Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Nash, a prisoner at HMP Bedford, on 30 April 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Ryan Nash, a prisoner at HMP Bedford, was found hanged in his cell on 30 April 2020. He was 25 years old. I offer my condolences to his family and friends.

I am appalled by the unacceptable and inhumane cell conditions that Mr Nash was held in for a period of five days after he damaged his cell. This is particularly concerning as he was being monitored under suicide and self-harm prevention procedures (known as ACCT).

I am concerned that the ACCT procedures were very poorly managed. HM Inspectorate of Prisons had identified significant weaknesses in the management of ACCT in 2018 and again in 2019, and this investigation suggests that the necessary improvements had not been made by the time of Mr Nash's death.

I am also concerned that a full roll check was not completed as required, and that this may have been affected by the level of broken cell observation panels at the prison, an issue affecting the health and safety of both prisoners and staff.

Although the clinical reviewer concluded that, overall, the clinical care that Mr Nash received was of a reasonable standard, I share his concerns about deficiencies in mental health care and that nursing staff tried inappropriately to resuscitate Mr Nash when he was clearly dead.

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

Sue McAllister CB
Prisons and Probation Ombudsman **November 2021**

Contents

Summary

Events

1. In April 2017, Mr Ryan Nash was remanded into custody and was later sentenced to eight years in prison. He had served previous prison sentences. On 16 January 2020, Mr Nash was transferred to HMP Bedford after he assaulted an officer.

2. Mr Nash had a history of mental health issues, paranoia and thoughts of self-harm and was assessed by Bedford's mental health team and a psychiatrist.

3. On 19 March, staff opened suicide and self-harm monitoring procedures, known as ACCT, after Mr Nash harmed himself. On 27 March, Mr Nash damaged the fittings of his cell, so he was moved to another one. On 29 March, he damaged his new cell and also set fire to it. He remained in the cell for five days with no furniture or sanitation and, for some days, with no mattress.

4. On 1 April, Mr Nash was transferred to another wing where he settled and raised no concerns. On 7 April, arrangements were made for Mr Nash to self-isolate after he showed symptoms of COVID-19.

5. On 14 April, ACCT monitoring stopped and several days later, he returned to his usual wing. During this time, Mr Nash raised no concerns with staff.

6. At around 7.30am on 30 April, an officer found Mr Nash in his cell with a ligature tied around his neck. Staff responded promptly but when paramedics arrived, he was pronounced dead.

Findings

7. We are extremely concerned about the unacceptable cell conditions in which Mr Nash lived for several days while being monitored under ACCT procedures. Mr Nash's cell conditions were degrading and unacceptable and would undoubtedly have had an impact on his mental health.

8. We told Bedford of our concerns about Mr Nash's cell conditions during the investigation. The Governor issued an order which we are satisfied has remedied the issue. However, we were concerned that the Governor did not provide us with full information about the origins of a local order about keeping prisoners in damaged cells.

9. Although staff appropriately started ACCT procedures when Mr Nash harmed himself, Mr Nash's ACCT monitoring was very poorly managed. The assessment interview and first case review did not take place within 24 hours, reviews were not sufficiently multidisciplinary, reviews did not take place when there was a change of risk, and caremaps were poorly completed and not meaningful.

10. Some prisoners alleged that prison staff behaved inappropriately outside Mr Nash's cell on the evening / night before Mr Nash was found dead. We consider that these serious allegations require further investigation.

11. We are concerned that a member of staff did not complete the roll check properly on the morning that Mr Nash was found hanged in his cell. This is unlikely to have

affected the outcome for Mr Nash as he had been dead for some time, but it could make a critical difference in other cases.

12. The observation panel in Mr Nash's cell was broken, as were many other observation panels on the wing. We are concerned that the safety of staff and prisoners is put at risk by the number of broken observation panels at Bedford.

13. When officers found Mr Nash, they thought that he had probably already died but instinctively started cardiopulmonary resuscitation (CPR). However, we are concerned that when nurses arrived, they continued to try to resuscitate Mr Nash, even though rigor mortis was present.

14. The clinical reviewer concluded that the care that Mr Nash received at Bedford was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community.

15. However, the clinical reviewer identified a number of concerns in Mr Nash's care, including the need for urgent referrals to the mental health team to be assessed within five days; that the mental health team and offender management team should liaise with each other when prisoners are referred to other prisons as part of their care needs; that staff receive dyslexia training; and that when prisoners are discharged from the care of the mental health team, the reasons are fully explained to them.

Recommendations

Special accommodation

- The Governor should ensure that all managers understand the definition of Special Accommodation and the required protective measures set out in PSO 1700.

Cooperating with PPO investigations

- The Prison Group Director for Bedford, Cambridgeshire and Norfolk should ensure that prisons fully cooperate with PPO requests for information and understand that the PPO must have unfettered access to any information relevant to their investigations, in line with PSI 58/2010.

ACCT monitoring

- The Governor should ensure that prison staff manage prisoners identified as at risk of suicide or self-harm in line with PSI 64/2011, including that:
    - the ACCT assessment interview and first ACCT case review are completed within 24 hours of the start of ACCT procedures;
    - first ACCT case reviews are multidisciplinary and always include a member of healthcare staff and staff who have had previous contact with the individual, such as key workers or the ACCT assessor;
    - staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews;
    - a case manager is appointed at the first case review, who should lead all subsequent case reviews whenever possible;

- a multi-disciplinary review is held when there is evidence of a significant change in risk; and
- case managers should ensure that caremaps are completed at the first ACCT case review, set specific and meaningful caremap actions, tailored to the individual to reduce their risk and identify who is responsible for them and review progress at each review.

Allegations made by prisoners

- The Governor should initiate an investigation into the allegations made by prisoners about the behaviour of prison officers who were on the wing on the evening and night of 29 April 2020 with a view to considering whether disciplinary action is appropriate.

Roll checks and broken cell observation panels

- The Governor should ensure that staff understand the importance of conducting roll checks as required.
- The Governor should ensure that:
  - Bedford Staff Community Notice 19/2020 is updated to provide guidance to staff about measures to take when carrying out roll checks and other welfare checks on prisoners with damaged, broken or blocked observation panels; and
  - broken observation panels are replaced as soon as possible.

Resuscitation

- The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

Mental health

- The Head of Healthcare should ensure that all prisoners referred urgently to the mental health team are assessed within five days, in line with the team's policy.
- The Governor and Head of Healthcare should ensure that there is a communication plan in place between OMU and the mental health team so that referrals to the PIPE programme are progressed and prisoners are updated about the status of their referral.

Learning lessons

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact him. No one contacted him.

17. The investigator obtained copies of relevant extracts from Mr Nash's prison and medical records.

18. NHS England commissioned a clinical reviewer to review Mr Nash's clinical care at the prison.

19. The investigator interviewed 13 members of staff and five prisoners at Bedford on 16 and 19 June, 1, 2, 22 and 28 July and 6 August, some jointly with the clinical reviewer. All the interviews were conducted remotely either by video or by telephone because of the restrictions imposed as a result of COVID-19.

20. We informed HM Coroner for Bedfordshire and Luton of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent her a copy of this report.

