Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mariusz Pioro, a prisoner at HMP Bedford on 16 July 2021

A report by the Prisons and Probation Ombudsman

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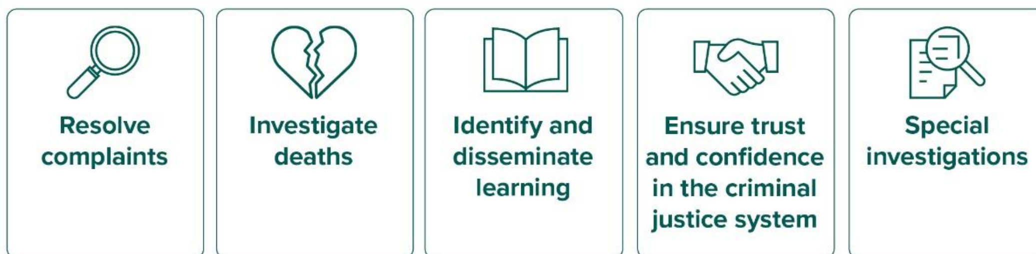
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mariusz Pioro died of a heart attack on 16 July 2021 in his cell at HMP Bedford, less than 48 hours after he had arrived. This was caused by coronary atherosclerosis (a condition that causes narrowing and clogging of the arteries in the heart.) He also had fatty liver disease which did not cause but contributed to his death. He was 44 was years old. I offer my condolences to his family and friends.

Before he arrived at Bedford, Mr Pioro had been arrested for driving under the influence of alcohol and was prescribed medication for alcohol withdrawal while he was in police custody. Prison staff received documents saying that he had a history of alcohol dependence and delirium tremens (a severe form of alcohol withdrawal) but they did not read this information at reception or pass it on to healthcare staff.

The clinical reviewer found that the clinical care that Mr Pioro received at Bedford was not equivalent to that which he could have expected to receive in the community. Healthcare staff did not identify Mr Pioro's history of alcohol dependence at his initial health screen, which meant that no one considered if he needed support with alcohol withdrawal. Healthcare staff also failed to review Mr Pioro after officers reported concerns about him displaying confused behaviour and symptoms suggesting alcohol withdrawal. This may have been a missed opportunity to identify earlier that Mr Pioro had a life-threatening condition.

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

Sue McAllister CB
Prisons and Probation Ombudsman **February 2022**

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Summary

Events

1. On 14 July 2021, Mr Mariusz Pioro was remanded to HMP Bedford for driving under the influence of alcohol. While in police custody, he had been given medication for alcohol withdrawal.

2. An officer conducted a reception screen and first night centre interview. The officer noted that Mr Pioro did not report any substance misuse problems and that he had reviewed the person escort record (PER). However, there is no evidence that he read the healthcare section of the PER which said that Mr Pioro had a history of alcohol dependence.

3. That evening, a nurse conducted Mr Pioro's initial health screen. He completed an alcohol use audit but noted that Mr Pioro said he did not drink alcohol. There is no record that he saw the PER or the medical documentation that arrived with Mr Pioro.

4. On 15 July, an officer saw Mr Pioro on the Integrated Drug Treatment Service (IDTS) wing for an induction and escorted him to another reception wing. He told us that a healthcare assistant asked him to move Mr Pioro as he did not need IDTS support.

5. As the afternoon progressed, officers raised their concerns about Mr Pioro's very confused presentation with a mental health nurse. They were told to contact the emergency response nurse, but there is no record that Mr Pioro was seen. An officer says he spoke to the nurse and that she said it was a mental health issue not a physical one and she did not see Mr Pioro. The nurse says she does not remember an officer speaking to her.

6. At 8.25am on 16 July, an officer looked through Mr Pioro's cell door observation panel to conduct a roll check and saw that he was moving around on the floor, talking to himself. Another officer checked on Mr Pioro twice between 8.30am and 9.00pm and saw that he was sitting on the floor, talking to himself. They did not consider there was any cause for concern.

7. At around 9.15am, a prisoner asked an officer to check on Mr Pioro as he did not appear to be moving. Two officers went to the cell, saw Mr Pioro lying face down on the floor, with no sign of movement, and entered the cell. One of them started cardiopulmonary resuscitation (CPR) while the other radioed a medical emergency code. At 9.20am, a nurse arrived, administered oxygen and applied a defibrillator. Paramedics took over the resuscitation efforts at 9.35am, but Mr Pioro was pronounced dead at 10.19am.

