Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Beckford, a prisoner at HMP Wandsworth, on 23 June 2021

A report by the Prisons and Probation Ombudsman

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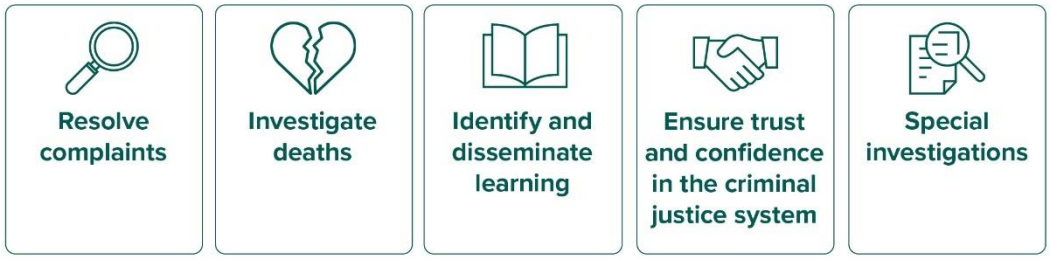
OUR VISION

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 Daniel Beckford died in hospital due to a lack of oxygen to the brain on 23 June 2021, six days after he was found hanging in his cell at HMP Wandsworth. He was 39 years old. I offer my condolences to Mr Beckford's family and friends.

Mr Beckford spent only three days in Wandsworth. He had a history of depression, self-harm and substance misuse. He had also experienced trauma in his life. He had been referred to the relevant support services, but his engagement with these services was mixed. Mr Beckford was frustrated that he could not access phone calls during his time at Wandsworth, due to ongoing security checks.

On 16 June Mr Beckford took an overdose of his prescribed medication for a chest infection. On 17 June, he was found hanging from a ligature in his cell. At the time of his death, he was being monitored and supported via 'Assessment, Care in Custody and Teamwork' (ACCT) procedures for prisoners at risk of suicide and self-harm.

The clinical review into Mr Beckford's death found that the healthcare he received was equivalent to that which he could have expected to receive in the community.

My key concerns regard delivery of ACCT procedures by prison and healthcare staff. Specifically, we found failings in the systems for ensuring regular wellbeing checks and the sharing and recording of risk information relating to suicide and self-harm at Wandsworth. I am also concerned that when Mr Beckford said he had taken an overdose of his prescription medication, the risks associated with his continued possession of medication were not assessed. There was also a failure by the prison to liaise with and support Mr Beckford's family after he was taken to hospital.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **July 2023**

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Summary

Events

1. On 14 June 2021, Mr Daniel Beckford was remanded to HMP Wandsworth. This was not his first time in prison. At reception it was identified that Mr Beckford had a history of substance misuse, depression and self-harm. At the time of his death, he had post-traumatic stress disorder (PTSD) relating to the death of his son. He had also experienced trauma in his life, relating to the deaths of his mother and daughter.

2. Mr Beckford had a chest infection when he arrived at Wandsworth. He asked for more of the antibiotics he had been prescribed in the community, which were provided.

3. On 15 June, the day after his arrival, healthcare staff attended Mr Beckford's cell for a wellbeing check due to his detoxification. They were unable to fully assess Mr Beckford as he was behaving aggressively but noted that he was not displaying signs of withdrawal. On 16 June, Mr Beckford met a substance misuse worker, and discussed ways of addressing his issues.

4. Mr Beckford told staff that his telephone account was not working and he was unable to make calls. A prison officer said that he would check and get back to him.

5. On 16 June Mr Beckford told staff that he had taken an overdose of his antibiotics. A nurse came to assess him, but he refused to let her examine him. In response, prison staff opened an ACCT. Staff were to check on him at least once per hour, with regular multidisciplinary reviews.

6. On 17 June, during one of Mr Beckford's ACCT reviews, staff completed referrals to the prison trauma clinic to address Mr Beckford's post-traumatic stress, and to the substance misuse team to help him with his substance misuse issues. They also discussed the issues Mr Beckford had been having with his telephone account and encouraged him to escalate these by making an application (this is the process used for making requests to various prison departments). Staff were to check on him at least once per hour during the day and twice per hour during the night.