21. We contacted Mr Nash's family to explain the investigation and asked if they had any matters they wanted us to consider. They had no specific questions.

22. Mr Nash's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Bedford

23. HMP Bedford is a local prison holding around 500 men. Northants Healthcare NHS Foundation Trust provide all healthcare services at Bedford.

HM Inspectorate of Prisons

24. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Bedford in August/September 2018. Inspectors reported that the number of incidents of self-harm had increased substantially since their last inspection (in 2016) and was higher than in comparable prisons. There had also been five self-inflicted deaths since the last inspection.

25. Inspectors reported that ACCT processes were weak, poorly managed and ineffective, including that some care plans failed to address issues of concern, that case reviews were often not multidisciplinary, that many entries in ongoing records were observational and did not evidence meaningful engagement, that healthcare did not attend all initial reviews and that prisoners subject to ACCT monitoring experienced poor living conditions.

26. Inspectors found that many cells had broken or blocked observation panels, that there was a huge backlog of general repairs and maintenance and that many cells had been vandalised and assessed as not fit for habitation. Inspectors found a prisoner located in a cell without a bed and working toilet. HMIP recommended that all prisoners should live in clean and decent conditions.

27. Inspectors reported that there was a well-integrated mental health team that offered a limited range of primary support but lacked capacity to provide sufficient levels of therapeutic interventions.

28. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State in September 2018, setting out his significant concerns about the treatment of prisoners, including the management of prisoners at risk of suicide or self-harm.

29. HMIP carried out an Independent Review of Progress in August 2019. Inspectors found that work to address weaknesses in suicide and self-harm prevention processes had been far too slow to develop following the Urgent Notification issued in September 2018. Inspectors noted however that there had been improvement in reducing the number of maintenance repairs waiting to be completed.

Independent Monitoring Board

30. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2019, the IMB reported that levels of self-harm were amongst the highest in the country and that ACCT procedures applied at Bedford were failing to reduce levels of self-harm, partly due to systemic weaknesses and failures of implementation. The IMB reported that there were clear signs of improvement in the mental health provision, but that significant problems still needed to be resolved.

Previous deaths at HMP Bedford

31. Mr Nash was the sixth prisoner to have died at Bedford since the start of January 2017. Two of the previous deaths were self-inflicted and three were from natural causes. In our report into the self-inflicted death of a prisoner in March 2017, we made a recommendation about the need for healthcare staff to attend first ACCT case reviews. In July 2020, there was a further self-inflicted death at Bedford. In our report on that death, we made recommendations about the need for ACCT case managers to attend and lead reviews whenever possible, that triggers should be considered during reviews in determining levels of risk and that ACCT observations should be carried out as directed.

Assessment, Care in Custody and Teamwork (ACCT)

32. 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. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

33. 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. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

COVID-19 restrictions

34. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HMPPS issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown of 23 March. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent up to 23 hours a day locked behind their cell doors.

35. The key worker scheme was suspended at Bedford on 20 March due to the COVID-19 pandemic. The Exceptional Regime and Service Delivery Operational Guidance required prisons to make every effort to ensure resources were available to support prisoners subject to ACCT procedures on the basis that for many, the risk of self-harm could increase as a result of prolonged periods in cells.

Key Events

Background

36. On 11 April 2017, Mr Ryan Nash was remanded to HMP Peterborough, charged with grievous bodily harm and aggravated burglary. On 15 December 2017, he was sentenced to eight years in prison. He had previously served time in prison.

37. In February 2018, Mr Nash was transferred to HMP Wayland, where he told staff that he felt unsafe due to debt. Staff offered to move him to the prison's Vulnerable Prisoners' Unit, but he declined. Mr Nash was found under the influence of drugs on at least two occasions.

38. On 15 January 2020, Mr Nash assaulted an officer with an improvised weapon and took his keys from him. Mr Nash was re-categorised as a Category B prisoner and was identified as posing a risk of escape. This meant that he became an E List prisoner, who was subject to additional security restrictions.

HMP Bedford

39. On 16 January, Mr Nash was transferred to HMP Bedford due to his increased risk of escape and was sent to the prison's segregation unit.

40. The following day, a mental health nurse assessed Mr Nash. He said that he had a history of depression, hearing voices and thoughts of self-harm and had used illicit substances. It was noted that Mr Nash appeared agitated, and he was referred urgently to the prison's mental health team and to the prison's substance misuse team. Mr Nash had dyslexia (a learning disorder that involves difficulty reading, writing and spelling).

41. Staff started suicide and self-harm monitoring procedures, known as ACCT, because Mr Nash had made comments about feeling suicidal in a letter in 2017. At an ACCT case review on 18 January, Mr Nash said he did not understand why he was being monitored under ACCT procedures, as the letter had reflected his feelings in 2017. Mr Nash denied any thoughts of suicide or self-harm and the ACCT was closed.

42. An officer introduced himself to Mr Nash as his keyworker and a nurse from the prison's substance misuse team assessed him. Although Mr Nash denied the use of illicit drugs, the nurse referred him to the Westminster Drug Project, a drug and alcohol charity, for further support. On 20 January, a prison GP assessed Mr Nash. No significant physical medical conditions were identified, and he tested negative for drugs.

43. On 27 January, Mr Nash was moved from the segregation unit to a cell on A wing, considered suitable for an E List prisoner.

44. On 28 January, Mr Nash told a worker from the Westminster Drug Project that he did not wish to work with the team, had no drug issues and needed no further intervention.

45. On 5 February, Mr Nash told his keyworker that he no concerns about his safety or wellbeing. The keyworker complimented Mr Nash on the cleanliness of his cell. Mr

Nash said he did not want to remain on the E List and that his mental health issues had contributed to his actions at Wayland, which he regretted.

46. On the same day, a mental health nurse assessed Mr Nash, who told him that he had had hallucinations and delusional thoughts and voices in his head from an early age. The nurse referred Mr Nash for a psychiatric assessment and gave him a self-help leaflet about hearing voices.

47. On 12 February, Mr Nash complained to his keyworker and a mental health nurse about the length of time he had to wait for mental health support. He said that although he heard voices in his head, he did not feel the need to act on them. Mr Nash said that he had initially feared being attacked by other prisoners at Bedford but was now making friends and felt more settled. An appointment was made for Mr Nash to be assessed by a psychiatrist.

48. On 19 February, Mr Nash told his keyworker that he was still waiting to see the mental health team but understood that it took time. The keyworker noted that Mr Nash was engaging and polite and took pride in keeping his cell clean.

49. A forensic psychiatrist was unable to assess Mr Nash on 25 February, as there were not enough staff available to escort Mr Nash to the appointment. His appointment was rearranged for 3 March.

50. On 27 February, Mr Nash was sent a letter which explained that due to the COVID-19 pandemic, mental health services had been streamlined, that there would be reduced contact with prisoners until further notice, that routine appointments would not take place and that self-help guides would be distributed.

