

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Richard Wiggins a prisoner at HMP Bedford on 15 September 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Richard Wiggins was found hanged in his cell in at HMP Bedford on 15 September 2016. He was 35 years old. I offer my condolences to Mr Wiggins' family and friends.

The investigation found that Mr Wiggins was a vulnerable man with a history of mental ill-health, self-harm and attempted suicide. I am concerned that Mr Wiggins' risk of suicide and self-harm was not identified and managed adequately in Bedford. On a number of occasions, staff from various departments missed indications that his risk had increased. It is not the first time that we make recommendations to address shortcomings in the operation of suicide and self harm prevention procedures at Bedford, and the Governor must prioritise this area as a matter of urgency.

The clinical reviewer found that the pathway for mental health services at Bedford was fragmented. Mr Wiggins could not access talking therapies, even though these are specified in the contract with the provider. As a result, the clinical reviewer concluded that his clinical care was not equivalent to that which he could have expected to receive in the community.

Finally, it is unusual for me to pass comment on broader aspects of prison delivery beyond the issues pertinent to our investigation. However, I feel bound to note that prison staff at Bedford, from all areas and grades, described to my investigators their acute difficulty in delivering an effective regime due to the lack of staff. Similarly, many prisoners said they felt unsafe. Given the unacceptable events at the prison in November 2016 the Prison Service needs no reminder from me that improvement at the prison is essential. I hope the specific learning from Mr Wiggins' tragic case helps in this process.

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

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

**May 2017**

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# Summary

## Events

1. On 23 December 2015, Mr Richard Wiggins was remanded to HMP Bedford charged with arson with intent to endanger life and assault. It was his first time in prison.
2. At an initial healthscreen, Mr Wiggins said he was prescribed anti-psychotic medication and was known to the community mental health team. His community records showed that he had not had recent contact and his most recent prescription had been dispensed in March 2015. Mr Wiggins was referred to Bedford's mental health team but was discharged from their services as it was considered that his main issue was his substance misuse. Although Mr Wiggins told staff he used illegal drugs in prison, staff had no specific concerns and he provided negative drug tests. He was prescribed antidepressant medication.
3. Mr Wiggins set fire to his cell in an attempt to kill himself and was subject to suicide and self-harm prevention measures (known as ACCT) for around a month between April and May 2016. Mr Wiggins spent the majority of this time in the healthcare unit. He told staff he was at risk because other prisoners knew he had previously committed a sexual offence and applied for vulnerable prisoner status. Because the vulnerable prisoner unit had limited spaces he was often located on a standard residential wing, where he and other VPs were routinely "tormented" by other prisoners. The day before he died, a probation officer spoke to Mr Wiggins and saw he had self-harmed, but he asked her not to start ACCT procedures.
4. On 15 September, the vulnerable prisoners on C Wing were locked up all morning, although other prisoners on the wing were allowed to socialise. At around 12.20pm, a prison officer found Mr Wiggins hanged in his cell. Staff and paramedics were unable to resuscitate him and, at 12.50pm, Mr Wiggins was pronounced dead.

## Findings

### Assessment and management of risk

5. Mr Wiggins entered Bedford with known mental health issues. The reception nurse correctly referred him to the mental health team for assessment, but the prison psychiatrist discharged him from prison mental health services. This was based only on the psychiatrist's prior knowledge of Mr Wiggins, and his belief that his mental health problems were directly linked to his substance misuse.
6. Mr Wiggins was subject to suicide and self-harm prevention measures, known as ACCT, on only one occasion. There were a number of further occasions when an ACCT might have been considered in the months before his death, but was not. A probation officer saw evidence of self-harm marks on Mr Wiggins' neck the day before he died, but did not start ACCT procedures and did not record any concerns on his prison record.

## Clinical care

7. The clinical reviewer concluded that the mental health pathway at Bedford was fragmented and that the mental health care received by Mr Wiggins was not equivalent to that he could have expected to receive in the community.

## Management of Mr Wiggins' mental health

8. Mr Wiggins often displayed bizarre, delusional and aggressive behaviour and on two occasions was admitted to the inpatient unit. However, his discharge from mental health services remained in place, as advised by the prison psychiatrist, despite prison staff and Mr Wiggins himself submitting a referral for assessment. Too much emphasis appears to have been placed on Mr Wiggins attempting to obtain anti-psychotic medication, rather than providing treatment for his underlying mental state, which may well have deteriorated as a consequence of his imprisonment.
9. Because Mr Wiggins did not fit the fixed criteria for treatment by the prison mental health, or substance misuse services, his mental health issues were never properly addressed, despite there being a contractual obligation to provide a broader range of treatment than was offered.
10. An independent psychiatrist diagnosed Mr Wiggins with a personality disorder and suggested that he should have a detailed specialised assessment, information contained in the pre-sentence report dated March 2016. However, neither prison nor healthcare staff considered this report. Even if this information had been known, Mr Wiggins would not have received psychological intervention (talking therapies), as they were not available at Bedford even though they should have been part of the contracted service.

## Substance Misuse Services

11. The substance misuse team did not assess Mr Wiggins until four months after his arrival and, because he told them that he had not used drugs while in prison, they immediately discharged him from their services. On two occasions of which we are aware, Mr Wiggins disclosed his use of New Psychoactive Substances (NPS). The team did not believe that substance misuse was Mr Wiggins' main issue and, while this view is supported by a negative drug test in April, we note that drug tests at that time were not capable of detecting NPS.

## Location of vulnerable prisoners

12. Mr Wiggins frequently moved from F Wing, the vulnerable prisoner unit, to C Wing. There were a limited number of vulnerable prisoner places available at Bedford and the investigation identified that bullying and intimidation of those placed on the 'overspill' wing left them unacceptably exposed to threats. This is something that Mr Wiggins told staff on several occasions and of which staff were fully aware.

