

**Investigation into the circumstances surrounding the death of
a prisoner at HMP Bedford,
in December 2004**

Prisons and Probation Ombudsman for England and Wales

December 2005

This is the report of an investigation into the death of the man who died in December 2004, in hospital. The man was a prisoner at HMP Bedford and was found, that evening, hanging from the window bars of his cell.

I offer my sincere condolences to the man's family. Despite coping with his drug and alcohol addiction in recent years, they always remained loyal, loving and supportive. I have great respect for the dignity they have shown.

I also offer my sympathies to management and staff at the prison. They have to work under difficult circumstances with large numbers of very vulnerable men who, in the great majority of cases, are withdrawing from drugs. The number of deaths that have been prevented thanks to the care and diligence of prison staff can never be truly quantified. Yet when a death occurs, as in the case of the man, it invariably has a profound effect on staff and they often feel personally accountable.

Two investigators from my office conducted the investigation.

I am grateful for the assistance they received from the staff and management of HMP Bedford. I wish to acknowledge too the ready help of the Bedfordshire Police who carried out their own enquiry into the man's death and shared all available information. My thanks also go to Bedford Primary Care Trust who conducted the clinical review.

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Summary

This is the report of an investigation into the death of a man. The man was aged 23 when he died at 8.53pm on 27 December 2004 in hospital. He was a prisoner at HMP Bedford and had been found hanging from the window bars of his cell earlier that evening.

The investigation team reviewed the man's prison records and interviewed both prison staff and prisoners. A report prepared by Bedford PCT on clinical matters.

The man had been at Bedford since 18 September 2004, having been charged with possession of an offensive weapon. This was not the first time the man had been in prison custody. He was not considered to be at risk of suicide when he died, but had been so on two occasions previously.

During the reception procedure, the man disclosed his alcohol habit and his history of depression. He claimed that cannabis was the only drug that he misused and said that he last attempted suicide in May 2004.

The man said that he was paranoid and heard voices telling him to hurt someone, so he was located in a single cell accommodation. In the following weeks, the man was assessed by a Community Psychiatric Nurse (CPN) and referred to Alcohol Anonymous (AA) meetings.

On 1 November, the man was sentenced to eight-months in prison, with a release date of 16 January 2005.

On 3 November, the man said that he was depressed and wanted to kill himself. A F2052SH¹ was opened and he was admitted to the Healthcare Centre (HCC).

Over the following weeks, the man's mood fluctuated and he frequently threatened to self-harm and physically did so on three occasions. As his mood changed, so did the frequency that staff observed him.

The F2052SH was closed on 17 December 2004 as the man appeared to be stable. However, another F2052SH had to be opened on 21 December 2004 as the man threatened to kill himself.

On 23 December, there was an incident where the man smashed his TV and was threatening and abusive to staff. This was adjudicated upon the following morning. The incident arose as the man had been denied a move to another wing.

On the morning of 24 December, before the adjudication, a F2052SH case review was held and a decision was made to close the document. The CPN who attended the review described the man as "purposeful and giving positive

¹ Documentation for recording the monitoring, care and support of prisoners identified as being at increased risk of suicide/self-injury.

intentions". The review described the man as apologetic, but said he was blaming the wing senior officer (SO) for not allowing him to move wings. The review chair made it clear that the man would not be moving wings. The man was about three weeks away from release, and assured the review that he would not self-harm again.

On the evening of 27 December 2004 at 7.45pm, during a routine roll check, the man was found hanging from the bars of his cell window. Attempts to resuscitate the man were made and a pulse was found. Actions taken by staff following the discovery of the man hanging in his cell are described in detail within the report. All staff concerned reacted quickly and made every effort to revive the man.

He was subsequently taken to the local hospital but died at 8.53pm.

This report focusses on the man's time in prison custody and evaluates the systems in place to establish whether they were (and are) fully effective.

The report makes eight recommendations and identifies one example of good practice.

Investigation Outline

The investigation into the man's death was conducted by two of my investigators. They visited the prison and were shown the areas where the man would have been, including the reception and induction areas, the healthcare unit, the segregation unit and the wings on which the man was located.

They issued a notice to staff and prisoners inviting anyone with information relating to the man's death to make themselves known to the investigation team. Two prisoners who knew the man came forward, as did one member of staff.

My investigators also spoke to the Chair of the Independent Monitoring Board (IMB), the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff, including the governor who is the team leader for violence reduction and suicide prevention. They also spoke to three prisoners. Two of these prisoners had seen the control and restraint incident in which the man was involved (one of whom was going to act as a witness for the man at his forthcoming adjudication). The third prisoner was located in the cell next door to the man when he died. He spoke little English and my investigators spoke to him through their interpreter.

My investigators formally interviewed seven prison staff who were involved in the events surrounding the man's death.

The prison gave my investigators full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession. My investigators obtained some further information from the probation and court services.

One of my investigators and one of my Family Liaison Officers visited the man's father and stepmother, to discuss their concerns about what had happened to the man.

Finally, my investigators commissioned the Director of Care from Bedford Primary Care Trust, to conduct a clinical audit of the man's care while in prison.