51. On 3 March, the psychiatrist assessed Mr Nash. He told the doctor that he heard voices in his head telling him that people were plotting against him. Mr Nash denied thoughts of self-harm. The psychiatrist noted that Mr Nash was not psychotic and diagnosed him with a dissocial personality disorder. He told Mr Nash that he might benefit from therapeutic treatment and suggested that a recommendation should be made for him to transfer to a prison with therapeutic treatments and a psychologically informed planned environment (PIPE) unit. Mr Nash agreed. (PIPE units run a regime and environment that enables prisoners to progress through a pathway of therapeutic interventions, providing support to prisoners with their personal development.) The psychiatrist told Mr Nash that medication would not change how he felt and told him to refrain from taking illicit drugs as they would have a negative effect on him. A mental health nurse was tasked with referring Mr Nash to a PIPE unit and the psychiatrist discharged him from the care of the mental health team, noting that he could be re-referred if necessary.

52. On 8 March, Mr Nash was verbally aggressive to an officer when he collected his meal. The following day, a weapon was found in his cell.

53. On 14 March, the keyworker was unable to meet Mr Nash for their regular keyworker session due to time constraints. Mr Nash had no further keyworker sessions with Mr Nash as, due to COVID-19, the keyworker scheme was suspended at Bedford on 20 March.

54. On 17 March, a mental health nurse met Mr Nash to discuss the referral process to a PIPE unit. Afterwards, the nurse contacted the prison offender management unit

(OMU), responsible for considering prisoner referrals, assessments and transfers to PIPE units as part of a prisoner's overall sentence planning.

ACCT: 19 March to 14 April

55. On the afternoon of 19 March, staff started ACCT monitoring procedures after Mr Nash made a cut to his face and it was noted that his behaviour was withdrawn. He was put on hourly observations. An immediate action plan was completed, and a Supervising Officer (SO) was allocated as the ACCT case manager.

56. On 20 March, Mr Nash was discussed at a multidisciplinary mental health team meeting. A clinical psychologist later noted that due to COVID-19 business continuity plans, Mr Nash should be seen every six weeks, a reduction in the contact that he currently had with the mental health team. She noted that the team would write to Mr Nash to tell him and noted that OMU were looking into transferring him to a PIPE unit.

57. On 22 March, Mr Nash refused to leave his cell to attend the ACCT assessment interview with an officer. He said that he did not want to be monitored under ACCT procedures. A SO noted that as Mr Nash felt unsafe, it would be better to contact him when other prisoners were locked in their cells.

58. At 2.00pm, a SO chaired Mr Nash's first ACCT case review, with an officer, at his cell door. It was noted that the mental health team could not attend. Mr Nash could not explain why he had harmed himself but said he did not trust staff, did not need mental health support and was happy to stay in his cell, watching television and reading. Mr Nash denied having any issues relating to bullying or debt but said that he wanted to transfer to another prison. The caremap was completed with one action: to contact OMU about a transfer. A further review was scheduled for 25 March.

59. Later that afternoon, Mr Nash tried to climb onto the wing's safety netting. He was restrained and returned to his cell. That evening, Mr Nash handed over several broken items from his cell, which officers described as homemade weapons, and a "pole" with which he had broken his cell door observation panel. He said he had done this because he was angry with an officer on the wing.

60. At 9.30am on 25 March, Mr Nash told an officer that he had a razor blade in his mouth, wanted to move to healthcare for a fresh start and would go mad if he was not moved. A mental health nurse noted that he had been unable to visit Mr Nash for a mental health appointment. The nurse asked when Mr Nash's next ACCT review would take place and was told that the mental health team would be told so they could attend. The nurse noted that he heard nothing further and assumed the review had been completed without him.

61. At 5.00pm Mr Nash's ACCT assessment interview took place, six days after the ACCT was opened. Mr Nash told the assessor that he had harmed himself "because he could", that he did not trust anyone and wanted a move to healthcare for a fresh start. At 6.00pm, a SO noted that due to the timing and the "situation" on the wing, a full ACCT review would take place the following day. The SO noted that Mr Nash had said he was okay to wait until the next day.

62. On 26 March, an officer noted his concerns that Mr Nash was withdrawn and paranoid. At 2.40pm, a SO tried to carry out an ACCT review but noted that as Mr Nash was not interested, he would try again later that day.

63. On Friday 27 March, Mr Nash flooded and damaged the fittings in his cell because he wanted to move wings and was paranoid that staff were "out to get him". It was agreed that Mr Nash would be moved to another cell. Because Mr Nash had threatened staff with damaged items from his cell, officers used Control and Restraint (C&R) techniques to move him to another cell on A Wing. After the move, Mr Nash damaged the fittings of his new cell and again threatened staff with improvised weapons. Prison staff again restrained Mr Nash and the debris was cleared from his cell.

64. A CM (Custodial Manager) said that she and another CM spoke to the duty governor about Mr Nash, and it was agreed that it would be best for him to move to D Wing. The duty governor considered moving Mr Nash to the segregation unit, but as the unit was full and Mr Nash was being monitored under ACCT procedures, he did not consider that the segregation unit was suitable.

65. The duty governor sought advice from the Deputy Governor about the move. He said that she told him that because Mr Nash had damaged his cells and there was a lack of alternative cell space, Mr Nash's current cell should be made safe, and he should remain in it. (Mr Nash's cell was cleared of debris and furniture, leaving him with only a mattress, and he had no access to running water or sanitation as he had damaged his toilet.)

66. A SO chaired Mr Nash's second ACCT review alone at Mr Nash's cell door. A mental health nurse, who was unable to attend, provided a report about Mr Nash's mental health. Mr Nash calmed down when the SO told him that he would move to D wing. Mr Nash's observations were increased and the caremap was updated to note that a referral to the mental health team had been made. An ACCT review was scheduled for the following day. During the review, the SO was told that senior management had said Mr Nash was "NOT to move cells… under any circumstances".

67. A nurse treated a cut to Mr Nash's finger and noted that his trousers were stained with faeces. That evening, Mr Nash told staff that he was cold and asked for bedding and water. He was also given clean clothes.

68. On 28 March, a nurse was unable to assess Mr Nash as he refused to cooperate. That afternoon, Mr Nash told his keyworker that staff were trying to poison him. His keyworker assured him that this was not the case.

69. In the early hours of 29 March, Mr Nash was noted to be awake, standing in his cell. He was seen holding an improvised weapon and lying on his mattress, with a towel over his eyes. That day, he also covered his broken cell observation panel. Despite his behaviour, officers wrote in the ACCT document that no concerns were raised.

70. Shortly after midday, Mr Nash set fire to his mattress and staff were deployed to extinguish it. The fire and ambulance services were also called to attend. When the fire was put out, staff used force to take Mr Nash from his cell as he was

threatening staff with an improvised weapon. Staff cleared further debris, including his burnt mattress, from the cell, before Mr Nash was returned to the fire and water damaged cell. Paramedics and a nurse assessed Mr Nash and noted that he had no injuries, and that no treatment was required.

71. That afternoon, it was noted that Mr Nash was sitting on the floor of his cell and had asked for a jumper, as he was worried about being cold. He also asked for hot water. Mr Nash was given clean clothes but was not given a mattress. He continued to have no access to running water, sanitation or other cell facilities. Staff raised no further concerns but noted that Mr Nash was sitting on the floor of his cell that evening.

