

**INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF A MAN AT
HMP BULLINGDON IN AUGUST 2004**

**Report by the Prisons and Probation Ombudsman for
England and Wales**

March 2005

This is the report of an investigation into the circumstances of the death of a man in HMP Bullingdon in August 2004.

I offer my sincere sympathy and condolences to his family who I know were close to him.

A colleague in the Ombudsman's office carried out the investigation on my behalf and another colleague conducted the liaison with the man's family. Another officer from my office and an officer from the area office, assisted in the early stages of the investigation. My deputy ombudsman carried out the clinical review.

I wish to extend my thanks to staff at Bullingdon for their help and cooperation during the investigation. I make a number of recommendations relating to both to the series of events immediately predating this man's death and to the contact the prison had with his family. Both the prison and solicitors representing him have made a number of helpful comments on the draft report. In light of this, some amendments have been made to the final report.

The man died while in Bullingdon's segregation unit and his is one of a worrying number of deaths of segregated prisoners I am investigating. At Bullingdon, not all the appropriate safeguards were being followed. However, even if they had been, the death of this man – at the painfully young age of 23 – is a reminder of the vulnerability of all prisoners when subject to a segregation regime.

Stephen Shaw
Prisons and Probation Ombudsman
March 2005

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Summary

The man was 23 when he died. He had started using drugs in his teenage years and had become a chaotic poly-drug misuser.

The man was received into HMP Bullingdon on 13 August 2004. He was due back in court on 2 September for sentencing. He had been in Bullingdon on a number of previous occasions.

Upon reception, he was assessed by healthcare but the correct documentation was not completed. He was located on Blackthorn wing in a single cell. The following day he commenced a 12-day Subutex detoxification programme.

The man went to Oxford police station on 25 August to answer enquiries on further crimes and remained there overnight. Whilst in police custody he was seen by the Forensic Medical Examiner and prescribed medication to help with his withdrawal symptoms. Due to being in police custody, he missed his last Subutex dosage on 25 August.

On his return to prison, he asked for his Subutex. Given that the detoxification programme had finished, and he had received drugs at the police station, he was not given any further medication.

Having returned to the wing, he found he had lost his single cell and was located into a shared cell. He was not happy about this. He reported that he had lost his property from his previous cell.

On 27 August, the man refused to return to his cell and was voluntarily moved to the Separation, Support and Challenge Unit. Healthcare did not complete a Safety Algorithm within two hours of his reception and staff did not observe him every 30 minutes as required. Later that afternoon he flooded his cell.

At 2.30pm the following afternoon, the man was subject to two adjudications and received 12 days cellular confinement in total. He was unhappy about the punishment. As a prisoner undergoing cellular confinement, he was not observed hourly in accordance with the Prison Discipline Manual.

At 5pm the man was found hanging in his cell. Emergency assistance was immediately summoned and attempts were made to resuscitate him. These were unsuccessful and he was pronounced dead at 6.10pm.

HMP Bullingdon

Bullingdon Community Prison is a category C local training prison for convicted and unconvicted adult male prisoners, serving courts in Oxfordshire and Berkshire. Opened in 1992, it is a 'new gallery' prison by design, with its four main house blocks divided into three galleried units. The original house blocks, A and D, have been supplemented by a fifth since April 1997. There are single, double and triple cells. Bullingdon has a healthcare centre providing 24-hour cover.

Events leading to the man's death

The man was remanded into HMP Bullingdon from the Magistrates Court on 13 August. He was due back in court on 2 September for sentence.

Upon his arrival at Bullingdon, he had a routine interview with a member of the healthcare staff, who made comprehensive notes in the Inmate Medical Record (IMR). However, the reception nurse did not complete a reception healthcare screen which includes an assessment of the prisoner's mental health and risk of self-harm. Asked in interview about his state of mind, she stated that she had no concerns about him.

The man disclosed to her that he was a heavy user of crack and heroin and was receiving a daily 60ml methadone script. Although he presented with a number of physical health problems relating to his drug use, the nurse did not feel that they were sufficient to require inpatient care. The man asked to be admitted to healthcare saying he had a problem with someone on Blackthorn wing and did not want to be located there. He had been assaulted during a previous period on remand, but it is unknown whether this played a part in his request and there is no evidence to indicate he advised staff of this on reception. The prisoner who had previously bullied him was not located on Blackthorn wing.