## Emergency Response

13. There was delay in calling an ambulance.

## Recommendations

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:

- All staff should have adequate ACCT training and refresher training;
- All known risk factors of newly-arrived prisoners should be considered and recorded when determining their risk of suicide and self-harm, using all available information such as that from Person Escort Records;
- Staff should set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review;
- Staff should ensure prisoners at risk of suicide or self-harm are not placed on the basic level of the incentives and earned privileges scheme unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances;
- All staff are reminded of their responsibility to start suicide and self-harm measures if a prisoner self-harms or states their intent to die, and ensure information is fully recorded.

The Governor and Head of Healthcare should establish a clear process so that the prison administration team sends copies of pre-sentence health reports to healthcare administrators to be uploaded on prisoners' medical records for clinical reference.

The Head of Healthcare should ensure the implementation of the Mental Health Pathway that includes:

- Appropriate initial specialist assessment;
- Communication between the visiting psychiatrist and resident psychiatrist team;
- Delivery of a personality disorder pathway with supporting psychotherapy service;
- Mental health assessments take into account all relevant information, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.

The Governor should ensure vulnerable prisoners are appropriately separated, have access to a safe regime and are not exposed to intimidation and bullying.

The Head of Healthcare should ensure substance misuse services are effective and provide:

- Swift access to appropriate support;
- Assessments take into account all relevant information (including the validity of drug tests) and use standard assessment tools;
- Communication with mental health team and prison staff about individuals' presentation and needs;

- Details of all interventions from substance misuse services which are fully recorded in prisoners' records.

The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency and that control room staff call an ambulance immediately a medical emergency code is received.

The Governor should consider instigating a Prison Service investigation, as detailed in PSI 06/2010 & AI 05/2010 Conduct and Discipline, into the circumstances surrounding the apparent altering of the control room log.

The Governor should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.

## The Investigation Process

14. The investigator issued notices to staff and prisoners at Bedford, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator visited Bedford on 19 September, and obtained copies of relevant extracts from Mr Wiggins' prison and medical records. She spoke to several prisoners and staff on C and F Wings.
16. NHS England commissioned a clinical reviewer to review Mr Wiggins' clinical care at the prison.
17. The investigator and a colleague interviewed 16 members of staff and one prisoner at Bedford between October 2016 and January 2017. Interviews on 13 October were conducted with the clinical reviewer, who also interviewed the prison doctor by telephone. One education worker did not respond to the investigator's requests to be interviewed.
18. We informed HM Coroner for Bedfordshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Wiggins' family to explain the investigation. Mr Wiggins' family requested information to help them to understand the reason why he was deemed to be a vulnerable prisoner, why suicide and self-harm prevention measures were ended, and what involvement and assessment Mr Wiggins had with the mental health team.
20. Mr Wiggins' family received a copy of the initial report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
21. The prison also received a copy of the report and identified a factual inaccuracy, which we have amended.

## Background Information

### HMP Bedford

22. HMP Bedford is a local prison holding about 500 men. South Essex Partnership Trust delivers primary physical and mental health services at Bedford. Northampton Hospital Foundation Trust provides integrated drug treatment services. There is an inpatient unit with 9 cells for single occupancy and a two-bed dormitory. One of these cells is safer by comparison due to the enhanced safety feature of minimal ligature points. There is also a gated cell (for prisoners under constant supervision).

### HM Inspectorate of Prisons

23. The most recent inspection of Bedford was in May 2016. Inspectors found self-harm levels had risen significantly since their last inspection in 2014. They found that staff did not manage ACCT procedures well, with poor assessments, insufficient and incomplete care plans, inconsistent case management at reviews, poor attendance by appropriate specialists at reviews and only observational contact rather than interaction between staff and prisoners.
24. Inspectors found that the integrated mental health team provided a reasonably good level of secondary mental health care, although the range of treatment for primary mental health was limited and needed further development. Inspectors also noted the current incentives and earned privileges policy, dating from 2013, had not been reviewed. There was no evidence of quality assurance to ensure that the scheme was applied fairly and effectively and no records of how well a prisoner behaved while on basic.

### Independent Monitoring Board

25. 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 November 2016, the IMB reported that the number of incidents involving self-harm have increased. There has been an upsurge in bullying, related to an increase in demand for new psychoactive substances.

### Previous deaths at HMP Bedford

26. Mr Wiggins was the seventh prisoner to take his life at Bedford since 2013. In five of our investigations, we found staff operated suicide and self-harm prevention procedures ineffectively and we made recommendations to improve the ACCT process. There remains a significant problem at Bedford which the Governor should address as a matter of priority.

### Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

### **Incentives and Earned Privileges Scheme (IEP)**

30. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

## Key Events

31. On 23 December 2015, Mr Richard Wiggins was remanded to HMP Bedford charged with arson with intent to endanger life and common assault. The victim was his former partner. This was Mr Wiggins' first time in prison.
32. On arrival at Bedford, Mr Wiggins' person escort record (PER), a document which accompanies all prisoners when they move between police stations, courts and prisons, noted that he had a number of physical health issues. (These included high blood pressure, asthma and possible heart disease.) It also noted that he had self-harmed in 2001 and taken an overdose in August 2015.
33. At an initial health screen, a nurse recorded that Mr Wiggins had told her he was agoraphobic, had high blood pressure and had mental health issues. She recorded that Mr Wiggins said he was prescribed an anti-psychotic (chlorpromazine), an anti-depressant (mirtazapine) and medication for stomach acid (lansoprazole). She referred Mr Wiggins to the prison doctor and the mental health team. She recorded that he appeared calm and had no thoughts of suicide or self-harm.
34. A prison doctor assessed Mr Wiggins in reception and recorded that he had been treated for alcohol and drug induced psychosis, but had no thoughts of suicide or self harm. He recorded that Mr Wiggins had not used illicit drugs for a month and was a binge drinker when stressed. He recorded Mr Wiggins had been prescribed an anti-psychotic (chlorpromazine), but had not taken it since March 2015. He prescribed blood pressure medication and gave Mr Wiggins advice on losing weight.
35. An officer completed the cell sharing risk assessment (CSRA) which is designed to assess the risk of violence a prisoner poses. Mr Wiggins was assessed as a standard risk and considered suitable to share a cell with another prisoner. The officer recorded that Mr Wiggins had no thoughts of suicide or self-harm and had stated that "he was doing okay". A nurse completed the CSRA health assessment and noted no increased risk. There was no comment about Mr Wiggins' mental health or history of self-harm. Mr Wiggins was located to a single cell on A Wing.
36. On 24 December, a safer custody administrator recorded on Mr Wiggins' prison record that he had been identified as having suicide and self-harm warnings on his police record. There is no evidence prison staff reassessed his risk. He moved to a shared cell on 26 December.
37. On 30 December, a mental health nurse assessed Mr Wiggins. She refused to issue anti-psychotic medication to Mr Wiggins until she had considered his community medical records, and Mr Wiggins walked out of the assessment. She later confirmed that Mr Wiggins had been discharged from the community mental health team in 2013 and had not been prescribed anti-psychotic medication since. This was due to non-attendance. She confirmed Mr Wiggins had last been prescribed an anti-depressant by his GP in November 2015. However, he was re-prescribed anti-depressants by the prison doctor the next day.