7. That evening, Mr Beckford told another prison officer that he still had no access to his telephone account. The officer said he would check what action had been taken so far and get back to him. A short time later another officer was undertaking ACCT checks and found Mr Beckford hanging from a ligature in his cell. The officer went into the cell, lowered Mr Beckford to the floor and called for assistance. Prison officers then began cardiopulmonary resuscitation to attempt to revive Mr Beckford. They were joined by nurses soon after. Attempts to resuscitate continued until ambulance paramedics arrived and transferred Mr Beckford to hospital. Mr Beckford had not named a next of kin, so prison staff identified a friend through Mr Beckford's telephone records and contacted them. Mr Beckford's brother was identified as next of kin but no further action was taken to contact him. Mr Beckford died in hospital on the afternoon of 23 June, after a period in intensive care.

Findings

Management of Mr Beckford's suicide risk

8. When Mr Beckford told staff about his overdose, they rightly initiated the ACCT process. However, they did not risk assess his ongoing possession of medication.

9. The nurse who attended Mr Beckford's ACCT review had not received ACCT training.

10. Healthcare staff did not make notes on his ACCT document.

11. There was no clear process for how ACCT checks were allocated and disciplinary staff were unclear on who was responsible for undertaking them. Mr Beckford's ACCT document did not contain full notes on checks made on him.

Emergency response

12. The officer who first found Mr Beckford hanging did not use the correct emergency code (code blue). The delay in this instance was minimal but could make a difference in future.

13. The healthcare response to the emergency call was timely and appropriate.

Mr Beckford's healthcare

14. The clinical reviewer concluded that the healthcare Mr Beckford received in Wandsworth was equivalent to that which he could have expected to receive in the community. She makes some recommendations that we do not repeat here, but which the Head of Healthcare will wish to address.

Liaison with Mr Beckford's family

15. Mr Beckford did not name a next of kin when he came into prison. When he was found hanged, prison staff identified a friend using Mr Beckford's telephone records but when they were told that his brother was next of kin, they did not make official contact or provide ongoing support in line with policy.

Recommendations

- The Governor and Head of Healthcare should ensure that the relevant risk assessments are undertaken regarding the possession of medication, where a prisoner overdoses.

- The Governor and Head of Healthcare should ensure that staff contributing to the ACCT process have the necessary training.

- The Head of Healthcare should ensure that staff understand and know how to implement their mandatory duty to document their interactions with prisoners under ACCT management.

- The Governor should ensure that prison staff understand and know how to implement national HMPPS policy requirements for the management of prisoners at risk of suicide and self-harm, including:
    - ensuring that staff are clear on who is responsible for making ACCT checks, and;
    - ensuring that staff adhere to the frequency of observations as specified in the ACCT document.
- The Governor should remind all staff of the appropriate emergency codes and how these should be used.
- The Governor should ensure that a family liaison officer is appointed for prisoners who are seriously ill and that official contact is made with a next of kin as soon as possible in line with PSI 64/2011.

The Investigation Process

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

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

18. The investigator interviewed seven members of staff and one prisoner at Wandsworth. Some interviews took place remotely due to COVID-19 restrictions.

19. NHS England commissioned an independent clinical reviewer to review Mr Beckford's clinical care at the prison. They jointly interviewed healthcare staff.

20. We informed HM Coroner for London Inner West of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

21. One of the Ombudsman's family liaison officers contacted solicitors acting for Mr Beckford's family, to explain the purpose of the investigation and to ask if there were any matters that they wanted the investigation to consider. Mr Beckford's family asked about his suicide and self-harm risk assessment processes, healthcare, and the emergency response.

Background Information

HMP Wandsworth

22. Wandsworth is a local men's category B prison in London, with some category C provision. It holds up to 1,452 men in eight residential wings. Physical healthcare is provided by St George's University Hospital NHS Foundation Trust. Mental health services are provided by South London and Maudsley NHS Foundation Trust. These services are commissioned by NHSE&I Health and Justice.

HM Inspectorate of Prisons

23. The most recent full inspection of Wandsworth was in September 2021. Inspectors found that the prison had acted swiftly in response to recommendations about previous self-inflicted deaths and had taken action to address levels of self-harm. It found that the administration of ACCT procedures varied.

Independent Monitoring Board

24. 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 31 May 2021, the IMB reflected that attendance at multidisciplinary ACCT reviews varied and were often attended by staff who did not know the prisoner. The IMB also found that there was a high demand for telephone PIN codes, which required additional staffing resources.

Previous deaths at HMP Wandsworth

25. Mr Beckford was the twelfth person to die while a prisoner at Wandsworth since June 2019. Out of these, he was one of eight prisoners to take his own life. In previous investigations, we have made recommendations about mental healthcare provision and the management of ACCT.