The man was located onto Blackthorn wing and, although deemed suitable for cell sharing, he was placed in a single cell. It is not known how he came to be located into a single cell but, given subsequent events, it was most likely as a result of his preference.

The following day, 14 August, the man was seen by the prison doctor and prescribed a standard twelve-day Subutex detoxification to begin that day. The doctor deemed him fit for ordinary location. On 18 August, the governor agreed to a request from the police for him to be questioned about further offences on 25 and 26 August at the police station. On 19 August, the man completed an assessment with the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team, again reporting heavy drug use. The intention was to start working with him after his detoxification to enable him to address his drug use.

On 24 August, he was visited by his probation officer and a police sergeant from the IRIS team based at the police station. The purpose of their visit was to assess his suitability for a Drug Treatment and Testing Order for his court appearance on 2 September. However, he did not want to be assessed and a report was not prepared. From their experience of him, this was not unusual as he often fluctuated between wanting to go into rehabilitation and then not being motivated to go. The police sergeant describes him as having been quiet but nothing that caused them any concern.

On 25 August, he was collected from HMP Bullingdon and taken to the police station for the purpose of clearing up some Taken Into Consideration (TICs)

offences. During the day a psychiatrist interviewed him. This had been pre-arranged in advance by the IRIS team, as there had been some concerns that he might suffer from Attention Deficit Hyperactivity Disorder (ADHD). However, the psychiatrist concluded that the man did not suffer from ADHD. In addition, she made a general assessment of his mental health including his risk of self-harm and suicide. The report states that he had taken two intentional overdoses in the past due to 'despairing of his life' but was not suicidal at this time. This is the only reference to past suicide attempts found by my investigator and therefore seems unlikely that the prison were aware of these incidents.

Whilst in police custody, the man saw the forensic medical examiner (FME) and was given Dihydrocodeine (for withdrawal symptoms) and Diazepam at 5.35pm on 25 August and 1.10am the following morning. The man had missed his last dose of Subutex at the prison due to being taken to the police station. On the morning of 26 August, his mother and sister visited him. His mother reports that he was fine although she recalled him asking for medication. At 1.36pm the FME again saw him and he requested Subutex. The FME did not prescribe anything and recorded '*no medication indicated at present. Will get his routine medication on return to prison.*'

At the conclusion of the two days' inquiries, it was likely that he was going to have 60 TICs taken into account at his next court hearing. Whether he had any worries about this, and the additional sentence he might have received as a result, is not known.

The man arrived back at HMP Bullingdon on 26 August at 4.35pm and was placed in the holding cell waiting to be processed back through reception. Whilst there he was spoken to by the orderly officer because he was kicking the door of the cell and causing a disturbance. The man was agitated and asking for his Subutex. He told the orderly officer that he was detoxing badly and the officer could see that he was shaking and that his mood was erratic. The nurse in reception was not aware that he was going to be there and phoned through to the healthcare office for his file to be checked. She was then able to explain to him that he had missed the last dose of his Subutex detox the day before. The nurse had a copy of the medication sheet from the police station and was able to see that he had been given some medication whilst there. The nurse explained this all to him and said that he calmed down. None of this encounter is reflected in his IMR and the only reference is in his core record '*seen by HCC. Reception*'.

The man was then located back onto Blackthorn wing but into a double cell as there were no vacant single cells. He was unhappy about this and asked for a single cell. It appears that wing staff were unaware that he was on a police production order and would therefore be returning to the prison. Under usual circumstances, when a prisoner goes out to court or the police station this is indicated in the wing office next to the cell number using the T-card system. In his case, this does not seem to have happened and it was assumed that the cell was free. However, even knowing that he was returning to the wing would not have secured his cell if a single one had been needed for another

prisoner. The senior officer on the wing at the time explained this to him and said that she would try to get him a single cell if one became available. In the meantime, he was placed in a double cell.

The man also complained that he had lost his property. My investigator has been unable to find out exactly what this property was and what happened to it. When he went out on his police production order it was his responsibility to take his possessions out of his cell and back through reception. There are large signs on the wing indicating this. The man told the wing SO that an officer had told him he did not have to do this as he was returning. Unfortunately, he was unable to recall which officer he had spoken with. The man's core record is stamped to indicate that the discharge procedure was completed but it is not signed by an officer. There is nothing on his property card to indicate that he took anything with him or stored anything there for his return. If any property was left in the cell it should have been removed when the cell was allocated to someone else and a cell clearance form completed. There is no cell clearance form on file.