72. In the early hours of 30 March, Mr Nash told the night officer that he had not slept. In the morning, Mr Nash told an officer that he did not have a bed as it had been taken away after he had set fire to his cell. Mr Nash was later seen sitting and lying on the cell floor and at lunch time, he said that staff were against him.

73. At around 10.00am, a SO chaired Mr Nash's third ACCT review. No one else attended, and Mr Nash did not take part as he said he did not know the SO. A review was scheduled for the following day but the caremap was not updated. Throughout this time, Mr Nash continued to have no access to water or sanitation. On the night of 30 to 31 March, an officer noted that Mr Nash had no bed or blanket in his cell and was lying on the floor. He was seen walking around his cell in the early hours.

74. At 8.15am on 31 March, an officer noted that Mr Nash's behaviour was "bizarre" and that he had no toilet, sink or furniture in his cell. Mr Nash tried to force his way out of the cell after throwing a cup of tea at officers. He was restrained and returned to the cell. The officer reported Mr Nash's living conditions to a SO. He said that he wanted to move Mr Nash as his cell was "inhumane and worse than special accommodation". The officer said that the cell had blackened walls and Mr Nash was crouched in the corner. A CM was told about the conditions of the cell and identified a new cell for Mr Nash later that morning.

75. However, later that afternoon, Mr Nash refused to move cells and he was later seen trying to remove electric piping from the cell's wall. A SO said that when he asked Mr Nash where he went to the toilet, Mr Nash pointed to a hole where the pipework would have gone.

76. That evening, Mr Nash asked staff for a mattress. A CM, the duty night manager, contacted the duty governor and told him Mr Nash's cell conditions were unacceptable, he had no sanitation or running water and the walls of his cell were blackened with smoke. Mr Nash was given a mattress and water. The CM said that the duty governor agreed that Mr Nash should be moved to D Wing the following morning for a fresh start.

77. At around 9.30pm, the CM chaired Mr Nash's fourth ACCT case review at his cell door, after she had established that the one scheduled for earlier in the day had not taken place. She sought information from a nurse, who referred Mr Nash for an urgent mental health assessment the following day. The CM noted that Mr Nash was paranoid, his behaviour was bizarre, and he said that staff were out to get him. Mr Nash was told that he would be moved to D Wing, and the CM noted he was

pleased. The CM considered that Mr Nash's risk of self-harm was high and raised his observations to five an hour. She scheduled a further review for the following day.

78. On the morning of 1 April, a SO chaired a multidisciplinary ACCT review which the clinical psychologist attended. They noted that Mr Nash was paranoid, wanted to move wings and said that staff and prisoners were "out to get him". It was noted that Mr Nash gave the impression that he had taken drugs, but he denied this. The caremap was not updated but a review was scheduled for later that day. The psychologist referred Mr Nash to the forensic psychiatrist for further assessment.

79. That afternoon, Mr Nash moved to a furnished cell on D Wing. He had a shower and made a phone call. A SO carried out a further ACCT review, and Mr Nash said that he was relieved to have moved wings. Mr Nash's ACCT observations were reduced, and a further review was scheduled for 6 April. Mental health nurses also reviewed Mr Nash who asked about his move to a PIPE unit. The nurses told Mr Nash that they had no news about his referral.

80. On 3 April, a nurse asked Mr Nash's offender supervisor if he could be considered for a move to a PIPE unit. He noted that Mr Nash had been given leaflets about PIPE pathways but that the mental health team were not clear about the referral process and sought further advice. There is no evidence the PIPE referral was made.

81. On 6 April, a CM asked the mental health team to assess Mr Nash as she was concerned about his bizarre and paranoid behaviour, which had been identified during routine telephone call monitoring of conversations with his family.

82. A SO chaired an ACCT case review with the forensic psychologist. The two caremap issues were noted as complete and a further review was scheduled for 13 April. Mr Nash said that his fresh start on D Wing was going well and the psychologist noted that he was clearly less distressed than he had been and interacted well and that ongoing mental health monitoring would be enough for his needs. Mr Nash told the review that he was not at risk of suicide or self-harm and specifically asked for this to be recorded.

83. On 7 April, a nurse assessed Mr Nash as he reported feeling unwell. The nurse believed Mr Nash's symptoms suggested that he had COVID-19. He was given symptomatic relief and arrangements were put in place for him to self-isolate for seven days. Mr Nash remained in isolation and complied with the prison regime.

84. On 13 April, Mr Nash moved to C Wing to continue his period of isolation. That afternoon, a SO carried out an ACCT review. No one else attended. Mr Nash denied thoughts of self-harm. A review was scheduled for the following day.

85. On 14 April, the forensic psychiatrist, who had been asked to reassess Mr Nash, was unable to do so as he was in isolation. A SO chaired Mr Nash's ACCT review, with another officer and a nurse. He then completed the review on his own in personal protective equipment (PPE) at Mr Nash's cell door. The SO noted that Mr Nash's paranoia had rapidly diminished, he no longer wanted to be monitored under ACCT procedures and that "all was good in the world". The SO stopped ACCT monitoring and a post-closure review was scheduled for 21 April.

86. On 15 April, Mr Nash was discussed at a mental health team meeting after officers raised concerns that Mr Nash was becoming more distressed and was hearing voices. They agreed that the forensic psychiatrist would review him.

87. On 17 April, Mr Nash's COVID-19 isolation ended, and he was moved back to A Wing into the cell which he had previously set on fire. Mr Nash told a CM that he was looking forward to getting back to normal and that he would tell staff if he felt paranoid again.

88. On 23 April, Mr Nash was no longer considered at risk of escape and his E List status was removed.

89. On 26 and 27 April, Mr Nash phoned his mother, but raised no concerns and told her that he would behave himself when he was released from prison.

90. On 28 April, the forensic psychiatrist and a nurse reviewed Mr Nash. He denied thoughts of paranoia, distress or thoughts of self-harm. The psychiatrist noted that Mr Nash interacted well and concluded that there remained no evidence of psychotic illness, his diagnosis remained the same and a move to a PIPE unit would be beneficial. After his appointment, the psychiatrist discharged Mr Nash from the mental health team at the multidisciplinary team meeting and noted that he should be given a self-help leaflet about personality disorders.

91. Mr Nash spoke to his mother and grandmother by telephone that day. He told his mother that he had spoken to a psychiatrist who he said had previously told him he was a borderline psychotic with a split personality but now said he was sane. He also talked about having some money sent in, told her he had enough vapes and that he would talk to her the following day. Mr Nash's grandmother told him that he sounded "a bit down", but Mr Nash told her he was okay.

92. The mental health team wrote to Mr Nash to tell him that he had been discharged from the mental health team and that if he required further input, he should liaise with wing staff.

93. A prisoner who knew Mr Nash said that Mr Nash had told him he was in a good mood. He said that in the preceding days, Mr Nash had been 'normal', kept to himself, was not bullied by prisoners, had no problems with staff and never talked of self-harm. He said other prisoners would look out for Mr Nash and would give him things if he needed them. He said that although Mr Nash had previously smoked psychoactive substances (PS), he had only smoked vapes since he returned to the wing.

