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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP Bedford  
in June 2014**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Bedford in June 2014. He was 42 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Bedford was undertaken. The prison co-operated fully with the investigation.

On Friday 13 June, five months after his release from prison on licence, the man was recalled to prison and arrived at Bedford. He had a history of mental health problems, had misused alcohol and drugs and had had thoughts of suicide and self-harm. Because of his evident risk, a nurse began Prison Service suicide and self-harm prevention procedures (known as ACCT) when he arrived. The staff decided that he should be checked twice an hour. His behaviour was odd and erratic, and a doctor and a mental health nurse considered that further assessments should be carried out the next week. There are no mental health nurses on duty at Bedford at the weekend and he had no significant contact with healthcare staff after he left the prison reception area.

On Saturday 14 June, the man was uncooperative with officers who attempted to assess and review him. They described his behaviour as bizarre, and assessed him as at high risk of suicide and self-harm. Despite the concern about his level of risk, they left the frequency of checks at twice an hour and did not take any additional steps to keep him safe. Officers spoke to him several times the next morning and had no particular concerns about him. At 11.40am that morning, an officer found him hanged from the cell light fitting. Sadly, he could not be resuscitated.

While the reception nurse appropriately identified the man's risk when he arrived at Bedford and opened an ACCT, there were deficiencies in the procedures subsequently put in place to support him. In particular, no member of the healthcare team was present at the first case review, contrary to national guidelines, and the level of observations was not increased in line with his perceived risk. I am also concerned that, although staff recognised his clear signs of mental ill-health, there is no routine mental health cover at Bedford at the weekend and this needs to be addressed.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**February 2015**

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## SUMMARY

1. In January 2014, the man was released from prison on licence. On 12 June, he was recalled to prison because he was behaving strangely and probation staff believed he had breached the conditions of his licence. He had a history of mental ill health, substance misuse and thoughts of suicide and self-harm.
2. The man arrived at HMP Bedford on Friday 13 June. The nurse who saw him in reception thought that he might harm himself or others. She began Prison Service suicide and self-harm prevention procedures, known as ACCT, and referred him to the doctor and mental health nurse, who saw him that afternoon. He refused to be admitted to the prison's healthcare inpatient unit and had a single cell on a standard residential wing. Staff were told to check him twice an hour.
3. Staff described the man as bizarre and difficult to engage in normal conversation. On Saturday 14 June, two officers saw him to assess and review him under ACCT procedures. They assessed him as at high risk of suicide and self-harm, but did not increase the frequency of the monitoring checks or consider any other steps to try to prevent him from harming himself.
4. The next morning the man spoke to officers several times. Nothing that he said or did caused them to think that he was planning to harm himself. At 11.40am, an officer found him hanging from the cell light fitting. Prison staff and paramedics tried to resuscitate him but, at 12.27pm, a paramedic pronounced him dead.
5. We found that the reception nurse appropriately identified the man's risk when he arrived at Bedford and opened an ACCT. However, staff did not complete some aspects of the ACCT procedures in line with national guidance. As staff had assessed him as at high risk of suicide and self-harm, we consider that the frequency of checks was not sufficient and the plan to support him was not detailed enough. The first case review on 14 June was not multidisciplinary as it should have been.
6. We are concerned that there are no mental health nurses on duty at Bedford at the weekend and little was put in place to support the man's mental health needs over the weekend. The nurse who saw him in reception carried out a thorough assessment, but the clinical reviewer identified some weaknesses in the assessments of the doctor and the mental health nurse. We make three recommendations.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. The investigator visited Bedford on 18 June 2014 and obtained copies of relevant extracts from the man's prison and medical records. She interviewed eight members of prison and healthcare staff in July 2014. Unfortunately, problems with the recordings of a number of the interviews meant that they could not be transcribed and the quality of some other transcripts was poor. We reinterviewed two officers by telephone in November 2014.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. He was present for the healthcare staff interviews.
10. We informed HM Coroner for Bedfordshire and Luton of the investigation, who sent the results of the post-mortem and toxicology examinations. We have sent the Coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to investigate:
  - Whether prison and healthcare staff, who knew that her son had a history of depression and self-harm, appropriately managed his risk of suicide and self-harm.
  - Whether staff carried out suicide and self-harm monitoring checks on him at the required frequency and whether there was any CCTV evidence to corroborate this. She was concerned that he had time to hang himself between the scheduled checks.
  - Why he was not being held in a safer cell, with reduced ligature points, despite his recognised risk of suicide.
12. The man's mother received a copy of the draft report. She raised some issues that do not impact on the factual accuracy of the report. The prison responded to correct two factual inaccuracies and to clarify where a piece of writing by him was found. Paragraph 75 has been amended as a result.

