

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Berry a prisoner at HMP Bedford on 16 March 2017

A report by the Prisons and Probation Ombudsman

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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.

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

Mr Michael Berry was found hanged in his cell at HMP Bedford on 10 March and died in hospital six days later. He was 24 years old. We offer our condolences to Mr Berry's family and friends.

Mr Berry had been at Bedford for less than two days before he died. When he arrived, staff appropriately assessed him as posing a risk to himself and started suicide and self-harm prevention procedures. Over the next two days they considered and increased his level of observations. There was some good practice apparent from these supportive measures, although it is disappointing that healthcare staff were not invited to Mr Berry's first case review. We have considered the clinical reviewer's opinion that Mr Berry should have been subject to constant observation before he died but are satisfied that staff made a defensible decision in the circumstances.

We are concerned, though, that the reception officer assessed Mr Berry without access to any documentation about Mr Berry's offending history or mental health, and without management oversight.

We are also concerned that information sent from court about Mr Berry's mental health was not processed effectively. In addition, Mr Berry's assertion that he was hearing voices telling him to kill himself should have prompted an urgent mental health assessment and a referral to a GP to consider prescribing antipsychotic medication as a matter of urgency. Mental health care has been an issue in some of our recent investigations at Bedford and it is very disappointing to find that significant issues remain in the delivery of this service. There was also no evidence of an integrated dual diagnosis approach involving both the substance misuse team and mental health services. As a result, we do not consider that Mr Berry's clinical care was equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 8 March 2017, Mr Michael Berry appeared at court, charged with 22 offences including violence, kidnap and sexual assault of an adult male. Mr Berry had a significant history of drug and alcohol abuse. He had recently been admitted to a mental hospital twice following an attempt to jump out of a window and after taking an overdose. He was remanded to HMP Bedford. The court liaison and diversion team assessed Mr Berry and emailed the prison's mental health team requesting that they assess Mr Berry's mental health and risk to himself. The mental health team at Bedford have no record of receiving this email.
2. A reception officer at Bedford assessed Mr Berry, without access to his documentation (including information about his mental health and his current charges and offending history). The officer assessed him as high risk to share a cell. Staff began suicide and self-harm monitoring procedures (known as ACCT) with observations set at twice an hour. A nurse made routine referrals to mental health and substance misuse services. Mr Berry was moved to the healthcare unit and was allocated a single cell.
3. On 9 March, prison staff held an ACCT case review. Healthcare staff were not invited, despite Mr Berry saying that he heard voices telling him to kill himself. Those present assessed Mr Berry's risk to himself as raised and increased his observations to three per hour. On 10 March, staff held another ACCT case review with a mental health nurse present. They noted that Mr Berry was finding it hard to ignore the voices telling him to kill himself, was distressed, hopeless, teary and prone to acting impulsively. They assessed his risk to himself as high and increased his observations to five per hour. During that afternoon, staff and prisoners said they heard Mr Berry calling from his cell. A doctor tried to speak with him but Mr Berry would not engage.
4. At 2.55pm, during an ACCT observation, a nurse found that Mr Berry had hanged himself. An officer radioed an emergency code and cut Mr Berry down. More staff responded and began cardio-pulmonary resuscitation (CPR). By the time paramedics arrived, Mr Berry had regained a pulse and was taken to hospital. He never regained consciousness and died on 16 March 2017.

Findings

Reception assessment

5. A reception officer assessed Mr Berry without any access to any of the usual documentation, basing his assessment solely on the answers that Mr Berry gave to his questions. The officer assessed Mr Berry as high risk to share a cell without any management authorisation.

Assessment of risk

6. Mr Berry was appropriately supported by suicide and self-harm monitoring procedures during his time at Bedford. As his risk to himself increased so did the number of observations staff were required to carry out. There was continuity of

case management and an appropriately targeted caremap. It is unfortunate that no healthcare staff were invited to Mr Berry's first ACCT review, although a mental health nurse was present for the second review.