94. Another prisoner said that although Mr Nash mixed with other prisoners, he mainly kept to himself and never discussed thoughts of self-harm. He said that when Mr Nash returned to A Wing, he was a lot happier and more cheerful as he had been removed from the E List.

95. Another prisoner said that when Mr Nash returned to A wing he seemed in good spirits and told him he had stopped smoking PS. He said he was surprised when he heard that Mr Nash had taken his own life.

96. A prisoner who occupied a cell opposite Mr Nash said that in the days leading to his death, Mr Nash was happy and smiling.

29 April 2020

97. Between 8.19am and 9.49am on 29 April, Mr Nash rang his cell bell four times. The officer who answered the cell bell said that Mr Nash was keen to know when he would be unlocked for association so he could make a phone call and shower. The officer said Mr Nash's demeanour seemed similar to normal but, that he was not smiling quite as much.

98. At around 10.00am, Mr Nash spoke to his grandparents by telephone. Mr Nash told them he was alright, and his grandmother told him he sounded better than when she had spoken with him the previous day and they talked about money being paid into his prison account. At around 10.45am, Mr Nash also spoke to his mother about money. He said that he was running out of credit on his telephone account. Mr Nash told her he would speak to her the following day. Mr Nash then collected his lunch.

99. That afternoon, Mr Nash rang his cell bell on four occasions between 3.30pm and 4.25pm. The investigator has been unable to establish why Mr Nash rang his cell bell.

100. A wing cleaner who lived next to Mr Nash's cell, said that he gave Mr Nash a packet of vapes during the day and said that officers had ignored his cell bell because the wing was busy. He said that when Mr Nash asked an officer for vapes, he was told that he could not have any. Mr Nash had then told the officer that if he did not get any, he "would do something wrong".

101. A prisoner said that he gave Mr Nash some vapes at about 4.45pm and said that he seemed fine and in good spirits. He said that prisoners had told him that Mr Nash shouted out for vapes later that evening, but he did not understand why as he had given him vapes.

102. Another prisoner said that he spoke to Mr Nash before cells were locked at around 5.30pm. He had asked Mr Nash if he wanted anything, but Mr Nash said that he did not as he had ordered his canteen (purchases from the prison shop). He said that Mr Nash appeared in good spirits and that he had been shocked to hear of Mr Nash's death.

103. Another prisoner said that Mr Nash appeared to be struggling and felt low and depressed. He had asked Mr Nash what was wrong but did not have time to speak to him as officers were locking prisoners in their cells.

104. At 6.33pm, several officers opened Mr Nash's cell door to give him a pack containing snacks, while conducting the evening roll check. An officer said that when the officers opened his cell door, Mr Nash looked surprised.

105. At 7.06pm, an officer pushed an information sheet under Mr Nash's cell door and at 7.19pm, another officer posted mail through the cell door. He said he could not recall speaking to Mr Nash.

106. A prisoner said that Mr Nash had shouted out to him that evening to say that he was watching television. Another prisoner said that he had heard Mr Nash talking to officers at about 9.00pm about getting vapes from another prisoner, but the

officers did not fetch them. The prisoner went to bed at about 1.00am and heard nothing further.

107. At 8.53pm, an Operational Support Grade (OSG) carried out a further roll check. CCTV shows that she lowered a towel that Mr Nash had used to cover his cell's broken observation panel in order to see into his cell.

108. A prisoner said that at about 8.30pm, he heard Mr Nash shouting out for his medication and that he wanted a vape. He said that Mr Nash rang his cell bell at about 9.15pm and shouted out that he could not settle down and was going to kill himself. The prisoner said that staff told Mr Nash "to do what he had to do".

109. Another prisoner said that Mr Nash rang his cell bell at about 9.25pm and asked officers for vapes. He was told that this was not possible as the prison was in patrol state. He said that Mr Nash was irate and upset that he could not smoke. He said that Mr Nash said that if he was not given a vape, he would commit suicide. He said that officers were standing outside Mr Nash's cell, and that they said that he would not kill himself and just wanted attention. He said the officers started laughing between themselves outside his cell for about ten minutes. He said that when Mr Nash said he would take his own life, he heard the officers say, "You have got to do what you have got to do". He said that he put his cell bell on and asked the officers to give one of his vapes to Mr Nash, but they did not do so.

110. Mr Nash did not have any prescribed medication. Although CCTV footage shows that officers attended cells close to Mr Nash's cell that evening, Mr Nash did not ring his cell bell after 4.25pm.

30 April 2020

111. At 12.03am, CCTV shows an OSG A appeared to carry out a check of the cells on the threes landing but did not check Mr Nash's cell. It is not known why the OSG checked these cells, but there was no requirement to check Mr Nash's cell at this time. At 12.05am, another OSG answered a cell bell for the cell next to Mr Nash's, and attended the same cell several times over the following two hours.

112. At around 5.34am, OSG A completed the early morning roll check, but CCTV shows that, although she walked past Mr Nash's cell door, she did not check him. During the local investigation carried out after Mr Nash's death, she told managers that she recalled there was a towel covering the broken cell observation panel but that she did not move it.

113. Officer A said that he received a handover from OSG A when he arrived on the wing at around 7.15am, and that she did not raise any issues about Mr Nash.

114. At 7.25am, Officer A started his roll check and at 7.29am, he checked Mr Nash's cell. The officer said that Mr Nash's observation panel was broken and a towel, which had been rolled up, was covering it. He pulled the towel down and looked into the cell. The officer saw Mr Nash hanging from the cell window in a sitting position, with a green ligature around his neck which was tied to the window.

115. Officer A immediately radioed a medical emergency code blue and asked for an ambulance to be called. (A code blue is used when a prisoner is unresponsive or having breathing difficulties and triggers an automatic request for an ambulance and for healthcare staff to attend). He unlocked the cell door. Officer B arrived

within 15 seconds and the officers went into the cell. Officer B cut the ligature from Mr Nash's neck. Officer A said that Mr Nash appeared stiff, and he thought that he had already died. Officer B said that Mr Nash was grey, he was not breathing, he appeared stiff, and the officer found no signs of life. Other officers who attended also believed that Mr Nash was dead, and that rigor mortis had set in. Officer B started cardiopulmonary resuscitation (CPR).

116. A nurse arrived with an emergency response bag at 7.31am, followed soon afterwards by three of her colleagues, who were also carrying emergency equipment. Another nurse attached a defibrillator, but it advised no shock. The nurses said that there were no signs of life and that rigor mortis had set in. They did not discuss whether to stop CPR. They continued with CPR until the first paramedic arrived at 7.41am and pronounced at 7.42am that Mr Nash had died.

Contact with Mr Nash's family

117. At 8.50am, a safer custody manager and family liaison officer telephoned Mr Nash's next of kin to break the news of his death. The prison contributed to funeral expenses in line with national instructions.

Support for prisoners and staff

118. The duty governor 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.

119. The prison posted notices informing other prisoners of Mr Nash's death and offered support. We understand that staff reviewed prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Nash's death.