Later that evening, he rang his cell bell. The wing officer responded and the man repeated his concerns about losing his cell and his property. The wing officer says that the man was angry and she wrote in the wing observation book, *'This prisoner did not take his property to reception on a police production order. He stayed out overnight therefore he lost his single cell and his property is misplaced. He has threatened to kick off tomorrow and not locate. STBA (Staff to be aware)'*.

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The wing SO spoke again with him on the morning of 27 August and he told her that being in a shared cell was *'doing his head in'*. He said that he was keeping his cellmate up because he was detoxing. After lunch, the SO was called to an incident on the wing where the man was refusing to lock up in his cell. The SO recalls trying to persuade him not to take this course of action as it would lead to him being taken to the Separation, Support and Challenge Unit (SSCU). She explained that healthcare staff would be doing their rounds later that day and he could speak to them about missing his Subutex. However, she states that the man said he wanted to go to the SSCU. Consequently he was placed on report for refusing an order and the SO took him down to the SSCU. He was located into cell S109 by wing officer and another officer. The wing officer described him as being compliant but not especially communicative.

All new prisoners placed in the SSCU must have a Safety Algorithm completed first by a nurse or doctor, and then the duty governor, within two hours of being admitted onto the unit. If this is not possible, the prisoner has to be monitored every thirty minutes until the algorithm is completed. There is no algorithm on file for him on 17 August or any indication that he was observed every thirty minutes.

Later that day, the man was seen to throw food out of his cell window. When challenged, he was abusive, and eventually moved to cell S104 where the windows cannot be opened. In interview, another SO stated that the man refused to take his bedding with him in spite of being told that he was going to be locked up for the night. The wing officer recalled him banging his door and shouting after being placed in cell S104.

At 6.25pm the man and another prisoner in cell S107 flooded their cells. This was not done by any prior arrangement between the two men. In interview the orderly officer, said that *'The man had actually joined in the other prisoner's (sic) protest'*. Both men were placed on report for this. A second wing officer went into both cells and turned off the water supply. The man gave an abusive response to him. The orderly officer decided not to move both men from their cells but to let them calm down. He spoke to the other prisoner and found him to be quite uncommunicative. He also spoke to the man who again complained about detoxing. The orderly officer explained that he knew his history, as he had been there when he had come through reception two days earlier. The orderly officer described him as eventually becoming calmer and he accepted the officer's offer to have his bedding returned to him. The two men remained in their waterlogged cells overnight. Their mattresses and bedding were not wet but the floor was.

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The orderly officer said in interview that, when he came back on duty in the morning, he arranged for the two prisoners to be removed from their cells temporarily whilst they were mopped up. He described speaking to him and stated that he was still showing signs of detoxing but was polite and respectful. During the morning, the wing SO spent about five minutes with the man inducting him. She recalls that he was *'quite dismissive'* but felt that this was not uncommon for prisoners who are about to be adjudicated upon. At 8.30am, a prison officer issued him with his adjudication papers.

There were a high number of adjudications that day, many of which needed a doctor to complete the adjudication paperwork. In total there were 16 prisoners on the unit that morning, ten of whom were facing adjudications. Both the prison doctors were absent from the establishment and a locum doctor had been called and this delayed the start of the adjudications. The duty nurse who had some knowledge of him as she had met him a number of times in healthcare, accompanied the doctor around the unit. The man did not give her or the doctor, any cause for concern and the doctor wrote in the IMR *'does not refer problems. Apparently fit'*. The Safety Algorithm was completed by the duty nurse, rather than the doctor, at 11.12am and indicated that he was fit for adjudication and a punishment of cellular confinement. The doctor did not complete the adjudication form, F256, as required.

The Adjudications

Given the volume of work, and the late start, the adjudications continued after lunch and for much of the afternoon. This was unusual. The man's first

adjudication began at 2.30pm and related to him disobeying an order (rule 51, para 22). Present in the room were the adjudicating governor, two prison officers, two escorting officers, and the man.