Mental health care

7. It is concerning that the mental health team have no record of the information emailed to them from the court liaison and diversion team. We also agree with the clinical reviewer that Mr Berry's escalating presentation was suggestive of a crisis situation requiring an urgent mental health assessment and the prescription of antipsychotic medication as a matter of urgency. His care was not equivalent to that which he could have expected to receive in the community.

Dual diagnosis

8. Integrated treatment options for Mr Berry's substance misuse and mental health issues were not considered and the clinical reviewer concluded that, here too, his care was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that reception officers have access to and consider all relevant documentation when assessing new prisoners, and a manager authorises all high risk CSRA assessments.
- The Governor and Head of Healthcare should ensure that a member of healthcare staff attends all first ACCT case reviews and subsequent reviews where relevant.
- The Head of Healthcare should ensure that information from outside agencies is recorded and considered appropriately.
- The Governor and Head of Healthcare should ensure that all staff are aware of how and when to escalate a mental health referral. In particular, they should ensure that there is no delay in prisoners being prescribed antipsychotic medication.
- The Head of Healthcare should ensure prisoners with dual diagnosis receive appropriately integrated treatment

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator visited HMP Bedford on 27 March 2017. She obtained copies of relevant extracts from Mr Berry's prison and medical records.
11. The investigator interviewed nine members of staff and three prisoners at Bedford in May. She interviewed a further two members of staff by telephone.
12. NHS England commissioned a clinical reviewer to review Mr Berry's clinical care at the prison. The clinical reviewer attended some of the interviews with the investigator.
13. We informed HM Coroner for Bedfordshire of the investigation. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Berry's parents, to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They asked:
 - How often was Mr Berry being observed?
 - What were the details of the emergency response?
 - What did Mr Berry use as a ligature?
15. Mr Berry's parents received a copy of the initial report. They did not make any comments.
16. HM Prison and Probation Service (HMPPS) also received a copy of the report. They accepted all the recommendations.

Background Information

HMP Bedford

17. HMP Bedford is a local prison holding about 260 men. Northampton Healthcare Foundation Trust provides physical and mental health services at Bedford along with integrated drug treatment services. Psychiatrists work at the prison on Tuesday and Thursday mornings. There is an inpatient unit with nine single cells and a four-bed dormitory. There is also a gated cell used for prisoners under constant supervision, and two 'safer cells' with minimal ligature points to prevent prisoners hanging themselves.

HM Inspectorate of Prisons

18. The most recent inspection of Bedford was conducted in May 2016. Inspectors found that levels of self-harm 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.
19. 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.

Independent Monitoring Board

20. 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 had increased. There had also been an alarming rise in the number of prisoners attempting to hang themselves. They found that healthcare was generally of a good standard but lessons had not been learnt following previous deaths in custody.

Previous deaths at HMP Bedford

21. Mr Berry was the eighth prisoner to take his life at Bedford since 2013. In six of our investigations, we found staff operated suicide and self-harm prevention procedures ineffectively and we made recommendations to improve the ACCT process. Four of these investigations also identified failings in the mental health support offered to prisoners and, as Mr Berry's case shows, this continues to be an issue. There has also been a further self-inflicted death at Bedford since that of Mr Berry.

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will

occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

23. In December 2016, Mr Michael Berry was admitted to a mental health unit after he tried to jump out of a window. Hospital staff believed he was using illicit drugs, so he was discharged on 24 January 2017 without medication. A doctor diagnosed Mr Berry with a mental and behavioural disorder due to drug misuse. Mr Berry said he intended to harm people. Within days, he took an overdose and was admitted to hospital. Following his discharge, he was referred to the community mental health team.
24. On 6 March 2017, police arrested Mr Berry for 22 offences, including assault, kidnap, burglary and sexual assault of an adult male, committed between 4 February and 3 March. During his time in police custody, clinical staff noted that Mr Berry was withdrawing from heroin and crack cocaine and prescribed him diazepam (a sedative) and dihydrocodeine (a painkiller). He told them he had recently tried to hang himself and continued to hear voices telling him to harm himself. A nurse assessed that he was at risk of suicide and self-harm and should be monitored.