38. An officer was assigned as Mr Wiggins' personal officer. Personal officers are expected to get to know the prisoners for whom they are responsible, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress. On 24 January, she recorded that Mr Wiggins had settled on the wing and there were no issues. This is the only personal officer entry on Mr Wiggins' prison record.
39. On 8 February, Mr Wiggins referred himself to the mental health team. On 15 February, a nurse assessed him and Mr Wiggins told her that he heard voices. He asked to be prescribed quetiapine (a highly tradable anti-psychotic drug). She recorded in Mr Wiggins' medical record that he had good insight, although he appeared to have paranoid thoughts about his brother pursuing him and believed he had derogatory messages sent to him through the television. She was concerned that Mr Wiggins was trying to get hold of medication. Mr Wiggins told her that he did not have a substance misuse problem and declined to be referred to the supporting offenders in recovery and treatment team.
40. On 18 February, Mr Wiggins was discussed in the mental health multi-disciplinary team meeting. A doctor who knew Mr Wiggins from the community advised that Mr Wiggins should be discharged from the mental health team and referred to SORTT, the substance misuse services. He did not meet Mr Wiggins in person during his time at Bedford.
41. A consultant forensic psychiatrist assessed Mr Wiggins at the request of his solicitor, as part of the pre-sentence process. He submitted a report dated 14 March. He assessed Mr Wiggins with a primary diagnosis of emotionally unstable personality disorder. He outlined that people with this type of personality disorder can be challenging, find it hard to engage and are often suspicious of others. He suggested transfer to a prison with facilities specifically for individuals with a personality disorder, such as HMP Swaleside or HMP Dovegate.
42. Mr Wiggins received three IEP warnings for not attending education (16, 23 and 24 March). In addition, Mr Wiggins was removed from his music lesson on 22 March, as he was talking incomprehensibly, and an education worker informed healthcare staff.
43. On 23 March, the acting Head of Offender Management asked that the mental health team reassess Mr Wiggins. He reported that Mr Wiggins acted strangely on the wing, believed he was being poisoned and said there were cameras in his cell. A nurse told him that Mr Wiggins had been discharged from the mental health team. She went to see Mr Wiggins on the wing, but he told her that he recognised her from the earlier assessment in February and did not want to be assessed on the wing as he wanted some privacy. She recorded that in her brief interaction with Mr Wiggins he did not appear mentally unwell. She asked wing staff to arrange a private room for another assessment to be completed.
44. The Head of Residence told the investigator that staff numbers were inadequate and officers were failing to deliver basic services on the residential wings. He said they often did not have the capacity to unlock prisoners for healthcare assessments.

45. The next day, two mental health nurses assessed Mr Wiggins in the healthcare unit. An officer was also present. Mr Wiggins disclosed that he had previously used drugs as a means of escape. One nurse recorded that Mr Wiggins said he “called himself dead or to end up dead next week as this coincides with anniversary of his sentencing”. The officer thought this was “unlikely” and the two nurses concluded that as Mr Wiggins had good insight, was functioning at a high level and displayed no evidence of thought imbalances, they again discharged him from the mental health team. There is no evidence of further exploration of his threat of suicide or self-harm or the reference to an anniversary.
46. On 26 March, at 6.15am, an officer recorded that Mr Wiggins’ displayed bizarre behaviour, was aggressive and smashed his television. She placed Mr Wiggins on report and he was moved to the healthcare unit for assessment. Mr Wiggins refused his anti-depressant medication as he thought it might be interacting with ‘Spice’, an illicit psychoactive substance, he said he had taken a few days earlier. Mr Wiggins’ remained there until 15 April.
47. On 28 March, the Head of Safer Custody held an adjudication hearing. Mr Wiggins pleaded guilty and was ordered to pay £60 for the damage to the television. During the adjudication, Mr Wiggins said that his cell mate had sexually assaulted him. An officer reported the allegation to the police. The police interviewed Mr Wiggins later the same day but took no further action as there was no evidence of a sexual offence having been committed.
48. A nurse referred Mr Wiggins to the mental health team because of his “bizarre behaviour”, but, on 29 March, another nurse recorded that Mr Wiggins had been removed from the waiting list as he had only recently been assessed and discharged.
49. On 30 March, Mr Wiggins applied to be treated as a vulnerable prisoner for his own protection, because of an earlier historic offence, and did not want to return to a standard residential wing. He remained in the healthcare unit because F Wing was full.
50. On 5 April, a chaplain recorded on Mr Wiggins’ file that he was disgruntled and claimed that nobody listened to his needs. She noted Mr Wiggins said “what’s the point of living, if you don’t feel alive?” followed by “putting this comment aside he appeared well’. There is no evidence she spoke to prison staff or considered whether this was an indication that his risk of suicide or self-harm had increased. That afternoon, a nurse recorded that Mr Wiggins flooded his cell and was given an IEP warning. The same evening, another nurse recorded that Mr Wiggins was argumentative. For a short time, he barricaded his door with a table, but subsequently removed it. Mr Wiggins slept through the night and there were no other problems.
51. On 6 April, a prison doctor recorded that Mr Wiggins had refused his medication the previous night and was waiting for a mental health assessment. However, there was no physical health reason why he needed to remain in the healthcare unit. A nurse assessed Mr Wiggins later the same day and concluded that he was manipulative and tried to obtain medication. She noted he presented with a ‘pseudo psychosis’ caused by long-term amphetamine and other substance misuse. (This is a condition where someone believes he is psychotic when he is