Background

Bedford Prison

Bedford prison is a small local prison serving the courts in the county and nearby, and provides for a rapidly changing population of adult male prisoners. It is a Victorian prison, with some new buildings added in the early 1990s. Its accommodation is ideally for 325 prisoners, and its maximum operational capacity is 494. On 27 December 2004, it was holding 437 prisoners.

A wing is the largest wing in the prison, and on 27 December it held 123 prisoners. In comparison, C wing, which is mainly used as an induction wing, held 64 prisoners.

In January 2004, Her Majesty's Chief Inspector of Prisons conducted an announced inspection. She found Bedford to be a fundamentally safe and well-controlled prison. She said that it provided a largely respectful environment with good, mutually respectful staff-prisoner relationships. She found that there were effective systems in place to minimise bullying and reduce the risk of suicide and self-harm, although she said that the latter could be better co-ordinated. But she was concerned about the induction process, and the provision available for people for whom English was not a first language. She said that black and minority ethnic prisoners should be more actively involved in the development of the prison's work on race. She also considered that replies to complaints were often dismissive and of poor quality. In addition, she identified a key problem as being the lack of purposeful activity for prisoners.

The Chief Inspector had some specific concerns about the approach to prisoners at risk of suicide or self harm. She said that better co-ordination of elements within the safer prisons strategy would create a preventative rather than a reactive approach. She also raised the issue of suitable access to Listeners. (Listeners are prisoners trained by the Samaritans to provide a listening ear to prisoners in distress.) Finally, she was concerned that there was a lack of structured, wide-ranging refresher training for staff. She said that a local target of 20% of staff to receive refresher training each year was not being met.

In February and March 2004, the Prison Service conducted its own internal audit of Bedford prison. It found the prison to be operating at a high level and improving, although there were some areas of concern. Health and Safety arrangements (rated 61% compliant with standards) were considered to be deficient, and it said there was an expectation from managers that staff and prisoners could take care of their own safety without guidance from management. Suicide and self harm procedures were good (rated 92% compliant), but some inconsistencies of process and monitoring were noted and reviews were not always acted upon. It was noted that there was no agreed course content for anti-bullying, suicide and self harm awareness sessions in the induction programme, resulting in some inconsistency of

delivery. In race relations (rated 81% compliant), there were weaknesses in the recording and monitoring of racial incidents.

A 'Measuring the Quality of Life' survey at the prison in March 2004 identified some concerns about the high level of drug availability at Bedford, especially on A wing. But it reinforced the Chief Inspector's findings about good relationships and safety within the prison.

In November 2004, Bedford prison was rated level 4 in the Prison Service's Performance Rating System. Level 4 is awarded to exceptionally high performing establishments, consistently meeting or exceeding targets, with no significant operating problems, achieving significantly more than similar establishments with similar resources. The rating is based on cost performance and output data, compliance with Prison Service standards, findings from external inspections, and the views of the Prison Service Area Managers and Management Board.

There have been four other deaths in Bedford in just over two years. Three prisoners died towards the end of 2002, and there was one death in November 2003. The Chief Inspector said, following her January 2004 inspection, that the small number of recommendations arising from the investigations into the 2002 deaths had all been implemented.

The investigation of the death of a prisoner in 2003 raised some concerns about communication between healthcare professionals, and put forward recommendations concerning the treatment of prisoners who speak little English. As a result of these inspections and investigations, various action plans have been drawn up, which the Governor told us were being pursued.

Suicide and Self Harm Procedures

Prison Service suicide and self-harm procedures are set out in Prison Service Order (PSO) 2700.

The Order says:

“An act of self-harm should always be taken seriously. Even if the prisoner appears to be using self-harm as a means of gaining something, it is still a desperate act and the prisoner should be helped to find constructive ways to meet the underlying need.”

For prisoners who have self-harmed:

“The prisoner should be asked if they are being bullied or intimidated, and if so the Anti-Bullying Co-ordinator should be notified.”

“After consultation with the prisoner, the nominated next of kin must be notified, unless:

- There is a clinical reason not to, or;
- If aged 18 or over, the prisoner does not consent, or;
- The prisoner’s support plan indicates otherwise (e.g. in the case of a prisoner who repetitively self-harms).”

In relation to adjudications, the Order says:

“Special consideration should be given to prisoners on an open F2052SH [a procedure for dealing with prisoners at risk of self harm] who are subject to an adjudication ... Adjudicators should consider the implications of the punishment they may impose on a prisoner who is found guilty of an adjudication, and who is subject to F2052SH procedures, such as removal from association, loss of canteen and cellular confinement ...”

In relation to the processing of an F2052SH, the Order says at annex B that when an F2052SH is opened, the manager of the unit where the prisoner resides must:

- Decide, in consultation with healthcare staff, whether to manage the prisoner on the residential unit or refer initially to the Healthcare Centre (HCC), and document reasons.
- Ensure that, where available, prisoners on an open F2052SH have been offered the opportunity to talk to a Listener and/or Samaritan.
- Ensure a case review is held within 72 hours, and document a summary of the review and agreed support plan.