8 March

25. On 8 March, Mr Berry appeared at court and was remanded to HMP Bedford. Police staff recorded on Mr Berry's Person Escort Record (PER) that he had previously attempted suicide by cutting, had a back problem due to a previous injury and mental health issues. Mr Berry arrived at the prison at 4.05pm and prison staff signed the PER to acknowledge receipt of the document.
26. At court earlier, a nurse from the court liaison and diversion team (CLDT) had assessed Mr Berry and, at 4.15pm, emailed the mental health team at Bedford. She detailed Mr Berry's recent suicide attempts, auditory hallucinations and contact with psychiatric services. She advised Bedford's mental health team to monitor Mr Berry's withdrawal symptoms and his risk to himself and to assess whether he had an underlying acute mental illness. A mental health team leader at Bedford told the investigator that this email had been sent to the correct address but she could find no evidence of its receipt.
27. At Bedford, at 4.45pm, a nurse assessed Mr Berry. She noted that he was very quiet but stable and recorded that he said he had no thoughts of suicide or self-harm. He told her he had previously cut himself and had tried to hang himself in December 2015. He said he had recently missed an appointment with the community mental health team and had previously been an inpatient in a mental health unit. The notes indicate that this assessment took 10 minutes and that she referred Mr Berry for substance misuse and mental health assessments. Since the latter was marked as a standard assessment, according to policy, it should have taken place within seven working days.
28. An officer completed Mr Berry's initial reception screening. The officer told the investigator that he did not have access to any information about Mr Berry (such as the PER and information about his offending history and current charges) and based his assessment solely on what Mr Berry told him. He said that often staff on the reception front desk still had possession of the relevant documentation while he was separately assessing new prisoners. Mr Berry said that he had

mental health, alcohol and substance misuse issues. He told the officer that he used heroin and cocaine and suffered from back pain. Mr Berry said that he had attempted to hang himself and cut his arms earlier in 2017. The officer circled 'yes' to the question asking whether there were any issues with the prisoner's demeanour or behaviour. He did not record any further details, nor was there any space on the form to do so.

29. After the screening, the officer spoke to a senior Officer (SO) and a nurse indicating that he was concerned that Mr Berry presented a risk of harm to himself. He said Mr Berry seemed vulnerable and he thought he should be located in the healthcare unit as he would not settle well on a general residential wing. They agreed that suicide and self-harm monitoring procedures, known as ACCT, should be started and the nurse completed a concern and keep safe form at 5.35pm. The SO completed an immediate action plan indicating that Mr Berry should be observed every 30 minutes.
30. The officer filled in the first part of Mr Berry's cell sharing risk assessment (CSRA) which is designed to assess the risk of violence a prisoner poses. He circled 'no' to sexual assault with a same sex adult victim, and to kidnap or false imprisonment (although Mr Berry had been remanded in custody on charges that included kidnap and sexual assault of an adult male). He wrote that Mr Berry was undergoing detoxification, refused to share a cell due to his medical conditions, that an ACCT document had been opened and that Mr Berry was a "very fragile prisoner". The nurse then filled in the second section of the CSRA. She assessed that Mr Berry constituted an increased risk to others due to his mental health issues. She recorded that he was detoxifying and appeared fragile. The officer then ticked the section of the form indicating that Mr Berry was a high risk for sharing a cell. The form itself indicates that this decision must be authorised by a manager, but this did not happen.
31. At 5.00pm, a nurse assessed Mr Berry to determine whether he needed to be prescribed any medication. He told the nurse that he had been drinking 87 units of alcohol a week in the community and had been misusing benzodiazepines (sedatives), smoking crack cocaine daily and injecting and smoking heroin daily. Mr Berry told the nurse that he did not want to be prescribed methadone (a heroin substitute) but would like other medication to minimise the withdrawal symptoms from heroin. Mr Berry tested positive for benzodiazepine, cocaine and opiates and appeared to be suffering from mild withdrawal symptoms. To help alleviate some of his symptoms, the nurse prescribed Mr Berry diazepam, with the intention of gradually reducing the dose.
32. At 5.34pm, a prison GP assessed the injuries Mr Berry had on his arms from injecting heroin. He had no concerns and noted that the injuries should be reviewed over the following 48 hours.
33. At 6.00pm, Mr Berry made a telephone call. All new prisoners are offered an initial two-minute telephone call in reception. Mr Berry moved to a single 'safer cell' (a cell with minimal ligature points) in the healthcare unit that evening. At 7.40pm, a nurse noted that she had seen Mr Berry in his cell and he had said that he was alright.