- not.) She contacted the forensic psychologist, who reiterated that Mr Wiggins should remain discharged from the mental health team as there was no history of mental illness and his problems were a result of his drug use. He advised Mr Wiggins should be referred to SORTT, and this was processed the next day by her.
52. Over the next week, healthcare staff encouraged Mr Wiggins to comply with his medication. He told a nurse on 15 April that he was not happy he had been discharged by the mental health team. Mr Wiggins moved from the healthcare unit to C Wing that day. As F Wing, the Vulnerable Prisoner (VP) Wing, was routinely oversubscribed since it had only around 30 spaces, Bedford used C Wing as an overspill for VPs. Although they had access to the F Wing regime, while on C Wing VPs were locked behind their door while other prisoners on the wing associated. A wide range of staff told the investigator that VPs were often subject to taunts and bullying on C Wing. The Head of Residential Services said it was unrealistic to stop this, and that a review was being undertaken of where VPs were to be located.
  53. On 17 April, an officer told Mr Wiggins to remove a paper obscuring his observation window, but he ignored her request. The next day, Mr Wiggins barricaded his cell and set fire to some paper. Prison staff removed his lighter.
  54. On 18 April, an officer contacted the mental health team as he was concerned about Mr Wiggins' behaviour. He recorded that the mental health team had assessed Mr Wiggins previously and his case was closed so they would not see him. Two days later, F Wing workshop removed Mr Wiggins because he behaved strangely and made accusations about staff and other prisoners. Mr Wiggins submitted a referral to the mental health team on 20 April but, on the advice of a prison doctor, he remained discharged from the service. The next day, a workshop instructor issued Mr Wiggins with an IEP warning for not attending work.
  55. On 22 April, at 9.12am, an officer recorded that Mr Wiggins believed his water had been contaminated with LSD and that drugs were being sprayed under his door. He was also noted to be angry towards staff. At 11.26am, Mr Wiggins refused to uncover his observation panel or respond to staff checking on his well-being. A Senior Officer (SO) recorded that he and an officer went into Mr Wiggins' cell, that he was agitated and intent on assaulting a member of staff. When Mr Wiggins continued to threaten them, they used force to restrain Mr Wiggins. They placed Mr Wiggins on report and he was downgraded to the basic IEP regime. Mr Wiggins was moved to the segregation unit, pending his adjudication.
  56. On 24 April, at around 7.15pm, Mr Wiggins started a fire in his cell. A nurse recorded that flames were coming out from under his door and his cell was engulfed in smoke. Prison staff extinguished the fire and removed Mr Wiggins from his cell; nurses administered oxygen and he was taken to hospital. Mr Wiggins had superficial burns and was suffering the effects of smoke inhalation, but he discharged himself against hospital advice. When he returned to Bedford, he was located in the healthcare unit.

57. The nurse began ACCT suicide and self-harm prevention procedures when Mr Wiggins returned to Bedford at 1.06am. She recorded that Mr Wiggins had started a fire with the intent to take his own life. Mr Wiggins was observed every thirty minutes and referred to the mental health team.
58. An officer carried out an ACCT assessment at 3.15pm the same day. Mr Wiggins said he had set fire to his bedding and intended to kill himself. Mr Wiggins disclosed that he had tried to hang himself a few weeks earlier. He said he wanted to die as he felt vulnerable and someone might hurt him. He also said that he had superficially cut himself while on A Wing. Mr Wiggins said he had been sexually assaulted on 24 April, but appeared confused and paranoid that someone was trying to hurt him and that this would lead to him attempting to take his own life. The officer recorded that Mr Wiggins had rekindled his faith and had been praying, but Mr Wiggins did not want to speak to Samaritans or a Listener. (Listeners are prisoners trained by the Samaritans to support other prisoners.) He recorded Mr Wiggins should be referred to the mental health team, and remain on half hourly observations. Mr Wiggins also referred himself to the mental health team and requested a review of his medication. A nurse thought this application was similar to that from another prisoner, and submitted a security intelligence report as she was concerned they were trying to obtain medication.
59. On 25 April, a prison doctor examined Mr Wiggins. She recorded that Mr Wiggins had started the fire in order to hurt himself, but not anybody else. Mr Wiggins told her that other prisoners had given him a range of drugs which he thought was probably LSD, but that it could have been 'Spice'. She noted that staff reported Mr Wiggins rarely came out of his cell so was unlikely to have been given drugs, and he continued to act bizarrely. She noted the mental health team had discharged him despite his display of delusional thoughts and paranoia, but that he should be referred to the substance misuse team. She requested a drug test (which was negative) and Mr Wiggins asked to see the prison psychiatrist for medication for his personality disorder, identified during his pre-sentence psychiatric assessment.
60. The Matron of Healthcare was assigned as Mr Wiggins' ACCT case manager. She chaired an ACCT review along with an officer, a nurse and Mr Wiggins. She recorded that Mr Wiggins said he was tormented all day long by other prisoners, but had no current thoughts of suicide or self-harm. Mr Wiggins also wrote a letter in which he said prisoners shouted abuse at him on a daily basis. The review assessed that he was at a raised risk to himself, and observations remained half hourly. She recorded on Mr Wiggins' caremap that he should have contact with the mental health team. There are no other actions listed. She attended eight of the ten ACCT case reviews. There is no evidence that Mr Wiggins' basic IEP status was ever considered or reviewed.
61. The Head of Safer Custody adjourned an adjudication hearing relating to the cell fire, on a charge of endangering the health and safety of others, on 26 April. He referred the case to the police and gave Mr Wiggins ten days to seek legal advice. There is no evidence of the outcome of the referral to the police. The investigator was told that the police can routinely take in excess of six months to respond, and currently no record is maintained of those cases.

