Investigation into the circumstances surrounding the death of a man at HMP Bullingdon in December 2004

Prisons and Probation Ombudsman for England and Wales

June 2005

The man, who had been a remand prisoner at HMP Bullingdon, was found dead in his cell in December 2004. This is a report into the circumstances surrounding his death. The loss of any family member is distressing, but especially so whilst they are in custody, and I offer my sincere condolences to his family and friends.

Two colleagues from my office carried out the investigation. I wish to thank the Governor of Bullingdon for making the necessary facilities available to my investigators and for the assistance of the Principal Officer and the Senior Officer.

In the course of the investigation, I asked for a clinical review to be undertaken of the care and treatment received by the man from HMP Bullingdon. I am most grateful for the reviewer's work on my behalf.

This report shows that on 6 December the man made a written application to see a doctor stating that he was feeling *very very depressed*. The application, which was not processed until 9 December, was then filed away pending an appointment scheduled for 15 December. The person/s dealing with the application did not alert any concerns to the Medical Officer or wing management.

During the night of 27 December, two days prior to his death, he asked to speak to a member of the Listener team. The Night Orderly Officer (NOO) facilitated his request. However, he and the Wing Night Patrol Officer failed to record the request in the Wing Observation Book which would have alerted wing management and staff that the man was potentially vulnerable.

I am not satisfied that the man was cared for appropriately and have recommended that the Area Manager undertakes two separate investigations. There are a significant number of other recommendations, plus two examples of good practice.

Stephen Shaw CBE **June 2005**
Prisons and Probation Ombudsman for England and Wales

Contents

Summary

Investigation Process

HMP Bullingdon

Findings

Recommendations for the Prison Service

Recommendations for the Area Manager

Recommendations for the Prison

Clinical Review Recommendation

Good Practice

Summary

1. On 20 October 2004, the man was remanded into custody by East Berkshire Magistrates' Court on suspicion of making threats to kill and blackmail. His trial was to be held at Reading Crown Court, on a date to be fixed.

2. Due to the nature of the alleged offence, he was subject to Prison Service Order 4400 (PSO 4400) "Protection from Harassment". On October 29 he was interviewed by a Probation Officer and informed that he was subject to PSO 4400 and that his telephone calls and outgoing correspondence would be monitored.

3. He completed an application form to see a doctor, which he had dated 6 December, and on which he wrote that he was *very very depressed* and *not coping well*. The application form was placed into the wing confidential healthcare post box and then collected by a nurse sometime later. It is unclear to the investigation team when the application form was collected from the post box by a nurse. However, it is date stamped as being received into Healthcare on 9 December.

4. During the night of 27 December, he made a request to the night staff to be allowed to speak with a Listener. The NOO agreed and arrangements were made for a Listener to be taken to see the man. However, the NOO did not inform anyone that the man had been unlocked during the night to facilitate a Listener, nor made an entry in the Wing Observation Book or the man's history sheet.

5. At 08:30am on 29 December, an officer unlocked the man's cell door and initially thought that he was standing watching TV. She then realised that he was suspended by a ligature from the cell light fitting.

Investigation Process

6. On 13 January, the investigation team met with the Governor who gave an overview of the circumstances surrounding the death. A Principal Officer was appointed as the Liaison Officer. A number of documents were made available to the investigation team, along with routine reports which the team wished to examine.

7. The team was taken to the wing where the man lived and viewed the cell where he had been found. A member of the wing management gave them a full tour of the wing. The team was later introduced to a member of the local Prison Officers' Association and a member of the Independent Monitoring Board.

8. A number of staff were identified whom the investigation team wished to interview and arrangements were made for the interviews to take place. All staff cooperated fully with the investigation process.

9. The investigation team offered the Governor the opportunity to receive feedback at the end of each day. Significant findings were fed back immediately. Additionally, feedback regarding healthcare matters was given to the Clinical Nurse Manager.

10. On 8 March, one of my Family Liaison Officers (FLOs) and one investigator met with the man’s sister to discuss the concerns of his family. Following the meeting, a further visit to the prison was arranged to review the visiting arrangements and to speak to a member of the family who was also in custody at the time of the man’s death.

11. A Clinical Review was carried out. The reviewer visited the establishment, along with my investigator, as she wished to interview a number of nursing staff and the Clinical Nurse Manager.

12. Following the completion of the work required during the second visit, my FLO and investigator met with the Governor and informed her of all the investigation findings and potential recommendations.

HMP Bullingdon

13. Bullingdon is a male establishment, which opened in April 1992, providing places for Category C prisoners. Additionally, it performs a local function for convicted and unconvicted adult males, serving courts in the Oxfordshire and Berkshire area.

14. The Certified Normal Accommodation is 767, with an Operational Capacity of 963. The population breakdown is:
    - Remand Prisoners, 21 percent.
    - Convicted Prisoners, 79 percent.