9 March

34. On 9 March, around 5.30am, a nurse noted that Mr Berry had slept well and his clinical observations raised no issues.
35. A safer custody administrative officer completed Mr Berry's second day CSRA. She also circled 'no' to sexual assault and kidnap and noted that she had access to Mr Berry's previous convictions and his prison record but not his warrant (including the current charges) or PER. She confirmed that Mr Berry was a high risk for cell sharing.
36. A prisoner located in the healthcare unit first met Mr Berry that morning. He said Mr Berry had seemed "fine" and had asked him a number of questions about prison procedures.
37. Around 10.00am, a nurse from the drug treatment team assessed Mr Berry. The nurse noted that Mr Berry had mild opiate and benzodiazepine withdrawal symptoms, had thoughts of suicide or self-harm and was experiencing auditory hallucinations. The nurse also assessed Mr Berry as suffering mild to moderate withdrawal symptoms from alcohol. A patient health questionnaire he completed indicated that he had minimal symptoms of depression. He told the nurse that he had recently been admitted to a mental health unit, had previously self-harmed by cutting and had taken an overdose three weeks earlier as he had wanted to commit suicide. The nurse noted he had been referred for a mental health assessment.
38. At 1.40pm, a pharmacy technician discussed Mr Berry's medication with him. Mr Berry asked to see the mental health team and requested another mattress. The technician added Mr Berry's name to the complex pain clinic and asked a prison GP to review his pain treatment. The GP did so without seeing Mr Berry himself. He prescribed naproxen (a painkiller), omeprazole (to protect his gut) and paracetamol.
39. At 2.40pm, a nurse from the drug treatment team assessed Mr Berry. Mr Berry said that he was hearing voices telling him to hurt himself but he was ignoring these voices. He said he did not have any current plans to self-harm. She assessed Mr Berry as suffering from moderate withdrawal symptoms.
40. At 3.00pm, a nurse saw Mr Berry in his cell about his withdrawal symptoms. He told her he had no stomach cramps but did have leg pain and hot and cold sweats. She prescribed him ibuprofen for the pain and promethazine to help him sleep.
41. During an ACCT assessment held at 3.55pm with an officer, Mr Berry said that the voices in his head were causing him stress. The officer noted that Mr Berry appeared very distressed and distracted by possible visual hallucinations. Mr Berry told the officer that he had been thinking about self-harm but had not found the means to do this. Mr Berry said he had attempted to hang himself in December 2016 but the rope had snapped and he had cut his arms six months earlier. He said he did not want to be dead but the voices in his head were getting stronger and pressurising him to kill himself.