After Mr Nash's death

120. In addition to comments made by prisoners who spoke to Mr Nash or lived on the same landing as him, other prisoners mentioned after his death that two female officers working at night, and thought to be the two OSGs, had been talking and laughing loudly with some prisoners in their cells on Mr Nash's landing.

Post-mortem report

121. A post-mortem examination found that Mr Nash died from asphyxia due to hanging. The toxicological tests did not identify any drugs in Mr Nash's body.

Findings

Cell conditions

122. PSI 75/2011 on residential services states that prisoners should have access to furnishings, fittings, clothing, bedding adequate for warmth, decency and health and safety.

123. Prison Service Order (PSO) 1700 on segregation defines 'Special Accommodation' as any cell anywhere in a prison from which furniture, bedding or sanitation have been removed in the interests of safety. Special Accommodation is the most austere and extreme form of custody and therefore requires special protective arrangements. PSO 1700 says that Special Accommodation must only be used to hold, for the shortest necessary time, a violent or refractory prisoner to prevent that prisoner injuring others, damaging property or creating a disturbance that hinders the maintenance of good order. It must not be used as a punishment and "every effort must be made to keep the time a prisoner is held in Special Accommodation to a minimum, i.e., minutes rather than hours or days".

124. The use of Special Accommodation must be authorised by the Duty Governor who must specify how frequently the prisoner's continued location in Special Accommodation must be assessed (at least once an hour) and how frequently the prisoner must be observed (at least five times an hour). When the use of Special Accommodation is authorised, healthcare must be informed immediately and must complete the Initial Segregation Health Screen to determine if there are any clinical reasons why the prisoner should not be held in Special Accommodation.

125. Prisoners identified as being at risk of suicide or self-harm must not be placed in Special Accommodation unless they are additionally identified as violent or refractory. Further precautionary measures must be taken based on their individual ACCT plan and an enhanced ACCT case review must be held within two hours of the decision to place the prisoner in Special Accommodation.

126. On 27 March, Mr Nash damaged his cell and was moved to another cell which he also damaged. Staff considered moving Mr Nash to the segregation unit, but this was ruled out as the unit was full and Mr Nash was being monitored under ACCT procedures. Managers agreed that a move to another wing would be best for him, but the Deputy Governor overruled this and said that Mr Nash should be returned to his cell once it had been made safe. After Mr Nash set fire to his cell two days later, the cell was cleared of debris and he was returned to it.

127. Between 27 March and 1 April, Mr Nash was located in a cell with limited facilities and no access to sanitation and running water. For two nights after he set a fire, he had no access to a mattress or bedding, and was expected to sleep on the floor of his fire and water damaged cell. We note that some of the prisoners we interviewed considered that staff kept Mr Nash in these conditions to punish him for damaging his cell.

128. Many officers described the conditions of Mr Nash's cell as unacceptable, with one officer describing them as inhumane. Despite this, it took until 31 March before the conditions were brought to the attention of senior managers, and it was only then

that plans were made to move him to a cell with appropriate facilities.

129. We consider that the conditions that Mr Nash was expected to live in for several days were degrading, inhumane and unsafe and fell far below the required standards. We are appalled that Bedford could have considered that Mr Nash's cell conditions were appropriate for any prisoner, let alone a prisoner with mental health issues and subject to ACCT procedures. We consider that his cell was not fit for human habitation.

130. We are also very concerned that managers did not appear to appreciate that the cell Mr Nash was held in had become Special Accommodation as defined in PSO 1700 and that, as a result, none of the special safeguards required by the PSO were applied.

131. Although we consider that the appalling cell conditions were unlikely to have had a direct impact on Mr Nash's decision to take his life a month later, it seems very likely that they would have affected his mental health and contributed to his paranoia and thoughts that staff were "out to get him".

132. We note that on 27 March, following his disruptive and destructive behaviour, Mr Nash was not moved to the segregation unit because there was no room in the segregation unit and because he was subject to ACCT procedures. Although prisoners being monitored under ACCT procedures should only be sent to the segregation unit in exceptional circumstances, we consider that Mr Nash's actions on 27 March would have met that criteria and, even if the segregation unit had been full, staff should have prioritised his move. We do not accept that COVID-19 restrictions would have prevented the consideration and arrangement of such a move. Instead, Mr Nash was held in significantly more austere conditions than would have been the case in the segregation unit and with significantly fewer safeguards.

133. On 1 April, Bedford issued Resident Community Notice (RCN) 30/2020 to prisoners. It stated that:

"To reduce the risk of contamination and to protect both staff and residents we will be taking a robust stance on any resident who deliberately damages their cell. That is, residents will not be relocated from a cell which they have damaged and will need to live in that cell despite the damage they have caused."

134. Although the RCN was issued on 1 April, it would appear that the Deputy Governor implemented its contents on 27 March before it was formally issued.

135. On 2 July, the investigator drew Mr Nash's cell conditions to the attention of the Governor. In response, the prison carried out a managerial inquiry into the management of Mr Nash between 27 March and 1 April 2020. The inquiry report made several recommendations, including that the then Deputy Governor should be interviewed to understand the decisions she made about Mr Nash's location, and that formal proceedings may be appropriate, or advice and guidance given. The Governor did not accept this recommendation.

136. The managerial inquiry also recommended that the RCN 30/2020 should be rescinded, and a new order issued to staff, stating that no prisoner should be left in a cell without facilities. The Governor accepted this recommendation and issued Order 621 on cell decency on 20 August 2020. This rescinded RCN 30/2020 and instructed staff that a prisoner should not be left in a cell without a bed, bedding, working toilet or sink in any circumstances and particularly when subject to ACCT procedures.

137. Given the action already taken by the prison, we make no recommendation about the RCN. We do, however, make the following recommendation:

The Governor should ensure that all managers understand the definition of Special Accommodation and the required protective measures set out in PSO 1700.

138. We asked Bedford who drafted the Community Notice and ordered its issue. Bedford did not provide the requested information. However, we identified that HMP Leeds had issued an identical instruction. This suggested that the instruction may be a national one and we, therefore, raised our concerns with the Director General of Prisons. He confirmed that the instruction had not been issued nationally but had been drawn up by senior managers at Bedford and Leeds. He also said that the Governors of both prisons had been told that the instructions were not acceptable.

139. We are very concerned that our attempts to establish the origin of the instruction with senior staff at Bedford were fruitless. It is extremely important that prisons cooperate fully with our investigations. We recommend:

The Prison Group Director for Bedford, Cambridgeshire and Norfolk should ensure that prisons fully cooperate with PPO requests for information and understand that the PPO should have unfettered access to any information relevant to their investigations.

Identifying and managing risk of suicide and self-harm

140. Prison Service Instruction (PSI) 64/2011 on safer custody requires staff to start ACCT procedures when they receive information about a prisoner which may indicate that he is at risk of suicide or self-harm. HMPPS's Exceptional Regime and Service Delivery Operational Guidance to prisons during the COVID-19 pandemic said that every effort must be made to ensure resources are available to support prisoners at risk of suicide and self-harm. It stated that for many, the risk of self-harm could increase due to prolonged periods in cells and that, despite any staff shortages, ACCT was a more important tool during periods of increased cellular confinement.