8. A post-mortem examination concluded that Mr Pioro died of a heart attack caused by a narrowing and clogging of the arteries in the heart.

Findings

9. We are concerned that healthcare and prison staff failed to thoroughly review the documentation that arrived at Bedford with Mr Pioro and so failed to identify his history of alcohol dependence. As a result, Mr Pioro was not monitored for alcohol withdrawal symptoms.

10. We are concerned that Mr Pioro appears to have been moved off the IDTS wing on the morning of 15 July at the request of a healthcare assistant and that the move was not authorised by the movements officer.

11. We are concerned that prison and healthcare staff have given different accounts of some key events. Communication between prison and healthcare staff was poor.

12. Although prison staff raised concerns about Mr Pioro's mental and physical health on the afternoon of 15 July, healthcare staff did not review Mr Pioro in person. If they had done so, it may have resulted in the earlier identification of a potentially life-threatening condition.

13. We consider that prison staff should have opened suicide support procedures (known as ACCT) given their concerns about Mr Pioro's mental health.

14. We agree with the clinical reviewer that the healthcare Mr Pioro received at Bedford was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that reception staff thoroughly review the person escort record and any other documentation that arrives with a prisoner so that any needs or risks can be identified promptly and addressed.

- The Head of Healthcare should:

    - ensure that healthcare staff do not sign to confirm that they have completed an initial health screen until they have reviewed the person escort record; and

    - review mental health triage processes to ensure that all staff are aware of their responsibility to contact the emergency response nurse if they consider that a physical health review is required in person.

- The Governor and Head of Healthcare should ensure that all staff understand that movements between wings must be authorised by an appropriate member of custodial staff.

- The Head of Healthcare should share this report with three nurses and HCA A and discuss the Ombudsman's findings with them.
- The Governor should remind staff that they should consider opening an ACCT if a prisoner has risk factors for suicide or self-harm.
- The Governor should ensure that prison staff record any conversations they have with healthcare staff when they have concerns about the health and wellbeing of prisoners.

The Investigation Process

15. 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.

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

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

18. The investigator and clinical reviewer interviewed 14 members of staff and one prisoner by video link between 7 and 15 September.

19. We informed HM Coroner for Central Bedfordshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Pioro's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She asked what time Mr Pioro died and whether he had died immediately. We have addressed her questions in this report in so far as we can.

21. Mr Pioro's wife received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Bedford

23. HMP Bedford is a local prison holding around 500 men. Northants Healthcare NHS Foundation Trust provides all healthcare services. There is an inpatient unit, with nine single cells and a four-bed dormitory.

HM Inspectorate of Prisons

24. The most recent full inspection of HMP Bedford was in August/September 2018. Inspectors found that reception processes were good, but many prisoners were not sufficiently supported on their first night. Wing staff were often unaware of new arrivals and did not routinely check on their welfare. Officers were exceptionally inexperienced. Most were committed to their work, trying to do their best, but as a group were out of their depth. Inspectors also found that progress against some PPO recommendations was too slow and some actions had not been completed.

25. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State on 12 September 2018, setting out his significant concerns about the treatment of prisoners.

26. In August 2019, HMIP carried out an Independent Review of Progress which followed up 13 of the 61 recommendations they had made after their 2018 inspection. Inspectors found a mixed picture with progress ranging from none to good but, in most areas, progress had been insufficient. The attention given to preventing self-harm was poor and the use of force was exceptionally high. The prison officer group remained relatively inexperienced, with half having less than a year in service. Although some experienced custodial managers from other prisons had been allocated to Bedford temporarily, there was a lack of experienced middle managers to hold officers to account and support them in their day-to-day work. Inspectors said it was clear that some officers struggled with implementing rules consistently and/or lacked knowledge about the very basic aspects of life in the prison.

27. A HMIP scrutiny visit in March 2021 found that Bedford had been under considerable pressure as a result of the impact of COVID-19, but prison leaders had worked hard to apply guidance on isolating prisoners. Inspectors found that several steps had been taken to prevent the spread of COVID-19 while prisoners were in reception and all new prisoners received a private safety interview. Healthcare services were well governed, and all new arrivals received an initial face-to-face health assessment. The size of the safer custody team had been increased but many of HMIP’s previous concerns about prisoner safety remained. The quality of staff–prisoner relationships remained mixed, with not all staff buying into the vision of a rehabilitative approach set out by the governor. Some weaknesses in the care and support given to those who were vulnerable or at risk of self-harm continued.