42. At 4.15pm, a SO chaired Mr Berry's first ACCT case review along with an officer and Mr Berry. No one from healthcare was invited. Mr Berry said he was hearing voices telling him to commit suicide or harm himself. However, he also said he felt safe on the wing and was looking forward to making contact with his family. She told the investigator that Mr Berry seemed distracted during the review. She was unsure whether this was because he was experiencing hallucinations or because of other activity in the healthcare unit at the time. In any event, his distraction concerned her, so she assessed his risk to himself as raised and scheduled the next review for the following day.
43. Mr Berry's caremap included the following actions: to be assessed by the community psychiatric nurse by 10 March; to have telephone contact with his family by activating his prison telephone account also by 10 March; to write to his family; and to have regular reviews with healthcare staff about detoxifying from drugs. A SO increased Mr Berry's observation to three times hourly for extra support until he had been assessed by the mental health team. She told the investigator that after the review, she spoke to a nurse but this is not evidenced in Mr Berry's record.
44. A nurse completed some of Mr Berry's ACCT observations that afternoon. Mr Berry asked her for an extra mattress as he was having difficulty sleeping. She directed him to prison officers who said this was not possible. She saw Mr Berry talking to other prisoners and cleaning his cell. She told the investigator she had no concerns about him. At 5.15pm, Mr Berry rang his cell bell asking for pain relief and at 5.55pm, he received this medication. (The investigator asked for the cell bell records but was told that due to a technical issue these were not available.)

10 March

45. On 10 March, around 9.00am, a nurse assessed Mr Berry as suffering from mild withdrawal symptoms. He told the investigator that he did not have any concerns about Mr Berry. An officer unlocked Mr Berry around this time for association.
46. At 9.45am, a SO chaired an ACCT review with Mr Berry, a nurse (from the mental health team) and an officer. Mr Berry was very distressed, teary, appeared disoriented and hopeless. The nurse noted that Mr Berry was suffering mild withdrawal symptoms and, in terms of his risk of suicide, had the potential to be impulsive and unpredictable. Mr Berry said that he could hear voices telling him to kill himself but was trying to ignore these as he wanted to live and did not want to upset his mother. Mr Berry told staff it helped if he distracted himself by writing letters or drawing.
47. A SO and a nurse told the investigator that Mr Berry seemed to relax during the course of the review. Mr Berry also told staff he felt better at the end of the review as talking to staff had helped him. Those present considered that Mr Berry's risk to himself had increased to high and raised his observations to five times hourly. They scheduled the next review for the following day. The SO said that when she left the unit, Mr Berry seemed relaxed and was talking to another prisoner outside his cell.

48. After the review, an officer ensured that the numbers which Mr Berry wanted to call (his parents and solicitor) were authorised on the prison telephone system, and that he had an account set up and credit on his account. He explained this to Mr Berry and gave him some paper to write to his family. He ensured that Mr Berry knew how to get money sent into the prison. The officer said that Mr Berry was very appreciative and seemed calmer, less stressed and more positive than during the ACCT review.
49. Prisoner A also spoke to Mr Berry that morning. He said that Mr Berry seemed “a bit jittery”, anxious and keen to understand the practicalities of prison. However, Prisoner A said that this was normal for new prisoners. Prisoner B also met Mr Berry for the first time. Prisoner B invited him to his cell for a cup of tea. Mr Berry did not stay long or say much to Prisoner B or his cellmate. Prisoner B thought that Mr Berry seemed nervous but he did not have any concerns that Mr Berry was a risk to himself.
50. Staff locked Mr Berry into his cell around 11.00am. He was unlocked to collect his lunch around 11.30am and then locked back into his cell. A nurse completed many of Mr Berry’s ACCT observations that morning. She noted that he came out of his cell for association but was mostly by himself. He ate his breakfast and lunch and the nurse told the investigator that Mr Berry seemed calm and relaxed.
51. An officer started work on the healthcare unit around 1.00pm. He met Mr Berry when he responded to his cell bell. Mr Berry asked if he was going to be unlocked for association that afternoon. The officer told him that unfortunately it would not be possible due to a lack of staff. The officer recalled that Mr Berry seemed a bit “hyper” and “jittery”. A short time later, the officer said Mr Berry rang his cell bell again. The officer answered and Mr Berry asked to see a doctor. The officer explained that a doctor would come to the healthcare unit that afternoon and he would ensure that he saw Mr Berry.
52. A nurse told the investigator that Mr Berry rang his cell bell again shortly after 1.30pm and asked to see the doctor and mental health nurse. She said they were in the unit office, she relayed the message and they went to see him.
53. An officer said that in the early afternoon he heard shouting and screaming coming from Mr Berry’s cell. He went to the cell, accompanied by a prison GP and a nurse. The officer said that Mr Berry appeared to be talking to himself or talking to somebody else who he thought was present. He appeared to be arguing with himself and seemed “tormented”. He said the GP spoke to Mr Berry. The officer walked away from the cell and after a few minutes became aware that Mr Berry had calmed down.
54. Two prisoners also said that they heard Mr Berry shouting for a nurse or officer and that a nurse had spoken to him and calmed him down.
55. A prison GP told the investigator that he went to Mr Berry’s cell to introduce himself. He had not heard him shouting before this or been asked to go and see him. He said that Mr Berry was standing with his back to him, facing the open window and was either talking to himself or talking to someone outside the window. Mr Berry then walked towards his cell door and asked the GP what he was doing. He told Mr Berry he was a GP and had come to speak to him. Mr

