



**Investigation into the circumstances surrounding the  
death of a man  
at HMP Bedford in June 2011**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**June 2012**

This is the report of an investigation into the death of a man who was a prisoner at HMP Woodhill and HMP Bedford. He was 36 years old. One morning in June 2011, he was found with a ligature around his neck. Staff did not attempt resuscitation as it was clear he had died. I offer my condolences to his family and friends for their loss.

My colleague was appointed to carry out the investigation. A review of the man's healthcare was undertaken by a clinical reviewer. I am grateful to the Governors of HMP Woodhill and HMP Bedford and their staff for their co-operation during this investigation. I apologise that the report has been delayed.

The central focus of the investigation concerned each prison's assessment of the man's risk of self-harm or suicide. His risk factors were significant: he was charged with murdering his partner, it was his first time in custody and he had recently said he wanted to commit suicide. However, there were significant weaknesses in assessment of these risks. The murder of a family member puts the prisoner at an exceptionally high risk of suicide. The Prison Service's own orders recognise this and mandate that specific and particular care should be taken with such prisoners. Unfortunately, this did not happen in his case.

The letter left by the man suggests that he deliberately misled prison staff with regard to his intentions. This, and his generally calm demeanour, reassured staff that he was not at risk. However, this only makes it clearer that prisons must work hard not to over-emphasise the importance of a prisoner's presentation when assessing their level of risk. This investigation makes a number of recommendations designed to improve practices in this regard. One of these is a national recommendation designed to ensure that all prisoners charged with an offence so closely associated with both self-harm and emotional turmoil are routinely provided with the safeguard of a meeting with mental health professionals.

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

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**June 2012**

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## SUMMARY

1. The man was arrested on 10 April 2011 on suspicion of murdering his partner. He was charged with murder and remanded into custody at HMP Woodhill on 13 April. The documentation that accompanied him to Woodhill made reference to a previous assertion he had made regarding wanting to kill himself. On the basis of this, and the nature of the charge he was facing, the escort services opened a suicide and self-harm warning form and continuously observed him while he was in their custody.
2. Upon the man's arrival at Woodhill, staff did not consider him to be at risk of harming himself. Neither did they refer him for a mental health assessment. He was provided with a cell on the first night centre and no concerns were raised for his wellbeing while at Woodhill.
3. He was due to attend court on 15 April. The documentation completed by Woodhill staff was inaccurately completed and staff unintentionally minimised his risk of harming himself. Having appeared at court, he was taken to HMP Bedford. Staff at Bedford did not consider that he required any further support in terms of suicide prevention measures or a mental health assessment.
4. The man was a quiet and compliant prisoner while at Bedford. He conformed to the rules and did not come to the attention of staff. There is limited evidence that anyone made a particular effort to engage with him, other than a member of the chaplaincy. Even so, this yielded little information about his state of mind as he was a private and guarded individual.
5. Bedford provided him with a single cell on 15 June, in response to a request from him. The note left by him revealed that he had deliberately hidden his intentions and given the staff the necessary impression in order to secure a single cell. He was found early in the morning at the end of June having tied a ligature around his neck. By the time he was found it was clear he had died and no attempt was made to resuscitate him.

## THE INVESTIGATION PROCESS

6. An investigator was appointed to investigate the death of the man on behalf of the Prisons and Probation Ombudsman. He visited Bedford on 5 July where he met the then Governor and a Senior Officer, who was the prison's liaison officer for the investigation. He walked around the prison and visited the wing where the man lived. The investigator was provided with the man's prison records. He sent notices to the prison alerting staff and prisoners to the investigation. No-one came forward with regard to the notices.
7. The investigator visited HMP Bedford again on 28 July and 5 August. During these visits, he conducted interviews with six members of staff. He and a colleague also interviewed a member of staff who no longer worked at Bedford at their house. The investigator visited Woodhill on 20 October to interview three members of staff. He wrote to the acting Governor of Bedford in October 2011 with initial feedback on the progress of the investigation.
8. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care on their behalf and she was provided with all relevant documentation to assist this review. The clinical review was received on 8 December 2011. This, added to the change in job role of the investigator, led to the delay in the publication of this report.
9. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post-mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
10. One of the Ombudsman's family liaison officers contacted the man's family to inform them of the investigation and invite them to ask questions or raise concerns about his care. They did not raise any specific concerns. It is hoped that this report provides them with more information about his time in custody.
11. Following the publication of the draft report, the office received responses from the National Offender Management Service (NOMS) and the man's family. The response from NOMS accepted all of the recommendation apart from the national recommendation made at paragraph 71. The Ombudsman has subsequently written to the Chief Executive of NOMS to discuss this rejection, and work is ongoing at the time of the publication of this report to consider it further.