Independent Monitoring Board

28. 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 2020, the IMB reported that although there were concerns about issuing medication, healthcare services were of a good standard. They also noted that, in general, reception processes were well managed.

Previous deaths at HMP Bedford

29. Mr Pioro was the sixth prisoner to die at Bedford since July 2019. Of the previous deaths, three were self-inflicted and two were from natural causes. There are no similarities between Mr Pioro's death and the previous deaths.

Alcohol withdrawal

30. Alcohol is one of the most dangerous drugs to withdraw from. Minor alcohol withdrawal is characterised by tremor, anxiety, nausea, vomiting, and insomnia. For people who are severely alcohol dependent and who have been drinking excessively for a prolonged period of time, an abrupt reduction in alcohol intake may result in the development of an alcohol withdrawal syndrome, which, in the absence of medical management, can lead to seizures, delirium tremens, and death.

31. Delirium tremens (DTs) is the most severe form of alcohol withdrawal, and typically occurs two or three days after stopping drinking. It is characterised by confusion and symptoms such as sweating, palpitations, dry mouth, light headedness, and upset stomach, which can progress to cardiovascular collapse.

Key Events

14 July

32. On 14 July 2021, Mr Mariusz Pioro was remanded to HMP Bedford for driving under the influence of alcohol. He had a history of alcohol dependence and following his arrest, healthcare staff at the police station had given him chlordiazepoxide to treat alcohol withdrawal.

33. Mr Pioro arrived at Bedford at 4.31pm. A short while later, an officer conducted a reception screen and first night centre interview. He recorded that Mr Pioro did not report any mental health problems or that he needed substance misuse support. He noted that he had reviewed the person escort record (PER) that arrived with Mr Pioro but had not shared the PER with healthcare staff. There is no record that he reviewed the information in the PER indicating that it was the third time that Mr Pioro had been arrested for drink driving and that he had a history of alcohol dependence and delirium tremens (DTs, a severe type of alcohol withdrawal).

34. At interview, the officer said that Mr Pioro seemed nervous and was shaking slightly but was able to hold a rational conversation. He also said he was aware that Mr Pioro's alleged offence was drink driving. He said that Mr Pioro's English was quite fluent, but that he spoke some Polish himself and they joked a bit in Polish.

35. At 6.11pm, a nurse conducted an initial health screen. He noted that Mr Pioro did not report any mental or physical health problems and presented as stable. He took his clinical observations, which were acceptable, and conducted an alcohol audit screen (a series of questions). He recorded that Mr Pioro said he did not drink alcohol. There is no record that he saw the PER or the medical documentation from the police station.

36. At interview the nurse said that Mr Pioro was very anxious, and he wondered if the anxiety might be alcohol-related. However, he said he asked Mr Pioro if he drank, and Mr Pioro said he might have one glass of wine with his dinner. As there was no smell of alcohol and he did not know Mr Pioro's offence was drink driving, he did not explore Mr Pioro's drinking habits further.

37. At 8.32pm, an officer recorded that he had sent Mr Pioro to the integrated drug treatment service (IDTS) unit (D wing). All new prisoners were tested for COVID - 19 and sent to D or E wing, the dedicated reverse cohorting units (RCUs, designated wings for newly arrived prisoners awaiting the results of COVID-19 tests). The officer told the investigator that he decided to place Mr Pioro on D wing because he appeared shaky and he suspected he was withdrawing from something. He did not tell healthcare staff the reason.

15 July

38. At 6.30am on 15 July, an officer who was responsible for managing the movement of prisoners, received an email from Healthcare Assistant (HCA) A, which said that two prisoners, one of which was Mr Pioro, had been incorrectly placed on D wing. She said that there were prisoners on E wing who required IDTS support, and she wanted them to be swapped. The officer replied to say that it was not possible to

move anyone that day as a prisoner on D wing had tested positive for COVID-19. He said he would review the situation the following day.

