Bentley's issues and triggers, and worked together to reduce the impact of these, while allowing more frequent monitoring of his wellbeing. While we cannot say that this would have led to a different outcome, it would have given prison staff more chance of preventing his death. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and, in particular, the need to record, share and consider relevant information about risk, and start ACCT procedures when indicated.**

117. Mr Bentley's family told us that Mr Bentley had asked to speak to Listeners and the Samaritans at Swaleside. They said that he was unable to do so because the Samaritans number did not connect.

118. We have found no reference to either of these matters in Mr Bentley's prison records. However, we raised the family's concerns with Swaleside. They said that for a short period of time, there had been issues accessing the Samaritan's number. They said that this had been rectified at the time and that Listeners were available to prisoners.

## Self-seclusion

119. Swaleside's Self-Isolation Strategy, issued in July 2021, and self-seclusion monitoring document, provide a good framework for staff to identify, investigate and monitor prisoners who isolate themselves. The strategy states that a manager must investigate why a prisoner is isolating himself and create a plan to encourage re-engagement with the regime. The prisoner should then be supported and monitored daily using the self-seclusion document, including recording daily interactions and offering access to the regime such as showering and take exercise.

120. Despite having a good strategy in place, we are concerned that processes to monitor Mr Bentley were not completed to the expected standard. The self-seclusion monitoring document was poorly completed. The pre-assessment was not completed within 24 hours as required. The first review did not take place until a month after monitoring had begun and, when it did, it was not multidisciplinary and was completed at Mr Bentley's cell door. The management plan, which should be completed within 25 hours of the document being opened, was not completed at the first review. Daily records of conversations were at times of poor quality or not completed. On one occasion, no record of conversation was made for two weeks.

121. The clinical reviewer also reported that healthcare staff were not invited to contribute or participate in self-seclusion reviews, despite the process encouraging multidisciplinary collaboration.

122. A SO said that reasons for the document's poor completion included staff shortages, that A Wing had been lacking SO cover and had recently lost several experienced staff. The SO said that although quality assurance processes were in place, improvements could be made. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prisoners who are self-secluding are managed in line with local guidelines, including that:**

- **pre-assessments are completed within 24 hours;**
- **the first review and management plan are completed within 25 hours; and**
- **healthcare staff and other support services are invited and contribute to all reviews where their support is relevant.**

## Staff shortages

123. Swaleside has lost a number of staff in recent months and is currently operating with a staffing level significantly below their expected complement. In their latest annual report, published around a month after Mr Bentley's death, the IMB reported that Swaleside was operating with 160 staff in place out of a total of 261 posts. During our investigation, it became apparent that these shortages had a significant impact on staff's ability to deliver a full regime and to complete daily tasks to the expected standard.

124. This impacted directly on Mr Bentley, both in terms of the care directly provided to him and the provision and availability of services from which he could have benefited. His self-seclusion monitoring document was not completed to the expected standard, and staff told us that this was a direct result of shortages. Mr Bentley was not allocated a key worker and the scheme is not currently being implemented for all prisoners. He did not receive a prison induction on his arrival at Swaleside and the quality of his prisoner case history notes was poor. There is little evidence of any meaningful interaction between Mr Bentley and prison officers. There were no staff available to escort him when healthcare staff recommended that he should be taken to hospital. Mr Bentley was not referred to the prison's substance misuse team from Reception and recommended referrals to the SOS team were not completed for many weeks. There is little evidence that his allegations of threatening behaviour were properly investigated. His parole hearing was cancelled because there was no video link available.

125. Had Mr Bentley received better and more frequent interaction and support from staff, they might have been more aware of his increased risks and in a better position to consider how this and other issues affected him. It is possible that these factors, and the impact of spending long periods of time alone in his cell in the days before his death, might have affected Mr Bentley's mental health and contributed to feelings that he could not cope in prison any longer.

126. The Governor told us that there were ongoing staff shortages, staff fatigue and said that high levels of sickness were affecting the prison's regime. We note that HMIP also identified that impact of staff shortages at Swaleside and the impact this had on delivering a safe regime. We repeat the recommendation that HMIP made in their most recent inspection:

**The Director General of Operations for HM Prison and Probation Service (HMPPS) should ensure that clear measures are implemented as a matter of urgency to recruit and retain sufficient operational and specialist staff at HMP Swaleside to reinstate purposeful activity and support prisoners' progression.**

127. The clinical reviewer noted that on 2 May, Mr Bentley was not taken to hospital as a nurse advised after an eye injury. This was because there were no officers available to escort him. In addition, healthcare staff did not arrange to follow up and review Mr Bentley to ensure that he had been taken to hospital. Although this did not appear to have an adverse impact on Mr Bentley's physical health, we make the following recommendation:

**The Head of Healthcare should ensure that all prisoners, who are not taken to hospital as advised, receive appropriate clinical follow-up care.**

## Mr Bentley's concerns for his safety

128. PSI 64/2011 sets out how violent prisoners should be managed. It says that victims should be supported and protected. Being a victim of intimidation or violence are recognised risk factors for suicide and self-harm. The PPO has published a range of publications identifying the links between bullying and suicide and we identified the need for staff to record and investigate all reports or suspicions that a prisoner is being threatened or bullied and to consider the potential impact on the victim's risk of suicide.