## **HMP BEDFORD**

12. HMP Bedford is a local prison which means it accommodates sentenced and remand prisoners from Luton Crown Court and Bedford and Luton Magistrates' Courts. The prison also accepts sentenced prisoners from the London area because of overcrowding. It has an operational capacity of 506 prisoners. The prison has been on its present town centre site since 1801. A new gate lodge, house block, and healthcare centre were added to the earlier Victorian wings in the early 1990s.
13. There is a healthcare team based in the prison including doctors, nurses and nurse managers. Bedford's healthcare unit can accommodate up to 13 in-patients.

### **Suicide and self harm monitoring**

14. Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify a prisoner's individual needs, and provide individualised care and support.

### **Her Majesty's Chief Inspector of Prisons (HMCIP)**

15. The most recent HMCIP inspection was a short follow-up inspection from 2 – 5 May 2011. In the introduction to the report, the Chief Inspector wrote that "Bedford continued to be a generally safe prison, despite the many challenges posed by its population". Reference is made to the suicide and safe-harm work improving and to the fact that first night staff received specific training for the role.

### **Independent Monitoring Board (IMB)**

16. Each prison in England and Wales has an Independent Monitoring Board, made up of members of the public, responsible for monitoring day-to-day life in the prison, and to ensure that proper standards of care and decency are maintained. The most recent annual report published by the Bedford IMB covers the time 2010 - 2011. The board commented that self-harm had decreased from the previous year, and the Safer Custody Team conducts regular and thorough checks of ACCT documents.

### **Previous deaths at HMP Bedford**

17. Since the Ombudsman started investigating deaths in custody in April 2004 there have been thirteen deaths at Bedford, including that of the man. Bedford experienced four self-inflicted deaths in 2011. In all of the cases, the prisoners died within a relatively short time of arriving at Bedford. There are no direct similarities between the other cases and that of the man's, but concerns regarding suicide prevention measures had been previously raised.

## KEY EVENTS

18. The man was arrested on 10 April 2011. He was suffering from injuries to his hands and taken to hospital. He underwent an operation to one of his hands and returned to police custody in Milton Keynes. He was provided with antibiotics while at the police station and interviewed. He was subsequently charged with the murder of his partner and, on 13 April 2011, was transferred first to court and then to HMP Woodhill. This was his first time in custody.
19. The Person Escort Record (PER) is a document, individual to each prisoner, used by all the agencies involved in the management of the transfer of prisoners. In the case of the man, the PER that accompanied him first to the Magistrates' court and then to Woodhill, said in the box next to 'suicide/self-harm risk': "stated he wanted to kill himself". It was also noted that he had been arrested on suspicion of murder. A jailer at the police station, who completed the form, also noted in the section entitled 'health – mental' that "DP [detained person] on cell watch." The cell watch was also mentioned with regard to the cuts on his hand, so it is unclear for what reason he was observed while in his cell.
20. The man was taken to court. At 12.30pm a note was made in the 'history and events' section of the PER by the Prison Custody Officer (PCO): "2052 opened." A F2052 form was the previous method used to support prisoners deemed to be at risk of suicide or self-harm. The PCO was apparently indicating that his colleague had opened a 'suicide / self-harm warning form'. The decision was made to observe the man constantly. The second box 'nature of the concern' is not completed but section four provides an explanation for the opening of the form:

"States he's fine and has no intentions on [sic] suicide/self-harm. Form has been raised because of nature of offence and information given on PER."
21. The 'personal summary sheet' in the man's core prison record was completed by another PCO. It confirmed his next of kin details and noted that he was able to read and write. It also stated that he had not previously been in prison before. (This part of a prisoner's record is often completed by the escorting staff prior to their arrival at prison.)
22. The man arrived at Woodhill at approximately 1.30pm and his documentation was handed over to prison staff. An officer explained to the investigator that the senior officer in reception would have signed the suicide and self-harm warning form that arrived with him to acknowledge its receipt. When prisoners arrive at a new prison they go through the reception process. A number of interviews are undertaken to assess their physical and mental well-being, and initial needs.
23. A cell sharing risk assessment (CSRA) is always carried out by a prison officer to establish the level of risk a prisoner presents to a cellmate. An officer wrote on the form: "States he has no thoughts of self-harm. Willing to

share. Smoker. Carrying injuries.” He confirmed to the investigator that he had a copy of the PER when he undertook the interview with the man and would ask every prisoner about suicide and self-harm. The officer said that he took into consideration his records and his presentation to come to an overall view on a prisoner’s level of risk. He explained to the investigator:

“ ... because things are said in the heat of the moment particularly once they’ve been sent down by the judge they’ve been charged with murder and they’re going to prison. Now the first thing they think of coming out of the dock and going down is that’s it, you know, I’ve got nothing to live for, so you do get quite a few that initially will say that and they will come in with a warning but once reality sets in and they’ve had a chance to calm down a bit then they see it as, you know, it’s not the end of the world, there could be a light at the end of the tunnel.”

24. The second section of the CSRA is always completed by a member of the healthcare department. The section on the man’s form noted that there was nothing to suggest that he would be at increased risk of assaulting a cellmate, and in the comments box was written “nature of crime.” This section was not signed or dated by the member of healthcare staff who completed the form. He was assessed as being at standard risk once the information from the nurse and an officer was taken into account by a Senior Officer (SO) on the first night centre.
25. The first reception healthscreen was completed by a nurse. He noted the wounds to the man’s hands and the plaster cast on his ankle. He referred him to the doctor and wrote that he denied any thoughts of suicide or self-harm. No referral was made to the mental health team.
26. When a prison receives someone with a suicide and self-harm warning form, there is a section on the document which requires the prison to explain whether they have begun suicide prevention measures. Section 8 (confirmation of action taken by healthcare screener) shows that suicide and self-harm procedures were not begun. This section was signed by a doctor. He said that it did not need to be him specifically who signed it:

“I signed the form because I saw that entry, I spoke to him and I’ve seen the nurse’s entry as well there was no suicide or self harm risk so I didn’t go into that issue again, I simply discussed the problem with his hand and the need for a follow-up appointment on what day he had.”

27. The doctor explained to the investigator that the man was referred to him by the reception nurse because of the injuries to his hand, and not due to any concerns that he might harm himself: “He was put down for me to see because of his injuries”. He said that he understood the nurse to have checked such concerns with him, and would not have spoken to him about suicide concerns for any length of time as the nurse would already have covered it:

“ ... he did say that he’s fine so there was no question of whether he was at risk and he would have been interviewed by the nurse who saw him earlier on and whilst he has not expressed any self-harm or suicide ideation then we’ll no longer discuss that issue because it’s not been brought up as a risk.”

28. The man was taken to a cell on the first night centre (the area of the prison reserved for prisoners during their early time in prison). An officer made the following note in his prison record at 3.47pm on 13 April:

“1<sup>st</sup> night interview completed by an officer. This is his first time in prison. He seemed a bit shell shocked. Has no thoughts of self-harm at present. Good eye contact and body language. Smokers pack issued.”

29. An officer explained to the investigator that first night staff conduct two interviews with prisoners. Typically, one would be done on the first night and the second undertaken the following morning, before the prisoner moved to the induction wing. These assessments are aimed at checking what support the prisoner needs in prison.

30. A ‘Prisoner Security Information’ form was completed on 14 April which contained the man’s basic details and did not include any concerns regarding suicide or self-harm. An officer recorded the following note on his prison record at 10.10am on 14 April:

“Second day interview completed by an officer. Still a little quiet but appears collected. He said he had no thoughts of self harm he appeared to have a reasonable settled night as well.”