When a F2052SH is raised by non-healthcare staff, a doctor, nurse or health care manager must check the prisoner’s Inmate Medical Record (IMR), and record in it the raising of the F2052SH.

A healthcare officer or nurse must interview the prisoner as soon as possible. The prisoner must also be referred to a doctor as soon as possible, and in any event within 24 hours of any referral to the HCC. A record of these assessments must be made in the F2052SH and in the IMR.

A support plan must be drawn up and agreed. Multi-disciplinary case reviews must be held as necessary, including in the event of a further act of self-harm.

The F2052SH will be closed at a case review when the prisoner appears to be coping satisfactorily. The case review will agree after-care or follow-up requirements.

Bedford's local suicide prevention strategy document

In January 2004, Bedford agreed its local suicide prevention strategy. It sets out the role of the Safer Custody Committee and arrangements for dealing with prisoners at risk.

Once an F2052SH is opened, a case conference must take place within 72 hours. The local policy requires the review to be chaired by "a Residential or HealthCare Manager and **must** involve the minimum of 3-multi disciplinary persons with health care and wing staff input."

Once raised, an F2052SH can only be closed following a case review, as a result of team discussion, and normally only if there is a unanimous decision. Once the form is closed, any ongoing support should be recorded and copied into the prisoner's history sheet so that it can be referred to after the closure of the F2052SH. No later than one week after the form is closed, the prisoner is to be seen by the Residential Manager who will ensure that the prisoner is coping satisfactorily and that any ongoing support identified when closing the F2052SH is being delivered.

The policy dictates the frequency that prisoners should be observed, dependent on the assessed level of risk: -

- **Frequent** – to be observed randomly every two hours. Authorised by the Orderly Officer.
- **Intermittent** – to be observed randomly five times every hour. Authorised by the doctor or a nurse, or the duty Governor, in consultation with the doctor or a nurse.
- **Constant** – to be observed constantly. Authorised by the doctor or a nurse, or the duty Governor, in consultation with the doctor or a nurse.

The local policy states that "following all cases of self-harm, the next of kin must be informed, unless the prisoner refuses consent, there is a clinical reason not to do so, or the prisoners support plan indicates otherwise".

Follow-up to deaths in custody

PSO 2710 gives instructions on action to be taken following a death in custody, including the support arrangements for staff and prisoners.

The PSO says that priority must be given to communicating the facts about the death to prisoners and staff. It says it may be useful to issue a written statement to prisoners to defuse rumour and myth, but that this will depend on local judgement. Any prisoner who may have been particularly affected by the death should be offered support.

A record should be kept of all those entering where the prisoner died. There should be an immediate post-incident debrief (a 'hot debrief') of staff involved before they go off duty. A senior member of staff should act as a de-briefer and a duty care team member identified and, if necessary, called in on duty.

Chronology of Events

17 September 2004 to 23 December 2004

On 17 September 2004, police charged the man with being in possession of an offensive weapon. He appeared before the Magistrates' Court the following day. At 10.40am, the magistrates remanded the man in custody until 20 September. He arrived at Bedford prison at 1.45pm. The Prisoner Escort Record (PER²) was completed by the police and warned receiving agencies to be aware that the man had a history of violence and weapons.

On arrival at the prison, the man told staff that he had been living rough and that he had no home address. He gave his father's address (but no telephone number) as his next of kin. He appeared to be relaxed about being in prison.

The man was given a Healthcare Screening in Reception where he disclosed his alcohol habit and that he had a history of depression. He claimed that the only illegal drug he misused was cannabis, which he said he last used on 16 September.

The man was assessed as being of "low risk / medium", which means he was deemed suitable to share a cell with other prisoners. However, due to his request to be on his own and the history of paranoia and anxiety, a single cell was authorised on C-wing, the induction wing.

The next day, 19 September, the man told staff that he had made a suicide attempt over a year ago and that his last attempt had been in May 2004. He also said that he was worried about being with other prisoners. The man told induction staff that he was paranoid and heard voices telling him to hurt someone.

The Cell Sharing Risk Assessment was reviewed, and the man was considered to be a high risk to the safety of another prisoner if they were to share a cell.

On 20 September, the Magistrates' Court convicted the man. He was returned to Bedford to await sentence, as the bench wanted more information about him before sentencing.

In the following weeks, the man was assessed by a Community Psychiatric Nurse (CPN), and referred to Alcohol Anonymous (AA) meetings. On 7 October, during a CARATS³ assessment, the man spoke of desire to kill and said that he wanted to be a mass murderer. He said that he had lived rough for about two years and that he had been banned from hostels for being involved in witchcraft. The man said that he had no family contact and saw being in prison as salvation. He said that alcohol was the only drug that he misused, and this cost him about £21 per week. The CARATS worker

² The Prisoner Escort Record (PER) is a document completed before a prisoner is escorted, and is used to communicate potential problems from one agency to another. There is also a record made of all key events whilst on escort.

³ CARATS is a drugs service provided by different contractors but available in all prisons.

referred the man to a CPN for assessment, although, the man made it clear that he did not want any assistance from a CPN.