According to the paperwork, the man pleaded guilty to the charge of refusing a direct order, to locate into cell 229 Blackthorn wing at approximately 12.15am on 27 August. The first prison officer gave evidence and the man was then asked why he refused the order. He explained that he was withdrawing from drugs and that his cellmate was complaining about keeping him up. He went on to explain, in response to the governor's questions, that he was still withdrawing and was no longer on a detox. In interview, the governor said that he was aware that the man had missed his last day of Subutex but felt that it would have been such a limited amount that it would hardly matter. The governor explained that he would arrange for healthcare to see him regarding a possible re-detox. He found the charge proved and the man received five days cellular confinement and loss of all privileges, except tobacco. Included in the adjudication paperwork was a report from the wing that stated that he had not come to the attention of staff prior to the incident.

At 2.35pm, his second adjudication relating to the flooding of his cell and the one's landing (rule 51, para 17 – destroys or damages any part of a prison or any other property, other than his own) started. Again, the man pleaded guilty and the reporting officer presented the evidence. The man explained that he was *'pissed off, I couldn't breathe'* and said he had been moved cells because he had been throwing things out of his cell window. The case was proved and he received a further seven days cellular confinement and seven days loss of all privileges.

Prior to the man's adjudication, the prisoner, who had flooded his cell at the same time as the man who died, had his case proved against him. He received seven days loss of gym and loss of canteen and was returned to normal location.

After receiving his punishment, the governor said that the man said *'I can't do that'* which he did not judge to be a sign of distress. When he left the room the governor described him as a *'very unhappy man'*. The reporting officer and two escorting officers took him back to his cell as his demeanour gave them some cause for concern in terms of potentially being violent. The reporting officer said that the man continued to complain about the 12 days punishment and he wanted to contact his solicitor about it.

Three prisoners on the unit at the time were interviewed including the prisoner that had also flooded his cell. All stated that the man was aware of the other prisoner's punishment and was very angry about the contrast between the two punishments. Two prisoners recall that he was shouting, banging and ringing his cell bell a lot and asking for a light. One prisoner in cell S106 stated that he shouted they *'would pay for this later, the bastards'*.

After returning to his cell he shouted and banged the cell door intermittently. The reporting officer, who was the patrolling officer, recalls that when he rang

his cell bell, between 20 – 30 minutes after he had returned to the cell, he responded. Given that his second adjudication started at 2:40pm and lasted approximately five minutes, this was probably between 3:05pm and 3:15pm. The man was asking for a light, and due to his behaviour, the reporting officer passed him a light under the door rather than opening it as he would have done with a calmer prisoner.

The wing was busier than usual at this time because of the late running of adjudications. Staff estimate that adjudications finished at about 4pm and staff then had to prepare for the serving of tea. At some point during the afternoon, between him being returned to the cell after the adjudication and the discovery of him hanging, the second prison officer placed his adjudication paperwork under his door. His immediate response was to shove the papers straight back out onto the landing, where they remained. The prison officer is unable to recall at precisely what time this was and the reporting officer is unable to say if he saw the papers when he went to give him the light. This makes it difficult to know if the officer giving him the light at approximately 3.15pm was or was not the last time he was known to be alive.

The discovery of the man

The wing SO returned to the wing sometime around 4.30pm and the reporting officer briefed her about the afternoon's events. It was decided that they would serve him his tea last. This was in line with the unit's policy in dealing with potentially disruptive prisoners, so that if there are problems it will not affect the other prisoners.

Having finished serving the prisoners on the upper landing two wing officers and the second wing SO were getting the prisoners out individually for their dinner on the lower landing. The reporting officer was behind the servery on the lower landing. At 5pm the first wing SO walked passed the man's cell and thought he was very quiet for someone who had previously been very vocal. She opened the flap in the cell door and saw him hanging. The SO immediately shouted out and opened the cell door. The two prison officers were standing by the adjacent cell door and entered the cell immediately behind the SO. The SO radioed for level one assistance and records indicate that the ambulance was called at 5.04pm.

The officers supported his body and the first wing officer cut through the ligature (a sheet) with her fish knife (a knife specifically for cutting ligatures). The sheet had been slipped between the light fitting and the ceiling. The man was placed on the floor and both the SO and the first wing officer felt for a pulse but were unable to find one. Very quickly, a wing nurse arrived and her initial assessment was that the man was unresponsive and his lips were blue. At this point the man was moved out onto the landing to allow more room. Almost immediately, four more nurses reached the unit and Cardio Pulmonary Resuscitation commenced. A defibrillator was attached but the reading confirmed that nothing more could be done. The paramedics arrived at 5.28pm and CPR was ceased. A prison doctor arrived at 6.10pm and the man was pronounced dead.