## **HMP BEDFORD**

13. HMP Bedford is a local prison which holds up to 514 men. The prison takes sentenced and remanded prisoners from Luton Crown Court and Bedford and Luton Magistrates' Courts and sentenced prisoners from other prisons. South Essex Partnership Trust provides healthcare services.

### **HM Inspectorate of Prisons**

14. The most recent inspection of Bedford by HM Inspectorate of Prisons was in January/February 2014. Inspectors concluded that Bedford was a fundamentally well-run prison that was both safe and respectful. They found that the quality of suicide and self-harm monitoring procedures was good and some staff entries demonstrated a caring approach. Caremaps were detailed and updated and case reviews were multidisciplinary.
15. Inspectors described health screens for new arrivals and GP care as excellent and were positive about the mental health provision at Bedford.

### **Independent Monitoring Board**

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2014, the IMB reported that overcrowding and reduced staff numbers had had a negative effect on the prison. In particular, they noted that staff found it difficult to move prisoners from the first night centre and there was a lack of purposeful activity. There was often a shortage of officers to take prisoners to education or healthcare appointments, the incidence of self-harm had doubled and the IMB was concerned how easy it was for prisoners to get drugs. However, they added that staff and managers were committed to producing a humane environment for prisoners, with a clear and moral purpose. The IMB commended the level of support given to mentally ill prisoners, and said that the safer custody team worked with impressive professionalism.

### **Previous deaths at HMP Bedford**

17. The man was the ninth prisoner to die at Bedford since 2010 and the seventh apparently to take his own life. Since his death, another prisoner has died of natural causes. In an investigation in 2010 and another in 2011, we recommended that ACCT case reviews should be multidisciplinary. We make similar recommendation in this report. In 2011, we also recommended that ACCT caremaps should be completed in line with guidance. One of the recommendations in this report also refers to improving ACCT caremap entries.

### **Assessment, Care in Custody and Teamwork**

18. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-

harm. The purpose of the process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap about how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## KEY EVENTS

19. On 15 November 2012, the man was sentenced to prison for two years and eight months for assaulting and threatening to kill his then partner. It was not his first prison sentence. He had a history of alcohol and drug misuse and had mental health problems. While on remand at HMP Lewes in September 2012, staff briefly monitored him under ACCT procedures because he had threatened to harm himself.
20. On 3 January 2014, the man was released on licence from HMP Guys Marsh. His licence conditions included living at an approved premises (probation hostel) and addressing his alcohol and drug use. On 2 June, he moved to an approved premises in Luton.
21. On the evening of 11 June, the man began to behave oddly and hostel staff suspected that he might have taken drugs, specifically a synthetic cannabis substitute known as spice. They decided to carry out a drug test the next morning and to check him once an hour in the meantime. Shortly after 6.00am on 12 June, his behaviour became more alarming and he appeared distressed and disorientated. Hostel staff called the police and ambulance service. He said that he had had a fit, but the paramedics assessed him and found no cause for concern. They did not take him to hospital but advised him to see a doctor. He later told prison staff that he had gone to the local health centre on 12 June, but had left before his appointment because he did not want to wait.
22. After the emergency services had left, hostel staff told the man that he needed to take a drug test. He became aggressive and intimidating. He tested negative for illegal drugs, but the routine test equipment used by the hostel could not test for spice. Hostel staff decided that he should be recalled to prison because they feared he might harm himself or someone else, and because they suspected that he was misusing substances. They began emergency recall procedures and the police arrested him later that day.
23. At the police station, the custody sergeant completed a risk assessment with the man. He said that he had bipolar disorder and depression and was prescribed citalopram and mirtazapine (both antidepressants). He said that he also suffered with back pains after breaking his back several years earlier, and took co-codamol and etodolac for pain relief.
24. The man said that he had tried to harm himself “years ago” by taking an overdose. (According to his prison medical record, he took several overdoses between 2002 and 2004, cut his arm and had walked in front of a car.) He said that he was dependent on his prescribed medication but not on any other drugs or alcohol. The police sergeant recorded that he was in good spirits and calm and did not appear to be unwell or under the influence of any substances. Staff were instructed to check him at least every 30 minutes while he was in police custody, which is common practice in police stations.