62. On 30 April, a SO chaired an ACCT case review, attended by a mental health nurse and Mr Wiggins. The caremap was updated with an action to confirm whether Mr Wiggins' brother was at Bedford and spreading rumours about him after Mr Wiggins raised this as a concern. (She recorded that there was no evidence Mr Wiggins' brother was at Bedford or any other prison.) Mr Wiggins told the review he still had thoughts of self-harm, but talking to staff helped. The review noted that Mr Wiggins appeared to have a "discrepancy in time recognition", confusing the correct location of people and places in time. The review panel assessed Mr Wiggins' risk of suicide or self-harm had reduced, to 'low', and his observations were reduced to hourly.
63. On 3 May, the Matron of Healthcare chaired an ACCT case review, attended by a residential manager, a nurse and Mr Wiggins. The caremap was not updated and was never reviewed again. (However, the ACCT had been updated to indicate that it had.) The review panel assessed Mr Wiggins as being more settled, but he could not move to a standard residential wing as he wanted to be treated as a vulnerable prisoner. She noted Mr Wiggins was due to appear in court and that he would be located on F Wing and a transfer to another prison would be considered, after he was sentenced.
64. A probation officer read the psychiatric report dated 14 March, and completed a pre-sentence report. She concluded Mr Wiggins was at an increased risk of suicide and self-harm and the prison should closely monitor his emotional state. In addition, she identified Mr Wiggins' sentence plan should include an immediate assessment for a psychologically informed planned environment, known as PIPE. This is designed to enable offenders to progress through a pathway of intervention, maintaining developments that have previously been achieved, and supporting transition and personal development, particularly for those offenders who have mental health issues and/or personality disorders.
65. On 6 May, Mr Wiggins was sentenced at Crown Court to seven years (with a five year extended licence). The Matron of Healthcare chaired an emergency ACCT case review, attended by an officer and Mr Wiggins. Mr Wiggins told the panel he would harm himself and they assessed his risk of suicide and self-harm had increased to 'raised'. Observations were increased to half-hourly.
66. Over the next few weeks, there were five further ACCT case reviews chaired by the Matron of Healthcare. Mr Wiggins' assessed risk of suicide and self-harm fluctuated between low and raised, although it is not always clear upon what information the review based the decision. On one occasion, the review was not multidisciplinary as a member of prison staff did not attend. Observations were reduced as Mr Wiggins' risk lowered.
67. On 10 May, a SO completed the Initial Categorisation and Allocation form (ICA1). He used an algorithm to determine that Mr Wiggins' was a category B prisoner. He did not record whether he had reviewed the pre-sentence reports and did not record to which prison Mr Wiggins' had been allocated. Mr Wiggins was subsequently allocated to HMP Swaleside.
68. On 25 May, Mr Wiggins moved to C Wing. The Safer Custody Manager noted on Mr Wiggins' prison record that he had some concerns about going back to C Wing and she advised him to speak to staff if he found himself in a crisis. On 27

May, she chaired an ACCT case review. She recorded that Mr Wiggins had settled well and would be moving to F Wing later that day; Mr Wiggins moved that afternoon. She recorded Mr Wiggins had no significant history of self-harm. She noted on the ACCT on-going record that Mr Wiggins remained a high risk CSRA, but could share a cell with a suitable prisoner. The review concluded the ACCT should be closed.

69. On 2 June, a SO completed the ACCT post-closure review. He noted that Mr Wiggins coped well on F Wing and felt able to talk to staff and his cell mate. He used the library and was employed in the workshop. Mr Wiggins recorded that he felt well supported there and his issues were easier to deal with.
70. On 29 May, an officer reviewed Mr Wiggins' IEP status and he was reinstated to the standard regime. On 1 June, workshop instructor recorded that he worked well, was motivated and his behaviour had improved.
71. On 6 June, a senior probation officer from the offender management unit noted in Mr Wiggins' prison record that Mr Wiggins had been added to the transfer list for Swaleside as they offered programmes outlined in his sentence plan but then recorded "Rejected – being managed under Complex Needs with no further actions for [interdepartmental risk management team]". The investigator was unable to establish who made this decision and on what basis. The next day, an officer recorded that staff on F Wing were concerned about Mr Wiggins being paranoid and that he wanted to move from F Wing. He spoke at length to Mr Wiggins, who agreed to remain on F Wing. He recorded that Mr Wiggins would move to a single cell if there was no improvement. There were no other significant events during June, and the workshop instructor recorded at the end of the month that Mr Wiggins appeared settled, continued to work well and was happier on F Wing.
72. On 10 June, wing staff requested someone from the mental health team assess Mr Wiggins as he had had a "couple of wobbles". The mental health team declined to visit Mr Wiggins, and advised prison staff to signpost him to the chaplaincy, Samaritans or Listeners.
73. On 23 June, a worker from SORTT assessed Mr Wiggins. The record of this assessment is held separately from the prison and medical records and can only be accessed by SORTT. Mr Wiggins told her he wanted to abstain from alcohol and drugs when released, but his main concern was his mental health. Mr Wiggins asked for anti-psychotic medication, emotional support and cognitive behaviour therapy. She agreed to see him on a one-to-one basis to monitor his moods and she gave him an in-cell victim awareness pack to complete. She contacted the mental health team and the next day a nurse confirmed Mr Wiggins had been discharged from their service. Mr Wiggins later declined to engage with the worker.
74. On 1 July, Mr Wiggins' offender supervisor introduced himself. (He was responsible for his sentence planning and liaising with external probation services.) The same day, a probation officer working in Bedford met Mr Wiggins when he attended the F Wing surgery, which was an opportunity for prisoners to ask questions. Mr Wiggins asked about his OASys (an assessment of risks and needs) and she told him his offender supervisor would contact his community