Post-incident response

The adjudicating governor instigated the death in custody contingency plans. Unable to make contact with either the Governor or deputy, he eventually spoke with Governor A who came immediately to the prison. Once the coroner's officer and the police had left the prison, a debrief was held with the staff.

All the prisoners on the SSCU were spoken to and offered the opportunity to see Listeners and offered radios or television for the night. One prisoner in particular had been able to see the nurses working on the man and he was taken to healthcare for the night for additional support. A notice to staff and prisoners was issued informing them of the tragic death of this man.

Contact with the man's next of kin

The man's brother

One of the nurses was aware that the man's brother was a prisoner at HMP Bullingdon on Alpha wing. Governor A and two members of healthcare went to break the news to him. A decision was made to take him to healthcare and place him on a suicide watch as a precautionary measure. He remained in healthcare for a number of days before being returned to normal location.

The man's mother

The man's mother and stepfather were informed of his death by two local police officers at about 9.30pm that night. The police had very limited information and did not seem to be aware that two of her children were in custody. Understandably, the man's mother and her partner were distraught and tried to contact the prison. This involved them having to ring through to the answering machine and wait to be connected to someone. Governor A spoke to them but the conversation was very short.

In interview, Governor A said that there had not been any discussion about contact with the man's parents in advance and the task fell to him by default. Unfortunately, this meant that when the mother phoned the prison she did not have a direct number to call. The man's mother was also concerned about how the information was presented to her and the language used. Governor A disputes this. In addition, the police told the mother that they would go and inform the man's father but this never happened and the mother had to break the news to him.

The prison made arrangements for the mother and stepfather to visit the SSCU and for the brother to receive additional visits. Governor B spoke to the man's parents when they visited.

Issues considered during the investigation

The initial healthcare screening form

When the man first arrived at HMP Bullingdon, he was seen by a member of healthcare staff for an initial healthcare screening. This is a national assessment tool, including a section for risk assessment of self-harm and suicide. It should be completed when any new prisoner comes into custody. The reception nurse took comprehensive notes when she interviewed him and recorded details of all his physical problems. However, it was only in interview that she was able to say that she had given consideration to his mental health. The clinical review makes further comments on this.

Inadequate entries in the Inmate Medical Record

When the man returned to the prison from the police station he had quite a lengthy discussion with a nurse regarding his medication. None of this is recorded on his IMR.

The police production order

On 18 August the Governor gave consent for the man to go out on the police production on 25 August. However, it seems neither the wing nor healthcare were aware he was going. It is not entirely clear whether the man knew in advance. The staff on Blackthorn wing were unaware that he would be returning and subsequently allocated his cell to another prisoner. Healthcare did not make any arrangements for him to collect his medication in the morning prior to his release to police custody. Furthermore, there is no documentary evidence to indicate that his failure to attend for his treatment was followed up.

Safety Algorithm form

Staff from the SSCU are confident that they would have phoned healthcare to inform them that they had received him on 27 August. On this particular day, there was no doctor in the prison and there seems to have been some discussion about whether a nurse can complete a Safety Algorithm when someone is first placed in segregation. PSO 1700 states that a nurse is able to complete the algorithm. However, the man did not see any healthcare staff on 27 August.

On 28 August, the doctor did see him but failed to complete the adjudication paperwork or sign the algorithm.

Hourly checks

The regime for a prisoner serving a period of cellular confinement is laid down in the Prison Discipline Manual (PDM). The PDM stipulates that an officer must observe all prisoners who receive a punishment of cellular confinement

once an hour. This is repeated in Prison Service Order 1700, issued in November 2003. At the time of his death, this level of observation was not being met. In interview, neither the unit manager, the orderly officer, or the unit governor, the adjudicating governor, were aware of this requirement. It seems likely that they both inherited a unit where this had not been done. In this case, it is not possible to be entirely accurate about when he was last seen. However, it is probable that he was not seen for approximately one hour and 45 minutes prior to his death.