25. At 9.25am on Friday 13 June, a doctor examined the man in the police custody suite. He told her that he had asthma, depression and chronic back pain and had had a fit the day before. He said that he had had other fits but had never sought medical advice about them because he thought they were related to his substance use. She noted that he had suffered a head injury in 2003.
26. The doctor wrote a letter to accompany the man to prison. She wrote that he had described the fit and said that he had urinated during it, had pins and needles in his hands, had disturbed vision and felt disorientated afterwards. She noted that there was no family history of epilepsy and that the fits might be related to his traumatic head injury. She advised the receiving prison to carry out further investigations.
27. The doctor listed the man's medication as salbutamol and becotide inhalers (for asthma), etodolac and co-codamol for pain relief and citalopram and mirtazapine for depression. While in police custody, he took his medication as prescribed.
28. At 10.40am, the man was taken from the police station to HMP Bedford, arriving at 11.40am. The Person Escort Record, which accompanied him from the police station to prison, recorded that he had taken an overdose "years ago" and that his latest conviction was for a violent offence against his partner. The form showed that he took medication for back pain, and had bipolar disorder and depression. The words "unknown fits" were also written in the mental health problems box.
29. At 11.48am, a nurse assessed the man's physical and mental health. In a statement for the coroner, she said that he had two inhalers with him to treat asthma and said that he had the condition under control. She said that she had asked him whether he had recently had a seizure (which she had read on the Person Escort Record and the letter from the doctor) but he then became agitated. He said that he had been having fits for years but that no one had taken them seriously.
30. The nurse told the man that she took his history of seizures very seriously and that she wanted the prison doctor to assess him. She wanted to admit him to the prison's inpatient unit for closer monitoring but he flatly refused this and became angry. He signed a medical disclaimer form recording his refusal to be admitted as an inpatient.
31. The man explained that he been seriously injured in 2003 when he was thrown from a multi-storey car park. He had broken his back and so used a walking stick, which he had with him. He said that he did not need any help with personal care and did not need a disabled access cell. The nurse recorded that he should have a cell on the ground floor and should sleep on the bottom bunk. He agreed that Bedford could contact his community GP for a copy of his medical record.

32. The nurse noted that the man had two different antidepressant medications with him, mirtazapine and citalopram. She asked him if he had ever harmed himself and he told her that he had taken an overdose and cut his wrists years before. He said that he had no active thoughts of suicide or self-harm. He said that he had not drunk any alcohol or taken any drugs in the previous week.
33. The man said that he had been admitted to a mental hospital more than once because he had heard voices. The nurse asked him if he was still hearing voices. He did not answer the question directly and the nurse found his response odd and inappropriate. He asked her if she ever felt like emotionally hurting someone. She asked if he felt like that and he replied that he sometimes did. She made a detailed note of her assessment in his medical record. She noted that he had said he would not be "here much longer" but would not elaborate when she asked him what he meant, saying only that she would see.
34. The nurse said that the man was becoming increasingly agitated and impatient, so she suggested that he return to the reception desk to complete the reception procedures. She then phoned the doctor on duty and the mental health team lead and asked both to see him that day. In her statement, she said that she also completed a written referral to the mental health team, which she emailed to the team at 1.15pm.
35. The nurse spoke to a Supervising Officer (SO), who was in charge of the reception unit that day. She said that she was concerned about the man, that he had been hostile and agitated at times and that she did not think he should share a cell. She asked the SO to keep him in reception until the doctor and mental health nurse had seen him.
36. At 1.30pm, the nurse began ACCT procedures for the man because he had been difficult and agitated and their conversation had been bizarre at times. She noted his history of self-harm and his statement that he would not be "here much longer" and wanted to emotionally harm someone. She completed the triggers section of the plan, writing "bizarre conversation" and "stated that he would not be here much longer". (These entries related more to the reasons she had opened the ACCT plan than to triggers or events that might lead him to harm himself.)
37. At 1.45pm, the SO completed the ACCT immediate action plan. He recorded that the man had been assessed as unsuitable for sharing a cell, referred to the prison mental health team and should be checked twice an hour until the ACCT assessment interview had taken place.
38. A doctor saw the man at 1.47pm. When interviewed, the doctor could not remember whether he had read his prison medical record before assessing him in reception. (The record covered his prison medical history since 2010 and included details of his community mental health treatment before that.) During previous periods of imprisonment, healthcare staff had recorded

details of his excessive use of alcohol, dependence on drugs, mental ill health and risk of suicide and self-harm.