141. Prison staff appropriately monitored Mr Nash under ACCT procedures on 19 March after he made a cut to his face and appeared to be withdrawn.

142. However, we are very concerned that the ACCT procedures were very poorly managed and did little to support Mr Nash, particularly during a period of acute crisis when he was living in a cell with no bed, sanitation or other amenities. We are extremely concerned that senior managers decided that Mr Nash should remain

in such conditions while being monitored under ACCT procedures and that they failed to consider his vulnerabilities and address his risks during this time.

Assessment Interview

143. PSI 64/2011 states that the assessment interview should take place within 24 hours after ACCT procedures have started and if the prisoner is unable, or refuses to participate, the assessment should proceed based on available information.

144. Mr Nash's assessment interview was not attempted until 22 March, three days after the ACCT procedures started. Although Mr Nash refused to engage with the process, the assessment should have been completed in his absence. The assessment was not completed until 25 March, six days after the ACCT had been opened. We find this unacceptable.

Scheduling and completion of ACCT reviews

145. PSI 64/2011 states that the first ACCT review should take place within 24 hours after ACCT procedures have started. Mr Nash's review did not take place until 22 March, two days after ACCT monitoring began and before the assessment interview had been completed. A further review was scheduled for 25 March. Given the assessment interview had not taken place on 22 March, a review should have been scheduled for the following day and the case manager should have ensured that the assessment was completed immediately.

146. The review scheduled for 25 March did not take place despite Mr Nash telling an officer that morning that he had a razor blade in his mouth and would go mad if he did not move cells. That evening, a SO noted that due to the timing and "situation", he was unable to carry out a review and a full review would take place the following day.

147. On 26 March, it was noted that Mr Nash was paranoid, withdrawn and had not eaten and that concern about his welfare was high. A SO tried to carry out a review but noted that Mr Nash was not interested. The review was not completed, and one was not scheduled for the following day.

148. At an ACCT review on 27 March, a further review was scheduled for the following day. A further review did not take place until 30 March, despite Mr Nash setting fire to his cell on 29 March. At the review on 30 March, a further review was scheduled for the following day. This review did not take place during the day, although a review was held late that evening in response to a CM's concerns about the condition of Mr Nash's cell.

149. ACCT reviews are an essential element of the ACCT process and they should always take place as scheduled, after acts of self-harm or when increased levels of risk are identified, so that a prisoner's level of risk can be considered, and appropriate support offered, even if a prisoner refuses to participate. We are particularly concerned that reviews were not completed appropriately when Mr Nash was living in unacceptable cell conditions, during which time he would have been subject to excessive levels of stress and discomfort.

150. There has been one further death at Bedford since Mr Nash's. In our investigation of that death, we identified that the case manager appointed at the first case review did not lead many of the subsequent case reviews. The case manager appointed for Mr Nash led none of his nine reviews.

Multidisciplinary attendance at ACCT reviews

151. PSI 64/2011 requires ACCT case reviews to be multidisciplinary, where possible, and for the ACCT assessor and a member of the healthcare team to attend at least the first case review.

152. There were no healthcare staff at Mr Nash's first case review and a SO held the review with the assessor, who had not been able to complete the assessment at that point. There is not record that there was any attempt to contact healthcare or to seek their input.

153. The following two reviews were also not multidisciplinary. Although a healthcare report was sought for the second review, no member of the mental health team attended the ACCT reviews until 31 March, after Mr Nash's unacceptable living conditions were brought to the attention of senior managers. We also note that there is no record that case managers tried to invite Mr Nash's keyworker or someone from OMU in response to the caremap action. This meant that the staff who attended the reviews were unlikely to have fully appreciated his risk and would only partially have been equipped to understand his difficulties and needs.

154. PSI 64/2011 says that in addition to planned ACCT case reviews, a case review must be held where an ACCT trigger is activated or there are other concerns. We are concerned when Mr Nash was held in unacceptable cell conditions, told staff he had a razor blade in his mouth, or after he had set fire to his cell, staff did not hold an ad hoc case review to re-assess his risk. We are concerned that they therefore missed opportunities to identify if his risk was increasing, and to consider protective measures, such as increasing the frequency of his observations, moving him to another cell and arranging for an urgent mental health review.

Caremap

155. PSI 64/2011 says that case managers must complete caremaps with actions aimed at reducing the risk of suicide and self-harm and that reflect the prisoner's needs.

156. At the first ACCT review on 22 March, the SO added an action to Mr Nash's caremap and noted that OMU were to be invited to the next ACCT review. OMU did not attend the review on 25 March or any of the following reviews. Although there is no record that Mr Nash's concerns about wanting a transfer to another prison and referral to a PIPE unit were addressed at subsequent reviews, the action was noted as complete on 6 April.

157. We are also concerned that it was not until the second ACCT review on 27 March, after Mr Nash had damaged his cell and eight days after ACCT monitoring began, that a mental health referral was made. This is of particular concern as there was no healthcare representation input at the first review on 22 March, even though it was known that Mr Nash had had previous contact with the mental health team.

158. We are also concerned that even when Mr Nash's unacceptable cell conditions were drawn to the attention of senior management, no plan or actions for Mr Nash to move from these conditions were noted in the caremap following ACCT reviews on two occasions.

Post-closure review

159. PSI 64/2011 states that a post-closure review must take place within seven days of ACCT procedures ending. Mr Nash stopped being monitored under ACCT procedures on 14 April, but his post-closure review did not take place as scheduled on 21 April. Although we accept that there do not appear to have been any indications that Mr Nash was at an increased risk of suicide in the period after the ACCT was closed, it is still essential that staff review prisoners after an ACCT to consider how or whether they have progressed.

160. In their inspection of Bedford in 2018, HMIP identified significant weaknesses in the management of ACCT processes at Bedford. In their Independent Review of Progress in August 2019, they found that work to address these weaknesses had been far too slow. We were, therefore, very concerned to find significant deficiencies continued to exist at the time of Mr Nash's death in April 2020. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners identified as at risk of suicide or self-harm in line with PSI 64/2011, including that:

- **the ACCT assessment interview and first ACCT case review are completed within 24 hours of the start of ACCT procedures;**
- **first ACCT case reviews are multidisciplinary and always include a member of healthcare staff and staff who have had previous contact with the individual, such as key workers or the ACCT assessor;**
- **staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews;**
- **a case manager is appointed at the first case review, who should lead all subsequent case reviews whenever possible;**

- **a multi-disciplinary review is held when there is evidence of a significant change in risk; and**
- **case managers should ensure that caremaps are completed at the first ACCT case review, set specific and meaningful caremap actions, tailored to the individual to reduce their risk and identify who is responsible for them and review progress at each review.**

Allegations made by prisoners after Mr Nash's death

161. After Mr Nash's death, prisoners who knew him made allegations about the actions of staff the night before his death. Two prisoners alleged that Mr Nash had rung his cell bell a couple of times on the evening of 29 April, asking for his medication and shouting out that he could not cope and would take his own life if he was not given vapes. The prisoners alleged that staff had responded by telling Mr Nash that he should "do what he had to do". One of the prisoners alleged that staff stood outside Mr Nash's cell laughing and said Mr Nash would not kill himself and was just seeking attention. Allegations were also made that staff did not answer Mr Nash's cell bells.

