Investigation into the circumstances surrounding the death of a man at HM Prison Bedford in July 2006

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Bedford in July 2006. Shortly after 1.00pm that day, the man was found hanging in his cell. He was aged 33.

I offer my sincere condolences to the man's parents, his partner and his friends for their tragic and untimely loss. Although the complexity of the issues raised by his death necessitated a long and detailed investigation, I must also offer them my apologies for the length of time it has taken to produce this report.

The investigation was conducted by my colleague.

I would like to thank the Governor and his staff at Bedford for their help and co operation during the investigation. The death of this man is the fourth apparently self-inflicted death I have investigated at HMP Bedford since April 2004.

I also commissioned an independent clinical review of the management of the man's health needs while he was in prison. This was conducted by a representative of the Bedford Primary Care Trust (PCT). I am most grateful to the PCT for undertaking this review. However, both the Coroner and Bedford PCT may wish to consider whether there are additional issues relating to the man's mental healthcare needs that would benefit from a further examination.

Two months after he had first been received at Bedford, the man had been transferred to HMP Woodhill near Milton Keynes where he remained for nearly two months. On 1 June 2006, he returned to Bedford. There were marked differences between the two prisons in the way in which his risk of self-harm was managed. At Woodhill, there was a greater willingness to consider the wider issues the man presented when deciding whether to care for him in the healthcare centre or in normal residential accommodation. I consider that his mental health needs were appropriately met and managed at Woodhill.

However, I am critical of the decision not to admit the man to the healthcare centre at Bedford on the day before he died, when his suicidal ideation, his paranoia and his frequent acts of self-harm were in my view such that his admission would have been appropriate. That said, I also found an example of good practice at Bedford to which I refer at the end of my report.

Healthcare and other prison staff have to make decisions in very difficult circumstances on a daily basis. Although I am critical of some of the decisions made about the man, I am not suggesting that any one decision was responsible for his death. However, there are some important learning points for Bedford to take on board in the context of this investigation. I make a number of recommendations that I hope will help to prevent further similar tragedies occurring there and elsewhere in the Prison Service.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2007**

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SUMMARY

On 10 February 2006, the man was arrested for assault. After appearing in court he was remanded in custody at HMP Bedford to await trial. A week later he was sentenced to two years and three months imprisonment. He had not been in prison before.

The man told staff on reception at Bedford that he had a history of depression, and that in 1999 he had been involved in a road traffic accident that left him with significant head and other injuries. He said that, as a result of his injuries, his personality had changed. Although he declared that he had taken an overdose of drugs a year earlier, he did not currently feel suicidal.

The man was admitted to the prison's healthcare centre straight after the completion of reception procedures in order to receive treatment for a skin condition. On 17 February, after a court appearance, he was discharged to a wing where initially he settled down. However, on 30 March he told an officer that he was being bullied. He was offered a chance to move to the vulnerable prisoner unit (VPU) but said he preferred to remain where he was. On 4 April, he changed his mind, telling staff that he had been spat at and called a "grass". At his own request, the man was moved to the VPU in F wing.

On 6 April, the man was transferred to HMP Woodhill because it was thought he presented a threat to security as his father had been employed at Bedford prison some time earlier.

Two days after his arrival at Woodhill, the man told staff he wanted to self-harm. An ACCT (Assessment, Care in Custody and Teamwork) form was therefore opened. (This is a document used to monitor and manage those prisoners considered to be at risk of self-harm or suicide.) From this point, formal self-harm monitoring procedures remained in force until the man's death.

On 16 April, the man was admitted to the healthcare centre at Woodhill after self-harming and because there were concerns about his suicidal ideation. He remained in the healthcare centre until 25 April, when he was discharged to the prison's vulnerable prisoner unit. On 19 April, he was assessed by a psychiatrist whose preliminary opinion was that he was actively psychotic and paranoid.

On 1 June, the man was transferred back to Bedford. On 7 June, he was admitted to the healthcare centre after his CARATs worker (drugs worker) expressed her concerns about his low mood and threats to take his life. He remained in the healthcare centre until 26 June. On that day, he was discharged to the VPU.

At the beginning of July, the man was placed in a cell with another prisoner because it was thought he needed a "buddy". The next day, they were separated because the man had taken a dislike to the other prisoner.

Thereafter, the option of transferring the man to another prison was frequently discussed. However, he remained at Bedford.

A few days before the man's death, his parents separately called the prison to alert staff to their concerns about his mental state: he had told them he wanted to kill himself. The chaplain took both calls, spoke to the man at length and attended an ACCT case review that day. The chaplain called the man's parents later that day to reassure them that staff were aware of their concerns.

For several days before his death, the man frequently cut his wrists superficially and talked of wanting to kill himself. Healthcare staff took the view that he did not need to be admitted to the healthcare centre. They felt his wounds could be treated on the wing and there was no evidence that he was suffering from any specific mental illness.

Two days before his death, a cell sharing risk review was carried out after the man told staff he could not cope with having to share his own space. In light of his assertion, the man's risk of harming other prisoners was assessed as being high. He was therefore placed in a single cell.

The CARATs worker told my investigator that the day before he died, the man had told her he had tried to hang himself during the previous night, and that she had seen red marks on his neck. She said she raised these issues during a subsequent case review convened that afternoon. She said she represented her view that the man should be admitted to the healthcare centre and placed on a constant watch. The evidence is not clear on this point: there is dispute as to what was discussed at the case review. In the event, he was kept in the VPU and observed every 30 minutes.

Shortly after 1.00pm the next day, the man was found hanging in his cell in the vulnerable prisoner unit.

My investigation found that there seemed to be a greater willingness at Woodhill than at Bedford to consider the wider issues the man presented when deciding whether to care for him in the healthcare centre. I am critical of the decision not to admit him to the healthcare centre at Bedford the day before he died when his suicidal ideation, his paranoia and his frequent acts of self-harm were, in my view, such that his admission would have been appropriate.

That said, the structure and use of ACCT case reviews at Bedford as well as at Woodhill was impressive. The investigation also found an example of good practice at Bedford.

There are learning points for Bedford to take on board. These are expressed in a number of recommendations I have made

INVESTIGATION PROCESS

The investigation was opened three days after the man's death when my colleague met with the Governor of Bedford, together with a representative of the local branch of the Prison Officers' Association and a representative of the prison's Independent Monitoring Board. My colleague briefed them on the nature and scope of the investigation. On the same day, notices were issued to staff and to prisoners inviting anyone who wished to offer information relating to the man's death to make themselves known to my investigator.

I commissioned an independent clinical review of the management of the man's health needs while he was in custody. The review was undertaken by a representative of the Bedford Primary Care Trust.

Twenty one members of staff and two prisoners were interviewed at Bedford prison. As the man had spent eight weeks at Woodhill prison, a further seven staff were interviewed there.

On 21 September 2006, my investigator and one of my family liaison officers met with the man's mother. During this meeting, she raised a number of concerns that she wanted my investigator to take into consideration. On 29 September, my colleagues met with the man's father who raised a number of concerns of his own. Every effort has been made to address the parents' respective concerns in this report.

THE TWO PRISONS

HMP Bedford is a small local prison located near the town centre. The prison serves Magistrates' and Crown Courts in Bedfordshire, Cambridgeshire and North Hertfordshire. At the time of the investigation it could hold up to 494 male adult prisoners.

Healthcare at Bedford is commissioned by the Bedford Primary Care Trust. The healthcare centre provides 24 hour nursing cover and has inpatient beds for up to 13 prisoners.

The prison was last inspected by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, in April 2006. The report of that inspection congratulated the establishment for the improvements it had made in a number of areas since the previous inspection in January 2004. The Chief Inspector commented that Bedford remained fundamentally a safe prison. Following an apparently self-inflicted death at the prison prior to the inspection, steps had been taken to respond to the emerging lessons from that death.

In their report about Bedford for the period July 2005 to June 2006, the local Independent Monitoring Board commented that, under their new Governor, staff had continued to build on the changes made in recent years. Where suicide prevention was concerned, the Board said Assessment, Care in Custody and Teamwork (ACCT) had been started in September 2005 and vulnerable prisoners were regularly assessed. They drew attention to the fact that two prisoners had died during the reporting year. The Board also commented that, since the Bedfordshire Primary Care Trust had taken over the running of the healthcare unit in April 2005, staffing levels had increased and the unit continued to be motivated and well run in spite of several managerial changes. The Board reported that staff continued to cope very well with the mental health needs of many of the prisoners.

The man's apparently self-inflicted death is the fourth such death I have investigated at Bedford since April 2004.

HMP Woodhill

Opened in July 1992, Woodhill is a high security local prison in Milton Keynes. At the time of the investigation the prison could hold up to 762 prisoners in single or double cells.

The accommodation at Woodhill comprises seven separate house units, each with a different role. House unit 4B is used as a vulnerable prisoner unit.

Healthcare at Woodhill is provided by the Milton Keynes Primary Care Trust. The healthcare centre provides 24 hour nursing and medical cover.

Woodhill was last visited by Her Majesty's Chief Inspector of Prisons in August 2005. The report of that inspection contained no issues or recommendations relevant to this investigation.

KEY EVENTS

The man's time in custody can be divided into the following distinct phases:

- Phase One - Bedford prison, between 10 February and 6 April 2006
- Phase Two - Woodhill prison, between 6 April and 1 June 2006
- Phase Three - Bedford prison, between 1 June and July 2006

Phase One: Bedford, 10 February - 6 April 2006

On 10 February 2006, the man appeared at Bedford Magistrates' Court along with two co-defendants, charged with assault. He was remanded in custody at Bedford prison. He had never been in prison before. The Prisoner Escort Record (PER) for the journey from court to prison that day contained no notations of any risk of self-harm or suicide.

A cell-sharing risk assessment was completed as part of the reception procedures. This concluded that the man presented a low risk of harming others and raised no concerns about any risk of harming himself.

The man also underwent a first reception healthscreen. He said he had seen a doctor recently about "a gastric problem" and that an appointment had been made for him to undergo an endoscopy in May. He also disclosed that he had been prescribed Flucloxacillin (an antibiotic), Mebaverine (an anti-spasmodic drug prescribed for irritable bowel syndrome), Omeprazole (an anti-ulcer drug) and Domperidone (an anti-emetic). The man drew attention to scars he had on his right upper arm as a result of injuries he said he had sustained in a road traffic accident in June 1999. He also said he had impetigo. His face and arms were covered in spots. He said he did not use alcohol and had not taken drugs in the previous month. However, he disclosed that he had taken cannabis in the past.

As far as his mental health was concerned, the man said he had been prescribed Zispin and Amitryptyline for depression a year earlier. He said that, about this time, he had taken an overdose of drugs and alcohol and suffered a "borderline" heart attack. However, he said he did not currently feel suicidal, despite being in prison. He was therefore not made subject to self-harm monitoring procedures. He said he wished to see a doctor. The healthscreen form does not indicate why this was so.

That evening, the man was admitted to the healthcare centre because of his skin condition. At 7.00pm, the following entry was made in his medical record:

> "The man is a 32 year old Caucasian man admitted from reception first screening this evening. Admitted to HCC [healthcare centre] due to his skin condition. He has been allocated a single cell. On arrival to HCC he appeared physically well. Pleasant on approach. Express no suicidal

> thought. Rational in his thought. Coherent when spoken with. He is in cell 9."

A psychological nursing needs assessment was carried out upon the man's admission to the healthcare centre. The RMN (Registered Mental Nurse) who carried out the assessment observed no abnormal behaviour. There were no expressions of any delusions or of any suicidal thought or intent. According to the RMN, the man had full insight into why he had been admitted to the healthcare centre.

A note made in his medical record on 15 February shows that the man's skin condition had improved. However, at lunchtime that day he complained of stomach pains. On 16 February, he complained that he was feeling bloated. He was told his blood samples would be taken the next day and his endoscopy appointment would be chased up. That night, he was described as "being in bright spirits, chatting freely, with no complaints". He accepted breakfast the following morning, along with his medication.

An induction and resettlement form was also completed on 16 February. This recorded that the man said he had not been in prison before but that he did not feel suicidal and had no immediate concerns. However, he asked to see a member of staff about organising his finances.

On 17 February, the man appeared at Luton Crown Court for sentencing. He received 26 months imprisonment for assault. On his return from court, he was assessed as being fit to be accommodated in a wing rather than in the healthcare centre. He was allocated to C Wing.

On 20 February, a general healthscreen was carried out. No significant issues arose from this screen.

On 24 February, a CPN (Community Psychiatric Nurse) saw the man. She summarised her consultation with him as follows:

> "No previous contact with mental health services. No obvious mental health issues noted or expressed. States his personality has changed over the past 6 yrs as a result of an RTA [road traffic accident] - claims to consume up to ¼ oz cocaine daily plus alcohol+++ - believes he has anger management issues - referral made to frustration groups."

On 2 March, the man completed his induction period and moved from C Wing to a single cell in B Wing. On 6 March, he was admitted to the healthcare centre prior to undergoing an endoscopy in an NHS hospital the next day. The endoscopy revealed a mild inflammation of the gastric wall. After the appointment, he returned to Bedford for symptomatic management of this condition locally.

On 21 March, an OASys (Offender Assessment System) report was completed. This recorded no concerns about any risk of self-harm.

On 29 March, the man was granted enhanced privileges for good behaviour. The following day, he told a manager he had been labelled a “grass” by other prisoners. The manager raised an anti-bullying form on which he noted the man’s claim but that no specific threats had been made towards him. The manager offered the man a move to F Wing - the prison’s vulnerable prisoner unit (VPU) - but he said he preferred to remain on B Wing. The manager asked him to bring to the attention of staff any changes in his situation immediately. He agreed to do so. The manager’s concluding remarks on the form were that no further action was required at that stage unless the man were to report a change in the situation or unless staff noticed any changes. The manager told my investigator the man did not want any further action taken.

On 4 April, the man changed his mind and asked to be separated from the main prison community for his own protection. On his application form he wrote:

> “I wish to be separated from the main core of prisoners for the following reason:
>
> For my own protection the reason is: Being called a grass and a bacon which I am not either. Being spat at from the landing. Fears for my own personal safety because of this.”

(The term ‘grass’ is a derogatory term used by prisoners to describe anyone whom they consider has informed on them. The term ‘bacon’ is a term used by prisoners to denote sex offenders.)

The man was moved to the VPU that day. His application for separation was formally approved by the Deputy Governor on 5 April. My investigator was told that, in the absence of any names or specific details, it was difficult to investigate the man’s claims.

Also on 5 April, a Prison Officer who regularly worked in the VPU made the following entry in the man’s wing history sheet:

> “Received from HCC. On F Wing two hours and has refused to work. Put behind his door. Power off.”

At interview, the officer told my investigator that prisoners were required to work. If they refused to do so, sanctions could be applied under the incentives and earned privileges scheme in operation at Bedford. One such sanction was the withdrawal of the privilege of watching television. On 5 April, the man refused to work. The officer therefore turned the power off in his cell so that he could not watch television. On the same day, the following further entry was made in the history sheet:

> “Spoke to the man in the presence of F Wing officers. He seems to have a bit of an attitude. He informed me that he has an issue with a prisoner on D Wing and was spat at whilst

> on B Wing. Spoke to officer in healthcare who stated that the man feels threatened by these prisoners. Spoke to an officer on E Wing. He is likely to accept him on Tuesday 11th."

Once again, in the absence of any specific details from the man and any corroborative intelligence, his claims could not be investigated. The signature of the member of staff who made the entry is illegible. However, the officer explained that staff in the VPU knew the man was unhappy in the unit and a move to another wing might "lift him from the condition he was in". The officer said E Wing held prisoners who were on the enhanced level of privileges and the man was fortunate to be considered for a move to that wing. However, as his co-defendants were also on E Wing, the move did not take place.

On 6 April, the man was transferred to Woodhill. My investigator discussed this transfer with a member of staff with responsibility for deciding upon prisoners' allocations to other prisons. The officer said the reason for transferring the man to Woodhill was that his father had, in the recent past, worked in the prison. As a result, staff in the security department were concerned that his knowledge of the prison might present a threat to security. The officer stressed there were no other reasons behind the transfer.

Phase Two: Woodhill, 6 April - 1 June 2006

Upon the man's arrival at Woodhill on 6 April, a Healthcare Officer carried out a reception healthscreen. In the medical record, she summarised her findings as follows:

> "Seen in reception, transfer from Bedford. Says he had tests for coeliac disease [a disease of the bowel] and endoscopy - all clear. Also suffers from depression and has felt like this for some time. Says was prescribed Zispin from his GP but has not taken these for about a year. Feels now he is in prison they may help (1st time in prison). Will refer for sick parade. Also states not sleeping well. Says attempted overdose two years ago and although wanted to die at the time has no suicidal ideation at present. Also says has been feeling lethargic for a few weeks and wishes to speak to a doctor today if possible."

That evening, a cell sharing risk assessment was completed. The man told staff he had no concerns about sharing a cell but he was a person who quickly became angry or frustrated. The following comments were made in the assessment form:

> "Tried to commit suicide a couple of years ago. Racist crime was against a Scottish person – has shared at Bedford and says he would share again – says no problems."

The Duty Governor of the day made the following concluding comments in the form:

> "The man says he is happy to share a cell and has done so before. He has been in prison for 2 months and is really annoyed that he has been moved. Previous suicide attempt (overdose and alcohol). Occasionally feels anxious and like doing harm but reacts by 'filling someone in'. Informed of support mechanisms (Insiders, Listeners, and access to HCC). Will be located in shared cell. Medium risk - stated when anxious can react badly. Also offence GBH."

The next day, the man declined to take lunch and refused to attend a visit with two members of his family. Staff were so concerned about this that they decided to refer him to a doctor so that his mental state could be properly assessed. Consequently, a locum GP at Woodhill saw the man later that day. The GP made the following entry in the man's medical record:

> "Known depression, was taking mirtazapine [an anti-depressant]. Stopped medication 1 year ago by himself. Low mood, not sure about suicidal thought at present, not self-harm. Attempted suicide 2 years ago (alcohol and sleeping tab). Request to restart mirtazapine.
>
> 1. mirtazapine tab 30mg x od x 28d.
>
> 2. refer to MHIRT [mental health in reach team]."

On 8 April, an entry was made in the man's wing history sheet to record that he was very depressed and had made a statement of intent to self-harm. As a result, an ACCT (Assessment, Care in Custody and Teamwork) form was opened. (This is a form used to monitor, review and manage any prisoner considered to be at risk of self-harm or suicide.)

At 10.00am on 9 April, an officer conducted an ACCT interview with the man. The officer recorded that the man's main problem was that he did not want to be in prison. The man did not know why he had been transferred from Bedford. He told the officer he had had enough. He had never been in prison before and could not cope. The officer added that the man had not made any attempt to self-harm but had thought of killing himself. She wrote that he had tried to commit suicide 'a couple of years ago' by taking an overdose of drugs and alcohol. He told the officer he felt a lot of his problems related to a change in his personality because of a head injury he had sustained in an accident. The man said that before he came into prison, he had asked for help from psychiatrists but had never managed to achieve this. He was now keen to be referred to the mental heath in-reach team as he had mental health problems that had not been addressed. His girlfriend was keen to support him while he was in prison. He told the officer he had already been in the vulnerable prisoner unit at Bedford because he had been called a 'grass' and a 'bacon'. He did not wish to be allocated to a similar unit at Woodhill, although he was aware the option was available to him.

The officer decided to refer the man for a detoxification programme and to the mental health in-reach team (MHIRT). She also made out a care plan for him. The plan required that he should remain in a safer cell (a cell designed to minimise the risk of suicide), should be referred for mental health assessment and to the CARATs (Counselling, Assessment, Referral, Advice and Throughcare services) team, and should be supported in maintaining contact with his girlfriend. Other goals included increasing his medication, encouraging interaction, monitoring his behaviour and recording progress. The record shows a referral to the MHIRT was made the same day and that a referral to the CARATs team was made on 12 April.

At 10:45am that day, the first ACCT case review was convened. This was chaired by a manager. An officer was also present as was the man himself. The case review was summarised as follows:

> "The man says he is very frustrated at himself because he has ended up in prison due to losing his temper which he puts down to a head injury he sustained in an accident some time ago. He says he doesn't care about anything and doesn't want to be here which is why he is having thoughts of killing himself. He has said he has no plans of how to do this. He has agreed to move to a safer cell, and is grateful of being able to speak for himself although he sees this as a weakness. He has been in contact with his girlfriend who he is looking forward to visiting. He has explained definite plans for the future, getting out and being with his girlfriend. Agreed to have one observation am, pm and ed [evening] and 3 observation at night. He is happy to speak with mental health in-reach team".

The likelihood of further risk behaviour was considered to be low. However, it was decided to make an urgent referral for mental health assessment. The next case review was scheduled for 16 April.

On 16 April, the following entry was made in the man's medical record by a Healthcare Officer.:

> "Concerns for the man's mental state. He has said he is thinking of jumping from 3s landing and has made cuts to his right arm last night in his cell which was not reported to staff. He also claims he is prescribed Zispin for his depression but has not been taking it because it makes him feel funny. To see a doctor this am. Doctor is aware."

There is no evidence to show whether a form F213SH was completed. (This is a form on which the details of a self-inflicted injury to a prisoner are recorded.) My investigator was told that its absence was most likely due to the fact that the self-harm incident was not reported to staff at the time it occurred.

On the same day, the next ACCT case review took place as planned. The panel comprised two members of staff. The man was also present. The review was summarised as follows:

> "He says when I asked him how he was, says wants to end it all, has thought about jumping from the three's landing. Made an attempt of self harm last night with a plastic knife diagonally across his arm. Spoken to HCC Nurse ….to be seen by doctor in HCC this morning case review suspended due to this."

The man was seen by a doctor later that morning. The doctor wrote in the medical record:

> "Seen HCC.
> c/o [complains of] expressing suicidal ideation and intention to DSH [deliberate self harm]. Superficial lacerations to wrist. Feeling isolated because nobody is speaking to him. They think he is a grass. Sometimes gets very paranoid. Thinks people are talking about him. Was on mirtazapine, but stopped taking it. Hates being in prison, mostly would like to be transferred to Bedford prison. Currently does not associate with anybody on the wings making him feel isolated. Says life not worth living. Has 11 months left to do."

The doctor decided to admit the man to the healthcare centre.
A Healthcare Officer completed a clinical assessment form as soon as the man was admitted. She recorded as the reason for his admission the concerns expressed by wing staff about his expressions of suicidal ideation and his mental state. Also noted was the fact that superficial lacerations had been discovered on his right forearm.

An entry made in the man's medical file records that during the night of 16/17 April he told staff he could hear other prisoners making noises and he was being disturbed by them. The author of the entry, whose signature is illegible, noted the wing was quiet at the time.

On 17 April, a further ACCT case review took place at 10:30am. The review was chaired by a Healthcare Senior Officer. Two officers were also present as was the man himself. The review was summarised as follows:

> "The man is still very low in mood and is having fleeting thoughts of suicide. However, does not have any plans at the moment. Doesn't know the reason he was moved from Bedford and is having trouble adjusting to being at Woodhill."

The review panel judged that the man presented a high risk of self-harm. He was to be observed three times each session (morning, afternoon and evening) and hourly at lock up periods. The next review was scheduled for 23 April.

However, a further review took place that afternoon at 2.00pm. The review was summarised by another doctor as follows:

> "Inmate was refusing his lunch and refusing the visit for this afternoon. Very low in mood. Expressing suicidal ideation. No plans at the moment. Suicidal ideation getting worse. ACCT constant watch due to deteriorating of his mood and increasing of suicidal ideation."

The record of the review does not show who else was present.

At interview, the doctor told my investigator his decision to place the man on a constant watch was based on his concerns about both his paranoia and his suicidal ideation. The doctor stressed he was concerned that the man presented a high risk of killing himself rather than of simply self-harming. The man was therefore placed in cell 1 - 03 in the healthcare centre. This is a cell fitted with a metal grille instead of a solid wooden door so that the occupant can be seen at all times. The next ACCT case review was set for 18 April.

The decision taken on 17 April to place the man on a constant watch was clearly logged in his ACCT ongoing record. The case review summaries after that date show that was kept on a constant watch until 25 April.

At 10:15am on 18 April, the following entry was made in the man's ACCT ongoing record by an officer:

> "… Says he feels he has nothing to live for and spends his day looking around his cell for places to hang himself. Says he feels particularly suicidal at night. He also says the best way to hang himself is in his bed using his sheets and twisting himself around. Night staff be aware. I have suggested that he should maybe try to find purposeful activity to fill his days and make his time pass more quickly."

Further entries were made in the ongoing record at 10:30am, 11.00am, 11:30am, 12:30pm, and at varying intervals thereafter. At 4:05pm, the following unsigned entry was made:

> "Spoken to the man reference his counselling. He had a very serious motorcycle accident, sustained a head injury, broken neck, said he hit a railway bridge. This was 7 years ago. He said he was moved from HMP Bedford as his dad worked there. He does not work there any more. According to the man, he attempted suicide two years ago. Says that he has suffered mood swings since the accident. Has self-harmed yesterday and is not eating. Said he preferred it when he was in Bedford. Said his two co-defendants were in HMP Bedford. Mentioned that he was hoping to be eligible for HDC [Home Detention Curfew] in October and wanted to know who his Probation Officer was. I said this would be looked into nearer

> the time. Mentioned that I am happy to be involved with ACCT reviews and to submit an application if he requires any further help."

There is no evidence to show that the case review scheduled for 18 April took place. However, the first of two nursing care plans was set out by the healthcare team at Woodhill on that day. The plan highlighted two concerns: The man's low mood and his expressions of suicidal ideation. Two short-term goals were included in the plan. The first was to provide the man with a safe environment. The second was to keep him on a constant watch. Three longer-term goals were also set out. The first was to raise his mood. The second was to prevent him harming himself. The third was for the man to be able to "recognise and deal with stressors in an appropriate way". The care plan included the following interventions:

- to admit the man to the healthcare centre
- to nurse him on constant watch
- to refer him to the mental health in-reach team
- to offer support and to engage him in a therapeutic environment
- to encourage him to talk about his feelings
- to encourage him to adopt appropriate coping strategies.

The same day (18 April), the man was seen by a representative of the mental health in-reach team. He made a record of the fact that the man had been assessed, that his case had been accepted by the team and that a key worker, who was another member of the Mental Health in-reach Team, had been allocated. The key worker later made a note in the man's medical record to record that she would arrange for a psychiatrist to see him. She also noted that the Mental Health in-reach Team would review him after two weeks.

On 19 April, the man was seen by a psychiatrist who summarised his assessment thus:

> "Been at Woodhill a short time, transfer from Bedford. 2 year sentence for GBH. 1st time in prison.
>
> "6 yrs ago in m/cycle accident including head injuries. No idea how long in coma. Hit railway bridge @ 135 mph - was pillion. Driver out of hospital in a week. He was hospitalised x5months. After he left hospital noticed his personality had changed. 'I've been on a mad one for 6 years.'
>
> "However, things were ok at HMP Bedford. 'Don't know why they moved me. They ghosted me out. The officers were laughing at me in the van on the way over. When I got here they were shouting at me - called me a nonce and a rapist. I know I am under investigation. The screws and the cons all laugh at me. It goes on all night. Keeps me awake.'

> "Thinks someone may be messing with his thoughts - not sure. However, I am fairly certain he is experiencing auditory hallucinations - 2nd and 3rd person.
>
> "Says not eating or drinking – 'there is nothing to live for. If I get the chance I will kill myself. '
>
> "Preliminary opinion:
>
> 1. Actively psychotic and paranoid. Agrees to try Risperidone [an anti-psychotic drug] 2mg BD [i.e. twice daily].
> 2. Although suicidal, he is not clinically depressed. So stop
> 3. Continue on constant obs - high risk of DSH.
>
> I will review again tomorrow."

In fact, the psychiatrist saw the man again on 24 April. The investigation found no evidence to show the man was under investigation by the police.

On 21 April, a member of the Mental Health in-reach Team saw the man again and made the following entry in his medical record:

> "Seen by MHIRT.
>
> "Reviewed after he stated that he wished to 'confess'. States he wants to confess to rape. Knows that he is guilty because officers stand outside his cell and laugh at him. Other inmates on other wings shout 'rapist' and the police have put hidden cameras in his house which he knows are there because he gets feedback in his head. Unable/unwilling to accept any other explanation -? Delusional in intent.
>
> "Still actively psychotic and also expressing suicidal ideation and intent.
>
> "Discuss with a Prison Officer re ACCT review. In my opinion he should remain on c/w [constant watch]."

Also on 21 April, an ACCT case review was convened in the healthcare centre. It was attended by a member of the Probation department an officer and a nurse. The MHIRT representative contributed over the telephone. The panel was chaired by the case manager for that day. The review was summarised as follows:

> "The man has recently had his medication changed and appears to be benefiting from this. He is a little confused as to what is wrong with him. The psychiatrist will be seeing him on Monday so hopefully a diagnosis will be made and he can move. Appears a little more positive has a lot to live for,

girlfriend, house, money etc but states he still hears voices. Remain on constant supervision."

The panel considered that the man still presented a high risk of self-harm. The next review was scheduled to take place on 24 April. A reference to the ACCT case review was recorded in his medical record.

The next ACCT review took place, as planned, on 24 April. During the review, the man told the panel he preferred his own company and he wanted the constant observations to cease. He said he felt better and knew he could speak to staff if he felt down. He wanted to be moved to an ordinary cell. The panel concluded the constant observations could be terminated and decided to move him to a normal cell where he was to be observed on an hourly basis.

On the same day, the following entry was made in the man's medical record:

"Mood much better. Not hearing voices. No suicidal thoughts or intent to DSH. Would like to come off constant observation. Would like some work in the wing. Agreed to discontinue constant observation. Continue hourly observations."

The following further entry was made in the medical record:

"Increase Risperidone to 3mg bd (twice daily)."

(Risperidone is used to treat patients with acute psychiatric disorders. It helps to alleviate symptoms such as hallucinations and thought disturbances.)

The psychiatrist saw the man again that day. He wrote in his medical record:

"Making some progress. Has already requested an increase in Risperidone today. I agree with increase to 3mg bd. Can be further increased to 4mg bd in a few days if indicated.

"Tells me he still has symptoms and is 'just the same' but in fact closer examination confirms he is improving. As I'm about to go on 2.5 weeks' leave, I will hand this case over to a colleague (another psychiatrist).

"Please observe for evidence of EPSE [extra perennial side effects] and start Procyclidine if necessary.

"Asking if he can be transferred to hospital 'for a proper evaluation'- he has heard of Orchard Clinic. Otherwise he would be a case for Three Bridges S.U. [Secure Unit] Told to wait and see how he responds to present meds."

At 9:40am on 25 April, a further ACCT case review took place in the healthcare centre. This was chaired by the case manager and attended by a

nurse and a doctor. The review summary described the man as "a lot brighter in mood" and keen to be moved out of the healthcare centre. Consequently, the level of observations was reduced to three per session (morning, afternoon and evening) and five during the night. The panel considered that the man's risk of self harm was now low. A further ACCT review was set for 2 May. The doctor, who was present at the review, made the following note in the man's medical record:

> "Reviewed. Requesting transfer to o/l [ordinary location] … Slept without his sleeping tabs. Feeling better in himself. Says he has no intention to self-harm or kill himself. Plan: Reduce observations to 3 per session 5 at night. Fit for o/l [ordinary location]."

Another review was held ten minutes afterwards, with only the case manager and the man present. The purpose of this review was to assess the man's readiness to be discharged from the healthcare centre. The case manager summarised the review as follows:

> "Talked at length following the review with the MO. Very keen to go back to o/l as he feels being on HCC is doing him no good. Discussed coping strategies on the wing and support mechanisms."

The man was discharged from the healthcare centre to Unit 4B - the vulnerable prisoner unit (VPU) - later that day. A follow-up healthcare appointment was planned for 2 May.

The next day (26 April), an ACCT case review was convened on the unit to which the man had been discharged. He was reported to be glad to leave the healthcare centre. However, he asked to be moved from the cell to which he had been allocated as he was not getting on with his cell mate. He told the review panel he had not self-harmed during the previous week and had no thoughts of doing so. The chair of the panel decided to keep the ACCT form open for up to two more weeks to allow him time to settle on the unit. A further case review was scheduled for 10 May. The review summary did not mention the level of observations/interactions required but it did specify that a Probation Officer was to be invited to the next review. (In fact, the next review took place on 12 May.)

At 11.00am on 3 May, the man was seen by a psychiatrist, who recorded his consultation as follows:

> "I have read his notes. Currently on Risperidone 3mg bd. Preliminary imp: acutely psychotic. Previous history of depression. RTA (6 yrs ago) 'I was alright till yesterday.' Upset that he has to share a cell with another inmate. 'I want single cell.' Believes he is not coping in a shared cell with another prisoner. 'I may get wound up.' He didn't make any specific threats towards the new inmate in his cell. No specific

intention to harm this inmate. Sleep disturbed since yesterday. Want to increase Risperidone to 4mg bd.

"c/o [complains of] other inmates calling him 'grass' 'rapist'. No-one specific. Not confronted anyone. Not associating as much as before. Believes police are still 'trying to make a proper case' against him. Believes they have been into his home last week (info from GP). No other psychotic symptoms. Denies thought interference. Denies thought of self-harm. Last od 3yrs ago. Never been inpatient in 4 unit before.

"Plan: Increase Risperidone 4 mgs bd
Continue other meds
Review again 2/52 by my colleague."

At 11.00am on 7 May, the following entry was made in the man's medical record by a Healthcare Officer:

"Went to see this inmate with a Senior Officer after 4B staff had raised concerns about his suicidal ideation. He had written a letter to his partner about not being here anymore. He stated that he needed to have some medication to calm him down a bit. He said he felt it difficult to sit down and relax. I informed him that he was being moved from the 3s landing to the ground floor because of his paranoia. He said that he did not want to go to HCC on a constant watch. I asked him if he had attempted suicide before. He said yes, I cut my wrists and failed. I phoned the prison doctor and explained what was happening. He has referred him to MHIRT and will be seen by a psychiatrist next week. I increased his observations to one per hour on his ACCT. I issued his lunchtime meds at 11:45hrs and he appeared to have calmed down."

At interview with my investigator, the Healthcare Officer (HCO) explained that, whilst in the VPU, the man had said he wanted to jump off the third floor landing. The man had also said he thought he was going to be thrown from the landing. The decision to move him to the ground floor was a precaution. The HCO also explained that, in his letter to his partner, the man wrote that he wanted his life to end but did not know when or how that would happen. My investigator was unable to establish whether the letter was posted or whether anyone from Woodhill contacted the man's partner to tell her about his state of mind. The HCO thought the reason behind the man's reluctance to be placed in the healthcare centre on constant watch was that he had an aversion to being locked in a gated cell with someone staring at him all the time.

At 11:30am, it was noted that the man's observations had been increased to hourly, he had been moved to the ground floor landing and he had refused admission to the healthcare centre.

On 10 May, the man's case was reviewed by a doctor who noted in the medical record that he had complained about experiencing side effects of the medication he had been prescribed. The doctor wrote that the man was still describing feelings of paranoia and he thought that other prisoners were conspiring against him for being a 'grass'. The doctor was unable to detect any clear positive psychotic symptoms other than the underlying theme of persistent paranoia. The man no longer wanted to take Risperidone because of the side effects it was causing him. The doctor therefore suggested Olanzapine should be tried - initially 10mg by night. (Olanzapine is an anti-psychotic drug prescribed for the treatment of schizophrenia.)

The doctor concluded the record of his consultation by suggesting that, on his return from leave, his colleague, a psychiatrist, should consider referring the man to Three Bridges Regional Secure Unit for a full assessment under Section 47/49 of the Mental Health Act to establish whether he was suffering from a psychotic mental illness.

At 9:30am on 12 May, the next ACCT review took place in the VPU. The review was chaired by a Healthcare Officer and was attended by a Senior Officer. The man was also present. A representative of the Mental Health in-reach Team was consulted over the telephone. The review summary noted that the man had self-harmed that morning but no details of the event were recorded in the summary. The Healthcare Officer wrote:

> "Have spoken at length to the man after self-harming this morning. Feels that he is not being helped. Seen by the doctor this week. Medication reviewed and changed. Says he doesn't want to be at Woodhill**.** Is for transfer to Littlehey but has outstanding court appearances so no move until all completed. Says he won't be able to do the seven weeks until court.
>
> "Plan: ref HCC call up this afternoon, review location. Mental health to liaise ref doctor's examination + medication review. May need some time back in HCC until medication change has taken effect."

No details of the man's self-harm were evident in his core prison record or in his medical record. Neither was there any evidence to show whether a form F213SH (report of a self-harm injury sustained by a prisoner) was completed. On the same day, another doctor made the following entry in the man's medical record:

> "See notes dated 10. 5 06. Respiridone has been stopped. Started with Olanzapine tab 10mg nocte [by night].
>
> "Mood swing, at present low mood, cut wound to right forearm with the ID card. 5 cut wound … Said it is self-harm. No intention of suicide at present. Said hearing voices sometimes. At present not hearing voices. Said he hates

himself. Said he is wrong in his head. Said he is psychopath. Requests to be admitted to HCC.

"Admitted to HCC
On open ACCT
Increase observation to 1 per hour
Agree to start with anti-depressant (Mirtazapine).

1. Mirtazapine tab 30mg xod x 28 days
2. Zoplicone tab 7.5mg xod x 5 days nocte
3. to continue olanzapine, procyclidine and nefo …[entry illegible]"

On 14 May, the next ACCT case review was held as planned in the healthcare centre. The review was attended by two members of staff. The man was also present. It was summarised as follows:

"The man stated that he felt everyone on HU4B thought he was someone else and was calling him a rapist and that he could not cope with it. When asked why he didn't tell the staff, he seemed to give the impression that he was expected to get on with it. We explored how he felt on HCC and he said it's ok here, as it is a smaller unit, but that he wanted to go to Littlehey a.s.a.p. He spoke of a girlfriend he has, but has not written to her or his father. We suggested that it may be a positive step for him to take, to keep his family ties going and to work toward having visits, which he agreed. As he has not self-harmed whilst being on healthcare, this time, we decided to reduce his observations to 3 per session and 5 per night, and to arrange for the next review in 7 days' time. "

The man's risk of further self-harm was assessed as low. The next review was to take place on 21 May.

On 15 May, the psychiatrist who originally saw the man reviewed him again. He wrote in his medical record:

"Has been on ordinary location but returned to HCC 3/7 ago after claiming he has "had enough".

Risperidone has been changed to Olanzapine 10mg /day.

Started on Mirtazapine but since this will not enable us to asses the effects of Olanzapine, I have stopped this again. Zoplicone also stopped.

Complains of memory problems – has never had neuropsych assessment since his RTA/coma. Can we try to obtain a basic one now?

> There is no doubt this chap has an abnormal personality but may also be psychotic. Still c/o being called a rapist on the wing. This may be hallucination but information has recently emerged that there is another inmate (who is a sex offender) with a similar surname.
>
> Agrees to increase Olanzapine to 15mg/day."

My investigator spoke to the psychiatrist over the telephone to ascertain whether he was aware of the earlier suggestion by his colleague on 10 May that he should consider referring the man's referral to the Three Bridges Regional Secure Unit for an assessment to establish whether he was suffering from a psychotic mental illness. The psychiatrist confirmed that his colleague had spoken to him about this matter. However, the psychiatrist told my investigator he preferred to bring the man up to a full dose of Olanzapine (i.e. 20mg per day) before considering a referral. He said that, in reaching this decision, he took account of the fact that, at the time, the man was on ordinary location at Woodhill and was showing no obvious signs of formal mental illness. The psychiatrist said he was also aware that the man's condition might have been caused by his accident.

On 16 May, a second nursing care plan was established for the man by the healthcare team at Woodhill. The plan noted that there were two prime concerns: one was his low mood, and the other was his self-harm and suicide ideation. A number of goals - one short-term and three long-term - were set out for the man to achieve. The short term goal was to provide a safe environment for him. The long term goals were to raise his mood, to stop him self-harming and to enable him to 'deal with stressors appropriately'. The care plan also set out the following interventions:

- to admit the man to the healthcare centre
- to nurse him on hourly observations/interactions
- to refer him to the mental health in-reach team
- to offer him support and encouragement
- to encourage him to talk about his feelings
- to encourage him to adopt appropriate coping strategies.

On 21 May, the next scheduled ACCT review took place in the healthcare centre. The review panel comprised two members of staff. The man was also present. The review was summarised as follows:

> "The man has burns to the back of his hand from cigarette. He says he did it because he is angry and frustrated at being in Woodhill. Says if he has to return to HU 4B he will jump off the 3's landing. Says he hears voices but did not elaborate on this. He is seeing the psychiatrist and MHIRT on a regular basis. Says he sometimes feels close to losing control. Advised to inform staff if this is going to happen and we will place him behind his door. Obs to remain 3 per session and 5 at night."

Despite the above expressions, The man's risk of further self-harm was considered to be low. The date of the next review was to be 29 May. In fact, it was held on 26 May.

On 22 May, the prison doctor made the following entry in the man's medical record:

> " Seen on HCC. Angry at his continuing stay in Woodhill. Would like to be moved to Littlehey. Refuses to be moved to o/l [ordinary location]. Threatening to commit suicide if he is moved. Would like to go to the seg unit if he is fitted o/l. Remains on ACCT. Fit o/l."

On 23 May, the man was seen by the psychiatrist once more. This time, the psychiatrist wrote:

> "Remains much the same. Still says 'everyone' in the prison is calling him a rapist. It now seems increasingly unlikely that this is an auditory hallucination. Says Risperidone has made 'no difference'. So we will reduce the dose. Currently receives Olanzapine 15mg/day. Reduced to 10mg. See 2/52."

On 25 May, the man was placed on report after refusing to move to ordinary location.

On 26 May, the next ACCT case review took place in the healthcare centre, three days earlier than planned. The review panel comprised the prison doctor and a member of the healthcare staff. The man was also present. The review summary noted that his medication was to be increased in order to "help with his stress and agitation". The panel agreed to reduce his observations to one per session and three per night as he did not feel likely to harm himself or commit suicide. His risk of further self-harm was assessed as low. The next case review was to take place at Woodhill on 2 June.

On 27 May, the man was moved to the segregation unit for refusing to go on normal location. In the segregation safety algorithm completed upon his arrival in the unit, it was noted that he had said, "his self-harm was due to him being stressed out that he is here in segregation unit" (sic) and that he was currently refusing to go on normal location. Staff were to provide support and the man was to have access to Listeners or the Samaritans telephone, if required. The possibility of finding him accommodation on Unit 4B was to be explored.

On 28 May, the man was moved out of the segregation unit to a houseblock. A note in his wing history sheet indicated he was "happy to be back." His record does not make clear whether a disciplinary hearing took place while he was in the segregation unit or in which unit he was located on his departure from the unit.

On 1 June, the following entry was made in the man's history sheet:

> "Has been given conflicting information regarding his move back to Bedford. Had a line/noose removed from cell this morning by night staff and when opened for breakfast had cut his arms with a plastic knife. Nurse attended and dressed wounds. Officer states he's down for transfer this pm."

At 8:30am that day, a Staff Nurse made the following entry in the man's medical record:

> "Requested to see inmate this am who is currently on an ACCT. Inmate had made cuts to his arm. Some appeared to be superficial. Inmate stated he used a plastic knife. Same cleaned and dry dressing applied. During assessment inmate states he feels depressed and tried to hang himself this am. Duty room informed with the intention of inmate to be seen by the dr. Wing staff is also aware of this statement. Inmate is to be seen by the dr this am.
>
> Wing staff aware."

There is no evidence to show whether a Form 213SH was completed.

The man was also seen, for the last time, by the psychiatrist who wrote in the medical record:

> "Known self harmer. Cut wounds with the plastic knife to the right forearm. 5 cm wound. Reason low mood, would like to be transferred to Bedford, near to his family. Wound dressing done with steristrip. On open ACCT 3 obs per session and 5 at night. Inmate stated no intention of self-harm or suicide if he will be transferred to HMP Bedford asap. Inmate is on the list for transfer for today afternoon. Fit for transfer."

The man was transferred to Bedford that day, leaving Woodhill at 2:15pm. The Prisoner Escort Record for the journey to Bedford noted that he was at risk of suicide or self-harm.

Phase Three: Bedford, 1 June - July 2006

My investigator was told by an officer at Bedford that, shortly after the man was transferred to Woodhill, the Security Department reconsidered their assessment of the security threat they thought he had presented and agreed that he could return.

Upon his arrival at Bedford at 5:30pm on 1 June, an ACCT case review was held while the man was still in reception. The review panel comprised a Principal Officer, a Senior Officer and a nurse. The man was present. The review summary noted that he had just been transferred from Woodhill and that he had said he did not feel like self-harming. He said he was happy to be at Bedford and had no concerns, although he had not spoken to his partner. (The

man was allowed a reception telephone call.) Nevertheless, his risk of self-harm was described as raised. There were to be three interactions with him during the morning and afternoon periods and two during the evening. The next review was to take place on 6 June.

The following entry was made in the man's medical record that day by a registered general nurse:

> "Transferred from Woodhill. Says he suffers from depression since road traffic accident 1999. Has self harmed this morning when he was told he would not be moved HMP Bedford. Denies any more thoughts of self harm/suicide at present. Says he is fine now that he is in Bedford closer to family. Currently on Procyclidine, Olanzapine and Nefopam. Referred to MO [Medical Officer] 2.6.06."

The man submitted a written request to be separated from other prisoners. On his application form he explained that he had been called a "nonce" and a "grass" the last time he was at Bedford, and this had followed him to Woodhill. He did not wish to take risks now that he was back. He was placed straightaway in the vulnerable prisoner unit in F Wing where he had been located before his transfer to Woodhill.

The following day, the man declined to undergo a secondary healthscreen as he had been seen two months earlier. On that same day, a cell sharing risk assessment was carried out as part of the induction procedures. The officer who completed the assessment recorded on the form that he was to "remain high risk at this time". Although the form used does not make this clear, the comments suggest that he presented a high risk of harming others and could therefore not share a cell. It was also noted that the man had self-harmed the previous day but was "alright now, no thoughts voiced".

On 4 June, a review of the man's risk of harming others was undertaken. The officer who carried out the review commented on the cell sharing risk assessment form that, as he was separated for his own protection and was an enhanced prisoner (i.e. had attained the highest level of privileges under the Incentives and Earned Privileges scheme), he presented a low risk.

On 6 June, the next scheduled ACCT case review took place in the VPU. The record shows that the review panel was chaired by a Senior Officer. A Community Psychiatric Nurse and two unnamed colleagues also attended. The review summary recorded that the man did not want to be in prison and that he could not cope. He had made superficial cuts to his forearm and had burned his hand with cigarettes. He was reluctant to take part in wing activities and thought the other prisoners were calling him names. The panel thought his risk of self-harm was still 'raised' and set a further review for 13 June. Although no comments were made in the review summary itself about the level of observations set for the man, the front cover of the ACCT document shows that he was to be observed on an hourly basis.

The following day, a representative from CARATs (Counselling, Assessment, Referral, Advice and Throughcare) saw the man in the VPU. She wrote in his CARATs case record:

> "Was informed by a colleague that the man was back from Woodhill and is very low. He had been placed over on F Wing and had been self-harming with threats to take his life. I went to see him. He is extremely low. Feels he is unable to cope or continue with prison or life. He clearly stated that he wanted to kill himself. He has ended his relationship which was one positive thing he had.
>
> "I had some concerns about the man's current state of mind. I felt that he should be moved to healthcare where he could receive extra support. I went to healthcare and spoke to the doctor on duty and to CPN who agreed to go and see the man today. The conclusion of their visit is that he has now been moved up to healthcare. He feels a little better about this due to not getting any verbal abuse.
>
> "The man is extremely paranoid about what people are saying. He has trouble with his long term memory and cannot recall certain points in his life mainly due to the most of his adult life he has spent abusing substances."

On 8 June, an entry in the man's medical record shows he was experiencing poor sleep for which he was prescribed additional diphenylpraline (an antihistamine) for a week. On 9 June, he was seen by a doctor in the company of the CPN. The doctor made a note of his assessment of the man in the medical record in which he commented that he was having difficulty coping with imprisonment. The man told him he felt unsafe because he was a "supergrass". The man also told the doctor he found "fleeting relief with self-harm and that he missed alcohol and drugs". The doctor noted that the man was having difficulty in getting used to the "structure of imprisonment", and described him as "relaxed, over-familiar, mild elevation of mood, inappropriate effect when talking about life in danger as a consequence of 'grassing'." In his concluding remarks, the doctor said his impressions of the man were that he had personality difficulties around substance misuse and that he needed a further assessment. The doctor directed that there should be no change in the prescription of Olanzapine 15mg daily, but that his Mirtazapine prescription should be reduced to 15mg once daily. The Procycladine prescription was to be discontinued.

On 13 June, another doctor saw the man. He wrote in the medical record that the man was hearing voices, that he had not indulged in drug abuse for a year and that he felt low in mood. The man told the doctor his suicidal ideation had increased through the day but was unwilling to talk about his paranoid ideation. The doctor felt there were "no clear psychotic features present". His impression was that the man had personality difficulties. His plan was that the man's

observations should be continued and his medication should remain unchanged. He thought the man presented a mild to moderate risk of self-harm.

That same day, a further ACCT case review took place as planned, this time in the healthcare centre. The review panel comprised the case manager that day, a CPN, an assistant CPN, and a member of the chaplaincy team. The man was also present. The review summary recorded that he was feeling generally low and not wanting any visits. There were burn marks on his hand. He had been seen by his CARATs worker. The man agreed to take part in one-to-one Cognitive Behavioural Therapy (CBT) sessions. The first session was to be held the following day. The panel concluded that the man's risk of self-harm remained 'raised' and set a further review for 16 June. The review summary shows that a CPN and an assistant CPN were to be invited to join the panel at that review. Although the case review summary does not make mention of the level of observations/interactions required, a note to this effect was made on the front page of the ACCT form. The level decided upon was one per hour.

The next day, a Prison Officer from the CARATs team noted in the man's CARATs case record that she had completed a care plan for him and had arranged for him to be referred to the Bedford Drug Intervention Programme (DIP). She also noted that ongoing support would be available from CARATs. She recorded that the man had declined a copy of the care plan.

On 15 June, the man's principal CARATs worker made the following further entry in his case record:

> "Spoke with the man. He is still very low. Wants to go to Littlehey. He feels that people are out to get him. He overheard a conversation that another inmate was having on the phone and the inmate was writing down his prison number due to him giving the police information about other drug dealers, and he feels that he will pay someone to come into the prison and give him a kicking. I explained to him that he was probably in the best place. He would be very well protected and hard to reach in healthcare. Explained to him that I was going to security to ask advice and appropriate action on the information he gave me."

The investigation found no evidence to substantiate the man's claims about what he said he had overheard.

On 16 June, the next ACCT review took place, as planned. The review was summarised as follows:

> "The man seems very paranoid at present about people plotting plans about him. Very anxious. States that he thinks people are out to get him. Wants to move to Littlehey. Goes

> to court at end of the month. To stay in HCC and in dorm over the weekend. Observations/interactions to stay the same. Review Monday. Had long chat with CARATs team. Still has suicidal thoughts."

The review panel judged that the man presented a high risk of self-harm. A further review was to take place on 19 June. Although the case review summary shows that his observations/interactions were to "remain the same", the reader is left to guess what level he was already on at the time. The review record shows that the level was not reviewed. This suggests that he was to be observed every hour, in keeping with the frequency set at the review that took place on 13 June.

On the same day, the principal CARATs worker wrote again in the man's CARATs case record:

> "The man is still very low. He desperately feels that he would be better at a different prison. He feels extremely vulnerable. I have explained to him that I have informed security about his worries. ACCT review: to remain open."

Further ACCT case reviews took place on 18 and 19 June. Both were held in the healthcare centre. At the first of these two reviews, the man told the panel he still felt depressed and paranoid. He said he was concerned about the strength of his medication as it was not helping him to sleep at night. The man still believed that people in the prison were talking about him. The review summary shows a discussion took place about the option of transferring him to Peterborough prison as soon as his court appearance, due the following Tuesday, was completed. The panel thought the man's risk of self-harm remained high and decided that the frequency of observations/interactions should remain the same.

The following day (19 June), the next review took place. (It is not clear why this took place so soon after the review the day before.) During this review, the man said he was still feeling very paranoid. He said people were calling him a rapist. The man was asked whether his thoughts were driven by paranoia. He replied that he definitely knew people were talking about him. He said his court case was due the following week and he wanted to go to Peterborough afterwards. The review summary recorded that he voiced no suicidal intent but said he still had "self-harming thoughts". The summary also noted that the man had asked to be placed in a single cell. (His record does not make clear whether he was granted single cell status at this juncture.) The panel thought his risk of self-harm was low and decided to reduce his observations/interactions to every four hours. The next review was to take place on 21 June.

On 20 June, a doctor wrote in the man's medical record that he had clear personality difficulties and that, "Zispin might help to alleviate his anxiety and sleep."

On 21 June, the next ACCT case review was convened, as planned, in the healthcare centre. Included on the panel were the CPN and the man's principal CARATs worker. The man was present. The review was summarised as follows:

> "The man states he wants to go to a secure unit. Dreads getting up every morning. Wants to go to work in cell. Can't concentrate on anything at present. Wants to discuss medication with psychiatrist. Doesn't feel he's getting anywhere. Very anxious at present. Wants to speak to IMB [Independent Monitoring Board]. Still has suicidal thoughts. Wants to transfer out. Observations to stay the same. Review tomorrow."

The man's risk self-harm or suicide was considered to be high.

My investigator could find no evidence to show whether the man saw the IMB.

The following day, the man was reviewed again. The panel, comprising representatives from the healthcare centre, including the CPN, heard from the man that he was still feeling fed up at being called a 'nonce'. He was feeling paranoid and wanted to be moved to another prison. However, the man said he was aware that he had to remain at Bedford until his court appearance due the following Tuesday (i.e. 27 June). The man told the panel that he was still "hearing voices in his head and in the room". The review summary noted that there had been a discussion between the man and the CPN about his engagement with Cognitive Behavioural Therapy, and the possibility of being discharged from the healthcare centre to F Wing after his court appearance as "Littlehey was unlikely to take him from inpatient unit". The panel judged that the man's risk of self-harm was now 'raised' and decided that his observations should be reduced to 4-hourly. (In fact this was the same level as before. The reduction to 4-hourly observations had already taken place on 19 June.) A further case review was to take place on 24 June.

The CARATs worker made an entry in the man's case record after the ACCT review on 21 June. She wrote:

> "ACCT review. The man had a legal visit yesterday and was informed no further charges outstanding. CPN came to see and have altered some of his medication in the hope that it will help him sleep and support his anxiety levels.
>
> "He is stating that he wants to leave Bedford. He is in fear of his life. He still feels suicidal and if given the opportunity would try to kill himself - CPN to see him again."

My investigator was unable to clarify the significance of the legal advice quoted above: The man appeared in court on 27 June to face further charges.

On 22 June, the CPN made the following entry in the man's medical record,

> "No evidence of any suicidal ideation. Continue with ACCT documentation. Claims to experience voices instructing him to harm himself - although doesn't appear to be distressed by this and is not pre-occupied - did not appear to be thought disorder. Continues to believe people are talking about him - although interacting appropriately with others. Plan: 1. Has commenced CBT [Cognitive Behavioural Therapy] course this week to address his poor coping mechanisms. 2. Continue to engage with CARAT work."

On 23 June, the next ACCT case review took place in the healthcare centre. This time, the man told the panel he wanted to move out of the healthcare centre because it was too noisy. He said he could not stand it any more. There had been no self-harm attempts during the previous week and the man denied having any suicidal ideation. The review panel reminded him of the sources of support available. He was told the CPN team were happy for him to move. (the man was kept in the healthcare centre until 26 June.)

The review record shows that the panel considered the man's risk of self-harm to be high. They therefore decided that he should be observed three times every hour and that he should be reviewed after the weekend. The CPN wrote in the man's medical record:

> "Requesting transfer back to normal location - no evidence of any self harm - remain on ACCT for observations. Fit for normal location."

On 25 June, a Staff Nurse wrote in the medical record:

> "At approximately 18:25 hrs the man reported to nursing staff that he'd apparently taken some 'Lift' anti bacterial cleansing spray. The doctor was informed who advised to increase fluids and take observations. The man says he vomited (not seen). F213 and incident form completed. Spoken to with Senior Officer and given much reassurance. Offered Listener."

On 26 June, the next ACCT review took place (again in the healthcare centre). The review was summarised as follows:

> "The man identified that he has concerns about going to court tomorrow. No suicidal or self-harm ideation expressed. Happy to be moving to normal location. However, anxious in case 'people start picking on him'. Advised to speak to staff before lashing out. Agreed with advice. Therefore discharged from HCC."

A reference to the man's discharge to the VPU in F Wing was also made in his medical record the same day.

The ACCT case review record shows that the man's risk of self-harm was considered to be high. Despite this, he was discharged from the healthcare centre. The panel decided that he should be reviewed again on 30 June. (In fact, he was next reviewed on 28 June.)

On 27 June, the man was taken to Bedford Magistrates' Court where he was given a further sentence of imprisonment for one month. After his court appearance, he returned to HMP Bedford.

On 28 June, the man was reviewed again, this time in F Wing. The review was chaired by a Principal Officer and was attended by a CPN and an officer. The man was also present. He told the panel he was feeling more settled now that his court case was over. He was still worried other prisoners thought he had informed on them. He wanted to be in a prison far away from Bedford. The panel believed the man's thoughts of self-harm had receded, and he was confident he could speak to staff if things changed. The panel decided to change his observations to two per session and hourly by night. Although the record shows he was to be reviewed again towards the middle of July, the next review took place only two days later.

The ACCT case review convened on 30 June was chaired by a Principal Officer and was held in F Wing. The review was also attended by one of the F Wing officers and by a CPN. The man was also present. The review was summarised as follows:

> "The man discussed his difficulties in an open and honest way.
> Feels safe on F Wing. Is trying to move to HMP Littlehey.
> Staff to keep up their involvement. Good level of support.
> Remain on obs as directed on front page of ACCT document
> [i.e. two per session and hourly by night]."

The review panel judged that the man's risk of self-harm was low and set the next review for a date early in July.

At the beginning of July, an officer made an entry in the F Wing Staff Observations Book to record that the man had come off his high risk status so that he could be considered for enhanced privileges. The officer also recorded that it was necessary to move the man in with another prisoner in cell F2-7. The officer used the Staff Observations Book to warn colleagues of the possibility of friction between the two prisoners. At interview, the officer explained that the man's cellmate was, at the time, considered to be a high risk prisoner (i.e. at risk of harming others) and was in a single cell. The officer thought the decision to place the man and his cellmate together was possibly based on the notion that the man needed a "buddy".

The following further entry was made on the same day:

> "Wing PO's visit. 0920. Can staff continue to monitor and support the man due to his compliance and change for the better. I would hate to see him deteriorate again."

The next day, an officer made an entry in the Staff Observations Book recording that the man was not getting on with his cellmate and the two prisoners needed to be separated the following day on instructions from a Principal Officer. At interview, the officer explained that the man had made it clear he had taken a dislike to his cellmate. She confirmed they were separated only 24 hours after being placed in the same cell.

A few days later, a further ACCT review was convened on F Wing, as planned. This was chaired by a Senior Officer and attended by another Senior Officer. The man was also present. The summary recorded his principal concern as wanting a transfer to a training prison. The OCA [Observation, Classification and Allocation] Unit was to be contacted so that an allocation could be discussed. The man also told the panel he found being locked up difficult and said he still had thoughts of harming himself. The review panel nevertheless believed his risk of self-harm was low and did not change the frequency of observations. A further review was set for the middle of July. (In fact, the next review took place only three days later.)

A few days before he died, the man deliberately harmed himself by making three small scratches on his right hand, using a blade issued to him for shaving. No medical treatment was deemed necessary. An entry was made in the medical record to this effect. However, my investigator was presented with no evidence to show whether a F213SH was completed. Afterwards, the man was seen by a CPN who wrote in his medical record:

> "States he is unable to cope in his current location. Believes his life is in danger as he is a 'grass'. Requesting transfer to another jail where he would not be known. States he wants bereavement counselling to come to terms with the death of his grandma - same arranged - current ACCT observations increased [i.e. to hourly] and sharing a cell with fellow prisoner. Will review Wed."

At about midday the same day, the chaplain had received a phone call from the man's mother expressing her concerns about her son's state of mind. She was especially worried that her son had told her he wanted to kill himself. She wanted him to know he had her love and support.

At about 1:30pm, the chaplain took a call from the man's father who expressed similar concerns. He too wanted the man to know he loved and supported him. The chaplain thought it likely that the man had recently been in touch with both his parents, and that the incoming calls were a reaction to what he had said to them. (The father later explained that the man's mother telephoned him to voice her concerns about the man. The father made it clear he responded by telephoning the prison himself.) The chaplain went to see the man in the VPU

and spent some time talking to him. Afterwards, she made the following entry in the man's ACCT ongoing record:

> Seen by chaplain for approximately 20 minutes. Father and mother have separately made contact about his threats to kill himself. Says he attempted to hang himself yesterday evening and has previously tried to hang himself whilst in Woodhill. States continues to hear voices. Various issues raised during our discussion relating to childhood issues, parents and grandparents, particularly the death of his grandmother. Chaplaincy will contact his parents separately. Mother is due to visit on 12 July and father, although previously estranged for 14 years, will visit if he wishes."

Later that day, the chaplain called both the man's parents and told them she had spoken to him and reassured them that "all the people who were involved with him were fully aware of his particular circumstances".

At 3:10pm, following the man's act of self-harm, an ACCT case review was convened in F Wing. The review was chaired by a Senior Officer and attended by the chaplain, two CPN's and an officer. The man was present. The review was summarised as follows:

> "Following an act of self-harm, by scratching his arm, we have reviewed him. Says he has thought a lot about self-harm and ending it all. He can't see a future. We have discussed increasing his obs to hourly and sharing a cell."

At interview, the panel chairman said the review was prolonged. He said the CPN explained the clinical reasons why the man was not suitable for the healthcare centre. According to the chairman, the CPN felt the healthcare centre "was not a way forward for him". He said the man told the panel he did not like himself. He blamed his accident for this. The man was particularly self conscious about his arm which had been permanently damaged in the accident. The chairman said the man talked about his arm being ugly, saying, "It's not nice hating yourself". He told the panel he could not see the way ahead and "wanted to end it all". The chairman said the panel reminded the man he had a family who cared about him but he said he did not care because he "just wanted to end it all." The chairman explained that he increased the frequency of the man's observations because he thought there had been an escalation in his suicidal ideation. He interpreted the man's act of scratching his arm as a sign of this. The chairman did not want the man to be left on his own. He therefore asked a prisoner if he would mind sharing a cell with him. The prisoner was at first reluctant to do this as he had previously experienced sharing his cell with prisoners who were at risk of self-harm. However, the chairman persuaded the prisoner to share with the man for 48 hours only. Thereafter, the situation would be reviewed. The chairman told my investigator that, when that period elapsed, the two prisoners were separated. The chairman thought another prisoner was moved into the man's cell but the investigation found no evidence in support of that view.

At interview, the chaplain explained that she brought up the subject of her telephone conversations with the man's parents earlier that day. She said the man repeated to the panel what he had said to his parents.

The panel recorded their assessment that the man's risk of self-harm was 'raised' and set a further review of his case. He was to be observed every hour.

The next review took place at 10.45 on the day planned. This time, the review panel comprised a Senior Officer, the CPN, the assistant CPN and an officer. The man was present. The review summary recorded that he had indicated during a telephone conversation he felt ignored and "had to do something to get noticed". The CPN agreed to review his medication and see him again. The panel decided to keep the man on hourly observations and in a shared cell. A further review was set for later in July. However, later that day an officer made the following entry in the F Wing Staff Observations Book:

> "The man self-harmed during association tonight. He has been asking to be moved to healthcare all day. When this did not happen he made cuts to his right hand. He is now on a 30 minute watch."

The case review record makes no mention of any request or demand by the man to be located in the healthcare centre. My investigator was presented with no evidence to show whether a F213SH was completed after his self-harm.

The officer later told my investigator he thought the observation level set for the man was inappropriate. He felt the man should have been on constant watch in the healthcare centre. He said he mentioned this to the CPN either at that review or at the review held at 4.00pm on the day before the man died. He said, "The CPN claimed he had no intention of committing suicide and was attention seeking."

The next day, another case review was convened at 9.00am as a result of the man having self-harmed the previous evening. The panel comprised a Senior Officer and two officers. The man was also present. The review was summarised thus:

> "Yesterday evening, the man made numerous small cuts to his right hand. He states it is because he feels angry at himself for the way he has turned out. Every suggestion that has been made to him he has dismissed. To remain on half hourly obs and review on……."

The panel judged that the man's risk of further self-harm remained 'raised'. The case review record does not show whether his transfer to the healthcare centre was discussed or considered.

On the same day, the following entry was made in the man's medical record by a Community Mental Health nurse whose signature is illegible.

> "Case discussed with the doctor. Continue with care as per plan. No evidence of mental illness. May benefit from cognitive behaviour therapy. Although he remains a risk of self-harm, it may be counter productive should he move to healthcare as self-harm injuries do not warrant treatment in healthcare.

Another comment appears in the medical record immediately after the above entry:

> "Stuck a broken coffee jar into his right arm. Fed up. Doesn't want to live any more. Spoken to CPN yesterday. Can't handle it over on F Wing. I don't fit in. Discussed with CPN and staff in healthcare. In view of previous history and diagnosis it is not appropriate to re-admit to healthcare".

The signatures of the authors of these separate entries are illegible but the second entry seems to have been made by a doctor.

Later that day, an entry was made in the F Wing Staff Observations Book to record that the man had self-harmed again by cutting his arm with the coffee jar. A F213SH was completed.

At 2:30pm, another case review was convened following the man's further act of self-harm. This review was chaired by a Principal Officer and was attended by a Senior Officer, an officer and the man himself. The review summary noted that the man spent nearly half an hour talking to those present. He told the panel he did not want to self-harm "at this time". The summary indicated that he was prepared to try to calm down and to consider his move to another prison, possibly Littlehey (a category C training prison near Huntingdon). His observations remained the same and a further case review was set for the following day.

On the same day, a cell sharing risk review was carried out by a Senior Officer Helen and an officer. The man told the panel he could no longer cope with "sharing his space". As a result, his risk of harming other prisoners was assessed as having increased from medium to high. He was therefore placed in a cell on his own. The panel recommended wing staff to maintain regular observations of the man because he was subject to ACCT procedures. A further cell sharing risk review was to take place a month later. The man remained in unshared accommodation until his death.

Events on the day before the man died

At 8.00am on the day before the man died, an officer made the following entry in the man's ACCT ongoing record:

> "Spoken to the man in cell. He says he feels very low at the moment and would prefer to stay in cell. I asked him if he

> would like to speak to someone but he told me he could not see any point in that. I told him to press his cell bell if he either felt close to self-harming or if he wanted to come out on association."

At 9:30am, the man self-harmed again by cutting his arms. He was taken to the healthcare centre to have his wound dressed. He was then returned to F Wing.

At 10.00am, the following entry was made by an officer whose signature is illegible:

> "Asked him why he had self-harmed again. He said that he did not want to be on F Wing or this jail. Spoke to him about coming off R45 and going to D Wing or C Wing. He may think about going on to C Wing as the HCC Orderly has assured him that no-one will touch him and many prisoners are asking about him. He said he would think about it."

The officer then made the following further entries in the ongoing record:

10:30: "Seen by CARATs worker who reported that she was concerned about his condition."

11:00: "Talked to again by CARATs worker and a governor."

11:30: "Seen in cell lying on back. It was reported to staff by the servery orderlies that the man has not taken a meal for three days. He has given a choice every time the orderly has gone round with the menu board nor has he told wing staff that he is on food refusal."

Later that day, the CARATs worker made the following entry in the man's case record:

> "Came to see the man. Was informed by F Wing staff that he had been self-harming. He is back on ACCT document half hourly obs. He is very low again, stating that he wants to die. He stated that he will eventually kill himself.
>
> "The officers on F Wing are extremely concerned about his current thoughts and feelings. They believe that it is just a matter of time before he will do something very serious.
>
> "I spoke with the Safer Custody Manager in regard to my concerns and the concerns of the officers on F Wing in regards to what the man is saying and how he feels. The man should be placed in healthcare where he can receive more support than he is currently getting. The Safer Custody Manager has spoken with the CPN who said she would see the man at some time today. However, he is not suitable for

healthcare due to the fact that they do not think he has mental health issues.

Went back to see the man who told me he hasn't eaten in three days and that he has tried to hang himself. There are clear marks around his neck that would indicate he is telling the truth. He feels very negative and pointless about life. He is still concerned that someone will do him over in prison due to the trouble he was involved with in the community.

"I spoke with a governor about my concerns with the man and that I felt he should be placed in healthcare. Unfortunately, the governor is unable to override the decisions from the healthcare team, but has contacted CPN to request that they be present on the man's review.

"Review was held and no further changes to the man's care have been drawn up. CPN feel that he is behaving in this way in order to get what he wants, i.e. moving to healthcare. They disagree that there are mental health issues and say that if he was depressed he would be helped by the anti- depressants he is on. I stated that I felt he would continue to self-harm and attempt suicide and I feared that this would have devastating results if his care and support package was not changed.

"15:00hrs. Went back over to F Wing as the man has self-harmed again. He feels that he wants to end his life as he is unable to cope in prison. He feels that CPN are not taking him seriously. He stated that he hasn't eaten in three or four days and is on hunger strike. I spoke to the officers about this who said that they have spoken with him and he has told them he isn't hungry but has biscuits and noodles if he wants to eat. I feel that the man is very depressed due to his paranoia and practical situation of being in prison.

"I discussed the CBT course with him which he previously dismissed. He does not feel it will help but will consider this over the weekend. I have told him I will step up CARATs support again and will come back on Monday to see him and discuss the way he feels and CBT course. Also try to find a way forward with his feelings."

(It is important to emphasise that the comments above do not appear in the man's ACCT ongoing record, a file that can and should be read by wing staff. The comments are recorded in his CARATs file and, although they are very comprehensive, they could not be read by wing staff as the contents of a CARATs file are confidential.)

At interview, a governor told my investigator he was the Duty Governor at Bedford on the day before the man died. He explained that, during his rounds

of the prison, he visited F Wing and saw the CARATs worker in the computer classroom. The governor remembered her feeling strongly that the man needed to be admitted to the healthcare centre because of his risk of self-harm. The governor could not remember whether the CARATs worker described what had happened to the man. The governor said he could see that she was distressed. He told her he could not force healthcare to take the man. He said he would make sure a case review was convened straightaway and that she could be part of that process. The governor contacted an ACCT assessor and asked for a review panel to be assembled.

The record shows a case review was convened very soon afterwards. It was chaired by a Principal Officer and attended by an officer, the CPN and the CARATs worker. The man was also present. The governor did not take part in the review. Instead, he continued on his rounds of the prison. Some of those who attended thought the review took place earlier than 2:30pm - the time recorded in the case review record. The review was summarised thus:

> "The man states he has no way forward and cannot see a way to change his life. He says he cannot cope on F Wing but doesn't know what alternatives there are. CPN is of the opinion that he is not depressed though his mood is low. It is accepted that he will continue to harm himself to try to achieve an as yet unstated goal. Obs to remain at half hourly. To be considered for CBT."

The panel concluded that the man's risk of further self harm was still 'raised'. He was to be observed every half hour and was to be reviewed again on a few days later.

Significantly, no mention was made in the case review summary of the concerns expressed by the CARATs worker in the man's CARATs file. This gave rise to the possibility that no discussion about those concerns took place during the review. My investigator initially interviewed the CPN on 15 August 2006 about her general involvement with the man while he was at Bedford. On 28 September, he interviewed the CARATs worker. As a consequence of the evidence provided by the latter, my investigator saw the CPN again on 19 October.

The CARATs worker told my investigator she believed there was reluctance on the part of the healthcare staff to admit the man because they thought he was manipulative. She said she heard healthcare staff - she did not say who - comment that the man "was a drain on them, that he was attention seeking and they were not going to pander to him." The CARATs worker was aware there were vacancies in the healthcare centre at the time. She disagreed with the healthcare staff's opposition to the man's admission. She said that on the day before he died she contacted the Safer Custody Manager about her concerns for the man. She said the Safer Custody Manager rang the healthcare centre to ask if the man could be admitted. He was told that the CPN would see the man. Later, the CARATs worker witnessed the man being taken to the healthcare centre after he had cut his hands. She said the

CPN personally dressed the man's wounds but did not discuss with him the question of his admission to healthcare. The CARATs worker felt that the CPN could not have assessed the man's mental state in the few minutes she was with him at that time. She said she accompanied the man back to his wing and spent some time talking to him.

During their conversation, the man mentioned that he had tried to hang himself during the night. The CARATs worker said she lifted the man's chin and could see red marks on his neck. She said she was so concerned about this that she went to the wing office to discuss her concerns with staff. She said this was at about 11:45am. Shortly afterwards, she saw the governor and a case review was set up. The CARATS worker stressed that, before the case review started, she sat in the office talking to the CPN and the other staff who were there for the review about her concerns. She said she told the CPN she thought the man should be moved to the healthcare centre and placed on constant observations. She said the CPN disagreed with her. According to the CARATs worker, the man was then brought into the room. She said he made it clear to the panel he could not cope in the wing and did not want to be alive on the wing.

My investigator asked the CARATs worker to confirm whether she mentioned the fact that she had seen red marks on the man's neck. She said she mentioned this to the CPN before the man came into the room and again when he was present at the review. She said the CPN's response was that the man said he had "done that on Monday as well". She said the CPN asked the man, "When did you try to hang yourself?" The man told the CPN he tried to hang himself during the early hours of that morning. The CARATs worker told my investigator that the CPN said words to the effect of "Alright then". According to the CARATs worker, the CPN concentrated on "moving the man forward". She said she thought the suggestion that the man should be considered for the Cognitive Therapy Programme (CBT) was what the CPN meant when she wanted him to move forward. The CARATS worker explained that this programme required the man to attend one to one sessions once a week for an hour at a time. She said the man would be taken to the healthcare centre for this purpose and would be "sat in a room in front of a computer and answering questions from a computer". She said the man did not want to do that. He had tried it before and "it did not work for him".

My investigator asked the CARATs worker whether the need for the man to be admitted to the healthcare centre on constant watch was mentioned during the review. She said she saw no point in raising it at the review in light of what happened before the review began. She said, "There was no way the healthcare were going to agree to it." She said that, by the end of the case review, the man knew he would not be going to the healthcare centre, although he would not have known he would be observed every half hour. The CARATs worker thought the man was "lower" after the review. He said to her, "They are not listening, are they? They are not paying any attention. They are not taking me seriously."

She told my investigator that after the review there was a heated discussion in the office where the review had taken place. She said the Principal Officer who chaired the review said to the CPN, “So everything stays the same?” The CARATs worker said the CPN replied, “Absolutely”. She said to the CPN, “You’re not going to step up his obs? Surely you must see that he’s depressed. He’s got paranoia issues but surely you can see that he is depressed?” She said the CPN disagreed. She told my investigator she said to the CPN, “Surely, to cover your own arse, do something else because if one of his attempts, if you’re saying that he’s just attention seeking what happens if he does - to get attention to move to the healthcare centre - cut himself a little too deep or does succeed in hanging himself.” The CARATs worker said she put to the CPN the suggestion, “What happens if - worst case scenario - something f***s up and he succeeds in doing that? Cover your own arse.” She said she suggested to Miss Meehan that she should move the man over the weekend. She told my investigator “it was a ‘no’”.

Finally, the CARATs worker said she promised the man she would go back to see him before she left at the end of the day. She said she went back to the wing at 3.00pm, a little sooner than planned, because he had self-harmed again. She said he repeated to her that he could not cope and that he wanted to end his life. She said she promised him she would “step up his CARATs support” and would see him again after the weekend.

When my investigator interviewed the CPN, she remembered that there were “a few disciplines present (at the review) and we did actually say if anyone’s got any concerns please voice them now”. She said, “Fortunately, no concerns were voiced or they would have been recorded there.” The CPN was adamant that nobody present at the review spoke of any concerns about the man, and that no mention was made at the review of there being red marks on his neck after trying to hang himself. She could recall that a discussion had taken place before the review began. However, she could not remember whether any mention was made of the red marks on the man’s neck during that discussion.

During his interview with the CPN, my investigator read to her the full details of the record the CARATs worker made in the man’s CARATs file, and asked her if the CARATs worker had talked to her in the manner represented by those notes. The CPN said that, although she did not have access to the CARATs file, she knew the CARATs worker had raised her concerns about the man before. He CPN said this explained why her team “responded to them and why he was seen on various occasions by various numerous psychiatrists. All of whom concluded that he didn’t appear to be suffering from any mental health problems. He was at risk of self-harming but there was no evidence of any mental health illness.”

When asked if she was aware that, according to CARATs worker, staff in F Wing were very concerned about the man, the CPN said she did not get that impression. My investigator told her that the Safe Custody Manager, and the F Wing Officer who attended the case review on the day before the man’s death at which she, the CPN, was present, said they were both concerned but

felt neither trained nor qualified to override her. In response, the CPN said it was for everyone to express their concerns. She said, "It was not just for me to take it on the head and on my shoulders as to say if somebody can be admitted or not. If anyone's got concerns then it needs to be raised." She went on to say that, although she was not trying to suggest that the man had not tried to hang himself, she did not think there was any evidence that he had done so. She pointed out that there was no F213SH, she did not see any marks, and there was no immediate ACCT review. She confirmed she did not see the man again on that day. She had gone off duty by 4.00pm that day.

My investigator also interviewed the Principal Officer and the officer who attended the same case review.

The officer could recall the review. He said the man kept saying during the review he wanted to kill himself. The officer admitted he said very little during the review because the CPN and the CARATS worker "were doing all the talking". The officer told my investigator the CARATs worker was saying that the man should be in the healthcare centre on a constant watch. The CPN thought the man was attention seeking. The officer said the CARATs worker told him the man had tried to hang himself during the night, but he was not aware that he had red marks on his neck. He could not remember what was discussed in the wing office prior to the review, but felt sure that the CPN would have known that the man had attempted to hang himself earlier that day.

At his interview, the Principal Officer (PO) said he could not be sure whether or not the man was trying to manipulate his admission to the healthcare centre. When asked if he thought it was appropriate for the man to remain in his cell rather than being moved to the healthcare centre while he was self-harming, the PO said this was a matter about which decisions had to be made all the time. His view was that "people should be closer to medical help". He thought there was no reluctance by the healthcare staff to manage difficult people, but there was a reluctance to take on more of them.

My investigator also interviewed the Safer Custody Manager. He drew attention to the fact that the CARATs worker did not open a F213SH after seeing red marks on the man's neck. He suggested that, in the absence of the paperwork, there was no proof that he had tried to hang himself. He nevertheless confirmed that he spoke to the CPN after the CARATs worker had brought her concerns about the man to his attention. He was not forthcoming about what the CPN said.

Very soon after the first case review that day, the man self-harmed again. At 3:45pm, the following entry was made in his ACCT ongoing record by a nurse:

> "The man removed dressing. Dressing redressed. While applying dressing, the man asked if he could stay in healthcare. When I said he could not, he stated "he will be back later". I asked him if he had spoken to a Listener or the Samaritans. He stated he did not want to."

That afternoon, the CPN made the following entry in the man's medical record:

> "Continues to make superficial scratches to arms requesting admission to HCC. Informed that this would not be necessary at this point as his self-harming behaviour can be safely managed as per ACCT and doesn't require a hospital setting. Clear personality difficulties identified but no mental illness diagnosed."

At about the same time that day, an officer made the following entry in the F Wing Staff Observations Book:

> "The man is on 30 minute watch. He is constantly cutting up. Nothing serious at the moment but he is upping the ante in an attempt to get himself admitted into HCC who are as determined to keep him from achieving his aims as he is in succeeding (in my opinion)."

As a consequence of the man's continuous acts of self-harm, another case review was convened at 4.00pm. This review was chaired by a Senior Officer. Also present were an officer and the man. The review was summarised as follows:

> "The man stated to me that he was in low mood due to the fact he wanted to be re-located into the HCC. I told him that it was not an option, and although he was obviously low, he needed to take a long hard look at himself and stop this circle of self-harm if he was going to improve. The man accepted this. Staff will monitor him closely over the weekend. Review again on ….. July"

No comments were included in the case review record of what level of observations/interactions was to be maintained. However, entries were made in the man's ACCT ongoing record that evening as follows:

4.00pm	"Case review undertaken."
4:30pm	"Lying on bed."
5.00pm	"Lying on bed smoking."
5:30pm	"Lying on bed."
6.00pm	"Lying on bed. Acknowledged with 'I'm ok' when checked."
6:30pm	"Spent half hour chatting to the man, discussing the issues of why is self-harming and how the current situation can be resolved. It appears his current attempts at self-harm are to get a move to the HCC."
7.00pm	"Lying on his bunk. HCC contacted to come and redress his wounds."
7:30pm	"Dressing changed by HCC staff. Appears calm. No immediate concerns expressed."

8.00pm "Medication given. Demanded Nitol. Nurse advised medication should help him sleep. No other concerns raised."
8:30pm "Laid on bed. Appears asleep RH Side."

Regular entries were then made at 30 minute intervals through the night. Each entry indicated that the man was asleep.

Events on the day of the man's death

The copy of the ongoing record in the man's ACCT document presented to my investigator showed that the last entry for the night was made at 5:20am on the day he died. There are no other entries for the entire morning period. My investigator asked a member of staff at Bedford to find the original version of the ACCT document to enable him to ascertain whether there had been a photocopying error. However, the person concerned could not find the original document.

An officer who was on duty all day in F Wing told my investigator he first entered the wing at about 8:40am that day. As he had not been in the wing for three days, he familiarised himself with the wing handover book and the open ACCT documents. He saw that the man was subject to an ACCT form and that he was to be observed at half hourly intervals. The officer recalled that the man came down to the ground floor of the wing at about 9:20am, signed for his canteen expenditure and returned to his cell on the third floor. He did not notice anything untoward in the man's demeanour. At 10:30am, the officer gave the man the opportunity to take exercise. He saw the man sitting in his cell, rolling a cigarette. The man went on to the exercise yard about ten minutes later. The officer described him as quiet but thought this was not unusual. He said a short time after the exercise period had finished, the man came to the wing office to discuss his transfer. The officer told the man a place had been found for him at HMP Peterborough, an allocation he had requested. The officer thought the man seemed content with this. At 11.30am all prisoners in F Wing were returned to their cells in preparation for the serving of lunch. The man declined his lunch, saying that he was not hungry. The officer left the wing at about 12:30pm.

Another officer was on duty in F Wing as a patrol during the lunch period. At 12:31pm, he observed the man. He wrote in the ACCT record, "Sitting on his bed. Appears ok at present."

At approximately 1.00pm, that same officer approached the man's cell in order to carry out an observation of him as prescribed by the ACCT procedures. He opened the flap on the outside of the cell door and looked into the cell. He saw the man in a sitting position on the floor, leaning against his bed and apparently looking downwards. He knocked on the cell door and asked the man if he was alright. There was no response or movement. He therefore knocked on the door again but there was still no response.

At this point, the officer used his radio to contact the control room to ask for the Orderly Officer to report to the wing immediately. He then opened the cell

door. As he did so he asked the man again if he was alright. The man still did not respond. As the officer approached the man, he noticed what he thought was a piece of cling film at the back of his neck. The officer quickly realised the material was tied around his neck. He therefore sent a message on his radio to ask for urgent medical assistance. As he did so, a Senior Officer (SO) arrived at the cell. The officer asked the SO for his ligature knife and used it to remove the ligature from the man's neck. The officer passed the ligature to the SO who then checked to see if the man had a pulse in his wrist. As the SO was doing so, the officer noticed the cell window was open and there was something tied to the bars. The SO used his radio to ask the control room to call an ambulance. As the man's left leg was positioned on top of a chair leg, the SO lifted the chair away.

At this juncture, another officer arrived at the cell. She and the SO lifted the man and laid him on the floor of the cell. As they did so, the prison doctor arrived. He and an officer began to administer cardio pulmonary resuscitation (CPR). My investigator was told that the doctor asked for the "resus bag" which should have been brought to the cell by the healthcare member of staff designated the radio call sign "Hotel 2". An officer therefore used his radio to ask for Hotel 2 to attend but, as he did so, that nurse arrived. At interview, the officer said he told the nurse the doctor required the bag and she therefore left the cell to fetch it. In the meantime, CPR was being applied to the man by the doctor and an officer. Shortly afterwards, the doctor asked her to fetch the defibrillator. By this time other staff had arrived at the cell. At this point, the officer who initially discovered the man left the cell.

The following entry was made in the medical record by the doctor:

> "Medical emergency - called to see patient on F Wing. Patient lying on floor centrally and perfectly cyanosed. No air entry. No pulse. CPR started 30:2 until paramedics arrive. Continued for 30 minutes. No pulse. No air entry.
>
> "Paramedics arrived. De-fib monitor attached asystole. CPR continued. Patient intubated. No change in condition. 1mg adrenalin received. No effect. Patient declared dead at 13:25. May he rest in peace."

Informing the man's next of kin

A Principal Officer (PO) who was Bedford's Family Liaison Officer was off duty when the man died. An officer in the prison telephoned him at about 2.00pm to inform him of the man's death. The PO reported to the prison. At about 2:40pm, he attended a co-ordinating meeting involving the Governor, the doctor, the chaplain and representatives of Bedfordshire police. The Governor asked the PO to arrange for the man's family to be told of his death. The PO and the Imam travelled to the address shown in the man's file, arriving at about 4:50pm in the company of two police officers. They failed to get a response at that address. Thirty minutes later, they decided to go the address shown for the man's father. He was in when they arrived.

The PO told the man's father that his son had died and described the circumstances.

At 6:20pm, the PO and his colleagues went back to the man's mother's address but, once again, nobody answered the door. They therefore returned to the prison. Once there, a prisoner told the Imam that the man's mother worked until 7.00pm each day. At 7:50pm, the Imam and the PO went back to the address but were still unable to get a response. The PO contacted the Bedfordshire police and asked them to inform the man's mother of his death.

At 6:30am the next day, the police contacted the prison to say they had been unable to trace the man's mother at the address given. Information gained from his letter sheets showed he had sent visiting orders to his mother at another address. The Imam, the PO and a police officer went to that address but again there was no response. The Imam therefore tried to contact the man's mother by telephone using the number given for the original address for her. The man's mother answered. However, she quickly became distressed and unable to engage in any conversation. An agreement was made for the PO, the Imam and a police officer to go to the address so that the circumstances of the man's death could be explained in detail. This was done later that morning.

Arrangements were made for those family members who wished to do so to visit the man's cell at the prison.

The Governor offered to contribute towards the cost of the man's funeral. Representatives of the prison were present.

ISSUES

Phase One: Bedford, 10 February – 6 April 2006

I consider that, between his initial reception at Bedford on 10 February and his transfer to Woodhill on 6 April, the man's health needs were appropriately assessed and managed. His immediate needs were of a physical rather than mental nature. These were treated promptly and effectively. The man was seen by a CPN two weeks after he arrived in the prison. Although he had entered prison with a history of depression, and despite the fact that he had taken an overdose in the past, there were no presenting issues suggestive of a current risk of self-harm.

However, I am concerned about the decision to transfer the man to Woodhill on 6 April. My investigator was told that this was necessary because the man's father had formerly been employed as a member of staff in the prison. As a result, it was thought that the man presented a threat to the security of the prison. My investigator was unable to ascertain what specific security threat he presented at Bedford. His father was employed initially as a mailroom manager. He later became an Operational Support Grade when this grade came into existence. He worked at Bedford for four years until November 2000, when he retired. I suggest that, if the man presented a threat to security at Bedford because of his father's knowledge of Prison Service security procedures and policies, then he might also have presented a threat to security at Woodhill, a high security prison. My investigation found that by 1 June 2006 it was considered the man no longer presented any threat to security at Bedford, and it was deemed appropriate for him to return there. This suggests that, if any assessment of the man's threat to security was carried out, it was completed after his departure rather than before.

Shortly before he left for Woodhill, the man showed clear signs that he was having difficulty in coping with his environment by asking to be moved to the vulnerable prisoner unit. Had he been moved away from Bedford to allow him a chance to settle elsewhere, and thereby to avoid long term vulnerable prisoner status, his transfer might have been justified.

Whilst I make no formal recommendation on this matter, I want to emphasise that I consider the man's move away from Bedford as ill-conceived and unnecessary. Although, as I shall say later, the man was treated well at Woodhill, his transfer there got in the way of his contact with members of his family, impaired his capacity to forge continuous relationships with members of staff, and interrupted what chances there were of developing a sentence plan for him.

Phase Two: Woodhill, 6 April – 1 June 2006

The general management of the man's mental health needs

In the eight week period he spent at Woodhill, the man was seen by a psychiatrist on three occasions and by a representative of the Mental Health In-reach team on two occasions. He was assessed as being actively psychotic and paranoid. He was prescribed appropriate medication by the psychiatrist. He spent two periods in the healthcare centre: the first between 16 and 25 April and the second between 12 May and 27 May. The prison doctor told my investigator he felt it was appropriate for the man to be admitted to the healthcare centre because his mental health could be better managed there than on a wing. The doctor was especially concerned about the man's paranoia and self-harm ideation. Consequently, the man spent a considerable amount of time on constant observations. Although the decision to discharge him from the healthcare centre at the end of May was made at a time when it was clear he was very anxious about moving to a wing, and soon after he had threatened to take his life if he were discharged, it was made in the context of the need to move him back to Bedford where he said he wanted to be. I believe that decision was justified.

Comprehensive records were made of each consultation with the man by the medical team. His medication was regularly reviewed and adjusted where necessary, both by psychiatrists and by doctors. There was good cross-communication between the various agencies engaged in his management. Two separate but inter-related nursing care plans were drawn up for him, each of which mapped a structure for coping with his difficulties. The notion that he might be a suitable candidate for placement in a Regional Secure Unit was considered, as was the idea that he should undergo a "neuropsych" assessment. In the event, neither option materialised. As appropriate as it was to send the man back to Bedford, the timing of the move got in the way of follow-up action by medical staff at Woodhill.

I take the view that the intensity of the attention paid to the man by the range of professional medical and mental health specialists was probably in excess of what he might reasonably have expected to receive had he been in the community.

I consider that the man's mental health needs were appropriately met and well managed whilst he was at Woodhill.

The management of the man's risk of self-harm

During his time at Woodhill, the man threatened to self-harm on at least three occasions and actually hurt himself on three other occasions. In April, only two days after arriving at Woodhill, he was made subject to continuous formal self-harm monitoring through the ACCT procedures. After superficially cutting his arms and threatening to jump from a third floor landing on 16 April, the man was admitted to the healthcare centre.

It is clear that all those who came into contact with him, especially the healthcare staff, took very seriously the task of managing the man's risk of self-harm. ACCT case reviews were held frequently. The man was present at each of them and therefore had every opportunity to involve himself in the decisions made about his care. At each review, the frequency of observations decided upon was tailored to the risk of self-harm he presented.

The table below gives details of when ACCT case reviews were held, the perceived level of risk and the decisions made as to the frequency of observations/interactions set for the man during the period he spent at Woodhill:

Date of case review	**Perceived level of risk**	**Frequency of observation set**	**Location at time of review**
9 April	Low	One per session, 3 obs at night	House Unit
16 April	High	Not mentioned in review record	VPU
17 April 10:30am	High	3 per session. Hourly at lock up times.	Healthcare centre
17 April 2pm	High	Constant watch	Healthcare centre
21 April	High	Constant watch	Healthcare centre
24 April	Low	Hourly	Healthcare centre
25 April 9:40am	Low	3 per session, 5 obs at night	Healthcare centre
25 April 9:50am	Low	3 per session, 5 obs per night	Healthcare centre
26 April	Not mentioned	Not mentioned	VPU
12 May	Not mentioned	Not mentioned	VPU
14 May	Low	3 per session, 5 obs at night	Healthcare centre
21 May	Low	3 per session, 5 obs per night	Healthcare centre
26 May	Low	One per session, 3 obs at night	Healthcare centre

A close examination of each of the case reviews revealed the following issues:

Case review records

A different form was used to record the case reviews held on 26 April and 12 May. Unlike the forms used for other reviews, those used on these dates contained no boxes for staff to record the perceived level of risk or the level of observations. Also noteworthy is the fact that no case reviews were held between those two dates, despite the fact that the man began to deteriorate at the time.

The Governor of Woodhill should ensure that there is no variation in the forms used to record case reviews, and that each review record clearly shows what level of risk is perceived by the review panel as well as the observations set.

Discharge from healthcare centre on 26 April.

The investigation found that the man was discharged from the healthcare centre to the VPU on 25 April, only two days after he had been on a constant watch. Although I am surprised by the speed at which he was discharged on

this occasion, I believe the decision was made in light of his desire to leave the healthcare centre. However, I am concerned that, once having been discharged to the VPU, the man's case was not reviewed in the following two weeks. It is perhaps not surprising that he found himself back in the healthcare centre on 12 May.

The Governor of Woodhill should ensure that ACCT case reviews are not suspended, by accident or by design, once an at-risk prisoner is discharged from the healthcare centre.

Recording of levels of observations/interactions.

The front cover of the ACCT document presented to my investigator contained an array of dates and observation levels that were difficult to decipher. There were no entries on that page relating to the period the man spent at Woodhill. This may have been due to the absence of another page covering that period.

The Governor of Woodhill should bring to the attention of staff the importance of making clear on the front cover of the ACCT form precisely what frequency of observations/interactions should apply and for what length of time. This may help to guard against the risk that the wrong observation levels are invoked.

Forms F213SH

The investigation found no evidence that a form F213SH was raised when the man self-harmed at Woodhill on 12 May and 1 June.

The Governor of Woodhill should remind his staff that a form F213SH must be raised in respect of any self-harm attempt by a prisoner in keeping with the instructions set out at paragraph 3.3.1 of Prison Service Order 2700.

Notwithstanding these criticisms, I consider that the manner in which the man's risk of self harm was managed at Woodhill was impressive. Each case review comprised a multi-disciplinary panel. The man was present at every review. Medical, nursing and discipline staff were responsive to the man's acts, as well as to his threats of self-harm. Of particular interest is that healthcare staff at Woodhill decided to manage his risk of self-harm by admitting him as an inpatient on two occasions. During one of his periods as an inpatient, the man was subject to a constant watch. Later, I compare this approach to his management with that which was employed at Bedford during the man's third period of imprisonment.

Phase Three: Bedford, 1 June – July 2006

Here I consider the following questions:

- Were the man's mental health needs and risk of self-harm appropriately managed?
- Should he have been placed on a constant watch in the healthcare centre on the day before he died?
- Given that he was not admitted to the healthcare centre on that day, should the man have been placed in shared accommodation in the vulnerable prisoner unit?
- Was sufficient effort made to respond to his requests for a transfer to another prison?
- Was the response to the discovery of him hanging appropriate?
- Were appropriate courtesies offered to the man's family in the aftermath of his death?

I also respond to a number of specific questions raised by the man's family.

Were the man's mental health needs and risk of self-harm appropriately managed?

Despite the fact that the man had asked to be returned to Bedford from Woodhill, his mental health continued to deteriorate after his arrival on 1 June. After initially expressing his satisfaction at being back, he became increasingly paranoid, often expressing a wish to kill himself. It is clear that his mental health needs were difficult to manage. The community psychiatric nursing team intervened on several occasions, especially the CPN, who encouraged the man to engage with the Cognitive Therapy Programme in the hope that he would create for himself a strategy for thinking differently about his life and circumstances, and develop a way of coping with imprisonment. The man did not make the most of this opportunity.

Although the man did not seem to engage actively with the CARATs team, they supported him emotionally throughout his time at Bedford especially when his mood was low. The man's principal CARATs worker had known him before his imprisonment when he was involved in a community based drug abuse programme run by Addaction. She therefore already knew him quite well when she came across him at Bedford.

One member of the CARATs team set out a CARATs care plan for the man but he declined to take a copy of it. I am impressed by the level of support offered to him by the CARATs team at Bedford, especially in view of the fact that the prime purpose of this facility is not that of catering for prisoners' mental health needs.

The man spent two weeks in the healthcare centre between 13 and 26 June. Whilst there, he reiterated his desire to be transferred to one prison or another. (I say more about this below.) The man also said he wanted to go to a secure unit (a psychiatric facility for patients whose mental health needs cannot be met in the community or in a mainstream hospital.) In fact, it was the view of the CPN team and of the doctors at Bedford that, although the man had personality difficulties, he was not suffering from any specific mental health condition. This may explain why the suggestions made at Woodhill that he should be

considered for a Regional Secure Unit and for a "neuropsych" assessment were not followed up at Bedford. It is unfortunate that the man was not referred for a second opinion and for further consideration of whether a placement in a Regional Secure Unit was appropriate.

My investigator found no evidence of a nursing care plan for the period the man spent in the healthcare centre.

The Primary Care Trust must ensure that nursing care plans are established as a matter of course for all prisoners admitted to the healthcare centre.

The medical record shows that the man was seen by doctors and by a psychiatrist, as well as by the CPN team. However, they clearly took the view that he was not suffering from any specific treatable mental illness.

In my judgement, the process of managing the man's mental health needs was inseparable from that of assessing, monitoring and managing his risk of self-harm. It is to that subject that I now turn. The following table gives details of when ACCT case reviews were held, the perceived level of risk and the decisions made as to the frequency of observations/interactions set for the man during this final phase of his imprisonment:

Date of case review	Perceived level of risk	Frequency of observations/interactions set	Location at time of review
1 June	Raised	3 per session by day. 2 during evening.	Reception
6 June	Raised	Hourly obs	VPU
13 June	Raised	Hourly interactions	Healthcare centre
16 June	High	Obs not reviewed. Therefore as above.	Healthcare centre
18 June	High	Obs not reviewed. Therefore as above.	Healthcare centre
19 June	Low	Reduced to every 4hrs	Healthcare centre
21 June	High	Obs not reviewed. Therefore as above.	Healthcare centre
22 June	Raised	Obs reviewed. "Reduced to 4 hrs."	Healthcare centre
23 June	High	3 per hour	Healthcare centre
26 June	High	Obs not reviewed. Therefore as above.	Healthcare centre
28 June	Low	2 per session	VPU
30 June	Low	As above	VPU
X July	Low	Obs not reviewed. Therefore 2 per session	VPU
xx July	Raised	Increased to hourly	VPU
Xx July	Not shown	Hourly	VPU
Xx July 9am	Raised	30 minute obs.	VPU
Xx July 2:30pm	Raised	30 minute obs.	VPU
Xx July 2:30pm	Raised	30 minute obs.	VPU
Xx July 4pm	Raised	Not clear	VPU

The table shows that ACCT case reviews convened for the man were responsive to the risk of self-harm he presented. He attended every review. He therefore had opportunities to involve himself in decisions that would affect him. The case review panels comprised multi-disciplinary teams. I am especially impressed by the fact that a case review was held immediately upon the man's return to Bedford on 1 June, even before he left the reception

building. This is an example of good practice. I am also pleased the investigation found that, in most cases, the case review summaries were properly completed, and that the setting of future review dates was apparent at each review.

That said, the investigation also found that the level of observations set at each review was not always obvious. This may have been due to the fact that the front page of the ACCT form offers limited space for recording such detail. However, the ongoing record in the ACCT form shows that the level of observations actually carried out on the man was, in general terms, in keeping with what was intended.

The Governor of Bedford should bring to the attention of staff the importance of making clear in the ACCT form precisely what frequency of observations/interactions should apply and for what length of time. This may help to guard against the risk that the wrong observation levels are invoked.

Should the man have been placed on a constant watch in the healthcare centre on the day before he died?

The Suicide Prevention Strategy in place at Bedford offers guidance to staff as to the most appropriate location for at risk prisoners. On page 14 of that document it says:

> "Location: Residential Unit or Healthcare Centre
>
> The crucial considerations are the degree of risk and the level of support (not just supervision) that is available in the proposed environment.
>
> Advantages of Residential Unit
>
> - stay in contact with familiar environment and people
> - less stigmatisation and loss of self-esteem
> - encourage prisoners to take more responsibility
> - can improve coping skills in normal environment
> - any stress within the normal regime can be tackled directly with help from staff.
>
> Advantages of HCC
>
> - more intensive supportive care and safe environment
> - treatment compliance can be monitored more easily
> - more regular review of physical/medical condition sanctuary from stress in normal regime.
>
> The decision to admit a prisoner to the HCC will be made only by healthcare staff following an assessment of the prisoner."

On page 22 of the Suicide Prevention Strategy, advice is offered on the subject of managing prisoners located in the healthcare centre. This section opens with the comment:

> "Following a suicide attempt, act of self-harm, deterioration in a prisoner's state of well-being, information gained from a case review or assessment, or due to a positive reception health screen, the decision may be taken to locate a prisoner deemed to be at risk in the healthcare centre."

The investigation found a greater willingness to care for the man in the healthcare centre at Woodhill than there was at Bedford. On 17 April, for example, when the man was at Woodhill, the doctor decided to admit him after noting that he "had fleeting thoughts of suicide but no plans". The doctor confirmed his view that the man should be kept on a constant watch at that time because of the nature of his suicidal ideation and because he had self-harmed the day before by inflicting superficial cuts to his arms. The doctor stressed the importance of weighing in the balance all the presenting issues when deciding whether to admit the man: his mood, his thoughts and his actual self-harm. He told my investigator he believed there were advantages in managing the man as an inpatient at that time. These included the ability of healthcare staff to monitor his general mental state, his risk of self-harm, and his paranoia. The doctor also pointed out that inpatients had better access to the mental health in-reach team. These advantages are very similar to those listed in Bedford's own suicide prevention policy.

The investigation found clear evidence of a significant deterioration in the man's state of mind at Bedford in July. He began to self-harm frequently. The interval between each self-harm episode reduced. His tendency to limit his self-harm to cutting his arms was apparently interrupted a few days before he died when he told the CPN he had tried to hang himself, and again on the day before he died when he told the CARATs worker he had made another attempt at hanging himself, this time apparently leaving red marks on his neck. In my view, the man's attempts to hang himself should have been interpreted by the healthcare staff as clear evidence of active suicidal ideation. But nothing changed in their approach to his management. They continued to insist that the man did not require admission to the healthcare centre because he was not suffering from any specific mental condition. This approach was fuelled further by their suspicion that he was trying to manipulate his admission. It is disappointing that the clinical review is silent on this very important issue which is why I have suggested in my foreword to this report that the Coroner and PCT may wish to explore matters in more depth. But I take the view that, in judging how best to care for the man at that time, healthcare staff did not seem to take account of all the factors evident in his behaviour. He may well have been trying to manipulate his admission as an inpatient. However, the combination of his clear and unambiguous expressions of a desire to kill himself, his two apparent attempts to hang himself, his prolific self-harming, and his earlier diagnosis of paranoia and personality difficulties were such, in my view, as to warrant the man's re-

admission. Had this been done, the benefits described by the doctor at Woodhill might have materialised.

However, I feel there was a yet more compelling argument for the man to be admitted to the healthcare centre. At her interview, the CARATs worker gave compelling evidence that the man had attempted to hang himself during the early hours on the day before he died. She said she saw red marks on his neck. It is of obvious concern that she did not make a note of this in the man's ACCT ongoing record, and I say more about that below. However, I do not doubt that the CARATs worker was telling the truth. I take the view that this discovery should have been interpreted as evidence that the man was now actively suicidal and that he might well have benefited from being placed on a constant watch. Such intense observation could only have been achieved by admitting him to the healthcare centre where there is a special cell for that very purpose.

My investigator was told that on the day before the man died, the Duty Governor recommended to the CARATs worker that a case review should be convened to review the man's risk. The governor told her he could not force healthcare staff to take the man into the healthcare centre. In view of her serious concerns about the man's attempt to hang himself earlier that day, I believe there was case for "escalating" to more senior staff the consideration of how best to respond.

The Prison Service Safer Custody Group should consider drawing up national guidelines for the escalation to senior medical and operational staff in cases where there is disagreement about whether at-risk prisoners should be admitted to the healthcare centre.

Record keeping

I am concerned that neither the ACCT review summary nor the ACCT ongoing record carried any reference to the CARATs worker's discovery of an attempt by the man to hang himself during the early hours on the day before he died, or to any subsequent discussion about the increased risk of suicide such an event would have signalled. Although she made a comprehensive record of her meetings and discussions with the man on that day in his CARATs case file, this document would not have been seen by wing staff because of its confidential nature. If the CARATs worker could find the time to make a note of events in the CARATs file, she could also have recorded her concerns in the man's ACCT document. By so doing, she might have helped to prevent the mystery of what was actually said before and at the case review held on the day before the man died.

I am also concerned that, in the copy of the ongoing record in the ACCT document presented to my investigator, there were no entries between 5:20 am and 12:31pm on the day the man died. This may be nothing more than a photocopying error. As noted earlier, when my investigator asked the prison to check the original, he was told that it could not be found. But if it were proved that no such photocopying error had occurred, this would represent a

serious failing by wing staff at Bedford either to make the required observations or to record them.

Record keeping is an integral part of professional practice and one that should help the care process. Good record keeping helps to protect the welfare of prisoners by providing:

- high standards of care
- better communication and dissemination of information between members of the multi-disciplinary team
- an accurate account of treatment, care planning and delivery of care
- the ability to detect problems and changes in the prisoner's condition at an early stage.

The Governor of Bedford, in conjunction with the Primary Care Trust, should remind all staff working at Bedford of the importance of making comprehensive and accurate records in ACCT documents of all events and discussions relating to the discovery of self-harm incidents and to any other development that might point to an increased risk of suicide. The need to do so should be emphasised in Bedford's local suicide prevention policy.
That said, I believe that in all other respects, the CARATs worker reacted swiftly and professionally to an event which she considered to represent a significant indicator of suicidality.

Forms F213SH

The investigation also found a lack of clarity as to whether a form F213SH was completed on each occasion the man self harmed at Bedford. It may have been the case that forms were completed on each occasion but were not all presented to my investigator.

The Governor of Bedford should remind his staff that a Form F213SH must be raised in respect of any self-harm attempt by a prisoner in keeping with the instructions set out at paragraph 3.3.1 of Prison Service Order 2700.

Given that the man was not admitted to the healthcare centre on that day, should he have been placed in shared accommodation in the vulnerable prisoner unit?

The decision whether a prisoner should be placed in a cell on his own is normally based on two factors. Prison staff have to balance the risk the prisoner presents of harming himself with his risk of harming others. When a prisoner is first received into prison, he must undergo a cell sharing risk assessment. The purpose of this is to enable staff to measure what those two risks are and to allocate each prisoner to appropriate accommodation according to what they find. The initial assessment can and should be reviewed as necessary during the prisoner's time in custody.

The investigation found that efforts were made by staff to place the man in shared accommodation when the cell sharing risk assessment process allowed. Shortly before he died, staff asked a prisoner in the VPU to share a cell with the man. However, on 13 July, a cell sharing risk review was carried out after the man said he could no longer cope with "sharing his space". As a result of this assertion, his risk of harming other prisoners was assessed as having increased from medium to high. He was therefore placed in a cell on his own. The panel recommended wing staff to maintain regular observations of the man because he was subject to ACCT procedures. A further cell sharing risk review was to take place a month later. The man remained in unshared accommodation until his death.

Although it was most unfortunate that the man was thus left alone at such a critical time, I believe their decision to separate him at that time was understandable. However, as I have indicated above, I believe he should have been admitted to the healthcare centre.

Was sufficient effort made to respond to the man's requests for a transfer to another prison?

The man asked on a number of occasions to be moved to another prison. On 16 April, he asked to be transferred back to Bedford so that he could be near his family. He told staff he did not know why he had been moved away from Bedford and was having difficulty adjusting to being at Woodhill. On 12 May, when he was still at Woodhill, the man was told he was 'for transfer to Littlehey' but he could not go there while he had an outstanding court appearance. On 14 May, he asked to be allowed to go to Littlehey as soon as possible. It was suggested to him that this might be a positive step to take because it would 'keep his family ties going'. On 22 May, The man told a doctor at Woodhill he was angry at still being there, and reiterated his request to go to Littlehey. On 1 June, he returned to Bedford. After initially saying he was happy to be back at Bedford and near his family, the man again asked to be transferred to Littlehey. On 18 June, a case review panel discussed with him the option of transferring to Peterborough after his court appearance on 27 June. The court appearance came and went but was not followed by a transfer. On 28 June, the man said he wanted to be in a prison 'far away from Bedford'. Two days before he died, an ACCT case review summary indicated that further discussions had taken place about the possibility of transferring him to Littlehey. Only hours before the man died, he was told a place had been found for him at Peterborough.

My investigator was told by a Principal Officer at Bedford, that HMP Wellingborough, as well as Littlehey and Peterborough, was also considered for the man. The PO also said a prerequisite for the man's transfer was that he should "establish a more acceptable pattern of behaviour". The PO stressed this did not mean the man's risk of self-harm needed to reduce before he could be transferred. Rather, the regime of a training prison would demand of him an ability to take part in the programmes available. The aim was therefore to

monitor the man over a period of weeks and to help him settle down. It is clear that one of the reasons for delaying a transfer was the outstanding court appearance on 27 June, although this did not prevent the man's transfer to Woodhill.

My investigator was told by the Deputy Governor at Littlehey that the prison operates an 'integrated' regime. This requires vulnerable prisoners to live alongside other prisoners rather than being separated from them. The Deputy Governor also explained that the prison does not have an inpatient facility. She suggested it was difficult to cater for prisoners with mental health problems. The Deputy Governor said she thought that any prisoner who was suffering from paranoia and who therefore had difficulty mixing with others was likely to be sent back to the parent establishment if they could not settle. In my judgement, the man would not have been able to cope with such a regime. I also believe he was likely to have experienced the same level of frustration at Littlehey as he did at Woodhill at being distant from his family. (Littlehey is 22 miles from Bedford.) Neither can I be certain that the man would have coped any better at Peterborough, some 39 miles away, had he transferred there. I therefore do not criticise the fact that the man was not transferred out of Bedford.

Was the response to the discovery of the man hanging appropriate?

The investigation found that the officer who discovered the man hanging at approximately 1:30pm responded promptly and effectively to what he saw. The officer used his radio to call for the Orderly Officer's assistance as soon as he realised there was something seriously wrong, and asked for medical assistance when he realised the man was suspended by a ligature, a fact that was not immediately obvious before he entered the cell. The Orderly Officer arrived at the cell within a very short space of time. He and the officer removed the ligature from the man's neck using a special knife issued to staff for this very purpose. As they did so, Orderly Officer asked the control room to call for an ambulance. Soon after, healthcare staff arrived at the cell and gave emergency first aid until the paramedic crew arrived.

However, the investigation also found that, on two occasions, the response team did not have the right equipment. First, a nurse had to leave the cell in order to fetch a resuscitation bag containing vital emergency first aid equipment. On her return, she again had to leave the cell to fetch a defibrillator. Whilst there is no evidence that the initial absence of this equipment had any effect on the outcome on this occasion, there is the possibility that it might in the future.

The Governor should consider implementing the two recommendations made about this matter detailed in the clinical review. I paraphrase them here:

The Governor, in conjunction with the PCT, should review the local contingency plans for managing a life threatening situation to ensure that appropriate emergency first aid equipment is taken promptly to where it is needed.

The Governor, in conjunction with the PCT, should ensure that regular checks are made on the contents of emergency bags to verify that all identified equipment is present.

Were appropriate courtesies offered to the man's family in the aftermath of his death?

The man's mother asked my investigator and my family liaison officer to find out why there had been such a delay in informing her son's death and why the police had visited her deceased mother's address.

The investigation found that there were difficulties in informing the man's mother - his listed next of kin - of his death. The Governor asked the prison's family liaison officer to arrange for the man's family to be told. He and one of the chaplains, together with two police officers, travelled to the address of the man's mother that had been logged in his prison record. They failed to get a response. The group then went to the man's father's address and broke the news to him. They then returned to the mother's address but once again failed to get a response. The Family Liaison Officer (FLO) therefore returned to the prison. Once there, a prisoner told him that the man's mother did not normally get home from work until 7.00pm. The FLO and his colleague returned once again to her address. Again they got no reply. At this point, the FLO asked the Bedfordshire police to inform the man's mother. At 6:30am the next day, the police contacted the prison to say that they had been unable to trace the man's mother at the address given. Information gained from his letter sheets showed that he had sent visiting orders to his mother at another address. The FLO and a police officer went to that address but, again, there was no response. The chaplain therefore tried to contact the man's mother by telephone using the number given for the original address for her. The man's mother answered. However, she quickly became distressed and unable to engage in any conversation. An agreement was made for the FLO, the Imam and a police officer to go to the address so that the circumstances of the man's death could be explained in detail. This was done later that morning.

As much as I understand the concerns expressed by the man's mother, I believe the prison made very effort to trace her and to break the news of her son's death promptly. The FLO and his colleagues went to the correct address but he was not to know that the man's mother would not be there. The fact that the police appeared to have visited the address of the man's deceased grandmother is most unfortunate.

The FLO also made arrangements for the man's family members to visit his cell. The Governor offered to contribute towards the cost of the man's funeral. Representatives of the prison were present.

I am satisfied that the courtesies and support offered to the man's family in the aftermath of his death were appropriate.

Family concerns

Here I respond to the specific questions raised by the man's mother.

Why was the man in a cell on his own when the prison knew that he was very vulnerable as he had been self-harming for some time before his death?

This is covered in the main body of the report. See page 60.

The trainers that the man's mother to the prison to her son on her last visit should have had the laces removed from them. Why was this not done? There was other material - shoe laces, sheets and electrical flex - within the man's cell that could be used in a suicide bid. Why was this not removed in view of his self-harming state of mind?

It is not normal practice to remove such items from a prisoner. There are indeed numerous items in a cell that can be used to fashion a ligature besides shoelaces. When deciding how to manage a prisoner considered to present a risk of self-harm or suicide, a balance has to be drawn between preventing self-harm and enabling him to live in conditions of decency. I do not criticise the prison for not removing the items mentioned. Their actions are in line with national policy about such matters.

On the last visit that his mother had with her son, they had talked a lot and she described it as a good visit. But he spoke a lot about the bullying that he was suffering. What action was taken by the prison to prevent the man from being bullied?

The man gave very little detailed information to staff upon which they could reasonably be expected to act. It became clear during the course of the investigation that the man was suffering from severe bouts of paranoia. This was certainly the opinion of the medical staff who saw and managed him at Bedford and Woodhill prisons. It is most likely that the man's claims that he was being bullied were imagined because of his paranoia. Whilst at Bedford, the man asked to be separated from other prisoners. His request was immediately granted. He spent the majority of his time in custody, both at Woodhill and at Bedford, separated for his own protection.

The man's mother said all of the prisoners referred to the man as a Charlie Chester (child molester). What could have been done about this?

The investigation found no evidence to prove conclusively that anyone called the man by these names. Once again, his beliefs seem likely to have stemmed from his paranoia.

The man's mother had called the chaplain at Bedford but could not recall his name. She had also called the chaplain at Milton Keynes. She had told both of them of her concerns about her son. What action did they take following these calls?

The chaplain at Bedford confirmed that at about midday on a day in July she took a call from the man's mother who expressed her concerns about his state of mind. She was especially worried that her son had told her he wanted to kill himself. She wanted him to know that he had her support. The chaplain also confirmed that, at about 1:30pm that day, she took a call from the man's father who expressed similar concerns. He also wanted his son to know that he loved and supported him. The chaplain went to see the man in the VPU and spent some time talking to him. Afterwards, she made the entry in the man's ACCT ongoing record that I have quoted above on page 36. The chaplain also attended the ACCT case review that had already been planned for that day. Later, she called both the man's parents and told them she had spoken to him and reassured them that "all the people who were involved with him were fully aware of his particular circumstances".

Unfortunately, the chaplain at Woodhill was not available for interview. However, I am satisfied that the general level of care afforded to the man at Woodhill was appropriate. I also believe that the chaplain at Bedford acted promptly and effectively in her dealings with him.

What was the reasoning behind the man not being placed on 24 hour watch and who made this decision?

This is covered in the main body of the report. See pages 56 to 58.

Why did the police go to her deceased mother's address trying to inform her of the death? Why did the prison wait until Sunday to call the man's mother on her landline to tell her that her son was dead? (She had gone to Brighton on the Friday as it was her birthday and had waited all of the Saturday for his call as the man always called on her birthday, so she was in and nobody called.) In relation to the funeral, the man's mother felt that the prison acted very well.

These matters are covered in the main body of the report. See pages 48 and 49.

I now turn to the questions posed by the man's father.

Why was the man on F Wing which in my experience was always known as a wing for sex offenders?

The vulnerable prisoner unit (VPU) at Bedford holds prisoners who, for a number of different reasons, feel unable to mix freely with other prisoners. The man asked to be moved to the unit because he said other prisoners were bullying him. It is acknowledged that the man was not a sex offender.

If he was on suicide watch, why was he in a single cell?

This is covered in the main body of the report. See page 60.

Was the man being abused or threatened by any other prisoners and if so what action was being taken?

The man did not give staff any detailed information about bullying upon which staff could reasonably have been expected to act. It became apparent during the investigation that the man's belief that he was being bullied may well have been born out of his paranoia.

What happened in the period between his time on B Wing when he appeared to be getting on so well and the last days when he was apparently very troubled?

It is difficult to find an explanation as to what led to the man's deterioration. This was his first time in prison. He initially coped with his environment but there is evidence that, as time went on, he became increasingly paranoid and unable to think positively about his situation and his future. The man also became increasingly frustrated by the fact that he was not admitted to the healthcare centre where he wanted to be.

Why was the man sent to Woodhill and then brought back to Bedford?

The man was moved from Bedford because it was thought that, in light of the fact that his father had been employed in the prison, he presented a threat to security. The man was returned to Bedford after it was decided that no security threat existed, and because he asked to go back because he wanted to be closer to his family. I am critical of the decision to send him to Woodhill. See pages 13 and 50.

Was there at that time an intention for the man to transfer to Littlehey? If so, why did he not go and where did he get the idea he was going?

This is covered in the main body of the report. See page 61.

The man was apparently given some type of assessment on the Friday before he died. What happened at that meeting which his father understands the man attended? Who made the decision to leave him where he was, and why?

On the day before the man died, two separate ACCT case reviews were convened. The details of what was discussed and decided upon at the review can be seen on pages 39 to 46. Further information can also be found on pages 57 to 59.

What contribution, if any, was made by the Prison Service to the funeral costs?

Prison Service policy is that Governors should offer to make a reasonable contribution towards the cost of a prisoner's funeral. The cost of the man's funeral was £2,600. The Governor contributed £2,000.

LIST OF RECOMMENDATIONS

To the Governor of Woodhill

1. The Governor of Woodhill should ensure that there is no variation in the forms used to record case reviews, and that each review record clearly shows what level of risk is perceived by the review panel, as well as the observations set.

At consultation stage the Prison Service accepted this recommendation.

2. The Governor of Woodhill should ensure that ACCT case reviews are not suspended, by accident or by design, once an at-risk prisoner is discharged from the healthcare centre.

At consultation stage the Prison Service accepted this recommendation.

To the Governors of Bedford and Woodhill

3. The Governors of Woodhill and Bedford should bring to the attention of staff the importance of making clear in the ACCT form precisely what frequency of observations/interactions should apply and for what length of time. This may help to guard against the risk that the wrong observation levels are invoked.

At consultation stage the Prison Service accepted this recommendation.

4. The Governors of Woodhill and Bedford should remind their respective staff of the importance both of completing a form F213SH whenever a prisoner self-harms in keeping with the instructions set out at paragraph 3.3.1 of Prison Service Order 2700.

At consultation stage the Prison Service accepted this recommendation.

To the Governor of Bedford

5. The Governor of Bedford should remind his staff of the importance of making comprehensive and accurate records in ACCT documents of all events and discussions relating to the discovery of self-harm incidents and to any other development that might point to an increased risk of suicide. The need to do so should be emphasised in Bedford's local suicide prevention policy.

At consultation stage the Prison Service accepted this recommendation.

6. The Governor should review his local suicide prevention policy to ensure that clear guidance is given to staff about the need to give due weight to cell sharing in managing prisoners who present a heightened risk of self-harm or suicide.

At consultation stage the Prison Service accepted this recommendation.

7. The Governor, in conjunction with the PCT, should review his local contingency plans for managing a life threatening situation to ensure that appropriate emergency first aid equipment is taken promptly to where it is needed.

At consultation stage the Prison Service accepted this recommendation.

8. The Governor, in conjunction with the PCT, should ensure that regular checks are made on the contents of emergency bags to verify that all identified equipment is present.

At consultation stage the Prison Service accepted this recommendation.

To Bedford Primary Care Trust

9. The Primary Care Trust must ensure that nursing care plans are established as a matter of course for all prisoners admitted to the healthcare centre.

To Safer Custody Group

10. The Prison Service Safer Custody Group should consider drawing up national guidelines for the escalation to senior medical and operational staff cases where there is disagreement about whether at-risk prisoners should be admitted to the healthcare centre.

At consultation stage the Prison Service did not accept this recommendation and in response said:

"Safer Custody Group is aware of the importance of the operational and health staff relationship. This is referred to extensively in the forthcoming revised Prison Service Order 2700 (Suicide Prevention and Self Harm Management). The revised PSO will make it clear that the quality of each establishment /PCT partnership is crucial to success in developing an effective self-harm management strategy. Safer Custody Group has already considered providing national guidelines on safer custody related issues to be covered in local partnership agreements but on the advice of the Department of Health (Offender Health) has agreed not to impose such detail at local level. This is a matter for each local Partnership Board as described in the National Partnership Agreement (January 2007). If there is a disagreement, paragraph 3.17 deals with dispute resolution: 'Where issues cannot be resolved by the Partnership Board they should be referred to the SHA/Area Office'."

Good practice

I am especially impressed by the fact that a case review was held immediately upon the man's return to Bedford on 1 June, even before he left the reception building.