39. At 10.02am, a HCA conducted a secondary health screen and noted that Mr Pioro did not report any medical conditions.

40. At 11.40am, an officer recorded that he had conducted Mr Pioro's induction on the IDTS wing. He told us that after the induction, he took Mr Pioro to E wing as HCA A told him that he needed to be moved to E wing. He said that he had concerns about Mr Pioro's presentation during the induction as, although Mr Pioro was able to engage, he seemed quite confused, and his arms were constantly shaking. The officer said that he thought Mr Pioro might be withdrawing from something, so he spoke to the HCA before leaving with Mr Pioro to check if he had the right prisoner. He said the HCA asked Mr Pioro if he drank in the community and Mr Pioro said 'no'. The HCA did not mention this conversation at interview but said that Mr Pioro was not on the IDTS ledger, which meant that he did not require IDTS support and monitoring.

41. At 11.44am, an officer received an email from HCA A to say that the prisoners had moved. The officer told us that he had definitely not authorised the move and assumed that the HCA had asked a prison officer to move the prisoners without consulting him. The HCA told us that she did not authorise the move.

42. Prison records show that staff on E wing placed Mr Pioro in a cell with another prisoner. In his prison statement, the cellmate said that Mr Pioro was constantly shaking and sweating from the moment he arrived. He also said that Mr Pioro paced up and down the cell, thought he was on a building site and used his vape (electronic cigarette) like a telephone.

43. An officer told the investigator that when he went to give Mr Pioro his lunch, he noticed that he was sweating profusely, and he seemed to think that he was his nephew and that his cellmate was going to take them to work. He also tried to grab his keys, although the officer said this was not done in a threatening way, but more as though Mr Pioro was confused and did not understand he was in prison. The officer subsequently contacted a Supervising Officer (SO), who spoke Polish, and asked him to speak to Mr Pioro. The SO told us that Mr Pioro said that he was in a hotel, he was late for work and needed to go to the airport.

44. At about 2.30pm, the SO referred Mr Pioro to the mental health team by email and also spoke to Nurse A, a mental health nurse. He noted that Mr Pioro was very confused, did not appear to understand that he was in prison and needed urgent support. He also noted that Mr Pioro spoke Polish and needed an interpreter.

45. At 3.10pm, Nurse A recorded that she had received a mental health referral by phone from the officer. She told him to radio Nurse B, the appointed emergency response nurse, and ask her to review him to rule out a physical cause for his confusion.

46. At 3.37pm, Nurse A recorded that she received a phone call from an officer, who said that he had seen Mr Pioro in reception and that his presentation had changed since then. The officer said that the police had arrested Mr Pioro for drink driving and that he was very sweaty, clammy and confused. She told him to call Nurse B.

Nurse A recorded on Mr Pioro's medical record, "We do not know if this gentleman has some alcohol dependence, and he could be having withdrawals and the need to rule out any physical cause".

47. The officer said that shortly afterwards he radioed Nurse B and realised from the echo that she was on the wing. He said that he went to the medication hatch with another officer, who explained the situation to Nurse B and asked her to review Mr Pioro urgently. He said that Nurse B said, "If it's a mental health issue, then what use is it me doing observations?" He said he was annoyed by Nurse B's response and that he rang the mental health team again. They said that they would add Mr Pioro to their list to be seen, but he said he told them that Mr Pioro needed help urgently. He said Nurse B then packed up and left the wing without seeing Mr Pioro. The other officer did not mention speaking to Nurse B when we interviewed her, and Nurse B said she did not remember having a conversation about a prisoner in distress.

48. The officer said his shift finished at 5.30pm, but that he stayed on for an hour or so to try to settle Mr Pioro.

49. At 9.06pm, prison staff moved the cellmate to another cell as Mr Pioro continued to display erratic behaviour and was becoming increasingly aggressive.

50. Another prisoner told the interviewer that he worked in reception and returned to the wing at about 9.00pm. He heard a lot of banging and went to investigate and saw Mr Pioro, who he did not know, alone in his cell, looking distressed, sweating profusely and banging his head against the door. He tried to communicate with him but did not get much back. He said Mr Pioro looked very stressed and not quite with it. At that point the prisoner was locked in his cell for the night, but he said he decided he would check on Mr Pioro in the morning.