162. Prisoners also alleged that night staff were talking to and laughing loudly with some prisoners overnight.

163. We have considered whether there is evidence to support these allegations. Some appear to be without foundation – for example, Mr Nash was not prescribed any medication and the cell bell records show he did not press his cell bell after 4.25pm - but we consider that the very serious allegations that staff taunted Mr Nash and told him to go ahead and kill himself need to be investigated,

- The investigator was unable to speak to both OSGs about the allegations, as they resigned on 2 and 24 June respectively. However, there were also prison officers on the wing at various times. CCTV footage shows that staff were near Mr Nash's cell on the evening of 29 April at times. We make the following recommendation:

  The Governor should initiate an investigation into the allegations made by prisoners about the behaviour of prison officers who were on the wing on the evening and night of 29 April 2020 with a view to considering whether disciplinary action is appropriate.

Impact of COVID-19 restrictions

164. The restrictions imposed in response to the COVID-19 pandemic meant that prisoners were spending long periods locked in their cells, with significantly less interaction with staff and other prisoners than would normally have been the case.

165. On 20 March, the keyworker scheme at Bedford was suspended and Mr Nash had no further contact with his keyworker. We cannot say if the long periods of isolation affected Mr Nash's decision to take his life. If staff had had regular daily contact with him and had seen him interacting with other prisoners – as they would have done in normal times – they might have identified signs of distress, a deterioration in his mental health or an increase in his risk of suicide and self-harm. The restricted regime meant that Mr Nash had not had the opportunity to interact with staff and this may have limited his willingness to tell them about any concerns.

166. A few weeks after Mr Nash's death, the Exceptional Delivery Model for key work was introduced nationally and aimed to ensure that a form of key work continued for those subject to ACCT monitoring. We have not, therefore, made a recommendation about this.

Roll checks

167. A roll check is primarily a security check to count prisoners and ensure that they are in their cells, but it is also an opportunity for any concerns about prisoners' safety to be identified. The CCTV footage shows that OSG A did not check on Mr Nash during the early morning roll check at about 5.30am on 30 April. This was both a breach of security and a missed opportunity to check on Mr Nash's wellbeing.

168. OSG A was suspended on 1 May, while an internal investigation into the conduct of the roll check took place. She admitted she did not check Mr Nash. The investigation concluded that she had failed to conduct an adequate roll check of other prisoners and that she should face formal disciplinary proceedings. She resigned from HMPPS on 24 June.

169. Although we cannot be sure when Mr Nash died, we know that rigor mortis was present when he was found at 7.29am, meaning that he is likely to have been dead for some hours. It is therefore likely that he was already dead at the time of the 5.30am roll check and that OSG A's failure to perform her duty did not affect the outcome for him. Nevertheless, staff should always check a prisoner's welfare when carrying out roll checks as early intervention in emergencies where prisoners are found unconscious or in a critical situation might save lives. We recommend:

The Governor should ensure that staff understand the importance of conducting roll checks as required.

Damaged observation panels

170. During the investigation, the Prison Officers' Association (POA) contacted the investigator to raise their concerns about broken observation panels on cell doors at Bedford that were not being replaced. The POA said that broken observation panels risked the safety of staff when carrying out roll checks. They told us that on 7 June, there were 19 cells with broken observation panels on A Wing, which had risen to 22 panels on 22 July. Over a month later, the cell which Mr Nash had occupied still had a broken observation panel.

171. We understand that staff may feel reluctant to carry out roll checks on cells without observation panels where the panel has been covered by the prisoner, as in Mr Nash's case. We consider that the number of broken observation panels on A Wing is a serious concern and puts the safety of staff and prisoners at risk.

Bedford Staff Community Notice 19/2020 issued on 29 January 2020, provides advice to staff on the action to take when they discover a broken observation panel. It states that staff should always be able to observe prisoners in their cells in case they are unwell or there is an emergency situation, and they should report any damaged panels so that they can be "fixed quickly". The notice tells staff that they should ask the occupant of the cell to remove any obstruction and that, if the prisoner does not comply, they can enter the cell if it is safe to do so to remove the obstruction. The notice does not tell staff how to check safely on prisoners in cells

with damaged observation panels. We make the following recommendation:

The Governor should ensure that:

- **Bedford Staff Community Notice 19/2020 is updated to provide guidance to staff about measures to take when checking on prisoners with damaged, broken or blocked observation panels; and**
- **broken observation panels are replaced as soon as possible.**

Resuscitation

172. Resuscitation Council Guidelines say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made based on a careful assessment of an individual's situation. These decisions should never be dictated by 'blanket' policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

173. Officer A and other officers who found Mr Nash hanging observed no signs of life and believed that Mr Nash was dead. They described the presence of rigor mortis but instinctively started CPR. Nurses also identified rigor mortis but continued CPR efforts.

174. Although we understand that officers instinctively made attempts to resuscitate Mr Nash, we agree with the clinical reviewer that healthcare staff should have discussed the merits of continuing CPR as Mr Nash was clearly dead, there were no signs of life and rigor mortis was present, which indicated that resuscitation was futile. Paramedics told staff to cease CPR on their arrival. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

Clinical care

175. The clinical reviewer concluded that the care that Mr Nash received was of a reasonable standard and was at least equivalent to that which would have been received in the community. The clinical reviewer had no concerns about the physical healthcare that Mr Nash received and noted that when Mr Nash was identified with COVID-19 symptoms and was isolated, he was treated in line with COVID-19 guidance. However, he identified some deficiencies in Mr Nash's care which we address below.

Mental health care

176. The clinical reviewer was concerned that although Mr Nash was identified in reception on 17 January as a priority for a mental health assessment, the mental health team did not see him until 5 February. The target for an urgent referral is five days but Mr Nash waited for 19 days. We make the following recommendation:

The Head of Healthcare should ensure that prisoners who are referred to the mental health team urgently are assessed within five days, in line with the local policy.

177. The clinical reviewer noted that although the mental health team recommended that Mr Nash would be suitable for a transfer to a PIPE unit and the OMU was asked to process the referral, there was no evidence of any communication between the OMU and the mental health team to achieve a transfer and no evidence that a referral was made. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a communication plan in place between OMU and the mental health team so that referrals to the PIPE programme are progressed and prisoners are updated about the status of their referral.

178. The clinical reviewer also made recommendations about dyslexia awareness training for healthcare staff and the need to explain to prisoners why they have been discharged from the mental health team's caseload. The Head of Healthcare and the Mental Health Lead will need to take these recommendations forward.

Learning Lessons

179. We have identified a significant number of concerns in this report. We consider that it is important for staff to learn from the Ombudsman's investigations and our findings. We recommend that:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest Verdict

180. The inquest hearing into the death of Mr Nash was held on 1 August 2024. It confirmed that the medical cause of Mr Nash's death was asphyxia from hanging. The inquest concluded that this followed a period of mental stress, including the isolation of the COVID regime and detainment in inhumane conditions for upwards of 72 hours and that these events exacerbated Mr Nash's pre-existing mental health diagnosis.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100