39. When interviewed, the doctor said that the man's mood was very changeable, ranging from agitated and angry to elated, then low and tearful. In the notes he made during the appointment, the doctor wrote that the man said that it was a matter of time before there was a fatality. The doctor said that he believed the man meant that he would harm someone else, and that he had said that he did not have any thoughts of suicide or self-harm. The doctor said that the man talked a lot about his probation officer and that he should not have been recalled to prison. He told the doctor that women should not be employed in positions of authority. He repeated several times that he felt no one listened to him.
40. The man told the doctor that he had not used drugs or consumed alcohol to excess since he had completed a course of rehabilitation two years earlier. The doctor recorded that it was difficult to get information from him because he moved quickly onto different topics. He asked him about his history of seizures but he gave him little information. The doctor told the investigator that he could not remember seeing the letter from the doctor who had examined him in police custody.
41. The doctor recorded that the man presented as vulnerable and high risk. It is not clear if the doctor judged him to be a high risk to himself or to others. The doctor agreed that he should be admitted to the inpatient unit but he remained adamant that he did not want this because he would not be able to smoke there. He was offered nicotine replacement therapy but still refused to be admitted.
42. The doctor told the investigator that he thought the man showed signs of mental illness and perhaps of psychosis and agreed that the mental health team should assess him that day. He said that he had considered whether his bizarre presentation could be the result of drug or alcohol use and asked that he should take a drug test. The doctor did not arrange for this to be done urgently and made no further reference to whether he might be under the influence of substances or at risk of withdrawal. There is no record that he was tested for drugs at Bedford. Currently, Bedford cannot test for synthetic cannabis substitutes such as Spice. The doctor prescribed his medications.
43. A mental health nurse saw the man in reception at about 3.10pm. When interviewed, the nurse said that he had read the man's medical record and a letter written by a psychiatrist in 2002 before meeting him. The nurse said that he knew another nurse had begun ACCT procedures because the man had been acting strangely.
44. The nurse noted details of his assessment in the man's medical record. He wrote that his presentation was bizarre and that he seemed agitated, easily irritated and slightly hyperactive. The man said that he had not used alcohol or drugs recently. The nurse wrote that it was difficult to assess whether he was showing signs of psychosis.

45. Because the man seemed very impatient, the nurse ended the assessment early. He assessed him as posing a medium risk to himself and wrote that the mental health team should take him on their caseload and fully assess him the next week. The nurse also wrote that his medication should be reviewed as he was prescribed two different antidepressants. The nurse made a brief entry in the ACCT plan in which he recorded some details of the man's mood and the plan to review him fully the following week.
46. After meeting the man, the nurse rang someone he knew at the Luton approved premises who, he said, faxed him further information about the man. The nurse told the investigator that he had planned to see him again the next week. He had discussed and agreed his action plan with the mental health team leader.
47. At 3.20pm, the man was moved cell A2-21, a single cell on the ground floor of A Wing, a standard residential wing. He did not move to C Wing, the designated induction wing, because there are no single cells on that wing. The cell was not a designated safer cell with reduced ligature points. There are no closed circuit cameras on A Wing.
48. An officer wrote in the man's file at 3.20pm that she had spoken to him and that he had been in prison before and knew what to expect. She wrote that she had reminded him that he could speak to the Samaritans by telephone, or to a Listener (prisoners trained by the Samaritans to support other prisoners) if he needed support. She also told him to use his emergency cell bell if he needed to speak to staff. She noted that he had tried to make a telephone call but no one had answered.
49. An officer spoke to the man at 4.10pm and noted in the ACCT plan that he seemed very frustrated about his recall to prison. At 4.35pm, the officer wrote that he had come out of his cell to mix with other prisoners on the wing and appeared to be much calmer.
50. At 6.45pm, the man asked an officer about his medication. The officer wrote in the ACCT plan that he had checked with healthcare staff who said that the man would get his medication the next day. The officer wrote that the man accepted this. He told the investigator that the man seemed low in mood and made little eye contact.
51. Night staff checked the man twice an hour throughout the night. Their entries noted that he had slept for most of the night.

### **Saturday 14 June**

52. On Saturday 14 June at 9.35am, an officer tried to interview the man for an ACCT assessment. He recorded that the man had said that he would rather not talk. The officer wrote that he was displaying bizarre behaviour, was aggressive and that his personality appeared to have changed.

53. The officer explained to the investigator that when he asked the man about his mood, he replied by shouting “why do you want to know?” When the officer said he was there to help, he accused him of being “one of them”. The officer said that he kept his finger on his radio panic alarm because he seemed unpredictable and made him feel uneasy. The officer decided to end the assessment early.
54. The officer told the investigator that he did not think the man was under the influence of drugs, but thought that his bizarre behaviour was a symptom of mental illness. He said that he referred him to the mental health team after the assessment.
55. The officer said he spoke to the SO who was due to chair the first ACCT case review later that day. He told him that he would try to complete the assessment once the mental health team had seen the man the next week.
56. At 3.50pm, the SO and a custodial manager saw the man for the first ACCT case review. The SO recorded that the man was extremely upset, anxious and angry during the meeting. He told the staff that he had mental health problems because of his misuse of drugs and alcohol. The SO wrote that his behaviour was bizarre, and that he felt that no one was helping him, that he was lost and had nothing to live for.
57. The SO told the investigator that the man was manic and it had not been possible to have a normal conversation with him. He described his body language and tone of voice as erratic. The SO said that he had had mental health awareness training and that it was obvious that the man had mental health problems.
58. The SO said that the man told him that he felt unsupported by his probation officer and his family, who he said had disowned him. He said that he had asked him if he had any thoughts of suicide or self-harm. He responded that if prison officers carried guns, he would run at them. The SO had understood this to mean that the man would have tried to get officers to shoot him. He said nothing else about thoughts of self-harm. The SO said that he had been seriously concerned about the man’s safety and risk to others and had assessed him as high risk of suicide and self-harm.
59. The SO instructed staff to continue to check the man twice an hour. He said that he was reassured that the man was in a single cell very close to the wing office, and that two observations an hour were sufficient. He said that he did not consider removing items from his cell, which he could have used to harm himself. He said that such steps were normally taken only after a prisoner made a direct and specific threat of self-harm or had harmed himself.
60. The investigator asked the SO if he had considered moving the man to a safer cell with reduced ligature points. He said that he had not thought that the man needed to be constantly supervised in a safer cell, and that he had not given any clear indications that he was seriously contemplating suicide or self-harm.