Events on 16 July

51. At 8.25am, Officer A looked through Mr Pioro's cell door observation panel to conduct a roll check and saw that he was lying on the floor, moving around and talking to himself. At 8.30am, she asked Officer B if he could check on Mr Pioro as he was acting strangely, and she was aware he had mental health issues. Officer B went to Mr Pioro's cell, looked through the observation panel and said he saw him sitting on the floor, talking in Polish. He said he knocked on the observation panel and caught Mr Pioro's attention, although Mr Pioro carried on talking in what he assumed was Polish. Officer A said that Mr Pioro did not say anything to them but continued talking to himself in what she assumed was Polish. She said they agreed to leave Mr Pioro as he appeared fine physically.

52. Officer B told us that he checked on Mr Pioro again at around 9.00am, while he was escorting prisoners to collect their medication. He said that Mr Pioro was still sitting on the floor, talking to himself and that he did not have any concerns about his welfare as prisoners often behaved in unusual ways.

53. At around 9.15am, a prisoner checked on Mr Pioro. (He said he had expected to do so earlier as they were normally unlocked at about 8.00am, but they had been unlocked later that morning.) He then told Officer B to check on Mr Pioro as he did not appear to be moving. Officer B alerted Officer A and they went to the cell.

Officer B looked through the observation panel, saw Mr Pioro lying face down on the floor, with no sign of movement. He unlocked the door, and entered the cell with Officer A, checked Mr Pioro's vital signs and started cardiopulmonary resuscitation (CPR).

54. In the meantime, at 9.18am, Officer A radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing problems). At 9.20am, a nurse arrived at Mr Pioro's cell, with an emergency medical bag, and saw two officers doing chest compressions. She gave Mr Pioro oxygen and applied a defibrillator, but it did not detect a shockable rhythm.

55. The first ambulance arrived at the prison at 9.27am and paramedics arrived at Mr Pioro's cell at 9.35am. The paramedics took over the resuscitation effort and at 10.19am, an air ambulance doctor pronounced that Mr Pioro had died.

Contact with Mr Pioro's family

56. At around 10.20am, the prison appointed a Supervising Officer (SO) as the family liaison officer. The SO established that Mr Pioro had provided the name and address of his next of kin but not their relationship. At 12.00pm, he arrived at the address and two of Mr Pioro's three children greeted him and explained that their mother, Mr Pioro's named next of kin, was in Poland, attending her father's funeral and that their older sibling was at work. He broke the news of Mr Pioro's death to all three children and was present when Mr Pioro's wife was informed by phone. He offered support and provided his contact details.

57. At 2.00pm on 19 July, the SO returned to their home with a Custodial Manager (CM), and they introduced themselves to Mr Pioro's wife. They offered ongoing support to Mr Pioro's family and attended his funeral, which took place on 4 August. The prison contributed towards the cost in line with national guidelines.

Support for prisoners and staff

58. After Mr Pioro's death, a prison manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

59. The prison posted notices informing other prisoners of Mr Pioro'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 Pioro's death.

Post-mortem report

60. Post-mortem toxicology tests found the presence of chlordiazepoxide (which Mr Pioro had been prescribed in police custody) consistent with therapeutic use, and a low concentration of alcohol in Mr Pioro's urine (lower than the legal driving limit) and none in his blood. The pathologist noted that the absence of alcohol from the blood showed that it was not exerting any effects on Mr Pioro at the time of his death. The pathologist concluded that there was no compelling toxicological evidence to suggests that alcohol or any drugs were directly implicated in Mr Pioro's death.

61. The post-mortem report concluded that Mr Pioro died of a heart attack caused by coronary atherosclerosis (a condition that causes narrowing and clogging of the arteries in the heart). Mr Pioro also had fatty liver disease which did not cause his death but was a contributory factor.

62. It appears that the pathologist was not aware that Mr Pioro had been arrested for drink driving and been treated with chlordiazepoxide in police custody, or that he had a history of alcohol dependence and delirium tremens.

Findings

Reception procedures

63. Prison Service Instruction (PSI) 07/2015 on early days in custody says that the completed PER must be examined in reception to identify any immediate needs and risks already recorded. It also states that all prisoners must be interviewed, in private if possible, to discover and record any further immediate needs or risks. In addition, Prison Service Order (PSO) 1025 on communicating information about risks on escort or transfer says that reception staff should alert appropriate staff to any risks identified in the PER.