Assessment, Care in Custody and Teamwork

26. ACCT is the HMPPS 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.

27. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular, to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

28. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the

prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

29. On 14 June 2021 Mr Daniel Beckford was remanded to HMP Wandsworth on charges of burglary. Staff identified that he had a history of substance misuse and depression. There were also suicide and self-harm markers noted in Mr Beckford's Person Escort Record (PER), based on previous self-harm and an overdose in prison. Mr Beckford had previously been managed via ACCT procedures.

Reception screenings

30. An officer interviewed Mr Beckford on his first night in prison. She noted that he had been assessed as high risk in relation to cell sharing due to violence he had displayed previously in prison. He was given a single cell. Mr Beckford was issued with a PIN number for the telephone system, to enable him to make calls.

31. A nurse undertook Mr Beckford's initial healthcare screening. She did not identify, nor did Mr Beckford disclose, any physical health issues. Mr Beckford said that he suffered from depression but was not prescribed medication. Mr Beckford also mentioned that he had experienced problems with alcohol and drugs, primarily cannabis. She referred him to substance misuse services. Mr Beckford's previous self-harm in prison was noted, but he disclosed no active suicidal thoughts.

32. Mr Beckford attended an appointment with the prison GP, as part of his reception screening. Mr Beckford explained that his GP had recently diagnosed a chest infection and the prison GP prescribed the completion of his course of antibiotics (amoxycillin). Mr Beckford shared his history of depression and described that he had self-medicated with alcohol and cannabis use on a daily basis. the prison GP noted symptoms of dependence and withdrawal, including sweating and anxiety. Mr Beckford also shared previous thoughts of self-harm but none at present. As a result of the appointment, systems were put in place for staff to make regular checks on Mr Beckford as part of the Integrated Drug Treatment System (IDTS). He would be prescribed Librium to support detoxification from alcohol, and he was referred to Change Grow Live (CGL - a drug and alcohol charity which works with prisoners).

15 June

33. Healthcare staff made the appropriate checks on Mr Beckford during his first night in custody. No concerns were identified. The following morning, the clinical support worker attended Mr Beckford's cell to undertake clinical observations. She was unable to complete them due to risks assessed by prison staff regarding Mr Beckford's aggressive behaviour. However, she did observe him through the panel in his door. She noted no signs of withdrawal that required support.

34. Later the same day, Mr Beckford was due to attend his secondary healthcare screening. Staff did not take him to this appointment on the basis of his behaviour and associated risks. However, the clinical support worker attended his cell again that afternoon and noted no concerns with Mr Beckford's presentation. In addition, staff made IDTS checks on him through the night.

16 June

35. On the morning of 16 June, a clinical support worker attended Mr Beckford's cell to undertake the secondary healthcare screening. After initial reluctance to engage, Mr Beckford shared information on his alcohol and cannabis use. He said he would like some support and did not feel that he was getting any. She asked Mr Beckford what specific support he wanted. Mr Beckford said that he had no credit on his telephone PIN phone account. He said that he had no thoughts of harming himself. They discussed ways he could address his substance misuse while in prison. He said that he was due in court the following month and if he returned to Wandsworth, he would engage with substance misuse services then.

36. Later in the morning, an officer answered Mr Beckford's cell bell. He asked for his medication. The officer said that the medication round was underway and his antibiotics would be with him soon. In response, Mr Beckford became aggressive, punching the wall and door of his cell. The officer asked him to calm down and said that he would go and chase up the medication. The medication was given to Mr Beckford, and the officer asked if Mr Beckford was satisfied. Mr Beckford was upset that there was no credit on his phone. The officer said he would find out what had happened, which he actioned by sending an email to the PIN phone department.

37. An intelligence report submitted the same day showed that Mr Beckford told a member of staff that he found being on the induction wing stressful. When told that he had to be there for the purposes of COVID-19 measures, he became agitated and said "when I'm pushed over the edge I know what I'm like, I can become very violent". He did not directly threaten anyone, but staff on his wing were alerted and a note was put in the wing observation book.

38. Healthcare staff made welfare checks on Mr Beckford during the day. He said that he felt well and did not complain or display any withdrawal symptoms.

39. In the evening, Mr Beckford pressed his cell bell a number of times and banged on his door. When staff responded, he shared frustrations about being on the induction wing despite having previously spent time in prison and having tested negative for COVID-19. He threatened to attack staff if he was not moved. Staff issued a warning under the Incentives Policy Framework, (which is designed to encourage good behaviour and tackle poor behaviour and breaches of rules).