The SO said that there were no safer cells on A wing and it would not have been in the man's best interests to move to a different wing.

61. The SO recorded that the man's main problems were that he had not been given his prescribed medication and that he did not feel supported. He arranged the next ACCT case review for 16 June and noted that a member of the mental health team needed to attend the review.
62. The SO made two entries in the ACCT caremap. The first was that the man should see a doctor so that his medication could be prescribed. The SO wrote that he would make the appointment for 16 June. In fact, a doctor had already prescribed the medication. Secondly, the SO wrote that he would refer him to the mental health team for assessment on 16 June. A nurse had already intended to assess him again after the weekend.
63. After the ACCT review, the custodial manager noted in the man's prison record that his behaviour had been bizarre. He described him as calm one minute but aggressive and anxious the next.
64. In the afternoon, officers noted that the man had collected his medication and his evening meal. Staff checked him twice an hour at irregular intervals so that he could not predict their next check. Officers noted that he appeared to be asleep from shortly after 5.00pm.
65. A pharmacy technician wrote in the man's medical record that, as there was no full pharmacy service at the weekend, he had been given his medication from the supply he had brought with him to prison.
66. According to ACCT entries, the man slept until about 8.45am. He chose not to go to a religious service. At 9.10am, officers unlocked cells for an association period (when prisoners are able to socialise with each other). At 9.26am, he asked an officer where he could collect his medication. The officer told him he should go to the dispensing hatch at the end of the wing. There are no entries on his prescription chart so there is no record whether or when he received his medication that day.
67. At 9.50am, the man asked an officer if he could have a prison shop order form. The officer told him the forms would be distributed the next day.
68. At 10.15am, the man asked an officer about his medication. The officer noted that a member of pharmacy staff had said his medication would be ready at lunchtime and told him this. During the telephone interview, the officer said that he did not say he was in pain or discomfort but was clearly anxious to get his medication.
69. At 10.40am, the officer noted in the ACCT document that the man was sitting on his bed smoking a cigarette. When interviewed, the officer said that he did not talk to him this time.

70. At 11.10am, an officer (it is not clear from the records who this was) wrote in the ACCT document that the man was walking around the landing at the end of the association period. At 11.25am, the same officer noted that he was locked in his cell. The officer did not note any concerns, but there is no evidence from the record that he had any interaction with him.
71. At 11.40am, two officers began unlocking prisoners on A2 landing for lunch. Officer A opened the man's cell and saw him hanging from the cell light fitting with a torn piece of sheet around his neck. He shouted for help and Officer B rushed to the cell. Officer B said that he shouted for other staff to help them and radioed a code blue (which indicates a prisoner is unconscious, not breathing or is having breathing difficulties) and also a code red (when a prisoner is bleeding). Officer A supported the weight of the body while Officer B used his anti-ligature knife to cut the sheet from around the man's neck.
72. According to the control room log, Officer B radioed the emergency codes at 11.43am and control room staff immediately called for an ambulance. The first ambulance arrived at the prison at 11.47am and the second at 11.51am. The exact time that the paramedics arrived at the cell is not recorded in the incident log.
73. An officer and a custodial manager arrived at the cell shortly afterwards. The custodial manager told the investigator that he heard Officer A's shout and went straight to the cell just behind a nurse, who was also responding. The nurse brought the emergency response bag with him and the custodial manager said that he asked one of the officers standing near the cell to bring the defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) from the main wing office.
74. The custodial manager said that he was a trained first aider and he and the nurse quickly began cardiopulmonary resuscitation. The nurse gave rescue breaths while he delivered chest compressions. The defibrillator found no shockable heart rhythm and they continued cardiopulmonary resuscitation until the paramedics reached the cell and took over. At 12.27pm, after 40 minutes of advanced life support efforts, a paramedic pronounced that the man had died.
75. After the man's death, a piece of writing, with the title 'Goodbye this time' was found in his property. In it, he reflected on his life and that he could 'take no more'.