- probation officer. Over the next week, Mr Wiggins received positive behaviour comments in his prison record. Mr Wiggins was given a mandatory drug test on 3 July, which was negative. An officer recorded “There has been a vast improvement in [Mr] Wiggins since he first came onto the wing and his confidence seems to be growing...”.
75. On 6 July, Mr Wiggins submitted an application to have his anti-depressant medication increased as he felt low in mood. A nurse recorded he was polite and did not claim to be mentally unwell. He said he was happy on F Wing. She advised Mr Wiggins to talk to the prison doctor about his medication. There is no evidence Mr Wiggins made an appointment with the doctor.
  76. Mr Wiggins asked his probation officer about having a personal officer during the F Wing surgery held on 8 July, and she told him to speak to wing staff for advice. On 14 July, Mr Wiggins moved to C Wing and the next day asked his offender supervisor about a personal officer, and again was advised to speak to wing staff. On 21 July, Mr Wiggins moved back to F Wing but there is nothing recorded on his prison record to explain the moves.
  77. On 29 July, the probation officer recorded that Mr Wiggins had disclosed that he had difficulties with his cell mate. He went on to say the smell of drugs was coming into his cell at night and that he thought his brother was at Bedford but had died. She recorded that staff on the wing told her this was a “common theme at the moment”. Mr Wiggins was moved to C Wing.
  78. On 3 August, Mr Wiggins self-referred to the mental health team, as he said he suffered from the side effects of substance misuse (specifically psychoactive substances). A nurse told Mr Wiggins he would be placed on the psychiatrist’s waiting list, although there is no evidence that he was. She also recorded wing staff described Mr Wiggins as “functioning”, although he was often very paranoid and had “strange thoughts”.
  79. The probation officer recorded on 5 August that Mr Wiggins “seemed low in mood”. There are no entries on Mr Wiggins’ prison record for the next month.
  80. On 11 August, the prison pharmacist issued Mr Wiggins with a third course of sleeping tablets. On 15 August, he was moved back to F Wing but there is no record of any reason why.
  81. On 31 August, Mr Wiggins requested a health check with the prison doctor. He was added to the patient list for 13 September, and a prison doctor prescribed a fourth course of sleeping tablets, although it is unclear from the entry in Mr Wiggins’ medical record whether he actually saw him in person.
  82. On 7 September, Mr Wiggins was moved to C Wing; no reason is recorded. On 9 September, he told another probation officer at Bedford he had heard a rumour he was to be transferred to Swaleside. She recorded that she told Mr Wiggins not to listen to rumours. Mr Wiggins said he wanted to complete an assessment to transfer to HMP Grendon. This is the last entry in Mr Wiggins’ prison record.
  83. Although there is no information recorded in his prison record, Mr Wiggins attended the Personal & Social Development course in the education department. The facilitator for this group said in interview that Mr Wiggins was making a “terrific

improvement in how he conducted himself". Although other prisoners had described Mr Wiggins' paranoia, he himself had never witnessed it.

84. The probation officer told the investigator she had spoken to Mr Wiggins on 14 September, and saw that he had scratches on his neck. Mr Wiggins told her that 'it' [the scratches] made him "feel better", but asked her not to start an ACCT. She described Mr Wiggins as "blasé" about the scratches and reassured him that he could talk to probation staff. She did not think he appeared mentally unwell and was just feeling low. She said the facilitator was present and he had described Mr Wiggins as his star pupil, and that he engaged well. She said she intended to make an entry in Mr Wiggins' prison record the next day, but did not do so. She said she did talk to prison officers on the wing, who were also aware that he had self-harmed, but she could not recall who they were.

#### *Thursday 15 September*

85. Bedford was unable to provide the relevant CCTV footage of C Wing. The CCTV had been destroyed in a riot at the prison on 6 November. The investigator relied on police statements, prisoner and staff interviews.
86. On 15 September, Mr Wiggins did not leave his cell all morning. The investigator was told that there was a search of F Wing and prisoners were kept in their cells. As a result, those VPs on C Wing also remained behind their doors all morning, although other prisoners were allowed to associate with each other.
87. At around 12.15pm, an officer began to unlock prisoners on the wing for lunch. In her police statement, she said that as she unlocked Mr Wiggins' cell door, she saw him at the end of his cell hanging by a ligature made from bedding, attached to the window.
88. The officer used her radio and shouted for assistance as she went into the cell. Another officer, who was a short distance away, responded immediately. The officers cut the sheet and lowered Mr Wiggins to the floor and started cardiopulmonary resuscitation (CPR). Other staff arrived to assist and collected emergency medical equipment. The acting Head of Management used his radio to call a code blue medical emergency message to summon urgent medical assistance.
89. Healthcare staff and a pharmacy technician responded to the request for medical assistance and took over CPR until paramedics arrived.
90. According to the Control Room records made by an officer, assistance was requested at 12.17pm, the code blue was radioed at 12.20pm, and an ambulance was requested at 12.23pm. However, the hand written records appear to have been overwritten and the original times of 12.27pm (code blue) and 12.30pm (ambulance called) amended. The officer told the investigator "I cannot argue that it does look like it has changed, to the best of my knowledge this was not done by me".
91. East of England Ambulance Service records confirm they received a request for an emergency ambulance at 12.30pm. Paramedics arrived at Bedford at 12.34pm, but they were unable to resuscitate Mr Wiggins and at 12.50pm he was pronounced dead.

92. Mr Wiggins had written a letter on a request and complaint form and in the box 'who did you speak to?' wrote 'Miss X'. However, the investigation was unable to establish the identity of Miss X. Mr Wiggins wrote that the workshop instructor would know why he had killed himself, but she told the investigator she had no idea why Mr Wiggins would write that. She had not seen Mr Wiggins for a number of weeks before he died as he had been attending the Personal & Social Development course in education. Mr Wiggins also mentioned an officer in his letter, but we were unable to interview him as he has since retired from the Prison Service.
93. After Mr Wiggins died, a Listener told staff that he had spoken to Mr Wiggins a few days earlier and had seen cuts on his throat or neck. Mr Wiggins had told him that prisoners on C Wing had made threats and were abusive towards him. There is no evidence this information was passed on to prison staff before Mr Wiggins died.