40. At 9.33pm, an officer answered Mr Beckford's cell bell and he told her that he would harm himself and staff if his mental health was not taken seriously. He produced some capsules and swallowed six of them in front of the officer. The officer called an emergency and requested attendance by medical staff. A nurse attended but Mr Beckford refused to allow her to assess him and was rude and abusive. She noted that Mr Beckford had taken six of his prescribed amoxicillin (antibiotic) tablets, which was not a toxic dose. She did not identify any clinical concerns, observing that he was alert and orientated, with no breathing difficulties. She asked prison officers to continue to monitor Mr Beckford and call her again if they had any concerns. Staff opened ACCT procedures. The officer completed the Concern and Keep Safe Form and the Night Orderly Officer (in charge of the running of the prison during the night), a Custodial Manager (CM) completed the Immediate Action Plan. It was decided that Mr Beckford would remain in the same location and he was reminded that he could access Samaritans and/or Listeners (prisoners trained

by the Samaritans to provide peer support). Staff were to check on him at least once an hour.

17 June

41. Staff checked on Mr Beckford through the night, as required by ACCT procedures. Additionally, healthcare staff undertook scheduled wellbeing checks. In the morning of 17 June, an officer let Mr Beckford out of his cell for some fresh air. Mr Beckford said that his PIN phone issue was still yet to be resolved. The officer said that he had emailed the security department, then telephoned to follow up a response, but that the line was engaged. He said that he would pursue it further.

42. An officer undertook the second reception screening interview for Mr Beckford. He said that he had no physical issues but had asked for substance misuse support. Mr Beckford said that his brothers were supportive, and he did not want any further support.

43. In the afternoon, an officer gave Mr Beckford further time out of his cell. He told the officer that his PIN phone account was still not working. The officer spoke to the PIN phone team again, who informed her that the issues were due to a domestic violence security alert against Mr Beckford's account. Additional checks were required. The officer told Mr Beckford that they would have to wait until he had a response to his earlier email, and Mr Beckford seemed to accept that. The officer noted on Mr Beckford's record that there were no indications that he was feeling suicidal.

44. At 2.40pm, an officer carried out the ACCT assessment interview. Mr Beckford said that he was concerned about his partner and did not want to be on the reverse cohorting unit because it meant he was unable to have visits. He said that he had been diagnosed with Post Traumatic Stress Disorder (PTSD), following his mother's suicide and daughter's death. He said that he self-medicated for his depression with drugs and alcohol and had made several attempts to end his life. He felt depressed and felt isolated and wanted a job to keep him occupied. He would work with the mental health team, substance misuse team and the chaplaincy. He was anxious to get some credit on his PIN phone account.

45. At 3:00pm, following the assessment interview, a Supervising Officer (SO) and unit manager chaired Mr Beckford's first ACCT review. A nurse in the mental health team attended. An officer was unable to attend but briefed the SO before the meeting. Mr Beckford was present and engaged well. He said he had been managed under ACCT procedures before and understood the process. He shared information with staff on a range of issues, including his negative experience of antidepressants in the past. He shared that he had experienced many difficult issues in his life. The nurse said that she would refer him to the trauma clinic. He said he had a good relationship with his partner and had applied for a PIN phone account so that he could speak with her. He described a good rapport with officers on his landing, which had helped. Mr Beckford discussed his detoxification from alcohol and staff said they would make a referral to CGL for support. The nurse shared concerns about him being in a single cell but Mr Beckford said that he would take his emotions out on a cellmate. He said that he would like to get out of his cell more, so the SO said she would explore Listener and peer mentor courses that he

could get involved in. The meeting agreed that Mr Beckford presented a high risk of suicide and self-harm and that he had been referred to the appropriate services in accordance with his needs. They agreed that staff should check on him at least once per hour, with at least one quality conversation in both the morning and afternoon. Staff would check on him at least twice per hour during the night. He would continue with his application for a PIN phone account so that he could contact his family.

46. At 5.17pm a nurse checked on Mr Beckford. He told her that he had seen someone from the mental health team and he thought that they would prescribe him antidepressants. He said that he had been referred to CGL, which he saw as a positive thing. He said he had no thoughts of harming himself but was concerned about his chest infection. The nurse said that he was not wheezy and had no cough. Mr Beckford declined to allow her to monitor his vital signs. She advised him to speak to the GP if he thought he still had an infection.