### **Contact with the man's family**

76. There were no trained family liaison staff on duty that Sunday and a manager phoned a SO at his home and left a message asking him to act as family liaison officer. Two custodial managers and a duty governor were on duty at Bedford that day. This is the minimum number of senior staff who must be present in the prison and so none of them could leave to break the news to the man's family. The SO responded to the message at 3.20pm and arrived at the prison at 4.10pm.

77. In the meantime, a family liaison officer from HMP Ford, which is about half an hour's drive from the man's mother's house, agreed to visit her to tell her of her son's death. The SO spoke to the Ford family liaison officer that afternoon, who said that he had been to her house but she was not there. At 5.10pm, the Ford family liaison officer phoned the SO and said that he had told her of her son's death.
78. The SO and a prison chaplain visited the man's mother and other members of the family the next afternoon. They gave further information about his death. In line with Prison Service guidance, the prison contributed to the costs of the funeral.

### **Post-mortem report**

79. The post-mortem examination concluded that the man's death was from hanging. The toxicological examinations found the presence of codeine, mirtazepine and citalopram in his body, consistent with his prescribed medication. A further toxicological examination was later conducted to test for the presence of Spice. It is difficult to determine the presence of Spice, but the test found no trace of spice in his body and, therefore, no indication that he had recently taken it.

### **Support for staff and prisoners**

80. At 4.45pm, the Governor debriefed the staff involved in the emergency response, including the healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
81. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by his death.

## ISSUES

### Management of risk of suicide and self-harm

82. The man had a history of mental illness, substance misuse and suicidal thoughts. He had been recalled to prison because probation staff were concerned about his increasingly erratic behaviour. All of these factors are recognised as increasing the risk of suicide and self-harm.
83. When the man arrived at Bedford, a nurse began ACCT procedures because of the way he behaved and the things he said. Although he said that he did not have any active thoughts of suicide or self-harm, the nurse considered that he was vulnerable and a risk to himself based on her assessment of him and his known risk factors. We agree that his vulnerabilities were evident and it was sensible and appropriate to begin ACCT procedures quickly.
84. However, we are concerned that staff did not implement ACCT procedures effectively. In reception, a SO instructed staff to check the man twice an hour. The frequency of observations remained unchanged until his death, even though a SO assessed him as at high risk of suicide and self-harm on 14 June. He did not co-operate with the ACCT assessment, staff described his behaviour as bizarre and he had mentioned thoughts of suicide and self-harm.
85. We do not consider that the required level of observations in place at the time matched his assessed level of risk. However, this is mitigated by the fact that between 8.45am and 11.25am on 15 June, staff made eight entries in the ACCT ongoing record noting their observations of and interactions with the man, which is more frequent than the required two checks an hour. We also note that only 15 minutes had passed between the last ACCT entry noting that he had been locked in his cell at the end of association and him being found at 11.40am. We cannot say whether a higher level of observations would have made any difference to the sad outcome, but the level of required checks should be set in line with the perceived risk of harm.
86. A SO made two entries in the man's ACCT caremap, but both related to issues that were already being dealt with. The man told him that he felt unsupported by his family and probation officer, but there was no corresponding caremap entry about how this could be addressed.
87. Prison Service Instruction (PSI) 64/2011 covers safer custody and the ACCT process. It contains mandatory instructions to staff about managing prisoners at risk of suicide and self-harm, including that the first ACCT case review must be multidisciplinary and attended by a member of healthcare staff. The man's first ACCT case review was held on Saturday 14 June, but no member of healthcare staff attended. There are no mental health nurses at Bedford at the weekend (which we discuss further in the next section). The SO said that, although general nurses were on duty at weekends, they did not generally attend ACCT case reviews unless there were concerns about the physical health of a prisoner. The purpose of holding multidisciplinary case reviews is to ensure that the widest possible range of opinions is considered. We

consider that healthcare staff should always attend first case reviews in line with the Prison Service instruction.