On 8 October, the security department decided that due to his inappropriate comments, and the unsupervised structure of AA meetings, the man was unsuitable to attend AA meetings.

On 1 November, the man was sentenced to eight months imprisonment. His release date would have been 16 January 2005.

On 3 November, the man was admitted to the HCC. A F2052SH was opened as he said that he was depressed and wanted to kill himself. During the nursing assessment following his admission to the HCC, the man said that he was unable to cope on ordinary location and threatened to kill himself if he was not placed in a single cell.

The doctor assessed him and said that he was not acutely suicidal. The doctor authorised a single cell in the HCC and said that the man should be observed regularly. Later that night, the man was challenged by staff for putting his mattress on the floor to sleep. This made it difficult for staff to observe him.

At Bedford, all F2052SH documents have a locally devised sticker added to the front cover showing target dates for case reviews and when a review has been completed. This enables staff and managers to see easily if a review is required and when the last one was completed. A locally devised information page is inserted inside the front cover. This provides a series of tick-box prompts to assist staff in completing and managing F2052SH documents.

On 4 November, the man was found with a pillowcase on his head. When challenged, he told staff that he wanted to be left alone. On 5 November, the F2052SH document was reviewed. During the case review, which included a CPN, the man told staff that he felt insecure and intimidated. He said that he felt depressed but did not feel as though he would self-harm. The CPN reviewed the man's medication, and later that evening he saw a Listener.

On 8 November, the doctor declared the man fit for location on one of the main wings. The Cell Sharing Risk Assessment was completed, and the man was still regarded as a high risk to other prisoners who might share a cell with him. A single cell was authorised. Later that evening, the man told staff that he was depressed but now felt okay.

On 9 November, the man refused to associate but said that he was okay. On 10 November, he moved to the largest wing in the prison, A-wing. An induction exit interview was conducted and staff noted that the man became paranoid in large groups.

On 11 November, the man declined exercise. He sat in his cell reading and staff described him as being cheerful. On 12 November, the man was described as being "full of smiles". Later he asked to see a Listener, but used

the Samaritans phone as alternative. On association, he kept himself to himself.

On 13 November, the man was feeling very depressed and said he was suicidal. Staff removed razors from his cell and placed him on an intermittent watch. At about 8:10pm, he told staff that he was fine. However, at 8:40pm, the man was found with a ligature around his neck. He was kneeling on the floor near the heating pipes. His bed had been moved to block the door. Staff intervened but there was no need to resuscitate. This was not thought to have been a serious suicide attempt and he was placed in the Listener suite. Later, the man said he regretted his actions and that he would not do it again.

On 14 November, at 8:25am, the man's case was reviewed and the intermittent watch was stopped. He said that he was depressed and felt like hanging himself. It was agreed that the man would move back to the HCC at lunchtime.

At 9:55am, the man asked to see a Listener but was offered the Samaritans phone instead. This was because he was assessed as being a high risk to other prisoners. At 10:20am, he was given the Samaritans phone to use. The man said that he no longer wanted to kill people.

At 11:45am, the man attempted to hang himself and was moved to the HCC immediately and placed back on an intermittent watch. At 12:40pm, he used the Samaritans phone. At 3:30pm, he saw a Listener, and at 9:15pm, he used the Samaritans phone for over an hour. There is no evidence that after either of the self harm attempts on 13 or 14 November, the man was asked if he would like his next of kin notified.

On 15 November, at 9:15am, 11:00am and 3:26pm, the man was frustrated and repeatedly asked staff for the hair clippers. At 11:30am, during a F2052SH case review, the man said that he was depressed and had thoughts of killing himself so that he would be nearer the church. He explained that he wanted to be cremated and his ashes left in a church. This was so that he could be in the church forever. He was assessed by a CPN.

At 3:42pm, the man packed his belongings and refused to return to his cell, saying that he wanted to go to the Segregation Unit. This was not allowed, and at 4:40pm the man reluctantly returned to his cell, again complaining that he was unable to use the hair clippers.

At 5:54pm, the man saw a Listener, and at 6:10pm he told staff that he was low in mood and wanted to hang himself. At 6:25pm, the Duty Governor spoke to the man and, due to the concerns of staff about the man's suicidal behaviour; he was placed in strip conditions and given a sedative.

On 16 November, at 9:55am, the man had the haircut that he had been asking for. At 11:05am, following a F2052SH case review, the intermittent watch was changed to frequent observations. The man said that he was depressed and was having thoughts of self-harm. That afternoon, he told staff that he was

scared to go back to ordinary location, and that he felt that people were watching him through his blanket that covered the window. Later that evening, the man saw a Listener.

On 17 November, the man was deemed by the HCC to be fit for a single cell, on normal location. The man saw a CPN and asked to move to a normal location wing. That afternoon, the man was moved to C wing.

On 18 November, the man was described as "chatty" whilst on association and said that he was happy to be back on C wing. On 19 November, the man said that he felt very happy on C wing because it was a small wing and he struggled to cope with lots of people around him.

Unusually, on 21 November the man declined church. He was chatty, but said he felt depressed and lonely, and that he found it difficult to socialise. The doctor said that there was no evidence of mental illness, but described the man as being vulnerable.