31. The officer confirmed that the man was probably given the responsibility for typing up all of the interview notes onto the prison software system and that was why he inputted the other officer’s interview. He explained that the interview contains a standard question regarding suicide and self-harm that he would have put to him. He clarified that, as he was not subject to ACCT procedures, he would not have been monitored during the night so the reference to sleep would have come from him.

32. A member of the Offender Management Unit (OMU)/discipline administrative office sent the following email to the safer custody department at 2.29pm on 14 April:

“A9127CC. PER received stating “Stated he wanted to kill himself. His pre-cons also state the same message. Officer on FNC informed. Case notes added.”

33. (FNC refers to the first night centre. Case notes refer to the prison software system ‘C-Nomis’. This system shows that the member of OMU added information referring to the man’s suicidal statement at 1.37pm on 14 April.) An officer confirmed that he would often be contacted by OMU with such

information on the first night centre, but sometimes he would already know it from the prisoner's records. He also explained that the reference to himself in the note made by the member of OMU is simply because it was him who answered the telephone. He was unable to recall the telephone call but explained to the investigator that he would typically inform the senior officer (SO) on the wing. The SO would decide whether to ask a member of staff to speak to the person again regarding the information. The investigator has not seen any evidence that the man was spoken to again about this matter.

34. A note was made in the man's prison record which confirmed the above email. It is not clear who made this comment as the signature is illegible. A prison chaplain made the following note in his prison records: "Chaplaincy induction: He was informed of the services provided by the chaplaincy team, he had no issues".
35. The man went to Crown Court on 15 April for an initial hearing, before going on to HMP Bedford. There is no reference in his medical record to suggest that he was assessed as fit to be transferred to another prison. Another PER was begun which was completed by an officer. In the 'suicide/self-harm' section it says "Nil noted on CNomis [prison software system]". However, in the 'health – mental' section "On ACCT – self-harming warning from court" was added by someone whose signature is illegible. (This was not entirely accurate as he was not subject to ACCT procedures while in Woodhill, although a suicide and self-harm warning form had been opened by the escort services.)
36. The man arrived at Bedford at approximately 2.45pm. He underwent a first reception healthscreen at approximately 3.30pm with a nurse. (The investigator was told that Bedford staff were unable to access his medical record from his time at Woodhill as Woodhill staff had not completed the required actions on the electronic system. This meant that the nurse was unable to see any medical information pertaining to his time at Woodhill.)
37. The nurse recorded that the man had not received psychiatric or mental health care in the community, and did not feel like harming himself or committing suicide. The nurse noted his existing physical injuries and referred him to the doctor. He said that he had not taken drugs in the last month and, prior to entering prison, drank five units of alcohol a week. He went to see a doctor at 4.15pm, who confirmed his prescriptions of antibiotics and pain relief.
38. Another CSRA was undertaken by an officer and the man was confirmed as standard risk. A first night interview was also completed by the officer. During their discussion, he told the officer that it was his first time in custody, he had no concerns about being at Bedford and had never attempted to harm himself. He also said that he did not feel like harming himself at that time.
39. The man was taken straight to a residential wing, rather than to the first night centre as there was not enough room. The investigator was told that this did happen from time to time due to population pressures.

40. A resettlement interview was undertaken on 20 April. During the discussion with the officer, the man said he was 'slightly' concerned about being in custody, but did not feel at risk in any way. He said he was concerned by the size of his debts and was referred to the Citizens' Advice Bureau. He said that he was not withdrawing from drugs or alcohol.
41. A note was made in the man's prison record at 11.24am on 20 April. It said "The man has completed the first two modules of the induction programme with relevant referrals made and resettlement issues addressed".
42. A prison chaplain told the investigator that he first met the man approximately a week after he came into Bedford. He said that he was always very polite but did not wish to speak of his feelings or emotions. The chaplain recalled that during all the times he met with him the only time he mentioned anything of substance was when he said "I can't believe I did it." However, he did not elaborate on this comment. He told the chaplain that he did not go out much in the day. The chaplain presumed that he spent much of the day watching television. He said he asked him if he needed anything, but he said he did not. He said he had no concerns about him regarding mental health or suicidal ideation, and would have raised it with staff if he did.
43. An officer made the following note in the man's prison record at 11.06pm on 1 May:

"Pers Off [personal officer] Check: Has not been on A wing very long and have had no dealing with him so hard to say how he is settling in but have heard no negative comments about him from other staff."
44. The man visited the hospital on 5 May for further assessment of his injury. It was noted in the PER that accompanied him to and from hospital that he was polite and caused no issues while at the hospital. He arrived back at Bedford at 12.30pm.
45. Another officer made the following note in the man's prison record at 7.57pm on 13 May: "Due to the injury to his foot he tends to stay in his cell. He conforms to regime but has very little contact with staff".
46. The man visited hospital again on 16 May. The PER records that his plaster cast was due to stay on for another week. He visited the fracture clinic on 23 May.
47. An officer made the following note in the man's prison record at 8.01pm on 24 May: "Pers Off Check: Has not come to my attention and keeps to the wing regime well". The investigator spoke to the officer, who explained that his impression was that he was a very quiet man who "kept his head down" and did not seem to want to associate with the other prisoners. The officer could not recall him ever coming to him with any specific problems. He said that he had been very shocked when he found out he had died as he had not expected it at all.

48. The man visited the hospital for physiotherapy treatment on 1 June. He visited the fracture clinic on 13 June and his plaster cast was removed. He moved to a single cell on 15 June. The investigator was told that this was at his own request.
49. An officer made the following note in the man's prison record at 6.29pm on 14 June:
- "P/O [personal officer] check: Recently moved to single cell. Has injured foot hcc [healthcare] aware, has court Fri 17/6/11, bit worried about other prisoners finding out his charge if in press but states ok at present. Remains polite to staff and follows regime."
50. The man went to Crown Court on 17 June for a further hearing. There were no concerns raised during this time. He moved to a different single cell on this day. An officer made the following note in his prison record at 7.06pm on 19 June: "Personal officer entry: No real concerns this week, a good member of the wing". The chaplain told the investigator that he saw him on the Tuesday after this court appearance, but he did not raise any concerns with him. There is nothing further of significance in his prison record until 30 June.
51. The man was subject to no checks beyond the standard prison roll checks. His cell would have been checked as part of the evening roll check on 29 June, but there was no reason for staff to check on him throughout the night. At 5.45am an officer undertook the morning roll check on A Wing. When she reached his cell she could see his body and legs in an unusual position on the bed and floor but was unable to see his head. She knocked on the door but there was no response. She asked the night orderly officer to open the cell. The night orderly officer and her colleague went to the cell.
52. When they entered the cell, it became apparent that the man had a ligature around his neck. The night orderly officer radioed the control room to request healthcare support and to contact an ambulance, the police and the duty governor. Both officers removed the ligature with their anti-ligature knife. They could not find a pulse. Rigor mortis had already set in so the officers did not attempt cardio pulmonary resuscitation (CPR). Two nurses attended and placed the defibrillator on him. It told the nurses to start CPR so they administered oxygen through a bag valve mask (a means of providing oxygen to a person) and began chest compressions. The paramedics arrived at 6.00am and told the nurses to stop CPR. They pronounced the man dead at 6.04am.

### **Liaison with the man's family**

53. An officer was contacted at 6.01am and arrived at the prison at 6.40am. She was appointed family liaison officer and established the man's next of kin details. The officer and a member of the chaplaincy team arrived at the man's mother's house at 9.30am. One of his brothers was present and they telephoned his other brother to ask him to come to the house. The officer and

the chaplain broke the news and left their contact details with the family. His property was returned to his family on 11 July. The prison contributed to the cost of the funeral, which was undertaken by the chaplain.

### **Support for prisoners**

54. Following the man's death, all prisoners subject to ACCT procedures had an additional case review. Additionally, the local Samaritans visited the prison and made themselves accessible to all prisoners, particularly those on A wing. Listeners and the chaplaincy team were also available to offer their services alongside the Samaritans. (Listeners are prisoners trained by the Samaritans to provide emotional support to other prisoners.)

### **Support for staff**

55. A hot debrief was held at 8.45am on 30 June with all the people involved that morning. This is a meeting to give staff the opportunity to share their feelings regarding the finding of the man, and find out where to access support should they need it. The care team was made available to any staff who required it.