88. We are concerned that, although staff correctly identified that the man was at risk of suicide and self-harm, subsequent actions did not give him the level of support he needed. He did not really engage with the ACCT process, and we accept that this made it difficult for staff to support him. However, it is important that healthcare staff attend first case reviews, that caremap actions ensure that prisoners receive active support, and that the level of observations reflect the assessed level of risk. We make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **Healthcare staff attending all first case reviews;**
- **Setting appropriate levels of observations which are adjusted as the perceived risk changes;**
- **Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.**

#### **Clinical care**

89. The clinical reviewer reviewed the clinical care the man received at Bedford. He made a number of detailed recommendations in his review that the Head of Healthcare will need to address. Overall, he concluded that only some aspects of the clinical care the man received were comparable to that which he could have expected in the community.
90. The clinical reviewer was critical of a doctor and a nurse's failure to properly consider whether the man's presentation could be linked to his recent use of alcohol or drugs. He noted that substance misuse could have played a part in both his erratic and volatile presentation and his recent seizure. The man said that he had not recently used alcohol or drugs but the clinicians did little to investigate this. The doctor did request that he should have a drug test but this had not happened before he died. We make the following recommendation:

**The Head of Healthcare should ensure that clinicians appropriately identify, treat and monitor prisoners with possible substance misuse problems when they arrive.**

91. After he left the reception area on 13 June, the man had no further contact with healthcare staff except to receive his medication, even though there were serious concerns about his mental health.
92. The clinical reviewer found that there was no clinical leadership and no one took overall responsibility for the man's ongoing care over the weekend. There is no mental health cover at Bedford at weekends. A nurse told the investigator that prison managers knew they could call members of the mental health team at weekends if they needed advice. It seems that this is not a

formal arrangement and a SO was unaware of it. We consider that it is unsatisfactory for a prison such as Bedford not to have any dedicated mental health provision at the weekend. We make the following recommendation:

**The Head of Healthcare should ensure that there is sufficient mental health provision at the weekend to meet the needs of prisoners.**

### **Family liaison**

93. On Sunday 15 June, when the man died, none of Bedford's trained family liaison officers were on duty. The SO, who was asked to act as family liaison officer, did not arrive at the prison until 4.10pm, three and a half hours after death was pronounced. None of the managers on duty could be released to travel to break the news to the man's mother. A family liaison officer from HMP Ford, which is much closer to the mother's house, broke the news to her in the early evening.
94. PSI 64/2011 includes mandatory instructions about informing families when a prisoner dies. It instructs that wherever possible a family liaison officer and another member of staff from the prison should break the news in person. The instruction continues, however, that where the prisoner is held a long way from their family, consideration must be given to asking for help from the nearest prison. We are satisfied that in the circumstances, it was reasonable and in the man's family's best interests for a liaison officer from Ford to break the news to his mother. We note that the SO and the chaplain visited the man's mother the next day, which was appropriate.

## RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Healthcare staff attending all first case reviews;
  - Setting appropriate levels of observations which are adjusted as the perceived risk changes;
  - Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves.
2. The Head of Healthcare should ensure that clinicians appropriately identify, treat and monitor prisoners who might have substance misuse needs.
3. The Head of Healthcare should ensure that there is sufficient mental health provision at the weekend to meet the needs of prisoners.

### HMP Bedford

No	Recommendation		Actions Required	Identified Lead	Target Date
<b>PPO Recommendations</b>					
1	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> <li>- Healthcare staff attending all first case reviews;</li> <li>-Setting appropriate levels of observations which are adjusted as the perceived risk changes;</li> <li>- Setting ACCT Caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves</li> </ul>	Accepted	<p>Safer Custody Manager now responsible for ensuring that the quality of Assessment Care in Custody and Teamwork (ACCT) documents are in line with the current Prison Service Instruction (PSI 64/2011). This will form an overview presented at the Safer Custody meeting, which is attended and chaired by the Head of Safer Prisons.</p> <p>Daily reminders are given at the morning briefing to ensure that the correct people attend reviews. Particular attention is given to Healthcare staff attending first ACCT reviews.</p> <p>An e-mail will be sent to all those managers responsible for chairing the ACCT reviews</p> <p>Further training will take place to all Case Managers and Supervising Officers and health care</p>	Head of Safer Prisons	31 March 2015

			manager in setting appropriate levels of observations which are adjusted as the perceived risk changes and setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves		
2.	The Head of Healthcare should ensure that clinicians appropriately identify, treat and monitor prisoners who might have substance misuse needs.	Accepted	Email to be sent to all staff requesting they utilise the Problem Substance template on the Healthcare SystemOne  Amendment to be made to the reception template for nurses to demonstrate they have checked the patient's substance misuse history	Head of Healthcare	31/01/2015
3.	The Head of Healthcare should ensure that there is sufficient mental health provision at the weekend to meet the needs of prisoners.	Accepted	Governor has written to the lead commissioner for Health Services who has instructed South Essex Partnership Trust (SEPT) Healthcare to provide mental health cover at weekends	Head of Healthcare	31/01/2015
<b>Independent Clinical Reviewer Recommendations</b>					
4.	The Director and Clinical Group Manager (Integrated Clinical Lead) will explore the possibility of provision of a	Accepted	Create and review Service Specification for HMP Bedford Mental Health Services.	Integrated Clinical Lead for Criminal Justice and	31/01/2015