Berry did not respond but walked back to the window and continued to talk. The GP could not remember what he was saying but said he did not seem distressed. After a few minutes observing Mr Berry, he returned to the unit office.

56. In accordance with policy, ACCT observations were made at irregular intervals throughout the hour so that they could not be predicted by Mr Berry. At observations made at 1.46pm and 1.57pm, Mr Berry was seen to be watching television. At 2.09pm and 2.33pm, a nurse noted that Mr Berry was pacing up and down in his cell and talking to himself. A nurse told the investigator that this did not concern her, as this was quite common behaviour when a prisoner was not let out of his cell for afternoon association.
57. At 2.55pm, a nurse went to Mr Berry's cell to complete his next ACCT check. (She subsequently recorded this as occurring at 2.50pm but said this was an approximation and other evidence indicates that it was carried out at 2.55pm.) She looked through the observation panel and saw Mr Berry hanging from the window by a bed sheet, his feet off the ground. Nurses do not carry cell keys, so she shouted for help and said, "He's hanging". An officer, who was a few metres away, immediately ran to Mr Berry's cell, radioing a code blue and requesting healthcare assistance. (A code blue indicates a medical emergency in circumstances where a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.) The control room immediately telephoned for an ambulance.
58. An officer looked through the observation panel and unlocked the door. A nurse supported Mr Berry's weight while the officer cut the ligature using his cut-down knife. Another nurse and a prison GP also arrived at the cell. They laid Mr Berry on the floor, checked for a pulse, and whether he was breathing and started CPR. Another nurse arrived with the emergency equipment along with other healthcare staff. They attached the defibrillator, inserted an airway and administered oxygen. They continued CPR and by the time the paramedics arrived at 3.03pm, Mr Berry had recovered a pulse.
59. Mr Berry was taken to hospital by ambulance where he was ventilated, sedated and placed on life support. Mr Berry was escorted by two officers and was not restrained.
60. The Head of Reducing Reoffending was appointed as the family liaison officer. She telephoned Mr Berry's mother at 3.30pm and informed her of the news. She met Mr Berry's family at the hospital and remained with them throughout much of his time there.
61. Mr Berry had left a drawing on his cell wall depicting a person hanging and a wrist being cut with the words, "Bye bye hell waits for you" next to them.

11-16 March

62. Mr Berry remained in hospital until, on 15 March, his family were told that he would not recover. The next day, at 5.20pm, Mr Berry's life support was turned off and he died at 6.22pm with his family present.
63. The Governor sent Mr Berry's mother a letter of condolence and offered financial assistance with Mr Berry's funeral in line with Prison Service Instructions.

Support for prisoners and staff

64. After Mr Berry's death the Head of Residence and Safety debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
65. The prison posted notices informing other prisoners of Mr Berry's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Berry's death.