On 23 November, the man associated on the wing and was described as being in a good mood. He declined to go to the library and exercise, but he said that he was okay. On a F2052SH case review, which was not multi-disciplinary, the man said that he still felt a bit depressed and still had slight suicidal thoughts. Later, the possibility of in cell work was discussed with the wing manager. The man said that he was happy and comfortable on C wing.

Over the next few days, the man declined exercise but said that he had no problems although he declined Bible studies as he thought someone would go into his cell. He did, however, see the chaplain, who described the man as being in good spirits. The man was seen laughing and joking on the wing. On 29 November, the man said that he felt much better and had no problems. He asked the staff to prepare a homeless discharge grant for him, as he had no address to go to when released. This would have been issued to help with housing.

A F2052SH case review was held on 30 November. The man said that he was feeling better, but still wanted to be on his own. The CPN agreed to review the medication prescribed to the man and discuss cognitive behaviour treatment when the F2052SH had been closed. The wing manager spent time with the man encouraging him to spend more time out of cell. The man was described as being in good spirits, and was looking forward to doing some wing based work. The next day the man saw a Listener in the Listeners' suite, for 45 minutes.

On 2 December, the man told staff that he felt ready to come off the F2052SH. He was helping to clean the wing, declined exercise, and said that he had no problems. He was chatty on association. At 10:00pm, the man spoke to a Listener for an hour and 25 minutes.

At 11:40am on 6 December, the man told staff that he was concerned that if the F2052SH was closed staff would not speak to him as much. He was

reassured that support would still be available, regardless of the F2052SH. At 3:05pm, the man told staff that he was planning to hang himself that night but would press the emergency cell bell to alert staff and to give them a chance to save him. He said that if staff failed to save him, then it would be staff that would be blamed. At 8:30pm, staff found and removed two nooses and a razor from the man's cell. He promised not to hang himself, as he was now a wing cleaner. The man was placed on an intermittent watch and he later told staff he had had a bad day, but felt better after chatting.

On 7 December, the man completed his cleaning on the wing, and staff said that he seemed to be happy. A F2052SH case review was held where he told staff that he had made the nooses the previous night so that he could remain on an F2052SH. He felt that being on an F2052SH was a good method of engaging with staff. The review team told the man that that was not the purpose of the F2052SH. The man said that night staff would need to watch him closely, as he was feeling depressed. His observation levels were set as normal observations in the daytime and intermittent observations at night.

At 00:10am on 8 December, the man was found hanging from the end of the bed in his cell. He was still conscious and was seen by a nurse. He was issued with the Samaritans phone and spoke for about 26 minutes. At 1:55am, when the phone was retrieved, he said that he felt less like hurting himself.

At 10:49am on 8 December, a F2052SH case review was held to discuss what staff described as a disruptive night. The man said that he was depressed and that he had been giving his medication to other prisoners. He was kept on normal observations in the daytime and intermittent observations at night. Again it does not appear that the man was asked if he would like his next of kin contacted following his self harm attempt.

That afternoon, the man was moved to A wing, and this appeared to cause no problems. The man told day and night staff that he would press his cell bell if he was having thoughts of suicide or self-harm. Staff said that he seemed more relaxed.

On 9 December, the man declined exercise and association. To alleviate the problem of his giving his medication to another prisoner, the man collected his medication at the end of the association period. At 10:42am, a F2052SH case review was held and the man said that he attempted hanging when he was depressed and wanted to talk to staff. He said that he was happier, and night observation was returned to normal. The CPN saw the man and said that he appeared to be paranoid and confused.

On 10 December, the man complained that he did not have his radio which he had ordered from the prison shop. The man was allowed a supervised shave on association. He made an application to see the Independent Monitoring Board (IMB) regarding access arrangements to his son. He was advised to contact his solicitor.

Over the next few days, the man said that he was okay, but declined association and repeatedly enquired about his radio. It was explained to him that the radio he had ordered from the prison shop had been delivered, but to be electronically tested for safety. This would take some time to complete, as there was a queue to have the test completed. On 13 December, the man associated on the wing for a while. He was said to be happier now he understood what was happening with his radio.

By 17 December, the man appeared to be associating and coping on the wing. A F2052SH case review was held, and a decision was made to close the document. The review was multi-disciplinary, with three people present including a CPN. The review described the man as an "attention seeker and not a self-harmer", who had self-harmed due to a fluctuation in his medication. He was now taking his medication regularly and so was more stable and, on these grounds, the review team felt it was appropriate to close the document.

A F2052SH was opened on 21 December, when staff found three ligatures in the man's cell. The man said that he intended to kill himself. A CPN assessed him and the man said that he liked being on a F2052SH because he felt safer and supported by staff. The doctor's section of the F2052SH was not completed. A decision was made to manage the man on A wing with normal observations.

On 22 December, the man claimed to be feeling more stable as he was taking his medication on a more regular basis. He was assessed by a CPN who said that the man remained paranoid and insular. That night, the man had a long conversation with night staff, as the Samaritans telephone was not working.