## ISSUES

### The assessment of the man's risk

56. The man entered custody with a number of factors indicating that he was at a much increased risk of harming himself. It was his first time in custody, he was accused of the murder of his partner and his person escort record (PER) contained information that he had said he wished to kill himself. Despite this, neither Woodhill nor Bedford acted to put in place any protective measures. It is important to consider each aspect of his entry into prison to consider whether there are lessons to be learned.

### *The man's journey to, and arrival at, Woodhill*

57. The PER contained reference to his alleged offence, a statement (it is unclear when it was made) that he wished to kill himself and noted that he had been observed while in police custody. The escort services, despite his assertions that he did not intend to harm himself, opened a suicide and self-harm warning form and made the decision to observe him constantly. This was an appropriate decision given the circumstances of his offence and his statement regarding his suicidal ideation.
58. When a prison receives a prisoner with a suicide and self-harm warning form from the escort services, they must record on it whether they intend to begin ACCT procedures or not. A prison doctor signed the suicide and self-harm warning form at Woodhill and indicated that ACCT procedures were not required. During interview, he told the investigator that he only signed it because the reception nurse had seemingly forgotten to do so. The nurse in question no longer works in the prison, and the investigator was not been able to speak to him.
59. Prison Service Order (PSO) 2700 (Suicide Prevention and Self-Harm Management) provides a list of factors that can increase the risk of someone taking their life. Many of these apply to the man, such as it was his first time in prison, he was charged with the murder of his partner and he was in the early period in custody. In particular section 4.10 makes it clear that:
- “Prisoners charged with homicide are a particularly high-risk group, and within this prisoners charged with homicide against a partner or family member are at an exceptionally high risk of suicide.”
60. Given this, and the fact that a suicide self-harm warning form had been opened by the escort services, it is concerning that Woodhill did not feel it appropriate to begin ACCT procedures. When asked if he would have taken the charge the man was facing into account, an officer told the investigator:
- “No, not particularly. I would go on the individual in front of me rather than what he's done because, you know, by the grace of god everybody's done something stupid in their life and it could have been just one of those things so I tend to take the person in front of me

rather than the offence that he's committed."

61. This response does not reflect the seriousness PSO 2700 ascribes to the charge facing the man. On the contrary, it appears to minimise the effect of such a serious and tragic offence. Section 4.10 of PSO 2700 also says: "Reception/first night staff must be made aware of the suicide and self-harm risks associated with prisoners who are charged with offences related to violence against a family member and/or homicide". It is imperative that staff recognise the seriousness of such charges, and appropriately assess the risks associated with them.
62. It is insufficient to simply argue that, as the man did not take his life at Woodhill, then the actions taken there were appropriate. Actions or omissions can have cumulative effects and the lack of initial support to him at Woodhill could have impacted on his later decisions. A notable fact from his prison records is the lack of detailed conversations he had with any staff while in custody. ACCT procedures would have obliged such conversations to take place and would have alerted staff to his potential vulnerability.

*HMP Bedford's assessment of the man's risk*

63. Notwithstanding what had gone before, staff at Bedford, as the receiving prison, also had the duty to consider level of risk the man presented and act accordingly. Neither the nurse nor the officer who conducted the CSRA considered him to be at risk of harming himself.
64. Staff at Bedford, as at Woodhill, also did not consider the circumstances of the man's offence as sufficient reason to begin ACCT procedures, given his stable presentation. While presentation is important, it must be balanced against other factors. Staff only see a prisoner's presentation for a limited length of time while the risk factors exhibited by him were ongoing. It is encouraging to hear that Bedford has already taken steps in this area to display such key risk factors on a poster in reception to promote awareness among staff.
65. The man was charged with the murder of his partner. This offence is closely linked to suicide, and puts the prisoner concerned in the highest category of risk (based on offence), as noted in PSO 2700 mentioned above. While it is understandable that many staff, prison and healthcare, prefer not to know the offences of the prisoners they work with, the relevance of this charge means that, where it is known, it must be shared with appropriate staff. The section of PSO 2700 mentioned above indicates that knowledge of the charge can help identify those prisoners at the highest risk of harming themselves. The reception nurse at Bedford told the investigator that he preferred not to know the charge, and did not know what it was in the case of the man. However, he also acknowledged that had he known of it, it might have prompted him to a different course of action.
66. There are serious concerns about the process and judgements made at both Woodhill and Bedford with regard to the risk of the man harming himself.