129. Swaleside's Violence Management Strategy states that any victim or perceived victim of violence, threat or bullying will be given suitable ongoing support. It states that they will be interviewed as part of the investigation process and their ongoing safety needs should be assessed.

130. Mr Bentley had a history of isolating himself while in custody because he was worried that he would be attacked and felt threatened by other prisoners.

131. Although Mr Bentley frequently told staff that he felt threatened, we found no evidence that Mr Bentley was threatened or bullied at Swaleside. However, there is no evidence that staff investigated or addressed Mr Bentley's concerns and there is little evidence of interventions to help him feel less scared and to support him. We make the following recommendation:

**The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.**

## Roll checks

132. Prison Service Instruction (PSI) 75/2011 on residential services says that four formal roll checks should be carried out each day. Prison staff are not required to obtain a response from prisoners who appear to be asleep during a night-time roll check. However, if staff have immediate concerns about a prisoner's welfare, they should take appropriate action.

133. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, states that when staff discover that a cell door observation panel has been blocked and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare. In such circumstances, we would usually expect staff who cannot see or

speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe that the prisoner may be at risk, they should assess the risk of opening the cell door before help arrives.

134. An officer, the early start officer on the morning of 6 June, did not complete the early morning roll check and did not therefore check Mr Bentley as he should have. The officer said that he did not carry out the roll check because he arrived late on the wing to relieve an OSG and because a number of prisoners had blocked their observation panels. The officer said that he felt pressurised to report the roll as correct, knowing that the day staff were about to arrive and that they would carry out a full welfare check of all prisoners on the wing. However, our view is that the officer should have taken action to ensure that the roll was completed and that he should have reported his difficulties in completing it to the duty manager. It appears that there is a culture on the wing, where prisoners block their observation panels with little consequence and that this contributed to the officer's decision not to complete the roll check.

135. Although we cannot be sure when Mr Bentley died, we know that rigor mortis was present when he was found at 8.22am. This indicates that he is likely to have been dead for at least two hours (depending on several variables including the temperature in the cell). It is therefore likely that he was already dead at the time that the officer should have completed the roll check. We make the following recommendations:

**The Governor should ensure that staff complete roll checks as required, by looking carefully through the cell door observation panel and taking appropriate action if there are any immediate concerns for the wellbeing of a prisoner.**

**The Governor should ensure that prisoners who block their cell door observation panels are challenged, blockages are removed, and frequent offenders receive appropriate disciplinary action or support.**

## Family liaison

136. PSI 64/2011 instructs that, following a death in custody, prisons "must promptly notify the next of kin and any other person the prisoner has reasonably nominated to be informed". It instructs that prisons must record a next of kin for each prisoner and that prisoners may identify more than one next of kin or family member whom they wish to be contacted. PSI 64/2011 also instructs that prisons must return the property of the deceased to the family and offer the family a contribution to funeral expenses. It states that the family liaison officer will maintain contact with the family after the news of a death is broken, providing information and practical support, where relevant.

137. Because there was no family liaison officer available at Swaleside to break the news of Mr Bentley's death to his family, the prison asked a family liaison officer from Elmley to visit Mr Bentley's family on their behalf. Although not ideal, this was an appropriate measure in the circumstances.

138. Swaleside then appointed their own family liaison officer. However, there was no further follow-up contact from family liaison officers at Swaleside until 16 August,

over two months later, when the PPO asked the prison about their contact with the family.

139. Although Mr Bentley's family was told promptly of his death, it is unacceptable and disrespectful that they had no contact from Swaleside for such an extended period, during what would clearly have been a distressing time for them. It is particularly troubling that the lack of contact meant that Mr Bentley's family initially had to pay for his funeral themselves before waiting several weeks for reimbursement and that Mr Bentley's property was not returned to his family until after we issued our initial report into his death in December 2022.