47. Shortly after 7.00pm, an officer answered Mr Beckford's cell bell. Mr Beckford said that he was awaiting a response from an officer who had told him that he was going to help with his PIN phone account. He did not know the officer's name. The officer said that when he finished what he was doing he would make enquiries. The officer said in interview that Mr Beckford was agitated but did not appear to be angry.

48. During his round of ACCT checks, an officer arrived at Mr Beckford's cell at 7.20pm. The observation panel was obscured, so the officer made himself known by calling to Mr Beckford. When no response was received, the officer tried to open the door. Mr Beckford had blocked it with piled furniture. The officer pushed the door open and saw Mr Beckford with a ligature round his neck, tied to the bed frame. He shouted for assistance and forced his way into the cell. He used his anti-ligature knife and lowered Mr Beckford to the floor. He then checked for breath but could not detect any, so put Mr Beckford into the recovery position. The officer had arrived at the cell and used his radio to call a code blue emergency, meaning a prisoner not or having difficulty breathing. This prompted the control room to call an ambulance, as per the HMPPS Medical Emergency Response Codes guidance. While awaiting the ambulance, other staff responded to the emergency call. An officer began to perform cardiopulmonary resuscitation (CPR), in an attempt to revive Mr Beckford. A nurse arrived soon after and asked officers to move Mr Beckford onto the landing where there was more space. Other nurses arrived and applied a defibrillator (a machine that detects and, in some instances can restart, the heart). The machine advised that staff should continue CPR. They did so until ambulance paramedics arrived and took over. They detected a pulse so transferred Mr Beckford to an ambulance and to St George's Hospital.

49. Mr Beckford did not nominate a next of kin when he arrived at Wandsworth. A member of prison staff identified a friend using his telephone records, contacted them and met them at the hospital. It was later noted that Mr Beckford's brother was his next of kin. His brother and other members of Mr Beckford's family attended the hospital but there was no official contact from Wandsworth. Mr Beckford was supported in intensive care for six days. However, his condition did not improve and he died at 5.30pm on 23 June.

Support for prisoners and staff

50. When Mr Beckford went to hospital, 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.

51. A further de-brief was provided by the deputy governor, following Mr Beckford's death. The staff care team also offered support to staff, at the time and following Mr Beckford's death.

52. The prison posted notices informing other prisoners of Mr Beckford's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm, to discuss the impact of Mr Beckford's death and any support needs.

Post-mortem report

53. Post-mortem reports showed that Mr Beckford died due to lack of oxygen to the brain, consistent with pressure caused by the ligature used for hanging. No toxicology tests were undertaken.

Findings

Assessment Care in Custody and Teamwork (ACCT)

54. When Mr Beckford took an overdose of his antibiotics, staff rightly opened ACCT procedures. However, they did not risk assess the other tablets remaining in Mr Beckford's possession. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the relevant risk assessments are undertaken regarding the possession of medication where a prisoner overdoses.

55. A nurse attended Mr Beckford's ACCT review, as per the national policy requirement for these to be multi-disciplinary. However, she had not received any ACCT training. We recognise that training activity was impacted by the COVID-19 pandemic, but staff making vital contributions to reviews on prisoners' safety should have the necessary training, as a priority. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff contributing to the ACCT process have the necessary training.

55. The clinical reviewer noted that healthcare staff did not enter any notes on their observation of, and interactions with, Mr Beckford as part of ACCT procedures. This prevented the sharing of important risk information between those making decisions on Mr Beckford's care, which is a mandatory requirement within national policy (PSI 64/2011) She made the following recommendation, with which we concur:

The Head of Healthcare should ensure that staff understand and know how to implement their mandatory duty to document their interactions with prisoners under ACCT management.

56. We identified gaps in the records for hourly checks mandated in PSI 64/2011, for prisoners subject to ACCT. Between 1.45pm and 7.20pm there is only one entry. During this time period Mr Beckford had his assessment interview and his first ACCT review, he saw a nurse and he spoke to two officers. However, observations should be made and recorded as directed and we were unable to tell whether staff were checking on Mr Beckford as frequently as they were supposed to.

57. Further to this, we identified inconsistencies in officers' understanding of how ACCT policy should be implemented, specifically, who was responsible for undertaking ACCT reviews. In interview, staff said that responsibility for making checks was shared between the officers on each landing. The SO said that managers would check observations daily, but this would only pick up missed checks where several had been missed. An officer said that he was not responsible for the ACCT checks on Mr Beckford's landing but was helping out. An officer said that he did not think that he was responsible for the ACCT checks on the landing. We make the following recommendation:

The Governor should ensure that prison staff understand and know how to implement national HMPPS policy requirements for the management of prisoners at risk of suicide or self-harm, including:

- **ensuring that staff are clear on who is responsible for making ACCT checks, and;**
- **ensuring that staff adhere to the frequency of observations as specified in the ACCT document.**

58. Mr Beckford did not have a working PIN phone account because there was a security marker for domestic violence against his name. He was frustrated by this and complained to staff on several occasions. Staff tried to address the issue by contacting the security department. While we recognise the importance of assessing potential security risks, as per PSI 49/2011 *Prisoner Communications,* we also consider that contact with support systems is important for prisoners' wellbeing, particularly in the early days of custody and where an individual is being monitored by ACCT procedures. The security marker was being looked into at the time of Mr Beckford's death and he was not made aware of that being the reason for the delay. We consider that this was appropriate, based on Mr Beckford's volatile behaviour and vulnerability and the risks associated with him being made aware. We note the short period of time Mr Beckford was in custody (three days) and we consider that the action taken during the period was proportionate. We do not make a recommendation. However, we would like to take this opportunity to remind Wandsworth that processes should be in place to prioritise phone access for prisoners being monitored by ACCT procedures.

Mr Beckford's healthcare

59. The clinical reviewer concluded that the healthcare Mr Beckford received in Wandsworth was equivalent to that which he could have expected to receive in the community. She makes some recommendations that we do not repeat here, but which the Head of Healthcare will wish to address.

Emergency response

60. PSI 3/2013, *Medical Emergency Response Codes,* requires Governors to have a two-code medical emergency response system. Code blue should be used to indicate that a prisoner is unconscious or having breathing difficulties. Code red should be used when a prisoner is bleeding. The purpose of the emergency code is to trigger contact with the local ambulance service through the prison control room and alert healthcare staff to attend with the appropriate equipment.

61. When Mr Beckford was found hanging, an officer called for assistance from staff. He recalled this being the first step according to his training. When an officer arrived soon after, he called a code blue emergency.

62. The control room log shows that an ambulance was requested immediately after the code blue call was received in the control room, at 7.26pm. So there does not seem to have been a significant delay in this instance. However, a delay can be critical in an emergency situation and it is important that staff understand and implement use of medical emergency codes promptly in line with national policy. We make the following recommendation:

The Governor should remind all staff of the appropriate emergency codes and how these should be used.

Liaison with Mr Beckford's family

63. PSI 64/2011 *Managing Prisoner Safety contains requirements* on how prisons should liaise and support families of prisoners who are seriously ill or following a death in custody. A trained family liaison officer must be appointed, who should make and maintain contact with the family if the prisoner consents, to provide information and support where appropriate. A family liaison contact log should be kept. Prisons must offer to pay a contribution towards reasonable funeral expenses.

64. Mr Beckford did not nominate a next of kin when he arrived at Wandsworth. When he was taken to hospital, prison staff checked his telephone records to identify somebody appropriate. They contacted a friend and the duty governor met her at the hospital. It later became apparent that Mr Beckford's brother would act as his next of kin. This was noted on the family liaison log, but no family liaison officer was appointed and no contact was made. Wandsworth did not offer a contribution to Mr Beckford's funeral expenses despite the policy requirement to do so.

65. The prison told us that there was unprecedented strain on their trained family liaison resources at the time and they were unable to identify where the failure in the system occurred. We are concerned about this omission in procedure which must be addressed in order to ensure families are contacted and appropriately supported in future. We make the following recommendation:

The Governor should ensure that a family liaison officer is appointed for prisoners who are seriously ill and that official contact is made with a next of kin as soon as possible in line with PSI 64/2011.

Inquest

66. The inquest was held from 15 to 25 April 2024. The jury concluded that Mr Beckford died by suicide and found that, "Based on the evidence, the following possibly made a material contribution to his death: Failure to comply with the prison service instruction to facilitate a phone call within the first 24 hours; Insufficient support to secure a PIN."

67. They made the following findings of fact:

    1. Inadequate assessment of risk during the FNIC screening to ensure appropriate safeguarding measures were in place.

    2. Inadequate staff training in respect of ACCT procedures and insufficient regular basic life support training, which resulted in Daniel being placed in the recovery position before CPR/chest compressions commenced.

    3. Failure of management processes and failure of communication processes.

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