	seven day a week mental health service for the prison population.		<p>Cost Benefit Analysis to be carried out to determine costs and present business case to Commissioners regarding increased costings if there are any.</p> <p>Scoping exercise within prison to identify extent of mental health need over the week to determine service reconfiguration and whether to develop on-call system or nurses on site.</p>	<p>Secure Services</p> <p>Director for Secure Services</p>	
5.	<p>Head of Healthcare to lead a project to improve the use of primary care records to particularly ensure that:</p> <ul style="list-style-type: none"> <li>- An appropriate history, examination, diagnosis and care plan is documented following each clinical consultation.</li> <li>- Clinicians can demonstrate their ability to access the Past Medical History and Summaries within the SystmOne continuous clinical record, and link this information to care plans and risk assessments of all prisoners.</li> <li>- Clinicians are required to ensure a consultation start and finish time is entered in the clinical record.</li> <li>- All clinical documents accompanying prisoners are scanned into the clinical record.</li> </ul>	Accepted	<p>Service Innovation Project to be designed incorporating clinical standards to look at improving the quality of access to SystmOne records to incorporate what is required from a consultation and expectations of what needs to be recorded following any consultation.</p> <p>Memo to be sent to all healthcare staff informing them that consultation start and end times need to be added to SystmOne records before saving.</p> <p>Memo to be sent to all healthcare staff informing them that any documents accompanying prisoners must be scanned to SystmOne within 24 hours of arrival at HMP Bedford.</p>	Head of Healthcare	31/01/2015
6.	Head of Healthcare at HMP	Accepted	Review of the training	Head of	31/01/2015

	Bedford conduct an audit of the training records of all clinicians with particular regard to the management of acute drug/alcohol related problems.		<p>records to be carried out, looking at what mandatory training is included.</p> <p>Based on review of the mandatory training, consider whether further training is required in the identification of drug/alcohol issues.</p> <p>Review of referral pathways between Healthcare and Integrated Drug Treatment System (IDTS) in HMP Bedford.</p>	Healthcare	
7.	Head of Healthcare to conduct an audit of the training records of all clinicians to ensure that they are all up to date with the requirements of the Mental Capacity Act and are able to act in line with the recommendations of this act.	Accepted	<p>Review of the training records to be carried out, looking at what mandatory training is included.</p> <p>Based on review of the mandatory training, consider whether further training is required in the identification of Mental Capacity Act.</p>	Head of Healthcare	31/01/2015
8.	Head of Healthcare to conduct an audit into the training records of all clinicians with regards to clinical risk assessment procedures currently used at the prison.	Accepted	<p>Review of Mandatory Clinical Risk and compliance with same.</p> <p>Review of staff who have attended ACCT training.</p> <p>Review of Mental Health Awareness Training available to Healthcare and Prison staff.</p>	Head of Healthcare	31/01/2015
9.	Head of Healthcare conduct a review of the clinical	Accepted	Create and review Service	Head of Healthcare	31/01/2015

	leadership at the prison and the care available over a weekend period.		<p>Specification for HMP Bedford Mental Health Services.</p> <p>Cost Benefit Analysis to be carried out to determine costs and present business case to commissioners regarding increased costings if there are any.</p> <p>Scoping exercise within prison to identify extent of mental health need over the week to determine service reconfiguration and whether to develop on-call system or nurses on site.</p> <p>Review on-call rota and leadership out of hours at HMP Bedford.</p>	Integrated Clinical Lead – Criminal Justice and Secure Services	
10.	Head of Healthcare conduct an audit of the training records of all doctors to ensure that they are aware of their responsibilities for the Continuity and Coordination of Care as documented in the General Medical Practice Publication “Good Medical Practice 2013, Para 44 and 45”.	Accepted	<p>Guidance to be shared with medical staff</p> <p>Review understanding and awareness of responsibilities in supervision.</p> <p>Review supervision access for medical staff</p> <p>Review training records and systems for GP staff and Locum GP staff.</p> <p>Liaise with Training and Development as to whether there is a training need for medical staff and if training needs to be</p>	Head of Healthcare	31/01/2015

			sourced or developed for medical staff.		
11.	Head of Healthcare to conduct a review of all nursing staff training records and ensure that they are all aware of their responsibilities to ensure continuity of care, especially during out of hours periods, weekends and other holiday periods.	Accepted	<p>Review supervision records of all nursing staff to include specific agenda on continuity of care</p> <p>Nursing staff to be aware of responsibilities under the National Medical Council, "The Code"</p> <p>Liaise with Training and Development as to whether there is a training need for nurses and if training needs to be sourced or developed for nursing staff.</p>	Head of Healthcare	31/01/2015