**The Governor should ensure that prison staff liaise with families following a death in custody in line with national instructions, including that**:

- **a family liaison officer is appointed as soon as possible;**
- **the family liaison officer maintains contact with the bereaved family and provides appropriate information and support; and**
- **funeral expenses are offered and the deceased's property returned to their family within appropriate timeframes.**

## Clinical care

140. The clinical reviewer concluded that the clinical care that Mr Bentley received was partially equivalent to that which he could have expected to receive in the community. She identified several omissions in Mr Bentley's clinical management and has made several recommendations which the Head of Healthcare will need to address.

141. IC24 provided physical healthcare services at Swaleside until April 2022. Their missed medication policy stated that when a prisoner has not collected medication on five occasions, healthcare staff should ensure that an appointment with a GP is booked. The clinical reviewer identified that Oxleas NHS Foundation Trust, who have provided physical and mental healthcare services from April, did not follow the previous IC24 policy and did not have a policy in place for missed medication protocols until 20 June which was after Mr Bentley's death.

142. The clinical reviewer found that that the mental health team did not assess or review Mr Bentley after he stopped taking his medication, despite the marked change to his behaviour and subsequent mental health referrals. In addition, a GP appointment was not booked for him.

143. The clinical reviewer found that there was a lack of effective communication. The mental health team was not initially told that Mr Bentley was not taking his medication and when they were told at the SIM on 3 May, the issue was not escalated. This led to missed opportunities to review Mr Bentley's mental state, identify whether his risk profile had increased and provide him with appropriate support. The clinical reviewer concluded that that this was not equivalent care.

144. The clinical reviewer was also concerned about Mr Bentley's mirtazapine being stopped suddenly. When this medication is stopped abruptly, features of

withdrawal can include agitation and anxiety. The clinical reviewer noted that this should have been escalated to the mental health team and prescriber due to the potential increase in Mr Bentley's risk level and potential contribution to his mental health deteriorating.

145. We were told that since Mr Bentleys death, Swaleside have introduced new procedures to monitor prisoners who stop their medication. A pharmacy technician will now see the prisoner within three days to discuss the potential consequences of stopping the medication, explain potential withdrawal symptoms and signpost for support. Within seven days, a healthcare professional will complete a mood review and identify any emerging withdrawal symptoms.

146. The clinical reviewer also reported that following Mr Bentley's psychiatric assessment, an interim mental health care plan should have been initiated. The purpose of this should have been to monitor his mental state and newly prescribed atomoxetine to ensure that it was reaching a therapeutic level, particularly as a common side effect of the drug is suicidal ideation. The clinical reviewer concluded that while it was not possible to say whether this contributed to Mr Bentley's death, he did not have physical health checks during the time he was prescribed atomoxetine in line with NICE guidance.

147. We also note that when Mr Bentley arrived at Swaleside, he was not referred to the substance misuse team despite his history of substance misuse. We make the following recommendations:

**The Head of Healthcare should ensure that all patients who are prescribed medication licenced for ADHD have physical health checks and ongoing monitoring in line with NICE guidelines.**

**The Head of Healthcare should ensure that prisoners who do not collect their medication are monitored and reviewed in line with local policy.**

**The Head of Healthcare should ensure that all prisoners with a history of substance misuse are referred to the prison's substance misuse team at their reception health screen.**

## Learning lessons

148. We have identified a significant number of concerns in this report. We consider it is important that staff learn from our findings. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

## Inquest Verdict

149. The inquest hearing into the death of Mr Bentley was held on 19 June 2023. It confirmed that the medical cause of Mr Bentley's death was suspension by ligature. It concluded in a narrative verdict, that Mr Bentley took his own life but his intention

in doing so was unclear and that the failure to provide adequate physiological support through SOS and or a psychologist possibly contributed to his death. Other issues identified to be relevant to the circumstances of his death, but could not be concluded to have contributed to his death included; failure to open an ACCT on or after 16 April, failure to instigate a care plan, inadequate response to missed medication from 16 April, inadequate management of the self-seclusion plan and failures to implement agreed actions from CSIP and SIM meetings, ineffective communication between the prison and health provider and staff shortages and gaps in training.

150. On 3 July, the Coroner issued a Regulation 28 to the Minister of State for Prisons and Probation. (The Coroners and Justice Act 2009 allows a coroner to issue a Regulation 28 Report to an individual, organisations, local authorities, or government departments and their agencies where the coroner believes that action should be taken to prevent further deaths.) The Coroner raised two matters of concern. These were that there was evidence from prison staff from which it was concluded by the jury that the safety of deceased was compromised as a result in staff shortages and that the current complement of Band 2 Operational Support Group staff was 71% which was predicted to further reduce to 54%, that the current complement of Band 3 Prison Officers was 68% and which was predicted to further reduce to 46%.

151. The Coroner asked the Minister of State to respond with details of action taken or proposed to be taken, and a timetable for action taken, regarding staffing shortages at Swaleside.

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