23 December to 27 December 2004

At 3:45pm on 23 December, the man asked when he would be moved to C wing, claiming that wing Senior Officer (SO) had agreed to the change of location. When consulted about the agreed move to C wing, the wing SO said that she had not agreed to this and that the man was manipulating the system and would not be moving wings. It was explained to the man that C wing was for induction, and it was the policy to progress from C wing and not to return as space would be needed for new prisoners. At interview, the wing SO said that she had told the man a few days previously that she would do what she could about a move, but that she was not sure it would be possible.

At 5:25pm, the man told staff that he would commit suicide and that he was writing a suicide note. The man later denied saying this.

At 6:15pm, the man smashed the television in his cell, claiming that he was frustrated at being refused a move to C wing after the wing SO had said he could move. The man claimed that the wing SO had lied to him about his request for a move of wings. He calmed down and spent some time talking to staff. One of the wing cleaners began to clear up the broken pieces of TV and the wing remained on association.

At about 6:50pm, the man smashed up his furniture in his cell and placed it on the landing outside his cell. He was told to return to his cell but refused. He became aggressive towards the staff and was restrained using Control and Restraint techniques (C & R) and taken to the Separation and Support Unit (the SSU or segregation unit).

Following his location in the SSU, the man was found to have sustained no injuries during the C&R incident. The man told staff that he made comments about suicide because he was not being moved to C wing. At 7:55pm, the man was moved back to his cell on A wing. Following his return to the wing, the man apologised to the Officer to whom he had become aggressive and they shook hands. At 10:55pm, the man told staff that he felt down and depressed about the earlier incident.

On 24 December at 8:20am, the man used the Samaritans phone on C wing. This is recorded in the log section of the F2052SH, but not in the main part of the document. The man returned to A wing at 8:55am and told staff that he was fine.

At 9:10am, the man was told that he would be taken before a Governor and adjudicated on for two offences against prison discipline which had taken place the previous evening. These were charges as follows: -

1. Rule 51, Paragraph 17 – Destroys or damages any part of a prison or any other property, other than his own.
2. Rule 51, Paragraph 20 – Uses threatening, abusive or insulting words or behaviour.

At 10:15am, a F2052SH case review was held and a decision was made to close the document. This case review was conducted by only two people – an SO and a CPN – not the minimum three. Neither of the review team was aware that the man had used the Samaritans phone earlier that day. The CPN described the man as “purposeful and giving positive intentions”. The review noted that the man was apologetic, but was blaming the wing SO for not allowing him to move wings. The review SO made it clear that the man would not be moving wings. He told my investigating team that the man was worried that he would be put in the segregation unit following the adjudication. The review SO told the man that he would make sure this did not happen if the man gave him an assurance that he would not self-harm again. The man gave that assurance. The review team placed a great deal of trust in the man’s promises not to self-harm or attempt suicide. No specific follow-up was agreed.

At 10:45am, the man was taken to SSU for his adjudications which were heard by an adjudicating governor. By then, the review SO says he had already had a prior word with the adjudicating governor. At the hearing, the man: -

1. Pleaded guilty to damaging property and was punished with 14 days of half pay and 21 days with no TV. He was also given a suspended punishment of three days cellular confinement and 14 days of no association or canteen. The conduct report said that the man was like an attention seeking child, and used threats of self-harm to get his own way.
2. Pleaded not guilty to being threatening and abusive. As two of the officers involved were not available, the adjudication was adjourned until they could be present.

The adjudicating governor told my investigators that she had read through the man's F2052SH before the adjudication, was aware that he was vulnerable and did not want to put additional pressure on him. That was why she suspended some of the punishment.

At 11:35am, the man returned to A wing and said that he was not happy. He felt that nobody believed him and that the wing SO was picking on him by not allowing him a move back to A wing.

At 11:40am, the man spoke to a landing officer, and at 11:50am to the adjudicating governor. He was concerned about being in the same room as the officers involved in the incident of 23 December when the adjudication restarted. Both reassured him that staff would not intimidate him.

At 4:40pm, the man spoke again to the landing officer and at 5:00pm to the adjudicating governor. He was still concerned about being in the same room as the witnesses. Both staff reassured him that staff would not intimidate him. He had also asked for a Black or Asian governor to hear his case. Although not formally notified, the adjudicating governor told the man that the adjudication was likely to be reconvened on 27 December, provided the relevant staff were in. If not, she said that it would be held later in the week.

On the afternoon of 24 December, the man was issued with the radio that he had bought from the prison shop.

The review SO said at interview that he spoke to the man on Christmas Day or Boxing Day. The man said he was worried about the adjourned adjudication. The review SO assured him that he would not be sent to the segregation unit or lose his association.

There are no further references to the man in any document until 27 December when, at 2:00pm during the association period, the man and an Officer talked for about 15 minutes. The man was positive – especially about the future – with plans following his release from prison.⁴ However, the man was telling staff that he was worried about the remanded adjudication. The man had also discussed this with another prisoner who had agreed to attend the adjudication as support for the man. This prisoner said that the man was concerned that he would not be treated fairly. He said that the man expected

⁴ The man had an automatic release date of 16 January 2005.

the adjudication to be held on 27 December, and he had to reassure him a number of times that afternoon. It appears that the man was not told that the adjudication would not happen that day.