15. In July 2003 an announcement was made that the prison would be Performance Tested. In March 2004 the prison was successful with its bid and was granted a five year Service Level Agreement.

16. In January 2005, the prison was re-inspected by the Standards Audit Unit. The Executive Summary of the inspection said, *two years ago, it was clear that this prison presented the Governor and her staff with many challenges. Measured against Prison Service Standards, performance could best be described as mediocre. Security scored 74 percent, Standards 71 percent and efforts to run self-audit merited an awful 48 percent. We conducted a re-visit of some of the worst areas of concern a year later, and noted that recovery had commenced. Following a formal Performance Testing process, the Governor and her Area Manager signed a Service Level Agreement in April 2004. The establishment has benefited from the creation of its own Performance Improvement Unit, which also manages the self-audit process.*

    It is striking that Bullingdon Prison is a very different establishment today. Staff and managers appear enthusiastic and committed to improving performance further. They have already come a long way. Security now warrants a score of 83 percent, up nine percent in two years. Performance has improved even more when measured against Prison Service Standards baselines, and 83 percent has also been achieved for Standards, up 12 percent in the same period. Our own research within Standards Audit Unit suggests a clear correlation between the quality of self-audit processes and performance levels overall. This trend is reflected here, as the score for Standards Audit has increased from 48 percent two years ago to 82 percent today.

    An analysis of the scores awarded is useful to give additional context to the improvements that have been made. We have audited performance against 119 baselines that have been deemed to be critical by the Policy leads, across 22 different Standards selected for an audit of a local prison for adult men. Sixty-seven baselines are being compiled with fully, and a further 26 only require minor remedial action. There are 23 areas detailed in the summaries below for Decency and Health, Operational Effectiveness, Regimes and Safety that do not currently provide a safe level of assurance that those risks are being managed. There are only three substantial remedial actions identified, reflecting poorly managed purposeful activity monitoring and a large backlog of casework in Sentence

Planning. On this occasion we have found no instances of risk not being managed at all.

The baseline for Suicide and Self-Harm was audited and found to be compliant, bar one, which related to who is listed to offer support.

Findings

17. In every case of a death in custody the Ombudsman issues Terms of Reference and notices to prisoners, which he asks the Governor to display in the wings and areas where prisoners can readily access and read them. The notice informs prisoners that they can communicate directly, in confidence, with the investigation team. On the day the investigation commenced, the team was unable to find any evidence that the notices had been displayed as requested. One notice was found under several other documents in an office tray, but they were not found in any of the other accommodation areas. This was pointed out to the Liaison Officer who made immediate arrangements for new notices to be displayed.

18. Prisoners received into custody at Bullingdon are interviewed in the reception area by the First Night Officer (FNO) and reception staff. The FNO makes an initial assessment and identifies any risk to the prisoner and others and ensures basic information has been passed to the prisoner. The FNO interviewed the man and did not record any concerns on the Induction Passport form.

19. Additionally, a Cell Sharing Risk Assessment (CSRA) is carried out to identify any risk to other prisoners who may be required to share the same cell. An officer carried out the assessment and recorded his assessment findings as low, while a nurse assessed the risk as medium. As the man had indicated during the reception procedure that he had been in custody previously, section two, part four, of the CSRA should have been completed. Additionally, section four was not completed by the Locating Officer.

    The Governor should remind reception staff of the need to complete the Cell Sharing Risk Assessment accurately. (Repeat finding, Standards and Security Audit 17 February-7 March 2003 and Revisit Audit 5-9 January 2004.)

20. PSO 4400 "Protection from Harassment" requires the prison to monitor the telephone calls and all outgoing correspondence of any prisoner identified as falling within the scope of the Order. The instructions are a mandatory requirement.

21. On 29 October 2004, the man was interviewed by a Probation Officer and informed that, due to the nature of his offence, he would be monitored under the terms of PSO 4400. He signed the document acknowledging that the instruction had been explained to him. However, the Probation Officer did not sign, date or print his/her name and therefore the investigation team has been unable to identify who dealt with the document.

    The Governor should remind the prison probation staff to print, sign and date official documents.

22. The investigation team found that, although the man had signed the compact, the mandatory public protection requirement to monitor mail and telephone calls was not actioned until 24 December. This left potential victims vulnerable to further

harassment. However, the investigation team has found nothing to suggest that he breached the instructions given to him on 29 October.

The Governor should ensure that the mail and telephone calls of all prisoners identified as being subject to PSO 4400 is routinely monitored. (Repeat Recommendation, Standards and Security Audit, 17 February-7 March 2003 and Revisit Audit 5-9 January 2004.)

23. He was initially allocated to share a cell with another prison and later transferred to a single cell on B wing (B 2.38 Blackthorn). The man's cellmate had come to know the man quite well and described him as a depressed person, who would pace all night and not sleep well. However, when the man was unlocked, he would present a normal picture to everyone else in the wing.