PSO 2700 makes it clear that he was at an exceptionally high risk of suicide and self-harm, yet there is no evidence that this was appreciated by staff at either prison. PSO 2700 contains the following mandatory action for all prisons dealing with such prisoners:

*“Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken.”* [Emphasis in the original indicating that it is a mandatory requirement.]

67. While it is not appropriate to mandate ACCT procedures in all such cases, what is required are additional assessments (and recording of those assessments) because of the specific circumstances of the charge. The investigator has seen no evidence that anything particular was undertaken with regard to the man. This must be remedied and both prisons need to review carefully how they receive the highest risk prisoners in the estate:

**The Governor of Woodhill and the Governor of Bedford should ensure that appropriate safeguards are in place to mitigate the significant risk associated with prisoners who have committed domestic homicide, in line with the requirements of PSO 2700.**

### **Mental health referrals**

68. In some prisons, all prisoners charged with homicide must be referred for a mental health assessment. This is a local decision and not mandatory across the prison estate. There was no such obligatory requirement at Woodhill or Bedford. Officers knew about the nature of the man’s offence and told the investigator that they could refer prisoners for mental health assessments, but he was not referred. The reception nurse at Bedford said that he was not aware of his alleged offence, but he would have considered a referral had he known.
69. The man was not only charged with murder, but the murder of his partner. A referral for a mental health assessment, even when prisoners are not displaying overt mental health problems, for prisoners charged with this type of offence can act as an important safeguard. The impact of guilt, bereavement and the potential complications of contact with the rest of the family may well have an effect on a prisoner’s mental health. To compound this, he was in custody for the first time.
70. Prior to the introduction of the electronic medical record, a paper-based healthscreen process was used. In this system, a mental health referral was mandatory in the case of a domestic murder. The investigator asked the National Offender Management Service why this requirement was removed in the transition to the electronic system, and it is not clear why it was.

71. A mental health assessment does not assume mental health problems. It merely, but importantly, provides an opportunity for trained staff to assess a prisoner's mental health. Symptoms such as sleeplessness and depression can then be tackled before they develop into something more serious. In the case of the man, it would, at the very least, have provided an opportunity for staff to have a more detailed conversation with him, something which, unfortunately, does not appear to have happened much during his time in custody.

**The National Offender Management Service should ensure that prisoners charged with domestic homicide are referred for a mental health assessment.**

### **The man's Person Escort Record from Woodhill to Bedford**

72. PSO 1025 (The Person Escort Record) says:

“Dispatching staff will identify any other risks and complete the rest of the form in accordance with the detailed guidance provided alongside this PSO. It is especially important that any information from a PER from an escort completed the previous day is also taken into consideration. All information should be correct as close as possible to the time when the prisoner is to depart on escort.”

73. The PER that accompanied the man to Bedford contained different information to the one that arrived at Woodhill two days earlier. It also included information in the mental health section that would have been better placed in the suicide and self-harm section. This would have highlighted the risks associated with him.
74. It did not make reference to the man's assertion in police custody that he wanted to kill himself. Instead, next to the section entitled 'Suicide and self-harm' was written "Nil noted on CNomis" (the computerised prison record system). However, this was inaccurate as the prison record system contained specific information about his level of risk. When the investigator spoke to an officer about this matter, he suggested that the member of staff who completed the PER would only check the alerts on the software system. Alerts are letters that appear in the top right corner of a prisoner's profile on software system and quickly alert staff to certain issues. For example, his alerts were P (case managed by the MAPPA system) and T (hold against transfer). The alert indicating that a prisoner is subject to ACCT procedures is H. As he was not subject to ACCT procedures, it appears that Woodhill did not check his record further to see if there was any information regarding suicide or self-harm. However, by writing 'Nil noted on CNomis' the entirely wrong message was given about him. Instead of highlighting that he had been identified as at risk of harming himself, the impression was conveyed that there was little of note to pass on.
75. Although there was information on the PER regarding the suicide self-harm warning form from court the lack of information in the suicide and self-harm

section diminishes the power of this information and makes it appear of less relevance. The incomplete nature of the information included on the PER made the man's level of risk appear less than it was. It is imperative that, as PSO 1025 makes clear, all relevant information is included on the PER.