At 4:15pm, the association period ended and all the prisoners were locked in their cells. At 4:45pm, the prisoners were unlocked and served the tea meal. At 5:35pm, the prisoners were again locked in their cells.

At 7:45pm, an officer began to count the prisoners on A4 landing and found the man hanging from the window bars of his cell. The ligature was made from torn bed sheets. The officer who found him entered the cell and at the same time called out for assistance. He also summoned help from the communications room, using his UHF radio. The officer who found him cut the ligature and lay the man on the floor.

Two officers were conducting roll counts on another landing and responded to the shouts of the officer who found the man. An SO and a Nurse responded to an emergency message broadcast over the UHF radio. The response SO believed there was a faint pulse and commenced CPR with one of the roll check officers who had responded. The nurse arrived, she took over the CPR from the response SO.

The emergency services received a call at 8:02pm. At 8:07pm an ambulance arrived at the prison and at 8:15pm, the ambulance crew took control of CPR. At 8:20pm, the police arrived. At 8:31pm, the ambulance left the prison and took the man to hospital, arriving at 8:38pm. At 8:53pm, the man sadly passed away.

Events after the man's death

My investigating team spoke, through an interpreter, to the prisoner in the cell next door to the man. He said that no one had spoken to him about the man's death, and that he had been offered no support. He said he found it particularly difficult between Christmas and the New Year.

The local police informed the family of the man's death. This appears to have been handled with appropriate sensitivity. However, the police gave the family the main telephone number of the prison which was frustrating when the family rang. A direct number or mobile would have been more appropriate. (I feel bound to add that such apparently small but significant misunderstandings are all the more likely to occur when the police, not the Prison Service itself, inform a family of the death of someone in prison custody.)

Bullying

One prisoner told the investigation team that the man had difficulty standing up for himself, and was being bullied. He said that bullying was a particular problem on A wing. A prison Chaplain also said he wondered if the man was being bullied, although other staff said they saw no evidence of this.

However, the prisoner in the cell next door to the man on A wing said there were no problems on association, and that he had seen no violence against the man.

Clinical review

The Director of Care at Bedford Primary Care Trust, carried out the review. He concludes that the man was a vulnerable character, who was able to manipulate those around him, but that the man's medical needs were managed appropriately. He identifies record keeping, procedural and management systems that require review.

Findings and Conclusions

There is no doubt that the man was a vulnerable and troubled young man, who was not easy to manage in the prison setting. He made three self-harm attempts using a ligature while in Bedford, and during that time two F2052SHs were opened and closed.

F2052SH opened on 3 November 2004

The F2052SH was opened correctly and the man was referred to the HCC. The doctor assessed the man as “not acutely suicidal”. But due to known mental health problems and the threat of self-harm, the man was wisely admitted to the HCC in a single cell under “regular” observation.

There were ten case reviews completed and, apart from the review on 23 November, they were multi-disciplinary with particularly good CPN input. The assessments, observation levels and support plans were balanced and appropriate. However, observation levels are regularly described as “regular or normal” in the case reviews, when the local policy outlines three levels of observation – frequent, intermittent and constant. Entries in the supervision and support record are consistent with “frequent observations”. Although the practical outcome was the same, the use of different terms by staff could lead to confusion and should be avoided.

I am satisfied that, overall, the observation levels were appropriately considered and were followed. I do, however, have some doubts that the decision on 14 November to remove the man from intermittent watch following a self-harm attempt was right. Indeed, shortly after that decision, the man made another self harm attempt and the watch was resumed.

I am also concerned that the prison did not find out if the man wanted his next of kin contacted after any of his self harm attempts, as Prison Service Orders require. I do not know what the man might have wanted had he been asked, but contact with family could potentially be very important for a distressed or self-harming prisoner.

Entries in the supervision and support record indicate a good balance between observations and interactions with the man.

The F2052SH was closed at a multi-disciplinary case review held on 17 December. On the evidence available at that time, this decision was appropriate.

F2052SH opened on 21 December 2004

The document was opened correctly, and the man was managed on A wing in a single cell under “normal” observation. Again, this is not consistent with the terminology in the local policy.

National and local policy says that a doctor must assess a prisoner within 24 hours of a F2052SH document being opened. In this case, the doctor did not assess the man.

Entries in the supervision and support record indicate a good balance between observations and interaction with the man.

The F2052SH was closed at the 72 hour case review on 24 December. The review was multi-disciplinary, but only consisted of the review SO and a CPN. The decision was made in good faith but, in my view, without sufficient consideration of the control and restraint episode the previous evening, the telephone call that the man had made to the Samaritans early that morning, the adjudication that was about to take place, and the fact that it was the festive period. Additionally, the review team relied upon a promise from the man that he would not self-harm again, when this was obtained from him in return for the assurance that the adjudication would not result in him being placed in the segregation unit. I do not think it was appropriate to rely on a promise from the man given in such circumstances. My view is that it might have been wise to keep the F2052SH open. While this may not have prevented the man from making a further self harm attempt, as he had in the past, the additional attention of being on a F2052SH might have reduced the risk. In any event, once the document was closed a support plan should certainly have been put in place.