### **Contact with Mr Wiggins's family**

94. A family liaison officer and the Head of Chaplaincy at Bedford left the prison at 3.10pm and broke the news of Mr Wiggins' death to his next of kin. Bedford contributed towards the costs of Mr Wiggins' funeral, in line with national instructions.

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

95. After Mr Wiggins' death there is no evidence the duty governor held a debrief for all staff involved in the emergency response, despite this being a mandatory requirement set out in PSI 08/2010, *Post Incident Care*.
96. The prison posted notices informing other prisoners of Mr Wiggins' death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Wiggins' death.

### **Post-mortem report**

97. A pathologist concluded that Mr Wiggins had died from hanging. A toxicology report confirmed there were no substances in Mr Wiggins's blood at the time of his death, other than those properly prescribed.

# Findings

## Assessment and management of risk

98. When Mr Wiggins arrived at Bedford on 23 December 2015, the PER that accompanied him noted his risk of suicide and self-harm. Health screens conducted after he arrived did not take account of his previous history or identify any concerns. PSI 74/2011, *Early Days in Custody*, which covers reception processes, is clear that staff should examine all information, including person escort records. It requires that staff note all relevant information in the appropriate record, and that they inform other staff and act on the information identified, where necessary.
99. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. The risk factors were also listed in our thematic report published in 2014. Those that applied to Mr Wiggins while he was in Bedford, included mental health issues, recent contact with community services and mental health in-reach teams, history of self-harm and threats to kill himself. Mr Wiggins also had a history of substance misuse and told staff he took psychoactive substances. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including beginning suicide and self-harm prevention procedures, if necessary.
100. During an assessment conducted by the mental health team on 24 March, Mr Wiggins mentioned that he would be “dead the next week”. However, there was no evidence that this remark was fully explored. We would have expected the nurse to have identified that Mr Wiggins was at increased risk of suicide or self-harm. ACCT suicide and self-harm risk guidance suggests that a prisoner’s risk is ‘raised’ when he has suicidal ideas. She told the investigator that, from memory, she did not think an ACCT was necessary, but did not record any detailed justification at the time to support this decision. Shortly afterwards, Mr Wiggins alleged that he had been sexually assaulted. On 5 April, he also told a chaplain that he did not see the point of living, but again no action was taken.
101. Between 25 April and 27 May, Mr Wiggins was subject to ACCT procedures. Caremaps should reflect the prisoner’s needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time bound.
102. Staff only updated Mr Wiggins’ caremap once, and after 30 April it was not reviewed at all. During his ACCT assessment, Mr Wiggins had said that other prisoners had given him drugs, and the mental health team assessed that his mental health issues were a direct result of drug use. However, his caremap contained no specific action to help with this.

103. Staff used the IEP scheme to manage Mr Wiggins' behaviour on the wing, but no consideration was given to his vulnerability while on an ACCT. The Matron of Healthcare told the investigator that, although she was the case manager, she was not aware that Mr Wiggins had been on the basic IEP and she would not, as a matter of course, be involved in any discussion around this decision.
104. The probation officer disclosed during interview that she had seen Mr Wiggins the day before he died, and had seen that he had self-harmed. She was aware of the ACCT process and her responsibility to start suicide and self-harm prevention measures, but did not do so. She assumed that other staff, whom she believed were also aware, also had the opportunity to start ACCT procedures. Although she said she had discussed Mr Wiggins with wing staff and the facilitator, no record was made of her contact.

**The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:**

- **All staff should have adequate ACCT training and refresher training;**
- **All known risk factors of newly-arrived prisoners should be considered and recorded when determining their risk of suicide and self-harm, using all available information such as that from Person Escort Records;**
- **Staff should set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review;**
- **Staff should ensure prisoners at risk of suicide or self-harm are not placed on the basic level of the incentives and earned privileges scheme unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances;**
- **All staff are reminded of their responsibility to start suicide and self-harm measures if a prisoner self-harms or states their intent to die, and ensure information is fully recorded.**

### **Clinical care**

105. The clinical reviewer concluded that the mental health care Mr Wiggins received at Bedford was not equivalent to that which he could have expected in the community. The clinical reviewer considered that the mental health pathway at Bedford was fragmented and Mr Wiggins was denied access to the mental health team as he did not fit their criteria, but was not able to access his predominant care need of psychological therapies, contrary to NICE (National Institute for Care and Health Excellence) guidelines.

## Management of Mr Wiggins' mental health

106. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons, where mental health issues were involved. In the report, we highlighted the need to ensure mental health and substance misuse services work together, to provide a co-ordinated approach to prisoner care, and that all interventions from substance misuse services should be recorded on the prisoner's medical record. Further, that those prisoners with a personality disorder, who face a long time in prison, are managed through informed sentence planning and suitably structured regimes.
107. An independent psychiatric report, prepared for the court when Mr Wiggins was sentenced in May 2016, concluded that Mr Wiggins had an emotionally unstable personality disorder. Nobody from the healthcare team appeared to know about the report and so they did not consider the psychiatrist's assessment. The psychiatric report arrived at Bedford accompanying the pre-sentence report prepared by Mr Wiggins' probation officer. A copy of the report should have been sent to healthcare by the offender management unit to upload onto Mr Wiggins' medical record.