64. When Mr Pioro arrived at Bedford on 14 July 2021, staff failed to notice that the PER recorded his history of alcohol dependence and delirium tremens and that the police medical record showed that he was given chlordiazepoxide in police custody. An officer told the investigator that he did not receive any information from the police station but did see the PER. He said that he noted the basic information on the second page but did not look through the entire document as he had never been instructed to do so. If he had reviewed the document in full, he would have seen that Mr Pioro had a history of alcohol dependence and required IDTS support. We therefore consider that the officer missed this potentially crucial piece of information.

65. While we recognise that reception can be a busy environment, it is critical that staff obtain as much information as possible so that any immediate needs or risks can be identified and explored. We make the following recommendation:

    The Governor should ensure that reception staff thoroughly review the person escort record and any other documentation that arrives with a prisoner so that any needs or risks can be identified promptly and addressed.

Clinical care

66. The clinical reviewer found that the care that Mr Pioro received at Bedford was not equivalent to that which he could have expected in the community. Most relevant to Mr Pioro's death is the fact that the reception process failed to identify his history of alcohol dependency and that healthcare staff did not review him on 15 July.

Reception health screen

67. A nurse did not assess that Mr Pioro needed IDTS support during his initial health screen. This meant that he was not placed on the IDTS ledger and he was later moved to E wing without any extra monitoring or support. The nurse told us that Mr Pioro appeared very anxious and that, although he considered that his presentation might be related to alcohol, Mr Pioro repeatedly denied misusing alcohol.

68. We consider that the nurse relied too heavily on Mr Pioro's assertion that he did not have an alcohol problem. The clinical reviewer considered that he should have asked a GP or IDTS nurse, who would have been present in reception, for advice if he suspected Mr Pioro may be withdrawing from alcohol. It is essential that all risk

factors are identified and explored to ensure that a prisoner's needs are properly assessed.

69. We are also concerned that the nurse did not review the PER as part of the initial health screen. He told us that a lot of PERs are now electronic and that healthcare staff do not always receive them. While we appreciate that prison staff are responsible for providing healthcare staff with the PERs, we consider that he should have asked for a copy when he became aware that it was not available. As this case demonstrates, PERs often contain important information about a prisoner's risk and needs and it is therefore essential that they are reviewed as part of the initial health screen.

70. The clinical reviewer also expressed concern that Mr Pioro's initial health screen by the nurse and his second health screen by HCA A took only 15 and 8 minutes respectively, which she did not consider long enough.

Move from the IDTS wing to E wing

71. The clinical reviewer was concerned that prison officers and healthcare staff had a different understanding of what happened on the IDTS wing. Prison staff understood that once a prisoner was on the IDTS wing, they would be reviewed by the IDTS nurses. However, IDTS nurses only reviewed those prisoners who were on the IDTS ledger. As a result, it appears that Mr Pioro's shaking and sweating, which was obvious to prison staff, was not picked up by the IDTS nurses.

72. We share the clinical reviewer's concerns about the way Mr Pioro was moved off the IDTS wing on the morning of 15 July. We note that the movements officer subsequently reminded prison staff that prisoners should not be moved unless he had authorised the move, and we are satisfied that he had not authorised Mr Pioro's move. Although HCA A said that she had not authorised the move, it appears that she told an officer to move Mr Pioro, even though she knew that another officer had said he was not to be moved. Leaving aside the implications for Mr Pioro, we are very concerned that an unauthorised move between wings took place during the COVID-19 pandemic.

73. We recommend:

    The Governor and Head of Healthcare should ensure that all staff understand that movements between wings must be authorised by an appropriate member of custodial staff.

74. We note that an officer and HCA A gave different accounts of what happened before Mr Pioro left the IDTS wing, with the officer saying that after he expressed concerns, the HCA spoke to Mr Pioro and asked him if he drank, while the HCA did not mention such a conversation in her account.

Mental health referral and follow-up care

75. The clinical reviewer considered that Nurse A should have contacted an appropriate member of healthcare staff to review Mr Pioro when she received the mental health referrals from a SO and an officer on the afternoon of 15 July.

76. Nurse A said she considered that her advice to them to ring Nurse B, the emergency response nurse, was appropriate. Although we are satisfied that the advice was appropriate, we are concerned that Nurse A believed it was not her role to notify other members of the healthcare team. The Head of Healthcare told us that as Nurse A had identified alcohol withdrawal as a potential issue, she would have expected this information to be passed on to one of the IDTS nurses.