The adjudications

HMP Bullingdon's document 'A Guide to Adjudication Punishments' (December 2003) outlines a range of punishments available for all prison offences including the offence of destroying or damaging any part of the prison. Depending on the seriousness of the offence and any mitigating or aggravating factors, punishments range from referring the case to the Independent Adjudicator to (at the lowest end) seven days loss of privileges. The middle range is three to seven days cellular confinement with loss of all privileges.

Both the man and the other prisoner flooded their cells. His punishment was within the middle range whilst the other prisoner's appears to be below the minimum. To understand why the punishments were so different, my investigator examined the guidelines document and had a long interview with the adjudicating governor.

The adjudicating governor was asked specifically about the man and his decision making process. He described him as being '*very truculent*' and having a demeanour of '*complete disregard for the adjudication process*'. He explained that cellular confinement and loss of all privileges is a common punishment for refusing to lock up to try and deter people from using the SSCU as a way of getting a single cell. The governor said that he discussed with the man whether he was prepared to go back to the wing but he was not.

The governor explained that, during the first adjudication the man, talked about detoxing and that he had not had his last dose of Subutex. He stated that the Diazepam given to him whilst on police production did '*not do him any good*'. The governor believed that the man had been using drugs whilst in custody although he did not have any evidence to support this. The governor said that he intended to speak with healthcare staff the following morning and see the man to discuss a re-detoxification. This would have meant that healthcare staff would not have been contacted for at least 15 hours.

The governor explained that '*I just gave him the award of CC because I felt that was the place we could give him the better support*'. He went on to explain that '*some people could view cellular confinement as a punishment and yes it is in one extreme but I think me personally my motives for doing it were simply because of the higher level of support that we could give*'.

In relation to the second adjudication the governor stated that whilst, he gave consideration to the support issue, he also felt that *'he got seven days because he had shown absolutely no remorse whatsoever'*. He added later that *'there was nothing that I could actually use in mitigation other than the fact that you know he didn't like the windows being shut but to me it was just another example of a truculent young man that I had in front of me'*.

In discussing where he viewed him on the tariff, he stated that *'the mid range tariff is where he well and truly sat because he didn't satisfy anything for me to move into the lower range'*. On the other hand, the other prisoner, according to the governor *'was calm, he was collected, he was contrite, he was remorseful'*. He agreed to go back to normal location and left the SSCU that afternoon.

In deciding upon disciplinary punishments, there is properly much room for individual discretion. The local document is also only a guide. However, I am struck by the contrast between the punishments, received by the man and the other prisoner respectively. The governor knew that the man was withdrawing from drugs and used this to think about the extra support he felt the man would get by being in the SSCU. However, he may not have fully considered the effect of drug withdrawal on behaviour, or the impact a period of cellular confinement could have had on the man's frame of mind. A total of 12 days cellular confinement for the two offences is a severe penalty by any standard.

Family contact

PSO 2710 stresses that whenever possible, it is for the prison to break the news of bereavement to the next of kin. In this case, it is unclear why this was not done given the relatively short distance between the prison and the man's mother's home. In interview, the orderly officer said that he tried to get in contact with the chaplain but was not able to and he was conscious that information might be leaked if they did not act quickly. According to the investigation reports, in five of the past deaths in custody at Bullingdon the police have informed the next of kin of the death. From interviews with a number of the senior staff on the scene, it seems that the issue of speaking with the family was not discussed and therefore not planned.

The day after the man's death his family did visit the prison and saw his brother, Governor A and the orderly officer. They also made a subsequent visit to the prison. However, there appears to have been some confusion about the visit and access to the establishment. The mother had been led to believe that the family would be 'fast tracked' through the visitor's process. This appears not to have happened.

The man's brother was allowed to attend the funeral and this seems to have been conducted with sensitivity by the officers who accompanied him. He was allowed to sit with family members at the front of the church and spent time with his family throughout the day at the chapel of rest and the church. The family were concerned that he was not told until the day before that he was being allowed to go but this is understandable given security

considerations. I am pleased to draw attention to the staff involved in the brother's attendance at the man's funeral and to commend them for their conduct and sensitivity.

PSO 2710 states that '*the handling over of personal effects including all monies held on behalf of the deceased should be done with care and sensitivity*' (paragraph 6.2.10). The man's brother was released from custody some time later and was upset to be given some of the man's possessions when he left the establishment. He and members of his family should have been consulted about what they wanted to happen.