**The Governor and Head of Healthcare should establish a clear process so that the prison administration team sends copies of pre-sentence health reports to healthcare administrators to be uploaded on prisoners' medical records for clinical reference.**

108. The forensic psychiatrist told the investigator that if the details of Mr Wiggins' personality disorder had been known, his care would have been no different as there is no psychotherapy service available at Bedford, despite this being in the service contract. He explained at interview that the lack of psychotherapy services within the prison was currently equivalent to the level of care in the local community. All mental health nurses interviewed thought Mr Wiggins would have benefitted from talking therapies. In addition, if his diagnosis had been addressed, the offender management unit which would have considered a transfer to a personality disorder unit, as recommended by the independent psychiatrist. (Although Mr Wiggins was allocated to Swaleside which has a PIPE unit, the assessment was based on his offence and sentence length, rather than his actual needs.)
109. Mr Wiggins disclosed his previous contact with community mental health services during his initial reception screen, and was appropriately referred to the prison primary mental health team. The mental health multidisciplinary team discussed Mr Wiggins in a meeting, attended by primary and secondary care mental health practitioners on 18 February. The forensic psychiatrist had had previous contact with Mr Wiggins in the community and he advised that Bedford discharge him from the prison's mental health services. He believed that Mr Wiggins' mental health issues were caused by his substance misuse only, and that he should be referred to the substance misuse team (SORTT). However, Mr Wiggins had already had contact with SORTT two weeks prior to this meeting and had declined any intervention; this was not recorded in Mr Wiggins' medical record. The clinical reviewer concluded that an initial face-to-face assessment with a

prison psychiatrist would have been more appropriate, so that discharge from the mental health team was based upon Mr Wiggins' current presentation and not historical knowledge.

110. Mr Wiggins' was located in the healthcare unit between 25 April and 27 May, due to his 'bizarre' behaviour. A prison doctor told the clinical reviewer that Mr Wiggins was complex and very paranoid. She believed he had been referred to the mental health team again for further assessment. However, Mr Wiggins remained discharged from the mental health team on the advice of the forensic psychiatrist.
111. Mr Wiggins asked to see the mental health team on two further occasions before he died. A nurse told Mr Wiggins he would be placed onto the psychiatrist's waiting list, but this did not happen. On his last request for a medical check-up dated 31 August, Mr Wiggins was given a doctor's appointment for 13 September. It is unclear from the medical record whether he attended this appointment. A prison doctor prescribed Mr Wiggins with a fourth course of sleeping tablets. We make the following recommendation:

**The Head of Healthcare should ensure the implementation of the Mental Health Pathway that includes:**

- **Full delivery of the contracted service with failure to do so appropriately addressed;**
- **Appropriate initial specialist assessment;**
- **Communication between visiting psychiatrist and resident psychiatrist team;**
- **Delivery of a personality disorder pathway with supporting psychotherapy service;**
- **Mental health assessments which take into account all relevant information, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.**

### **Substance Misuse Services**

112. Despite the medical records repeatedly highlighting the need for Mr Wiggins to engage and address his substance misuse issues, he was unable to access SORTT for ten weeks, due to a lack of staff. The SORTT team leader told the investigator that Mr Wiggins was quickly discharged from the service in June, as he had not been using substances since he arrived at Bedford in December 2015. He did not believe that this was Mr Wiggins' main issue. This view is in part supported by a negative drug tests in April, when it was thought that Mr Wiggins' behaviour could have been drug-induced. However, drug tests at this time were unable to detect the presence of NPS, to which Mr Wiggins attributed, in part, his behaviour.
113. SORTT staff told the investigator they were unable to deliver a full service and complete assessments, due to the restrictive regime at Bedford caused by a lack of staff. Communication between staff outside of SORTT was described as "difficult", and a worker from SORTT told the investigator that she sent emails to

Mr Wiggins' personal officer, without realising the personal officer scheme no longer worked effectively - again due to a lack of staff. At the time of Mr Wiggins' death, SORTT staff had their own recording system that nobody else could access.

114. The SORTT team leader confirmed that an inferior SORTT assessment template has been replaced with a standardised document in line with that used in the community, and SORTT staff were now able to update medical records, although only with clinical intervention information.

**The Head of Healthcare should ensure substance misuse services are effective and provide:**

- **Swift access to appropriate support;**
- **Assessments which take into account all relevant information (including the validity of drug tests) and use standard assessment tools;**
- **Communication with mental health team and prison staff about individuals' presentation and needs;**
- **Details of all interventions from substance misuse services which are recorded in prisoners' records.**

#### **Location of vulnerable prisoners**

115. Mr Wiggins requested VP status because he believed other prisoners had discovered he had a previous conviction for a sexual offence. Bedford could not provide the exact dates of how long C Wing (2s landing) had been used as an overflow for VPs, but stated that it had been "for some time". F Wing only holds around 30 VPs and, when oversubscribed, VPs were moved to C Wing. Prison and healthcare staff told the investigator this was far from ideal and they had witnessed VPs on C Wing being "tormented" by other offenders, something which Mr Wiggins told staff that he was subjected to daily.
116. Locating VPs on a standard residential wing, without an effective personal officer scheme, when prisoners are subject to intense and prolonged hostility is unacceptable. We were told VPs are no longer located on C Wing (2s) but were not provided with specific information as to when this changed, or what measures had been put in place to combat VPs being routinely harassed.

**The Governor should ensure vulnerable prisoners are appropriately separated, have access to a safe regime and are not exposed to intimidation and bullying.**

#### **Emergency Response**

117. PSI 3/2013, *Medical Emergency Response* requires prisons to have a medical emergency response code protocol, which states how staff should communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used.

118. Bedford's local protocol is clear that an ambulance should be called immediately, when a medical emergency code is radioed, in line with PSI 3/2013. An officer used her radio to request healthcare assistance, but she did not use an emergency medical code because she panicked. The hand written log by another officer appears to have been altered, without explanation, to indicate that a code blue was radioed at 12.20pm. The Ambulance Service confirmed they received a request for an ambulance 10 minutes later. When assistance was requested, healthcare staff responded immediately with the correct resuscitation equipment, but they were unable to resuscitate Mr Wiggins. Any delay in requesting an ambulance could be crucial, and we make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency and that control room staff call an ambulance immediately a medical emergency code is received.**

**The Governor should instigate a Prison Service investigation, as detailed in PSI 06/2010 & AI 05/2010 Conduct and Discipline, into the circumstances surrounding the apparent altering of the control room log.**

### **Staff Support**

119. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or indeed good practice). It also provides those directly involved with an opportunity to process events. There is no evidence the duty governor held a debrief for all staff involved in the emergency response, which is a mandatory requirement set out in PSI 08/2010, *Post Incident Care*, and we make the following recommendation.

**The Governor should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations