Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Neal, a prisoner at HMP Wayland, on 18 August 2024

A report by the Prisons and Probation Ombudsman

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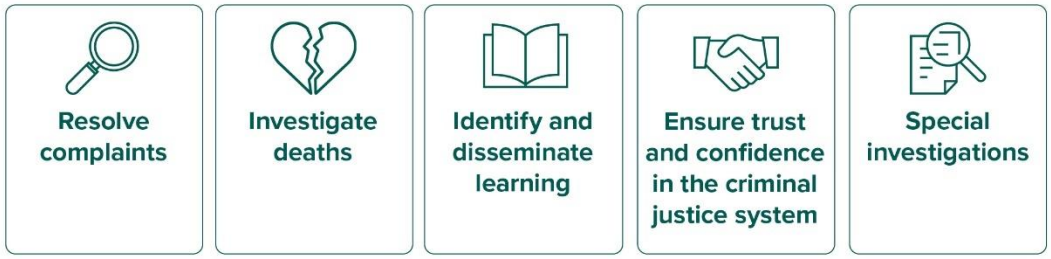
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Andrew Neal died in hospital on 18 August 2024, having been found hanged in his cell at HMP Wayland on 7 August. He was 53 years old. I offer my condolences to Mr Neal's family and friends.

Mr Neal was only in Wayland for around three weeks before he took his own life. His main concern was a neck problem which caused him pain and reduced mobility, which appeared to contribute to a deterioration in his mental health. My investigation found that staff missed some opportunities to assess, communicate and manage Mr Neal's risk of suicide and self-harm.

The clinical reviewer concluded that Mr Neal's clinical care was partially equivalent to what he could have expected to receive in the community. Improvements need to be made to ensuring prisoners' compliance with their medication, follow up actions to psychiatric assessments and ensuring primary care assessments happen in a timely manner.

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

Adrian Usher
Prisons and Probation Ombudsman **June 2025**

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Summary

Events

1. In March 2024, Mr Andrew Neal was remanded to HMP Bedford, charged with grievous bodily harm (GBH) against his partner. This was not his first time in prison. He had a history of attempted suicide, anxiety and depression, substance misuse and suffered pain from a previous neck injury. He was prescribed pain relief.

2. In April, Mr Neal told staff that he struggled with the prison regime and found it hard to cope because of his constant neck pain. A GP and mental health nurse assessed him and prescribed further medication to treat his low mood, nerve pain and improve his sleep. They also referred Mr Neal to the community musculoskeletal service for further assessment of his neck pain.

3. On 5 July, Mr Neal was sentenced to 30 months in prison. On 19 July, he transferred to HMP Wayland. During an initial mental health assessment, Mr Neal said that his mood was low, he did not sleep well and had neck pain. The nurse referred him to the psychiatrist for further assessment and noted that he had a GP appointment scheduled for 8 August, to review his medication. The psychiatrist saw Mr Neal on 25 July. They noted that Mr Neal would be assessed at his GP appointment and his medication reviewed and that he should be reviewed by the mental health team.

4. On 1 August, staff opened suicide and self-harm procedures, known as ACCT, after Mr Neal said that he was struggling and felt depressed because he was constantly in pain, which reduced his mobility. He said he found it difficult to walk to the medication hatches, which were located on two different wings. Staff set his ACCT observations at twice a day and hourly at night as he said he struggled more then. Staff also recorded that Mr Neal would be reviewed at his GP appointment on 8 August.

5. Mr Neal's medical records showed that he was not compliant with taking his pain medication and missed a lot of doses because of his refusal to take his medication and/or by not attending the medication hatch to collect them.

6. On 7 August around 8.42am, Mr Neal told officers that he, "wasn't doing very well". They tried to seek further advice from a prison manager and agreed between themselves to check Mr Neal more often. At 10.02am, a prisoner looked through Mr Neal's observation panel and saw him hanging from a ligature attached to a screw in the wall. He alerted staff and prison and healthcare staff provided emergency care. Paramedics arrived and took Mr Neal to hospital. On 18 August, Mr Neal died.

Findings

7. Mr Neal had several risk factors for suicide and self-harm. He had a history of attempted suicide, substance misuse and anxiety and depression. He also had a history of neck problems and experienced increased pain and reduced mobility. He had reported that he was struggling.

8. On occasions, staff missed opportunities to adequately record and communicate Mr Neal's risk.

9. The night before Mr Neal died, an officer falsified the ACCT document, indicating that he had checked Mr Neal when he had not. The officer was dismissed.

10. The clinical reviewer found that Mr Neal's healthcare was partially equivalent to that he could have expected to receive in the community. Mr Neal's pain and mobility were never formally assessed at Wayland. Staff also failed to understand and improve Mr Neal's poor compliance with taking his pain and antidepressant medication and how this impacted on his mental health. Staff did not consider moving Mr Neal closer to the medication hatch. Mr Neal was not reviewed by mental health staff as per the psychiatrist's plan.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and, in particular, the need to record, share and consider all relevant information about risk.

- The Governor and Head of Healthcare should ensure that when prisoners subject to ACCT monitoring have concerns with their physical health, they are referred to the primary care team to assess and review the prisoner's health and care plan in line with NICE Guideline NG57 'Physical Health of People in Prison'.

- The Head of Healthcare should ensure that the mental health team has a standardised process for communicating actions agreed during consultations with healthcare staff and update the standard operating procedure to reflect this.

- The Head of Healthcare should ensure that when prisoners do not attend for their medication on a number of occasions, a plan is documented within their medical records to ensure a multidisciplinary approach is taken when reviewing their care.

- The Head of Healthcare should incorporate closer healthcare observations for prisoners who are not compliant with their antidepressant medication, to monitor withdrawal symptoms and any adverse effects.

The Investigation Process

11. HMPPS notified us of Mr Neal's death on 19 August 2024.

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

13. The investigator visited Wayland on 29 August. He obtained copies of relevant extracts from Mr Neal's prison and medical records.

14. The investigator interviewed ten members of staff and one prisoner at Wayland in October 2024.

15. NHS England commissioned a clinical reviewer to review Mr Neal's clinical care at the prison. He conducted joint interviews with the investigator.

16. We informed HM Senior Coroner for Norfolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Neal's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Neal's family asked if Wayland were aware that Mr Neal had a history of mental health problems and suicidal thoughts. They also asked where Mr Neal obtained the ligature that he used to take his life. We have covered these matters in our report.

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

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Wayland

20. HMP Wayland is a training and resettlement prison in Norfolk. Practice Plus Group provides mental and physical healthcare.

HM Inspectorate of Prisons

21. The most recent full inspection of Wayland was in April 2022. Inspectors reported poor outcomes in several areas, including in safety. They found that the number of self-harm incidents was higher than at comparator prisons and there was no overarching strategy to reduce self-harm and support vulnerable people. Inspectors found that care planning for prisoners being monitored under ACCT procedures was not used well, and several such prisoners told inspectors that they did not feel well supported. Inspectors found that mental health services provided a comprehensive range of support.

Independent Monitoring Board

22. 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 May 2023, the IMB reported that there had been a reduction in self-harm and an improvement in ACCT procedures. Prisoners not attending healthcare appointments remained at an unacceptably high level.

Previous deaths at HMP Wayland

23. Mr Neal was the eighth prisoner to die at Wayland since August 2021. Four of these previous deaths were due to natural causes, two were self-inflicted and one was due to drugs. Our investigation following a death in 2022, found that staff did not accurately assess the prisoner's risk to himself and ACCT procedures were not considered. Up to the end of February 2025, there have been no further deaths at Wayland since that of Mr Neal.

Assessment, Care in Custody and Teamwork (ACCT)

24. 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. 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 multidisciplinary review meetings involving the prisoner.

25. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions have been completed. 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. When Mr Neal was at Wayland, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Key Events

HMP Bedford

26. On 23 March 2024, Mr Andrew Neal was arrested for an alleged offence of grievous bodily harm (GBH) against his partner. On 26 March, he attended court and was remanded to HMP Bedford. This was his first time in prison in over ten years. Mr Neal told staff that he had no history of attempted suicide or self-harm and had no current thoughts to harm himself. He had a history of cannabis misuse.

27. During Mr Neal's healthcare screening, he told a nurse that he had a history of anxiety and depression, but he denied that he had any current thoughts of suicide and self-harm. Mr Neal said that he was prescribed gabapentin (for nerve pain) for a neck injury that he had suffered eight years previously. They also spoke about his cannabis misuse. The nurse referred Mr Neal to a GP who prescribed Mr Neal gabapentin.

28. On 27 March, a mental health nurse completed an initial mental health assessment. They noted that Mr Neal had a history of depression, anxiety and had had a previous admission to a mental health hospital, after he had attempted suicide. The nurse noted no concerns about Mr Neal's mental health. Mr Neal said that he was sleeping well and had no current thoughts of suicide or self-harm.

29. On 5 April, a mental health nurse saw Mr Neal. Mr Neal said that he was struggling, was frustrated with the prison food and was not sleeping well. The nurse referred Mr Neal to a GP, who saw him on 11 April. The GP assessed his mental health, anxiety, depression, and neck pain. Mr Neal denied that he had any thoughts to harm himself. The GP prescribed amitriptyline (to treat low mood, nerve pain and improve his sleep) and citalopram (to help with his mood) in addition to the gabapentin he was already prescribed.

30. At his keywork session (a one to one session with a named prison officer) on 24 April, Mr Neal said that he was okay, but was still in some pain. He said that he had been attending physiotherapy sessions in the community, but had not had any sessions in prison. Mr Neal said that he had recently become a father again for the third time. He had older children but had not had any contact with them for many years. Mr Neal said he had no problems on the wing and felt safe.

31. Mr Neal attended court on 29 April and his hearing was adjourned until June. On 18 June, Mr Neal told staff that he was struggling, had constant pain in his neck and back and was not sleeping well. Mr Neal denied that he had any thoughts to harm himself.

32. Mr Neal attended court on 26 June and was scheduled to return to court again on 5 July.

33. On 1 July, a GP referred Mr Neal to the Circle Integrated Care Musculoskeletal Service in the community for further assessment of his neck pain and to consider ordering a Magnetic Resonance Imaging (MRI) scan. (This referral had been triaged at the time of Mr Neal's death, but no appointment had been offered.)

34. On 5 July, Mr Neal was convicted and sentenced to 30 months in prison. The court recorded that a restraining order was in place which forbade Mr Neal from contacting his ex-partner, the mother of his newly born child.

35. On 11 July, a GP saw Mr Neal and reviewed his mental health, anxiety, depression, and neck pain. Mr Neal engaged well and denied that he had any suicidal thoughts. The GP noted that although Mr Neal had started taking citalopram, this would take some time to work. Mr Neal's medical record showed that during his time at Bedford, his compliance with taking his medication was very inconsistent and he missed a lot of doses because of refusal to take his medication and/or not attending the medication hatch to collect it. Mr Neal said his medication was ineffective and his pain disturbed his sleep at night.

HMP Wayland

36. On 19 July, Mr Neal transferred to HMP Wayland. Officers completed Mr Neal's prison reception screening and first night interview. He raised no concerns. Staff noted that Mr Neal could share a cell but, due to his neck issue, he required the bottom bunk bed.

37. A nurse completing Mr Neal's healthcare screening noted that Mr Neal had anxiety and depression. Mr Neal said he had no current thoughts of suicide or self-harm and had last self-harmed over 20 years ago. He said that he felt slightly depressed due to his family issues. The nurse noted that Mr Neal had a long history of pain related to his neck problems but did not require any equipment or aids for his mobility. He said he was prescribed citalopram, gabapentin and amitriptyline which a pharmacy technician later prescribed. Mr Neal said he had a history of using cannabis. The nurse noted that she had no concerns about Mr Neal's psychological presentation. She referred Mr Neal to the GP and the mental health team.

38. Mr Neal was not allowed to keep his medication in possession, partly due to the dispensing set up at Wayland and also due to the toxicity of medications he was prescribed. (In addition, gabapentin is a controlled drug, subject to stricter control measures and never prescribed in possession.) To collect his medication, Mr Neal had to walk to two different medication hatches, which were on different wings. He collected gabapentin from B wing at 8.00am and 4.00pm and citalopram at 8.00am and amitriptyline at 4.00pm from N wing.

39. On 20 July, an officer from the safer custody team spoke to Mr Neal as part of his induction. Mr Neal said that he was happy to be at Wayland. The officer explained how to contact the team via the digital kiosk application system if Mr Neal had any issues he wanted to raise about his wellbeing or safety. Staff gave him a laptop to have in his cell.

40. On the same day, another officer completed a keywork session with Mr Neal. They explained the purpose of keywork and again explained how to use the kiosk, including how to apply for a prison job, use the gym and arrange visits. Mr Neal raised no concerns. He told the officer that he had a serious neck injury and did not have much contact with his family. (Mr Neal did not make any telephone calls or receive any visits while in prison.)

41. A nurse from the mental health team assessed Mr Neal. Mr Neal said that his mood was low, he had a poor sleep pattern and he felt anxious about being in prison. He talked about having trauma in relation to his neck pain and physical health and said that his mental health was deteriorating. He denied that he had any current substance misuse issues. While the nurse had no immediate concerns about Mr Neal's mental state, she referred him to be assessed by the psychiatrist. She also referred him to the Improving Access to Psychological Therapies (IAPT) service. She noted that he had an appointment scheduled with a GP on 8 August to review his medication.

42. On 20 July, a nurse completed Mr Neal's second health reception screen. They noted that he had no outstanding external medical appointments. (This was accurate at the time as the Circle Integrated Care Musculoskeletal Service had not yet processed his referral or offered an appointment.)

43. On 22 July, a nurse examined Mr Neal in his cell after he complained of pain in his spinal cord. His physical observations were within the normal range. The nurse noted that Mr Neal had been provided with exercises specially designed to manage his nerve pain.

44. On 24 July, a nurse did a standard health check for over 40s with Mr Neal and did some blood tests which were all within the normal range. On the same day, healthcare staff recorded that the Circle Integrated Care Musculoskeletal Service had received his referral. A member of the substance misuse team also saw Mr Neal. He declined to engage with the support service offered.

45. On 25 July, a psychiatrist assessed Mr Neal. Mr Neal said that he had several health issues that included: confusion, dizziness, dry mouth and tinnitus (the sensation of hearing ringing, buzzing, or other noises in the ears). The psychiatrist noted that Mr Neal's recent blood tests had all been normal. The psychiatrist assessed Mr Neal's symptoms to be side effects from his prescribed medication, amitriptyline, and were mild and manageable. He noted that Mr Neal should wait for his GP appointment (on 8 August) where his health would be further reviewed along with his prescribed medication. He referred Mr Neal to the optician due to his blurred vision and staff made him an appointment for 8 August. During the assessment, he noted that Mr Neal's mobility appeared good, and he did not demonstrate any slowness or apparent difficulty when he moved.

46. The psychiatrist diagnosed Mr Neal with reactive depression. Mr Neal denied any thoughts of self-harm but recorded he had "fleeting, mostly passive" thoughts of suicide. Mr Neal said he had no plans to take his own life. The psychiatrist noted that the mental health team should continue to monitor Mr Neal's mental state and he would review him again in three to four weeks. However, there is no evidence that staff actioned this plan and no one from the mental health team saw Mr Neal.

47. In the morning of 1 August, Mr Neal told an officer that he was struggling with his mental health and wanted to speak to a member of the mental health team. The officer contacted the mental health team who agreed to see Mr Neal.

48. On the same day, Mr Neal told staff that he "didn't want to be here anymore". He said he was struggling to get out of bed and "didn't see the point anymore". He felt depressed and the constant neck pain reduced his mobility. Mr Neal also said that

he was struggling with the breakdown of his relationship (with his ex-partner) and not being able to see his newborn child. Staff noted that Mr Neal had not been collecting his medication from B wing. A Supervising Officer (SO) started suicide and self-harm prevention procedures, known as ACCT. Mr Neal said that he felt well supported in his current location by his cellmate and prison staff on the wing. The SO reminded Mr Neal how to use the prisoner email system to request support from healthcare staff. Staff set Mr Neal's ACCT observations at hourly and planned for healthcare staff to attend his first ACCT review the next day.

49. An officer completed Mr Neal's ACCT assessment. Mr Neal was highly anxious due to his pain, concentration problems and not wanting to leave his cell. Mr Neal said that he felt as if his health had taken a backwards step, and he was unable to cope for long periods of time outside of his cell. He said he had no support from family or friends and only knew a few people on the wing. That afternoon, Mr Neal left the wing to collect his medications. However, he told staff that he was concerned about the walk to B Wing to collect his gabapentin and wanted to be escorted (staff told him this was not possible but that officers would be present along the route to B Wing).

50. On 2 August, a SO chaired an ACCT review with a nurse and a health support worker, both from the mental health team, and Mr Neal. Just before the meeting, Mr Neal said that he wanted to exercise first. The review panel said they needed to speak with Mr Neal to gauge how he was doing and to clarify what support he needed. They told him that the ACCT review was not scheduled to last for a set period of time and could be done at a quicker pace, if need be. Mr Neal appeared to interpret this as staff wanting to rush the review. The review team explained to Mr Neal that they said this because he had given them the impression that his exercise should take priority over the review. The review panel told Mr Neal that the ACCT review would take as long as needed. (Mr Neal's medical records showed that he had relied on exercise for many years to help him manage his pain and maintain mobility.)

51. During the review, Mr Neal described being tired and fed up with his physical health problems and his relationship issues, which made him feel like he did not want to be alive. He had not collected his medication for the past three mornings and said that nights were challenging for him due his pain. He had no contact with his children, including his newborn child, as he was not allowed. Staff noted that Mr Neal did not appear depressed or low in mood and he denied that he had any thoughts of suicide or self-harm. The nurse assessed Mr Neal to be future-focused, noting that he talked about wanting to progress to a Category D prison. He said he wanted to improve his diet and attend the gym each morning. The review panel offered to refer Mr Neal to the remedial gym for additional exercise but he declined this as he said that he lacked the energy to do this in prison. Mr Neal was aware that he had a GP appointment scheduled for 8 August and stated that there was nothing a GP could do for him.

52. The nurse told us that during the ACCT review, she did not observe Mr Neal to be in any obvious pain. She saw that he was able to move freely, including walking, sitting, and standing from a chair. She also thought that Mr Neal's request to want to exercise just before the ACCT review contradicted the extent of his self-reported difficulties with pain and mobility. She assessed that he could walk to the medication hatch.

53. Staff wrote actions in the care plan for Mr Neal to see a GP for a medication review, attend exercise and take his medication as prescribed. The panel noted that Mr Neal was unreceptive to the action points made during the review to support him. Staff reduced Mr Neal's ACCT observations to twice a day and hourly at night due to Mr Neal finding this period more difficult due to his increased pain. Staff scheduled the next ACCT review for a week later.

54. The nurse told us that after the ACCT review, she had attempted to book a GP appointment for Mr Neal but noted that one had already been scheduled for 8 August, to review his medical history, pain, medication and evaluate his reported medication side effects. She did not think that this GP appointment needed to be expedited.

55. An officer recorded in the morning summary section on the ACCT document that Mr Neal felt anxious about being in prison and was in physical pain. Staff failed to complete the afternoon summary on the ACCT, so we do not know if they had any conversation with Mr Neal.

56. That afternoon and evening, the ACCT summary page was left blank and there was no confirmation that staff had had a conversation with Mr Neal. (This omission was, however, highlighted during the manager's check the next day, with a reminder made to staff that they should ensure that appropriate ACCT entries were made.)

57. Healthcare staff recorded that Mr Neal was placed on the Circle Musculoskeletal Service Advanced Physiotherapy Pathway. This pathway included an option for a face-to-face assessment with an advanced physiotherapist who could order an MRI scan if required. However, no appointment had been scheduled.

58. Around 6.20am on 3 August, when checked by the night duty officer, Mr Neal stated that he did not know why staff kept checking him during the night, as they could not help him. The officer responded that he would do his best to help Mr Neal.

59. Later that day, Mr Neal went to the wing office and spoke to prison staff about his health issues for around 20 minutes. Staff reminded him that he had an upcoming GP appointment. An officer also emailed Mr Neal's offender manager on his behalf, as he had asked about progressing to a category D prison. Staff noted they had no concerns about Mr Neal's mental health at the time. During the afternoon ACCT check, Mr Neal told staff that he was still struggling, but he was okay. He said he appreciated that staff had taken the time to listen to him earlier that day. That evening, Mr Neal told staff that he was okay and just wanted to watch television.

60. The next day, Mr Neal had a conversation with staff about the size of his meals which he felt were not large enough. Staff reminded him that he could buy extra food items through the prison shop. In the afternoon, staff noted that Mr Neal collected his food and medication.

61. On the morning of 5 August, an officer recorded that Mr Neal said that he was in pain. He tried to persuade Mr Neal to collect his medication and attend the healthcare unit (for a scheduled dentist appointment), but he declined.

62. That afternoon around 4.00pm, Mr Neal attended the medication hatch. A prison GP noted in Mr Neal's medical records that he had tried to conceal his amitriptyline

tablets. Healthcare staff had to tell him multiple times to drink water to swallow the tablets. No further information about this incident was recorded. Mr Neal had also asked the nurse on duty if he could change the time that his citalopram medication was prescribed, from 8.00am to 4.00pm. The GP reviewed Mr Neal's request and noted that his medication would be reviewed at his appointment with the GP on 8 August.

63. On the same day, an officer completed a keywork session. Mr Neal raised concerns about his health and his category D status. She signposted him to the relevant departments in the prison to follow up his queries. At interview, She told us that she had had conversations with Mr Neal at the end of July/beginning of August and tried to encourage him to attend the healthcare unit, but he was unwilling to do so.

64. Prisoner A shared a cell with Mr Neal from around the end of July. He told the investigator that he got on well with Mr Neal. Mr Neal spoke to him about the pain he was experiencing and that he needed to exercise to help with the pain and his mobility. He also said that the medication hatch was too far for him to walk to collect his medication. The prisoner said that Mr Neal had never expressed any thoughts of suicide or self-harm to him. Mr Neal had, however, asked him what would happen to him if he took the prisoner's insulin. He said that he was shocked at Mr Neal's question and was unsure of his intention and what he meant by it. He reported this conversation to an officer, who submitted a security intelligence report about it on 7 August. The prisoner said that Mr Neal described his young child as his protective factor, and he talked positively about his future and release in March 2025.

65. In the morning of 6 August, Prisoner A attended his prison job. He had no concerns about Mr Neal when he left their cell. That morning, Mr Neal did not collect his medication. Staff again noted in the ACCT record that Mr Neal had complained about his health issues but refused to attend the healthcare unit to raise these.

66. Officer A told the investigator that she had started to build a good rapport with Mr Neal. At his keywork session that day, she noted that she had had several frustrating conversations with Mr Neal about his health. Although, she had advised Mr Neal to speak to the healthcare team, he said that he had no intention to do this or attend the healthcare unit. Mr Neal stated that healthcare staff would not help him. She noted that Mr Neal sometimes asked for help with his medical issues but then refused to accept any advice.

67. Officer A also told the investigator that during some of the interactions she had with Mr Neal, he had made "off the cuff" comments about self-harm. This included him stating that, "the only way to get what you want in jail is to scratch yourself, cutting yourself or something like that". On these occasions, she said that she had directly asked Mr Neal if he had any thoughts of suicide or self-harm which he denied. Mr Neal's explanation for making such comments was that it was just how he spoke. She could not remember the actual dates that Mr Neal made these and similar comments, and they were not recorded.

68. Prisoner A returned to the cell for the lunch period and then returned to work. He told us that he had no concerns about Mr Neal while he was in his cell.

69. At around 4.00pm, an officer unlocked prisoners on the wing for their evening meal and to mix with each other. He had a short conversation with Mr Neal, who said that

he was still in pain and felt anxious. However, he said he would collect his medication, which he did.

70. At around 4.10.pm, when Prisoner A returned from his prison job, he was relocated to a new cell on the ground floor (for reasons unrelated to Mr Neal). Mr Neal was not present at the time (he had gone to collect his medication), so he said that he did not see him to tell him that he had moved. Staff did not record in Mr Neal's ACCT document that he no longer had a cellmate nor is there any record of staff talking to him about the prisoner moving cell.

71. At Around 5.00pm, staff locked all prisoners in their cells, including Mr Neal. When staff completed the evening routine check at 5.12pm, they raised no concerns about Mr Neal.

72. Officer B was on night duty. He recorded that he completed Mr Neal's ACCT checks at 8.20pm, 9.30pm, 10.28pm and 11.30pm, and on 7 August at 12.32am, 1.35am, 2.27am, 3.29am, 4.24am, 5.35am and 6.52am. However, CCTV shows that he did not complete ACCT checks at 11.30am, 1.35am and 3.29am. The prison carried out an investigation into his actions, and he was dismissed.

Events on 7 August 2025

73. The investigator watched CCTV and body worn video camera (BWVC) footage. He also obtained information from the East of England Ambulance Service. The following account has been taken from all sources.

74. M Wing (where Mr Neal was located) is staffed by two officers. On 7 August at 7.30am, during the morning routine check and ACCT checks, Officer C raised no concerns about Mr Neal. At 8.14am, he unlocked Mr Neal's cell. He checked Mr Neal, who raised no concerns and said he was okay.

75. At 8.42am, Officer C returned to Mr Neal's cell to lock his door as all prisoners were due to be locked up. At this time, Mr Neal told him that he was not doing very well when locked in his cell and raised the issue again that he had no contact with his family. Mr Neal asked if he could stay out of his cell. The officer asked Mr Neal to give him a minute and either Officer A or himself would return to his cell to speak to him further, as at the time, all prisoners were required to be locked in their cells. At interview, the officer told us that he was considering increasing the frequency of Mr Neal's ACCT observations but wanted to speak to a SO first as he was unsure if he needed their agreement to increase the observations. He told Officer A that Mr Neal was not doing well and wanted to remain unlocked.

76. Mr Neal pressed his cell bell at 9.02am. Officer A responded within two minutes. She told the investigator that she did not recall exactly what Mr Neal wanted but remembered that she spent time with him trying to encourage him to collect his medication and attend his healthcare appointments. Mr Neal said he was unwilling to do this. Officers A and C both said that they discussed Mr Neal and agreed to informally check on him more regularly as he was struggling.

77. Officer A told the investigator that she had tried to contact a supervising officer for advice and a second opinion on whether Mr Neal's ACCT observations should be increased. She wanted this advice as she recalled that Mr Neal had previously

made “off the cuff” remarks about harming himself, and he had now told Officer C that he was struggling. Mr Neal was on one ACCT observation in the morning and one in the afternoon. She said she felt that this was a long time for a prisoner to go without checks, although she also considered that an increase in observations was sometimes more disruptive for some prisoners and made them feel worse. She said she wanted to get advice from a SO, so she would not make things worse for Mr Neal.

78. Officer A said that she used her radio and the office telephone to try to contact an SO but was initially unable to get a response. However, she said this was not unusual as they sometimes struggled to get an SO on the unit. Between 9.00am and 10.00am, SOs are also normally in a morning management meeting. When a member of prison staff (unknown) did eventually answer, they told her that the SOs were busy and not available. She said that she then started to type an email in which she requested support from an SO but was interrupted when she heard shouts coming from prisoners on the wing. She confirmed that she had not tried to contact healthcare staff.

Emergency response

79. At 10.02am, a prisoner (who had been unlocked to do their work on the wing) looked through Mr Neal’s observation panel. He saw Mr Neal had hanged himself and shouted for staff assistance. Officer C got to Mr Neal’s cell within 15 seconds. He looked through the cell observation panel and saw Mr Neal hanging from a screw in the wall by a laptop ethernet cable. He said that he was shocked at what he saw. He entered the cell and cut the ligature and lowered Mr Neal to the floor. Mr Neal showed no signs of life.

80. Officer C did not immediately remove the ligature from Mr Neal’s neck. At interview, he said that he had been trained to cut the ligature from a person's neck using his anti-ligature knife, but at the time he was overwhelmed by what he had seen and found it very difficult to process the situation. This was made more difficult due to several prisoners who were at Mr Neal’s cell door shouting at him to take the ligature from Mr Neal’s neck. Due to the stress, he said that his hands were shaking, which made him unable to press buttons on his radio to ask for assistance. He used his radio earpiece to request support, but it took him a couple of attempts to get onto the radio network. He assumed that other prison staff must have been speaking on the network at the same time (only one person can use a radio network at any one time). When he managed to get through, he requested assistance. BWVC footage shows that he also shouted for help, as he knew there were healthcare staff already on M Wing providing routine care to other prisoners.

81. Officer A had heard prisoners shouting on the wing and had already started to go towards Mr Neal’s cell. She got to the cell seconds before 10.04am and immediately told Officer C to remove the ligature from Mr Neal’s neck, which he did.

82. Within seven seconds, a nurse and a nursing associate (NA) arrived at the cell. The nurse told staff to radio a code blue emergency (indicating that a prisoner was either having difficulty or had stopped breathing). Control room staff immediately requested an ambulance. Healthcare staff took over the care of Mr Neal using medical equipment. Mr Neal was not breathing, was unresponsive and had blue

tinged lips. The nurse started cardiopulmonary resuscitation (CPR) assisted by the NA. They rotated chest compressions with prison staff.

83. At 10.23am, paramedics arrived. They took over Mr Neal's care. Paramedics detected a pulse. At 11.05am, the air ambulance crew arrived and landed outside Wayland's grounds. The ambulance took Mr Neal to meet the air ambulance at the front of the prison and Mr Neal was placed in an induced coma before being transferred to hospital and admitted to the critical care unit.

84. On 18 August, hospital staff pronounced Mr Neal's life extinct.

Contact with Mr Neal's family

85. The prison appointed two family liaison officers. Prison records noted that Mr Neal had not identified any next of kin. After Mr Neal was taken to hospital, hospital records identified that his ex-partner was his next of kin. However, his ex-partner was the victim of his offence and he had not been allowed contact with her. The family liaison officers went through Mr Neal's prison documents to try and locate another next of kin. They contacted his solicitor and the police. On 9 August, the police decided to visit Mr Neal's ex-partner and broke the news to her that he was critically ill in hospital. Mr Neal's ex-partner contacted the hospital thereafter to receive updates on his condition.

86. After Mr Neal died, the police informed Mr Neal's ex-partner. Mr Neal's brother, who was living abroad, also contacted the prison and was provided with further information about Mr Neal's death. Wayland contributed to funeral costs in line with national instructions.

Support for prisoners and staff

87. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. This included a hot debrief, chaired by a prison manager, for staff involved in the emergency response and Listeners (prisoners trained by the Samaritans to provide confidential peer-support) being engaged to identify prisoners most affected by Mr Neal's death.

Post-mortem report

88. Mr Neal died in hospital. The treating doctor noted his cause of death as anoxic brain injury (when the brain is deprived of oxygen) due to a hypoxic cardiac arrest (when there is not enough oxygen in the blood) which was caused by hanging. The Coroner did not request a post-mortem report and no toxicology tests were done.

Inquest

89. The Coroner's inquest concluded on 30 September 2025. The jury returned a narrative verdict, concluding that Mr Neal died as a result of a deliberate hanging, but his intent at the time is unknown.

Findings

Assessment and management of Mr Neal's risk of suicide and self-harm

90. When Mr Neal arrived at Wayland in July 2024, he had a number of risk factors for suicide and self-harm: he had a history of attempted suicide, mental health problems (anxiety and depression), substance misuse and had a spinal/neck injury that caused him pain and affected his mobility. He was taking antidepressant medication and painkillers. Mr Neal was supported under ACCT procedures from 1 August until he died. Throughout this period, Mr Neal constantly complained about being in pain, said he had anxiety, his mood was low and he missed his family. All these factors appeared to contribute to Mr Neal not wanting to engage fully with the healthcare team and not taking his medication.

91. We found that, overall, the ACCT procedures were managed reasonably well. Mr Neal's first and only case review was timely and multidisciplinary, with two members of the healthcare team in attendance. However, we also identified some deficiencies.

ACCT observations, communication and sharing of risk information

92. At the time of Mr Neal's death, Prison Service Instruction (PSI) 64/2011, governed staff responsibilities regarding ACCT suicide and self-harm prevention procedures. It required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

93. In November 2024, a revised Prison Safety Policy Framework was issued, which was fully implemented on 1 January 2025. It states that all staff have responsibility for ensuring that ACCT procedures are started if they believe a prisoner to be at risk of suicide or self-harm. Both PSI 64/2011 and the Prison Safety Policy Framework contain guidance and mandatory instructions on using ACCT procedures to manage prisoners at risk of suicide and self-harm. They highlight that staff should ensure they identify and record a prisoner's relevant risk information, which must be kept up to date and made accessible to all staff involved in their care. Information about Mr Neal's well-being was not always recorded and shared with staff and therefore could not be taken into account when assessing his overall risk of suicide and self-harm. Officer A told us that Mr Neal had made "off the cuff" remarks about harming himself, but she did not record them.

94. On 6 August, Mr Neal's cellmate (who he apparently got on well with) was relocated. We found that staff did not record this information in Mr Neal's ACCT document, nor did it appear that anyone spoke to Mr Neal to explain the move, see how he was or consider whether they should try and find him another cellmate.

95. Approximately 90 minutes before staff found Mr Neal unresponsive, he told staff that he was struggling and wanted to be able to come out of his cell. This was an indication that his risk may have increased. The PSI highlights that if there has been a change in a prisoner's behaviour that causes concern, an urgent ACCT review should take place.

96. Officers A and C acknowledged that they were concerned about Mr Neal and took some steps to try to provide additional support. At the time, Mr Neal was subject to only two checks during the day. Officer A attempted to seek advice from a more senior officer about increasing the frequency of Mr Neal's ACCT observations. However, no SOs were available. She was in the process of emailing for advice when Mr Neal was found unresponsive. In the absence of any specific guidance, Officers A and C decided that they would informally check Mr Neal more often than required. In fact, they did not make any additional checks in the 90 minutes before a prisoner found Mr Neal unresponsive, but we accept that this was a relatively short period of time and as the only officers on the wing, they undoubtedly had other duties to attend to. While the officers were concerned about Mr Neal, we conclude that there was not sufficient evidence to indicate he was in crisis and consider that they made reasonable efforts to try to keep Mr Neal safe.

97. In the context of the omissions in Mr Neal's ACCT and how staff assessed his risk, we make the following recommendation:

The Governor should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and, in particular, the need to record, share and consider all relevant information about risk.

Falsification of records

98. Overnight from 6 to 7 August, Officer B recorded several ACCT checks that he did not do. Following an internal investigation, he was dismissed.

99. We view the falsification of any document by a public servant extremely seriously. There may be many factors that prevent any routinely required check from taking place at the relevant time, which can be excused by the urgency of other duties. However, the recording of a check that has not taken place is a deliberate, and considered, act with intent to deceive. This dishonesty is most grievous when the action lied about was monitoring the welfare of an individual known to be at heightened risk, like Mr Neal, and who we now know, later took his own life. The fact that we come across such practice within HMPPS on a number of occasions every year gives cause for some concern and we will, as a matter of policy, refer all such instances to the police. The police response in this instance, was that as the falsified checks had no impact on Mr Neal's death they would not pursue further.

100. In October 2024, HMPPS' Director General of Operations instructed prisons to randomly sample CCTV footage to confirm that staff were carrying out ACCT observations as they had recorded. At the time of writing in March 2025, Wayland was setting up its quality assurance process, with a plan to compare recorded ACCT checks against CCTV twice a week. The prison told us that this process would begin very soon. We therefore make no recommendation.

Clinical care

101. The clinical reviewer found that the healthcare that Mr Neal received was partially equivalent to that he could have received in the community.

Physical healthcare

102. Despite Mr Neal's ongoing reported pain, mobility concerns, and poor compliance with his medication, there was no evidence that this was brought to the attention of the primary care team. This meant that there was no person-centred assessment of his pain or mobility, and it appeared that the sole plan was for his physical health to be further assessed at his GP appointment on 8 August. The commencement of ACCT procedures, and identification that Mr Neal's primary concern – and therefore risk - was his pain, should have triggered the healthcare team to have arranged a more urgent assessment Mr Neal's pain and mobility.

103. The nurse who was present at the ACCT review, acknowledged that as a mental health nurse she had no specialist knowledge or skills to assess Mr Neal's pain and mobility. Given Mr Neal's increased risk, healthcare staff should have requested Mr Neal's planned GP appointment on 8 August was changed to an urgent appointment and brought forward.

104. The clinical reviewer notes that, in line with NICE Guidelines (National Institute for Health and Care Excellence), relating to the management of chronic pain, Mr Neal should have had an immediate assessment of his mobility or support to understand how his pain impacted on his daily life, including mental health factors. This should have been completed to also understand how staff could improve Mr Neal's compliance with his medication. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that when prisoners subject to ACCT monitoring have concerns with their physical health, they are referred to the primary care team to assess and review the prisoner's health and care plan in line with NICE Guideline NG57 'Physical Health of People in Prison'.

Mental healthcare

105. The clinical reviewer concluded that Mr Neal's mental state and behaviour were not monitored in accordance with the psychiatrist's assessment on 25 July. She noted that this was due to there being no process in place to identify actions which needed to be followed up from consultations. We make the following recommendation:

    The Head of Healthcare should ensure that the mental health team has a standardised process for communicating actions agreed during consultations with healthcare staff and update the standard operating procedure to reflect this.

Medication

106. Mr Neal was compliant with his medication from when he arrived at Wayland until 29 July. After this, he failed to collect his morning medication (citalopram and gabapentin) six times in eight days and said that this was because his increased pain meant he was unable to comfortably walk to the wing to collect it. He continued to collect his gabapentin and amitriptyline at 4.00pm. The clinical reviewer noted that his poor compliance with gabapentin at 8.00am, meant that his pain relief was not optimised and may have contributed to him experiencing more severe pain.

107. Mr Neal was located in a cell on the first floor of M Wing. The medication hatches where he had to collect his medication were located on N Wing and B Wing.

108. The investigation found that for Mr Neal to walk from his cell to the exercise yard and back would have taken about three minutes and included 34 steps. For Mr Neal to walk from his cell to the two medication hatches, on N Wing and B Wing, and then back to his cell, would have taken around 20 minutes, and included 110 steps. Mr Neal was required to do this at 8.00am and 4.00pm each day. Therefore, Mr Neal's ability to walk to the exercise yard should not have been considered evidence that he could also walk to the medication hatches twice daily.

109. At interview, the Head of Healthcare told the investigator that if a prisoner had mobility issues, then healthcare staff could ask prison staff to move them to a different cell, closer to the medication hatch. We found no evidence that staff considered moving Mr Neal. There is no evidence that healthcare staff conducted any kind of assessment of the impact of the distance Mr Neal was expected to walk, or identified if any reasonable adjustments or adaptations could have been made to support Mr Neal in receiving his prescribed medication. This could have included a recommendation that Mr Neal be relocated to a cell closer to the medication hatches or administering his medication from one hatch instead of two, which could have reduced the distance he had to walk.

110. Staff did not consider how Mr Neal's noncompliance with his citalopram may have affected his mental health and his risk to himself. This was especially important as Mr Neal may have experienced withdrawal symptoms, something that can appear within a few days of reducing or stopping such medication. These symptoms can include low mood, confusion and problems sleeping, all of which Mr Neal had complained about.

111. Practice Plus Group's Local Operating Procedure, *Managing Omitted Doses of Medication (at Wayland)* states that if a prisoner does not attend the medication hatch to collect his dose of medication, healthcare staff should liaise with an officer and ask for the prisoner to be sent to the hatch. M Wing staff tried to encourage Mr Neal to collect his medication but he often refused. The operating procedure also states that if a prisoner misses three consecutive doses of their medication, the prisoner should be discussed in the handover meeting and a query or task on their electronic medical record created and sent to the prescriber to follow up. However, we found no evidence that this happened after Mr Neal missed four doses of citalopram between 30 July - 2 August, nor that healthcare staff had spoken to or planned to speak to him about his noncompliance. Had this been done, it could have better informed any subsequent discussions about his mental health. We make the following recommendations:

The Head of Healthcare should ensure that when prisoners do not attend for their medication on a number of occasions, a plan is documented within their medical records to ensure a multi-disciplinary approach is taken when reviewing their care.

The Head of Healthcare should incorporate closer healthcare observations for prisoners who are not compliant with their antidepressant medication, to monitor withdrawal symptoms and any adverse effects.

112. The clinical reviewer also made a number of other recommendations not directly related to Mr Neal's death which the Heads of Healthcare at HMP Bedford and HMP Wayland will wish to address.

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