Post-mortem report

66. No post-mortem was completed but a doctor at the hospital recorded Mr Berry's cause of death as global hypoxic brain injury (a lack of oxygen to the brain) caused by hanging.

Findings

Reception assessment

67. An officer completed Mr Berry's initial screening and CSRA without referring to any documentation. His assessment was based solely on information that Mr Berry provided when asked. Mr Berry's charges included sexual assault with a same-sex victim and kidnap but he did not disclose this to the officer who circled 'no' to these questions on the CSRA. Nor did Mr Berry disclose this information to the member of staff conducting an assessment on the following day.
68. *Prison Service Instruction (PSI) 07/2015, Early Days in Custody*, says that all available, relevant information must be considered when interviewing a new prisoner, including the PER and computerised records. Furthermore *PSI 09/2011, Cell Sharing Risk Assessments*, says that all relevant sources of information must be considered when completing a prisoner's CSRA. For Mr Berry these would have included: his police national computer records (for details of previous convictions), his prison record, his warrant (for details of his current charges) and his PER. The PSI says that all these documents, with the possible exception of the PNC record, will be available to reception officers. If this information is not available on the first day, it must be obtained and checked so that the risk assessment can be finalised the next working day.
69. An officer assessed Mr Berry as being a high risk on the CSRA form due to the fact he seemed fragile, was detoxifying from drugs, an ACCT had been opened and he refused to share a cell. The PSI also instructs that all high-risk assessments must be reviewed and authorised by a manager. The officer signed off Mr Berry's high-risk assessment and did not seek a manager's approval. The nurse who completed the second day assessment also did not have access to Mr Berry's warrant, nor was she a manager. The Head of Safer Prisons and Equalities told the investigator that this was standard practice at Bedford unless there was disagreement over a prisoner's risk, in which case a manager's view would be sought.
70. We do not disagree with the officer's assessment of Mr Berry as high risk for cell sharing, but we note that he reached this conclusion because he considered Mr Berry to be vulnerable. Because he did not have Mr Berry's criminal history and current charges, he was not able to make a meaningful assessment of the risk he might pose to others. The lack of this information made no difference to the assessment outcome in Mr Berry's case, but could make a significant difference in other cases. This demonstrates the significant inherent risk in relying on prisoners alone for information. We therefore make the following recommendation:

The Governor should ensure that reception officers have access to and consider all relevant documentation when assessing new prisoners, and a manager authorises all high risk CSRA assessments

Assessment of Mr Berry's risk of suicide and self-harm

71. Staff in reception appropriately opened an ACCT when Mr Berry arrived at Bedford. Mr Berry had recently attempted suicide in the community on more than one occasion, he had been discharged from psychiatric services, suffered pain due to a back injury, was in his first few days in prison, had been charged with violent offences and had mental health issues. These were all risk factors for suicide.
72. The first ACCT review took place less than 24 hours after support measures had been started but without any healthcare staff present. *Prison Service Instruction (PSI) 64/2011, Safer Custody*, states that healthcare staff should attend the first review. This was particularly relevant for Mr Berry given his mental health issues. A SO said that she had not invited healthcare staff to the review since the healthcare unit was very busy at the time. She had, instead, set the next review for the following day so that mental health staff could be involved. Nevertheless, we make the following recommendation:

The Governor and Head of Healthcare should ensure that a member of healthcare staff attends all first ACCT case reviews and subsequent reviews where relevant.