The mother received a letter of condolence from the Governor dated 8 September, eleven days after the man had died. She did not offer any financial assistance for the funeral and the man's mother had to write requesting some assistance. Funds were forthcoming and the family were grateful. However, it would have been more appropriate for the prison to have made the offer without waiting to be asked. As with the issue of the man's property, it is disappointing that the needs of the family were not considered more rigorously. There are important lessons from the tragedy of the man's death that Bullingdon needs to take on board.

Relevant recommendations from previous deaths at HMP Bullingdon

There have been a number of deaths at Bullingdon during the past five years. All have been investigated but inquests have not yet been held. Each investigation has made recommendations and three are of relevance to this case. None appear to have been fully complied with.

'All prisoners in the segregation unit should be the subject of regular checks throughout their stay.' (November 2002)

'There should be an instruction concerning the management of prisoners who are withdrawing and not located in the HCC.' (January 2002)

'Prisoners who fail to collect prescribed medication must be followed up, particularly medication for any mental disorder or management of substance misuse as these prisoner/patients are most at risk from deliberate self-injury.' (November 2002)

Findings and conclusions

Hourly observations were not undertaken following his punishment of cellular confinement, despite this being a requirement of the Prison Discipline Manual. Following his tragic death, local policy was reviewed and amended to reflect this requirement.

An internal audit should be undertaken to ensure continued compliance with the revised policy on observations of prisoners in cellular confinement.

Safer Custody Group should remind all Governors of the requirement to undertake hourly observations of prisoners on cellular confinement in accordance with the Prison Discipline Manual.

The man received seven days cellular confinement and loss of all privileges for flooding his cell. A prisoner in a neighbouring cell simultaneously committed the same offence. He received seven days loss of gym and returned to normal location.

The Governor of Bullingdon should remind her adjudicators of the need for consistency and fairness in setting individual punishments.

The safety algorithm was not completed for the man when he was received into the SSCU. The safety algorithm completed the following day was not signed by a doctor. Nor did the doctor sign the adjudication form, F256.

The Governor should remind staff that a safety algorithm must be completed on all new receptions into the SSCU. She should also remind clinical staff that a doctor must undertake and sign an algorithm for the purpose of cellular confinement, and arrange for regular audits to ensure compliance with PSO 1700.

The police production order was the start of a sequence of events that culminated in the death of this man. It is not clear how information about him being absent from the prison for two days was filtered through to the necessary units.

An internal audit should be undertaken to examine the current flow of information regarding prisoners leaving the establishment on overnight production orders.

In accordance with PSO 2710 consideration should be given to communications with the deceased family. In this case this was not done and some of the confusion and distress which coloured subsequent contact might have been averted if staff had made contact directly.

The Governor should remind all her managers that contact with the next of kin must be given high priority and conducted in accordance with PSO 2710.

The clinical review makes four recommendations.

Recommendations

An internal audit should be undertaken to ensure continued compliance with the revised policy on observations of prisoners in cellular confinement.

The Safer Custody Group should remind all Governors of the requirement to undertake hourly observations of prisoners on cellular confinement in accordance with the Prison Discipline Manual.

The Governor of Bullingdon should remind her adjudicators of the need for consistency and fairness in setting individual punishments.

The Governor should remind staff that a safety algorithm must be completed on all new receptions into the SSCU. She should also remind clinical staff that a doctor must undertake and sign an algorithm for the purpose of cellular confinement, and arrange for regular audits to ensure compliance with PSO 1700.

An internal audit should be undertaken to examine the current flow of information regarding prisoners leaving the establishment on overnight production orders.

The Governor should remind all her managers that contact with the next of kin must be given high priority and conducted in accordance with PSO 2710.

Appropriate systems must be put in place to ensure that there is effective interagency sharing of health information to enable continuity of care for individuals as they pass from the community to prison and back again.

All prisoners newly received into custody should have a full physical and mental health assessment on reception by a suitably qualified health care worker using the agreed screening and assessment tool.

A healthcare worker must complete the algorithm in all cases when prisoners transfer to the Separation, Support and Challenge Unit in accordance with National Policy. A copy of this should be placed in the clinical record and an entry made in the continuous medical record as documentary evidence that a prisoner has been seen.

The staff involved in the resuscitation of the man should be commended for their actions despite the tragic outcome.