77. Despite the concerns of prison staff, no one from healthcare reviewed Mr Pioro in person on 15 July. Nurse B told us that she could not recall anyone speaking to her about Mr Pioro and that if she was told that a prisoner was unwell, she would have gone to see them. There is documented evidence that both the SO and an officer had been sufficiently concerned about Mr Pioro to contact the mental health team and ask for Mr Pioro to be seen urgently. It, therefore, seems very unlikely that the officer would not have spoken to Nurse B, as he had been advised to do. However, as we have been unable to confirm exactly what happened, we cannot make a finding about whether Nurse B should have reviewed Mr Pioro.

78. However, irrespective of this, the clinical reviewer considered that there is consistent evidence that Mr Pioro was confused, sweaty and shaking, and that at least some healthcare staff were told this. The clinical reviewer said that healthcare staff should have arranged to take Mr Pioro's clinical observations and conducted a National Early Warning Score assessment (NEWS, a scoring system to assess clinical deterioration in patients).

79. We cannot know whether closer monitoring on the IDTS wing or a nurse review on 15 July would have changed the outcome for Mr Pioro, but it may have led to the earlier identification of a life-threatening condition.

80. We make the following recommendations:

The Head of Healthcare should:

- **ensure that healthcare staff do not sign to confirm that they have completed an initial health screen until they have reviewed the person escort record; and**

- **review mental health triage processes to ensure that all staff are aware of their responsibility to contact the emergency response nurse if they consider that a physical health review is required in person.**

The Head of Healthcare should share this report with three nurses and HCA A and discuss the Ombudsman's findings with them.

ACCT

81. An officer was clearly concerned about Mr Pioro and acted appropriately in contacting healthcare about him. However, given his concerns about Mr Pioro's severe confusion, we consider that he should have considered opening suicide and self-harm support procedures (known as ACCT) once he realised that healthcare staff were not going to see Mr Pioro on 15 July. We consider that Mr Pioro's mental state was a clear risk factor for suicide and self-harm.

82. We also consider that the staff who moved the cellmate out of Mr Pioro's cell on the night of 15 July, leaving Mr Pioro alone in the cell, should have considered opening ACCT procedures given Mr Pioro's behaviour was strange enough to justify opening the cell and moving his cellmate out during the night state (when cells should only be opened in exceptional circumstances).

83. We also consider that Officer A and Officer B should have been more concerned when they saw Mr Pioro lying or sitting on the floor talking to himself for at least half an hour, given that they knew he was the subject of a mental health referral. We think that they should have spoken to Mr Pioro to check on his wellbeing, rather than just knocking on the cell door.

84. We recommend:

The Governor should remind staff that they should consider opening an ACCT if a prisoner has risk factors for suicide or self-harm.

The Governor should share this report with three officers and arrange for a senior manager to discuss the Ombudsman's findings with them.

Communication

Communication between prison and healthcare staff

85. Our investigation found that there were many issues with information sharing between healthcare and custodial services. It is very worrying that prison and healthcare staff often gave us different accounts of what was said and done. We recommend:

The Governor should ensure that prison staff record any conversations they have with healthcare staff when they have concerns about the health and wellbeing of prisoners.

Communication with Mr Pioro

86. The Prison Service's policy on foreign national prisoners says: "Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline".

87. During our interviews with staff, the consensus was that Mr Pioro had a good command of the English language. A nurse told us that Mr Pioro spoke good English and an officer said he did not struggle to communicate. A HCA said she was able to communicate properly with Mr Pioro and would have not proceeded with the secondary health screen otherwise.

88. An officer told us that he asked a SO to speak to Mr Pioro in Polish as he was concerned about his deteriorating condition and wanted someone to talk to him in a language that he understood entirely. We commend the SO for attending the wing and for asking for healthcare staff to review him using an interpreter. We are satisfied that the actions of both the officer and the SO were appropriate.

Emergency response

89. Bedford's local policy on responding to emergencies instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.

90. Officer B responded swiftly when a prisoner told him that Mr Pioro was unresponsive. He alerted Officer A, opened the cell door and appropriately started CPR. Officer A radioed the correct medical emergency code, and the control room called an ambulance immediately in line with national policy. A nurse arrived with an emergency medical bag within minutes and assisted with the resuscitation effort. The clinical reviewer was satisfied that the actions of prison and healthcare staff were appropriate.

Inquest

91. At the inquest, which took place between 4 and 7 September 2023, the Coroner concluded that Mr Pioro died of natural causes.

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