73. During the first case review, staff assessed Mr Berry's risk to himself as raised and increased his observations to three per hour. The next day, during a case review, Mr Berry said he was hearing voices telling him to kill himself and he was finding these hard to ignore. Staff noted he was distressed, hopeless, teary, impulsive, unpredictable and suffering from withdrawal symptoms. Staff assessed that Mr Berry's risk to himself had increased and raised it to high and altered his observations to five an hour.
74. A SO said she had considered making Mr Berry subject to constant supervision. She discussed this with a nurse but they agreed that they did not consider Mr Berry to be at immediate risk and that his desire not to upset his mother was an important protective factor. She said Mr Berry had also appeared to relax during the review. The nurse did not recall this conversation taking place but agreed that he did not think constant supervision was warranted at that point. Staff addressed the actions on Mr Berry's caremap and the only one that remained outstanding was for Mr Berry to be assessed by the mental health team.
75. The clinical reviewer concludes that after this ACCT review, Mr Berry should have been subject to constant supervision. She says that if he had been in the community Mr Berry would have been admitted to hospital due to his recent suicide attempts and hearing voices telling him to kill himself. However, we recognise the careful consideration staff gave to their decision about Mr Berry's level of observations. This judgement is fundamental to the suicide and self-harm prevention procedures and relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. Constant supervision is a very intrusive procedure and can increase a prisoner's distress. For this reason, it should only be used in the most extreme circumstances. Staff considered that observing Mr Berry five times an hour would be sufficient to keep him safe. They did not have the benefit of hindsight, and in the circumstances, we cannot say that this was not a reasonable decision.

Mental health

76. Before he arrived at Bedford, mental health staff at the police station and at court had assessed Mr Berry. The court liaison and diversion team emailed the mental health team at Bedford indicating that the prison should monitor Mr Berry's risk to himself and assess his mental health. A mental health nurse could not find any record of this email. We therefore make the following recommendation:

The Head of Healthcare should ensure that information from outside agencies is recorded and considered appropriately.

77. Having seen Mr Berry during the ACCT review on 10 March, a nurse said that he did not believe Mr Berry's standard mental health referral needed to be escalated to being an urgent one. He thought that increasing Mr Berry's observations was sufficient to keep him safe and that, any rate, his mental health assessment would occur within the next few days. The Head of Healthcare told us that in view of Mr Berry's presentation, it would have been beneficial for the nurse to have completed the mental health assessment straight after the ACCT review. The mental health lead told us that healthcare staff could have contacted a psychiatrist by telephone or email if they were not in the prison for advice about medication.
78. The clinical reviewer considered that, following the ACCT review, the referral for mental health support should have been escalated to urgent with an immediate request for a psychiatric review and intervention. Presentation of this severity in the community - hearing voices telling him to kill himself - with the history of self-harm, would have led to admission to hospital.
79. She concluded:

“[Mr Berry's] escalating presentation was suggestive of a crisis situation requiring an urgent mental health assessment and pharmacological management. The prison GP would have been in a position to prescribe antipsychotic medication prior to referral to the visiting psychiatrist. Comparable treatment in the community would see Mr Berry undergoing a mental health assessment and GP review with regards to antipsychotic medication usage as a matter of urgency.”

80. We concur with this view and make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of how and when to escalate a mental health referral. In particular, they should ensure that there is no delay in prisoners being prescribed antipsychotic medication.

Dual diagnosis

81. The clinical reviewer concluded that healthcare staff did not identify and address Mr Berry's dual diagnosis (both mental health and substance misuse issues). As a result, she considers that the seriousness of Mr Berry's symptoms and behaviours was minimalised.

82. Mr Berry disclosed alcohol and drug misuse issues. He said he did not want to be prescribed methadone but wanted symptomatic relief. The clinical reviewer notes that the National Institute for Health and Care Excellence (NICE) guidelines advise that alcohol detoxification should be managed before opiate detoxification for dual diagnosis prisoners. There is no evidence that this was considered or discussed.
83. Mr Berry started a diazepam detoxification programme and was prescribed promethazine to aid sleep and naproxen to relieve the pain in his legs. The clinical reviewer says that there is no evidence of regular recordings being made in order to assess the effectiveness of this medication. She concluded that Mr Berry's substance misuse treatment was not equal to that he could have expected to receive in the community. We make the following recommendation:

The Governor and Head of Healthcare should ensure prisoners with dual diagnosis receive appropriately integrated treatment.

**Prisons &
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