24. The man's cellmate had seen him the day prior to his death and said that he appeared fine. He said that the man owned a bar in Thailand and had become concerned about the tsunami. He said the man tried to speak to a wing officer about the Asian tragedy, but received no help. The investigation team have been unable to establish whom he tried to discuss this with.

25. The Healthcare Department had recently introduced a confidential application system into the prison, which allows prisoners to make a request to see medical staff without wing staff being aware of what the request refers to. Each wing has a locked post box in which prisoners can place their completed application form and the box is then emptied by a nurse. The nurse emptying the boxes will take the application forms to the Healthcare Department for processing, which means that they are required to read the application form and allocate the prisoner to the appropriate healthcare service. The nurse issues the prisoner with an acknowledgement slip, which informs him of the time and date of his appointment. The nurse informs the wing manager separately of the appointment time.

    The confidential medical application system is good practice.

26. The man completed a confidential medical application form, which he dated 6 December, and posted it into the wing healthcare post box. He requested to see a doctor and wrote *I am feeling very very depressed and finding it hard to mix with other inmates, and feel at times that they are watching me and my life in danger and having very little sleep, if any at all.* A member of the Healthcare staff collected the application form and date stamped it as being received on 9 December. An appointment was made for the man to see the doctor on 15 December and the application was filed away. The member of the nursing staff who dealt with the application form did not follow-up the content of the application, or alert the wing to the man's state of mind. A nurse said that she believed it was her writing on the application form dated 9 December, but has no recollection of dealing with the form in its entirety. The investigation team has been unable to identify which member of the nursing staff dealt with the application, as there is no tracking procedure in place. As the Governor was not in the prison, the Deputy Governor was informed immediately of the finding. My investigator met with the Governor at a later date to give feedback of the

investigation findings to date. The Governor was unaware until then of the application finding.

The Area Manager should commission a separate investigation to determine who dealt with the man's application, why the content was not communicated to the wing management and why he was not referred or interviewed as a matter of urgency.

27. The investigation team met with the Clinical Nurse Manager and discussed the application process. She said that the boxes were emptied on a daily basis and that one nurse carries out the processing procedure. However, when the investigation team discussed the application procedure with the nursing staff, the responses varied with staff saying that the wing boxes were emptied anything from every other day up to every five days. Nursing staff also said that any one of the nursing staff can empty the wing box and that the application form is then placed into a tray in the wing office for processing. It was also said that the forms remain in the tray until a nurse has sufficient time to process them, which could be some days after they had been collected. An additional complication with the system is that no one person has the responsibility for dealing with the forms from start to finish. Several nurses can deal with sections of the application form, subject to the amount of spare time available. The investigation team felt that, whilst the confidential application system is good practice, it was not operating efficiently, and that the use of nurses to carry out what is essentially an administration task is a waste of valuable resources.

28. The investigation team discussed the procedures with prisoners to establish what their expectations were regarding the collection of the application forms. It was clear that prisoners believed that the boxes were emptied every day.

29. The team discussed this issue with the Clinical Nurse Manager who said that she had introduced a new system following the man's death, which would provide a better service. However, the new system meant that not all boxes would be emptied every day. The team discussed the new system with nursing staff, who, in the main, were unaware of the recent changes. Additionally, prisoners had not been notified of any change. The system is confusing and requires clarifying and communicating correctly to staff and prisoners.

The PCT, in partnership with the establishment, should review the procedure for prisoners making confidential applications to the Healthcare Centre and ensure that a clear audit trail is in place to identify who has processed the document, action taken, time and date.

The PCT should ensure that prisoners and nursing staff understand the procedures for making a confidential application.

30. In June 2004, Her Majesty's Chief Inspector of Prisons for England and Wales (HMCIP) carried out an unannounced follow-up inspection of Bullingdon. The report made a recommendation that *Healthcare staff should follow-up all patients who fail to attend healthcare appointments and rebook the appointment if appropriate.*

31. The Inmate Medical Record (IMR) shows that the man had medical appointments for 13 and 15 December, both of which he failed to attend. The appointment for 13 December was unrelated to the application that he had made on 9 December. Despite the recommendation made by the Inspectorate, medical staff did not follow-up the missed appointments. Had they done so, the missed appointments and his application to see the doctor would have been re-examined, and it is therefore possible that someone would have realised the importance of what he had written and followed up the application. There is no evidence to suggest that either of the missed appointments were followed up.

32. The investigation team discussed the procedure for missed appointments with nursing staff. It was clear that, once an application form has been processed and an appointment made, the form is then kept within the medical record and not seen by the doctor until the patient arrives at the surgery. If the prisoner fails to attend the appointment then the medical file is re-filed without any further examination of the medical notes taking place. This means that the doctor would not have been aware of the man's request and his feelings at the time of writing the application form.

    Healthcare staff should follow-up all patients who fail to attend healthcare appointments and rebook the appointment if appropriate. (Repeat Recommendation HMCIP June 2004.)

33. My investigation team found that the systems for missed appointments and application procedures were not robust, and the guidance to nursing staff and prisoners regarding wing applications was confusing. This requires remedying.

34. Bullingdon has a system where anyone who is considered at risk of suicide or self-harm is monitored using the F2052SH procedure. F2052SH is a document which is opened on an individual prisoner and records the concern that a member of staff has about a prisoner. The concern can be anything from an actual self-harm attempt to a feeling that someone may harm themselves. It is open to any member of staff to initiate the document and raise their concerns. Once the document has been opened, the prisoner will be interviewed and invited to attend a multi-disciplinary team meeting, whose role it is to understand what has caused the risk and to create an action plan designed to reduce or eliminate any risk. All prison staff have received extensive training in suicide and self-harm procedures.

35. The prison has a local Suicide and Self-Harm Prevention Strategy which had been revised in June 2004 and which follows the guidelines of PSO2700. Under the heading of "Opening an F2052SH" the policy instructs staff, that *in all cases where a prisoner expresses suicidal thoughts or performs an act of self-harm, an F2052SH must be raised.* The policy statement says, *HM Bullingdon Community Prison recognises that imprisonment can lead to depression, stress and feelings of isolation. We aim to be alert to the needs of those who find it difficult to cope and help reduce those feelings as much as possible.*

36. The application form that the man raised and his comments should have alerted the reader to be concerned for his safety, and they should have dealt with the information as per the suicide and self-harm policy.

37. The prison has a "Listener Scheme", which is a system where the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling vulnerable and at risk. The scheme is confidential and any prisoner can request to speak to a Listener at any time of the day or night. Prisoners can access a Listener easily by speaking to a member of staff, who will then make the arrangements for a trained Listener to speak to the prisoner concerned. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request from the night staff on duty. The NOO has the authority to unlock a Listener and to escort him to the cell of the prisoner who is requesting assistance. The prison has nine trained prisoners who operate on a rota system, with the scheme being overseen and managed by a very enthusiastic Senior Officer. The investigation team found the Listener scheme and accessing the service to be well publicised.

38. All prisons have a system where official notices and instructions from the Governor are published to staff by way of "Notices to Staff" (NTS). They are issued in numerical order, followed by the year of issue. An examination of the prison Suicide and Self-Harm Strategy identified NTS 87/2003, issued by the Governor on 18 March 2003 and which referred to *Use of Wing Observation Books.* Paragraph three of the notice reminds staff that *any prisoner who requests a Listener or the use of the Samaritans phone who is <u>not</u> on an open F2052SH must be recorded in the Wing Observation Book. The Wing Senior Officer to investigate.*

39. Operational Instructions, which are similar to the NTS procedure, give instructions for staff to follow. Operational Instruction 6/2004 "Wing Observation Book" was issued by the Governor to ensure:

- *Appropriate entries are made in the Wing Observation Book.*
- *Follow-up action is taken and recorded.*
- *Relevant Standard Audit Baselines for Safer Custody are met.*
- *Audit trail is available for Standards Audit Unit.*
- *Wing SOs or I/Cs respond to all entries.*
- *Residential Principal Officers take direct responsibility for management of observation books and for appropriate follow-up action that impacts upon their areas of responsibility.*

40. Paragraph 2.1 of the instruction says, *there is a clear need to improve upon our current recording of events and comments made in residential Observation Books and to ensure that appropriate documentation is completed and followed through to its conclusion.* Paragraph 2.2 says, *In general, entries should be made to ensure staff are fully briefed on residential and prison issues whether this concerns an individual prisoner, groups, potential problems, tangible problems or simply "gut feelings" or instinct that staff believe should be brought to the attention of other members of staff. No matter what type of entry, the reason for this instruction is to ensure an adequate response is recorded and given.*

41. The investigation team could find no evidence to show that the NOO recorded the unlocking of the Listener or the man in either the NOO Occurrence Book or the Wing Observation Book. At interview, the NOO was unable to recall unlocking

the Listener or the man. He did though accept that the Listener's log entry, which recorded the request and meeting with the man, was correct. The investigation team confirmed with the Listener that he had been unlocked by the NOO and taken to meet the man. As this was only the third night that the NOO had ever been in charge of the prison, the investigation team was surprised that he said that he could not recall unlocking the Listener or the man.

42. The investigation team understand from the NOO that he had received no training as a first line manager. Whether this is the case or not, not recording a significant event where the night security is broken by unlocking two prisoners and not following the instructions contained in NTS 87/2003 is a matter of concern.

43. A Senior Officer informed the investigation team that, following the death of the man, she became aware that he had requested a Listener during the night. She examined the Wing Observation Book to see if an entry had been made by the NOO and confirmed that it had not. She said that instructions had previously been issued to staff regarding the recording of anyone who requested a Listener and as the NOO had not followed the instructions, she re-issued them. The investigation team found the Senior Officer to be pro-active and highly dedicated to her role as Safer Custody Manager. The failure to follow the instruction of NTS 87/2003 requires further investigation. The investigation team informed the Governor of the finding. She was already aware of this failure from her own internal enquiries.

The Senior Officer should be commended for her work as Safer Custody Manager.

The Area Manager should commission a separate investigation to determine why the NOO and wing officer failed to record and notify anyone of the man's request for a Listener, thus failing to ensure effective communication amongst staff.

44. An examination of the Orderly Officer Occurrence Log sheets for 25, 26 and 28 December shows that the documents had not been signed for at key times of the day.

The Governor should remind the Orderly Officers to sign the Occurrence Log at the completion of the roll reconciliation periods.

45. The Prison Service requires all establishments to carry out "Desktop Exercises" of the local contingency plans for dealing with specific incidents. Desktop exercises simulate a real event and allow the prison management the opportunity to practice what they would do in dealing with an incident. With the exception of the contingency plan for hostage incidents, which is tested at least annually and is a mandatory instruction, the Governor can select any local contingency plan to test.

The Prison Service should consider making the testing of Death in Custody contingency plans a mandatory annual event.

46. My investigators examined the establishment desktop exercise record for dealing with a death in custody. It was noted that a recommendation had been made that

training should be given to the Senior Officers responsible for NOO duties. The latest exercise report is dated February 2004, with the date for the training to be completed as April 2004. There is no record of the recommended training having taken place. This requires remedying.

The Governor should carry out the recommended contingency plan training for Night Orderly Officers, as identified on 24 February 2004, as a matter of priority.

47. Prison Officers are required to carry out roll checks at specific times of the day. Roll checks require the officer to physically see the prisoner in his cell and submit the total to the Wing Manager, who in turn informs the Orderly Officer. The Orderly Officer collates the full prison roll count and reconciles the prison roll.

48. At approximately 8pm on 28 December, an officer carried out a roll check and confirmed that all prisoners were in their cells and that the cell doors were securely locked. He had checked the cell occupied by the man, but did not recall seeing anything unusual.

49. At 8:30pm on 28 December, an officer commenced duty as the Night Patrol Officer on B wing. He received a short brief from the officer who had carried out the previous roll check and then carried out a further roll check. The roll check is further confirmation that the cell doors are locked and secure and that the prisoner is inside the cell. This means that the officer is required to see the prisoner. The total roll count is passed to the NOO for reconciliation and, once the prison roll has been accounted for, the staff who have been on duty during the day are allowed to leave the prison. A further roll check is not then carried out until approximately 5:30am the following morning.

50. During the night the Night Patrol Officers are required to visit all areas of the wing that they have responsibility for and to activate "Pegging Buttons", which are placed at strategic points around the wing. Pegging buttons, once pressed, record that the officer has visited the area and the computer system records the action. At the beginning of the night duty, the officer is given a pre-determined route to follow which varies each night.

51. At approximately 5:20am on 29 December, the Night Patrol Officer began a full roll check of B wing, which he completed by 6am. He then telephoned the NOO with the wing roll. He said that if he is unable to see the prisoner and the television is not on, he will switch the light on briefly to observe the cell. He could not recall anything unusual when he checked the man's cell. He thought that he might have been in bed, but was unsure. He confirmed at interview that he had observed every prisoner that morning.

52. The Night Patrol Officer explained that an Officer Support Grade (OSG) was normally responsible for the wing night duties, but that he had been asked to cover the duty. He said that he had worked on the wing for the previous two nights, but that no one had asked him if he had carried out wing night duties previously. He was asked if he had any written night instructions. He said, *I only know that there was a folder for each wing. I wasn't exactly sure what was in it or that it was*

required of me to read it. It's not a duty I've ever done before. He said that no one had given him any guidance in what to do on nights.

The Governor should review the night instructions and ensure that all staff on duty at night are competent to undertake the duty.

The Governor should ensure that the Night Orderly Officer confirms that all night patrol staff understand their role.

53. At approximately 7:30am on 29 December, the Senior Officer assisted the wing staff in counting the wing roll. She recalled beginning on landing two and that the man's cell was the first one that she looked into. She said that, when she opened the door observation flap she could see that his bed was unmade and that he was not in bed. She could see a figure standing in front of the cell window, fully clothed, with his back towards the door. She believed that he was looking through the window. She closed the observation flap and continued the roll count.

54. Prior to unlocking the wing following the morning roll check, officers at Bullingdon carry out a procedure known as *accommodation fabric check* (AFC). This means that they enter each cell and check the physical security of the cell fabric, the door locks and the window bars/grills. Once the Wing Manager is satisfied that the security of the cells has not been tampered with, the wing is unlocked to allow prisoners out of the cells and into the communal area of the wing.

55. At approximately 8am, an officer entered the man's cell and observed that he was standing. She thought that he was watching the television and was about to speak to him when she saw that he was hanging. She immediately shouted for assistance. Two prisoners were the first to arrive and they assisted the officer by lifting the man and removing the ligature and then placing him on the bed. One of the prisoners lifted him, while the other removed the ligature from around the cell light fitting.

The Governor should write to the two prisoners and place on record the assistance they gave to prison staff.

56. The officer who found the man explained that she had not lifted the observation flap to check where he was but had gone straight in to the cell. She said, *I still can't figure out how somebody can hang themselves stood up, but he was stood up and to me he was just stood there and it wasn't until I went to speak to him and realised he wasn't just stood there.* She said that his back was facing her when she entered the cell. She went on to say, *he was towards the window and he was sort of stood so he was sort of more back to me than he was forwards.* She confirmed that his feet were on the ground.

57. The investigation team is satisfied that the view the officer would have seen through the observation glass at that time of the morning would be that of a silhouetted person who appeared to be standing. As the check requires the officer to look into the cell and identify that the cell is occupied, and not necessarily to communicate with the prisoner, it is understandable that the officer would have

accepted that the prisoner was in the cell and therefore moved on to the next cell. It would not be reasonable to have expected the officer to carry out a check other than to confirm occupation of the cell.

58. Another officer entered the cell almost immediately after the two prisoners and he attempted to carry out CPR. However, he was unable to open the man's mouth. One of the officers described him as being cold to the touch. Shortly after, the Principal Officer and two Staff Nurses arrived at the cell.

59. One of the Staff Nurses checked for a pulse. She said that she did not recall the man being cold and thought that he was warm. She said that they were unable to administer oxygen, as they were unable to open his mouth to insert an airway.

60. The Clinical Reviewer examined the man's IMR in order to complete the Clinical Review. The IMR entry shows that he appeared not to be breathing and that no pulse or respiratory output was detected. He had a deep mark around his neck, consistent with a ligature having been used. He also had extreme swelling around his face and neck. An attempt was made to place a Gadel airway in his mouth, but his mouth and tongue were excessively swollen. Two more Staff Nurses along with the Sister joined the medical team.

61. Three Staff Nurses and the Sister made a joint decision not to continue any further with resuscitation attempts. The prison doctor attended the cell and noted that the man was not breathing, there was no heart sound, or neck pulse and no breathing sounds. He noted that his face and neck were puffy. He examined the trunk and feet. He did not notice statis down his feet. He pronounced death at 8:48am.

62. The prison doctor said at interview, *I was surprised that when I arrived there, there was no team doing CPR, yes, and I wasn't happy to see the body on the bed.* He was asked where the body should have been. He said, *it should have been on the floor or hard surface and CPR should have been in process.*

The Governor and PCT should review the actions to be taken by staff on discovering an unconscious person. Additionally, all staff should be reminded that CPR should preferably be carried out on a firm surface.

63. Paramedics arrived at the cell at 9:04am and left at 9:22am. The police arrived at 10:01am, followed by a Scene of Crime Officer (SOCO) at 10:55am. The SOCO left at 11:25am. At 12:20pm, the man's body was removed by the undertakers.

64. Amongst the cell contents, a police officer found a letter written by the man on prison paper. The note explains his feelings at the time.

65. On 30 December the Consultant Forensic Pathologist carried out a post-mortem on the man at John Radcliff II Hospital Mortuary. The doctor gave the cause of death as hanging. Additionally, paragraph four of the report concludes: *The presence of multiple petechial haemorrhages and hypostatic discolouration in the lower legs and feet indicate that the body had been suspended for a period of some hours prior to discovery.*

66. A recent investigation at HMP Lowdham Grange has noted that prisoners there are routinely observed at least three times during the night-time lock up period and I have identified this as good practice. Their approach to prisoner observation is worthy of further examination by the Prison Service.

The Prison Service should review night-time observation procedures in light of the practice at Lowdham Grange.

67. The Clinical Reviewer examined the level of compliance and summarised:

- In my opinion the standards for Health Services for prisoners and clinical needs were not fully met by the prison.

- Evidence would suggest that in spite of documentation to suggest that the prisoner was depressed and anxious, there were no appropriate referrals made to specialists such as mental health inreach, psychiatry or psychology.

- Evidence would suggest that the appointment system, which was in place at the time of the incident, was unsatisfactory.

- Evidence would suggest that in spite of the man stating that he was anxious, depressed and not sleeping, there was no active 2052SH form opened.

- Evidence would suggest that in spite of a new protocol "Healthcare Application Process" which was devised after this unfortunate event, many of the members of staff interviewed were unaware of its existence or indeed where the policy/protocol folder was kept.

- Evidence would suggest that those members of staff who are detailed to carry out treatments on B wing are unaware that they are also responsible for the emptying of the application boxes, or of how frequently.

68. The Clinical Review makes several recommendations for the prison, all of which I support.

69. All prisons are required to supply "Anti Ligature" scissors/knives for use by staff in the event of a prisoner hanging. Some prison establishments supply staff with *fish knives,* which are designed to allow the user to get underneath the ligature. The knife has a concealed blade and the action of pushing the knife forward, cuts the ligature.

70. My investigation team asked a number staff if they were issued with personal anti ligature equipment. Whilst it was evident that some officers had their own fish knife, it was not a requirement for them to carry one as part of their day-to-day equipment. They were also asked if they knew where to find the wing anti ligature scissors. A number of officers said that they were not aware where they would find the equipment. This is worrying.

71. The investigation team discussed this finding with the Senior Officer a member of the B wing management. She had worked at other establishments and was aware

that cut down kits were available in the wings, but that Bullingdon did not have them. Whilst she was aware of the lack of equipment, she said that she had not raised it with the Suicide and Self-Harm team.

72. All prisons have a "Personal Officer Scheme" in operation. At Bullingdon, this means that every prisoner is allocated two officers who act as Personal Officers, and who have responsibility for writing reports, etc. on their particular group of prisoners. Prisoners are informed as to who their Personal Officers are and are able to contact them via the wing office.

73. The investigation team was unable to identify any officer who knew the man well enough to have noticed any change in his appearance, behaviour, etc. and asked staff to explain the Personal Officer scheme on B wing. The investigation team was informed that it did not operate on the wing, as the turnover of prisoners made it impossible to administer.

The Governor should introduce the Personal Officer scheme into B wing.

74. The Governor made available to the investigator a letter dated 13 January 2005 from the Head of Facilities at the prison. He informed the Governor that, following a previous death in the Segregation Unit and an attempted suicide in the Healthcare Centre (both incidents using the light fitting as a ligature point), a decision was taken to seal the edge of the fittings with a hard setting compound. The decision was taken to carry out the preventative work in the Segregation Unit and Healthcare Centre only, as it was considered impracticable to carry out the work to the rest of the establishment, as it would restrict the ability to carry out maintenance. My investigator wrote to the Governor and asked if a risk assessment had been carried out before the decision had been taken not to carry out the work on the remainder of the establishment. The Governor said that there was no requirement to carry out a risk assessment following a death in custody. This was the third known occasion in the prison where the in cell light fitting had been used as a ligature point. As a known cure to the problem had been identified, it is difficult to understand why the ligature point was allowed to remain without the full consideration of a risk assessment.

The Governor should re-examine the decision not to seal the light fittings in the residential units.

The Prison Service should consider issuing fresh advice to establishments on the sealing of all light fittings and reduction of potential ligature points.

75. As Ombudsman, I try hard to involve the family of the deceased person in my investigations. I have staff who work as FLOs and they work closely with the investigators and family and try to answer any concerns the family may have regarding the care and treatment of their relative. A part of that process is for the FLO and investigator to meet with the family during the investigation.

76. On 8 March the FLO and investigator met with the man's sister at her home in Hampshire. My staff were made very welcome and I am most grateful to her.

77. She raised a number of points in relation to the man's death. She also spoke about issues at Bullingdon which had made visiting her brother difficult. One of the main questions was how could the officer not have seen him hanging. I hope this report explains this matter fully.

78. The man's sister explained that she had experienced difficulties in arranging to visit him. She said that the difficulty began when trying to book a visit and that it could take several hours to get through on the telephone. She also said that, once the telephone had been answered, the staff would not allow a visit to be booked more than seven days in advance. As she was only able to visit at the weekend due to work commitments, she found that once the forthcoming weekend dates were full staff would not allow her to book the following weekend.

79. An additional area of difficulty was when she wanted to hand in a suit for her brother's court appearance. The visits staff informed her that she would have to post it in, and that he would have to make an application to have a suit sent in. She was also informed that he had to request the correct colour, otherwise he might not be allowed to have it if a different colour of suit was sent in. She overheard an officer informing other visitors that prisoners were not allowed to have anything black and assumed that it was because officers wore black uniform.

80. The investigation team discussed the visiting difficulties with the Governor. I understand she plans a review of the procedures to reduce the bureaucracy. I welcome this and on this basis have not made a further recommendation.

81. The man's sister had sent in a new pair of trainers at the beginning of December which he did not receive and which were returned to her unused. The trainers were still in the original box and had been placed in a brown sack. She was asked how his clothing had been returned to her. She said that the clothing was in a large brown sack and had not been washed. This was insensitive and not in keeping with PSO 2710.

82. A member of the prison Senior Management Team was asked if the establishment had contributed towards the cost of the man's funeral. The investigation team was informed that the prison had made a contribution. However, when the investigation team met with the man's sister, she was asked if the prison had contributed towards the funeral costs and she said that they had not. This was raised with the Governor by the investigator and also by the FLO with the Deputy Governor, who sought advice from Prison Service Headquarters. Following their advice, the prison agreed to contribute towards the funeral costs. The investigation team understand that the prison has since paid the full cost of the funeral.

    The Governor should remind senior colleagues of the advice given in PSO 2710 "Follow-up to Deaths in Custody".

83. I am satisfied that the care and treatment at the time the man was discovered in his cell was appropriate. I remain concerned that important information relating to his state of mind was not dealt with appropriately by prison staff and that he was not considered as being at risk.

84. The investigation team understands that the original charges of threats to kill had been reduced to harassment. In January 2005 the case against the man was heard in his absence and he was found not guilty.

Recommendations for the Prison Service

1. The Prison Service should consider making the testing of Death in Custody contingency plans a mandatory annual event.

2. The Prison Service should review night-time observation procedures in light of the practice at Lowdham Grange.

3. The Prison Service should consider issuing fresh advice to establishments on the sealing of all light fittings and reduction of potential ligature points.

Recommendations for the Area Manager.

1. The Area Manager should commission a separate investigation to determine who dealt with the man's application, why the content was not communicated to the wing management and why he was not referred or interviewed as a matter of urgency.

2. The Area Manager should commission a separate investigation to determine why the Night Orderly Officer and wing officer failed to record the request for a Listener, thus failing to ensure effective communication amongst staff.

Recommendations for the Prison

1. The Governor should remind reception staff of the need to complete the Cell Sharing Risk Assessment accurately. (Repeat finding, Standards and Security Audit 17 February- 7 March 2003 & 5-9 January 2004.)

2. The Governor should remind the prison probation staff to print, sign and date official documents.

3. The Governor should ensure that the mail and telephone calls of all prisoners identified as being subject to PSO 4400 are routinely monitored. (Repeat Recommendation, Standards and Security Audit, 17 February-7 March 2003 & Revisit Audit 5-9 January 2004.)

4. The PCT, in partnership with the establishment, should review the procedure for prisoners making confidential applications to the Healthcare Centre and ensure that a clear audit trail is in place to identify who has processed the document, action taken, time and date.

5. The PCT should ensure that prisoners and nursing staff understand the procedures for making a confidential application.

6. Healthcare staff should follow-up all patients who fail to attend healthcare appointments and rebook the appointment if appropriate. (Repeat Recommendation HMCIOP June 2004).

7. The Governor should remind the Orderly Officers to sign the Occurrence Log at the completion of the roll reconciliation periods.

8. The Governor should carry out the recommended contingency plan training for Night Orderly Officers as identified on 24 February 2004, as a matter of priority**.**

9. The Governor should review the night instructions and ensure that all staff on duty at night are competent to undertake the duty.

10. The Governor should ensure that the Night Orderly Officer confirms that all night patrol staff understand their role.

11. The Governor should write to the two prisoners who helped after the man was found in his cell and place on record the assistance they gave to prison staff.

12. The Governor and PCT should review the actions to be taken by staff on discovering an unconscious person. Additionally all staff should be reminded that CPR should preferably be carried out on a firm surface.

13. The Governor should introduce the Personal Officer scheme into B wing.

14. The Governor should re-examine the decision not to seal the light fittings in the residential units.

15. The Governor should remind senior colleagues of the advice given in PSO 2710 “Follow-up to Deaths in Custody”.

Clinical Review Recommendations for the prison

1. The protocol and procedural policy should be adhered to with regards to the GP referral system.

2. All members of staff should be informed of any new protocol and policy documents which have been introduced.

3. All staff should be informed of where the folder containing policy and procedures is located.

4. Consider detailing a member of the administration staff to collect applications from the wings daily and pass promptly to the identified clinician to make the appointments.

5. A member of the clinical team should be identified to assume the responsibility to make appropriate referrals and appointments on receipt of medical applications.

6. A system should be adopted in order to address patients' concerns and anxieties.

7. Members of staff should consider opening F2052SH forms on patients who state that they have concerns for their safety, claim to be depressed or anxious, thus raising the need to increase the levels of observation and alerting all members of staff of the patients vulnerability.

8. The Governor should ensure that a clear auditable tracking system is in place to identify which member of staff has dealt with any application form from start to finish. The tracking system should require the member of staff to print, sign and date the documents and to note any actions and outcomes.

Good Practice

1. The confidential medical application system is good practice.

2. The Senior Officer should be commended for her work as Safer Custody Manager