Although I accept that the man's behaviour often appeared manipulative, I am also concerned that, over time, this may have meant that staff started to take the man less seriously. Yet the fact that he made three self-harm attempts, whatever the motivation meant that the man was someone who was a very high risk indeed.

Regarding manipulation, the Prison Service Order says:

"An act of self-harm should always be taken seriously. Even if the prisoner appears to be using self-harm as a means of gaining something, it is still a desperate act and the prisoner should be helped to find constructive ways to meet the underlying need."

Bullying

The man said that he felt intimidated and was described as being vulnerable. There is no direct evidence of bullying. However, the man did admit to having given his medication to other prisoners, as a result of which he was given his medication when no other prisoners were in the area. There was no attempt to identify any of the perpetrators, or to check whether the man was in any additional trouble. My view is that the prison should have conducted an investigation into any possible bullying, including who was taking his medication.

Adjudication

The incident of 23 December appears to have been an attempt by the man to obtain a move from A wing to C wing. Although the regime and nature of C wing may have suited the man better, and this was where he found contact with staff easier, I accept that the system did not allow for continued placement upon this wing. I conclude that the placement on A wing was appropriate. I also consider that staff dealt well with what happened on 23 December, particularly that the man was quickly returned to his own cell and not kept in the segregation unit.

The punishment for smashing the TV was appropriate, as was the initial remanding of the adjudication for being threatening and abusive.

I am, however, concerned that the man was clearly expecting that the adjourned adjudication would be held on 27 December, and made his worries about the adjudication absolutely explicit. It seems that there are no systems in place to tell prisoners when to expect an adjudication to resume, apart from the F1127 (notification of report) which is issued at least two hours before the hearing. In the light of his extreme anxiety, my view is that the prison should have told the man as soon as it was clear that the adjudication would not happen on 27 December.

The man said that he wanted a black or Asian governor to conduct the adjudication hearing. There is no evidence to suggest that this was because he feared racial discrimination. The original adjudicator was the only black or Asian governor at Bedford, and the man perceived her to have treated him fairly. I am confident that the man simply made this request because he thought he would get a more sympathetic hearing if he had the same adjudicator.

Emergency Medical Assistance

The man was found hanging in his cell shortly after 7:45pm. The ligature was made from a prison bed sheet (the most common means of suspension in prison) and was easily cut.

The response was immediate, once the alarm was raised. Medical professionals were administering emergency aid within minutes of the man having been found. It is to the credit of all concerned that every effort was made to revive the man. The prompt arrival at the cell of the Ambulance Service is also impressive.

After the man was discovered

Procedures were followed in line with contingency plans. The various offices and individuals were informed of events as required.

However, I do have some concerns that the prisoner in the cell next to the man, who spoke little English, does not appear to have been told of the man's death, or offered any help or support over the Christmas period.

The adjudicating governor, a senior manager, was appointed as Family Liaison Officer. The adjudicating governor played a hugely important role in keeping the man's family informed of events and helping them come to terms with what had happened. However, the family was frustrated when they called the prison, as they were given the number of the main switchboard, and not a direct contact number. In this report and elsewhere, I have indicated where I believe responsibility for informing a family of a bereavement in prison should lie.

Medical Care

The clinical review concludes that the man's medical needs were managed appropriately, but identifies some record keeping shortcomings.

Suicide Awareness

Bedford prison's local "Suicide Prevention Strategy" is a comprehensive policy document which is consistent with national policy.

Recommendations

1. I recommend that the Governor of Bedford reminds staff that prisoners who self harm as a means of gaining something should be taken seriously, and helped to find constructive ways of meeting their needs.
2. I recommend that the Governor reviews arrangements for informing a family of a death in prison custody, in particular that the person who informs the family (whether Prison Service or police) has a direct dial number to call to save bereaved families the frustration of having to negotiate the main switchboard.
3. I recommend that the Governor of Bedford reminds staff to be vigilant to bullying for prescribed medications, and that all potential incidents of bullying are to be investigated.
4. I recommend that the Governor of Bedford reminds staff that, when setting observation levels, they use terminology consistent with the local policy.
5. I recommend that the Governor of Bedford reminds staff of the national policy concerning the notification of next of kin following incidents of self-harm, and that such decisions are to be documented in the F2052SH.
6. I recommend that the Governor of Bedford reminds staff that case conferences carried out 72 hours after the opening of an F2052SH reviews are conducted by three members of staff, as local procedures require.
7. I recommend that the Governor of Bedford reminds medical staff that a doctor must review all prisoners on an open F2052SH within 24 hours of the document being opened.
8. I recommend that the Governor of Bedford reviews procedures for informing prisoners when a remanded adjudication will be heard.

Good practice

Bedford has a very helpful locally devised sticker added to the front cover of the F2052SH. This shows target dates for case reviews and when a review has been completed. This enables staff and managers readily to see if a review is required and when the last one was completed. It also has a locally devised information page inserted inside the front cover. This provides a series of tick-box prompts to assist staff in completing and managing the F2052SH document.