**The Governor of Woodhill should ensure that PERs are completed in line with PSO 1025, particularly with regard to risk information.**

### **Clinical care**

76. The clinical reviewer reviewed the man's healthcare while in custody. She makes five recommendations that the Heads of Healthcare at Woodhill and Bedford will wish to consider. Two specific aspects of clinical care are discussed below.

#### *The transfer of the man*

77. Before prisoners leave a prison to enter another, they should be assessed to ensure that they are fit for such a move. The clinical reviewer writes in her review:

“There is no evidence in the clinical record that he was declared fit transfer to HMP Bedford. The review was told there have been a number of difficulties identified recently in relation to the inappropriate transfer of prisoners with healthcare needs and where prisoners have not been seen by Healthcare staff prior to transfer.”

78. This is unfortunate from both a physical and mental health standpoint. The man did have physical injuries that required ongoing treatment but, more fundamentally, he was a prisoner at an exceptionally high risk of suicide. Once again, this failure reflects the general lack of recognition that he required a specific and thought out plan to assess and safeguard him. The clinical reviewer makes the following recommendation which we endorse:

**The Head of Healthcare at Woodhill should ensure that all prisoners should be seen by a member of the healthcare staff and declared fit for transfer.**

#### *Bedford's access to the man's medical record*

79. The investigator was told that Bedford staff were unable to access the man's medical record from his time at Woodhill as Woodhill staff had not completed the required actions on the electronic system. This was not rectified until 18 April when the medical records were merged. He was not referred for a mental health assessment at Woodhill. However, due to the failure to access his medical record at Woodhill, had he been, Bedford would have been none the wiser until 18 April, three days later. Important risk information could also have been on the medical record that would have been initially hidden from Bedford's view.

80. The investigator was subsequently told that it is possible that receiving prisons can locate the prisoner's medical record, even if the transferring prison has not completed the requirements. This confusion reveals the need for Bedford to establish certainty in this matter. The sharing of complete medical information is so important prisons should ensure that staff understand how to use the appropriate processes correctly. The clinical reviewer includes a recommendation on this matter which has been slightly amended to read:

**The Head of Healthcare at Bedford should ensure healthcare staff are aware how they can retrieve records on the clinical system.**

### **Property in the man's cell**

81. In their response to the draft report, the man's family expressed concern that prisoners charged with murder are allowed items in their cells that can assist them in committing suicide. However, staff would not routinely remove objects from prisoners unless they had a specific reason to do so. They did not take things from him as they did not consider him to be at risk of harming himself. Even if staff had considered him to be at risk they may not have removed items from his cell. Prison Service Order 2700 - Suicide prevention and self-harm management (in force at the time of his death) states:

“However, removing personal belongings from a person who is feeling hopeless and depressed ... can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so.”

82. This report has highlighted failures in assessing the man's level of risk. However, even if he had been deemed to be at risk it is not certain that the items would have been removed from his cell.

## CONCLUSION

83. Due to the circumstances of his offence, the man was at an exceptionally high risk of suicide or self harm. It was also his first time in custody, and his offence must have had a significant impact on his wider family circumstances. This report has outlined a number of opportunities for staff to have engaged with him to explore these risk factors and the effect on his wellbeing. These were important omissions, reflected in the recommendations made in this report.
84. However, the man presented a difficult challenge to staff; he consistently hid his intentions and denied having any intention of harming himself. The note he left to his family reveals that he was determined to take his life and had deliberately misled staff. This enabled him to get a single cell and the privacy he needed to take his life. A chaplain said he felt that he knew him better than anyone in the prison but, due to his private nature, did not feel like he got to know him well at all. Such determination is particularly difficult to manage, which emphasises the need for an appropriate balance to be struck between presentation and risk factors.

## RECOMMENDATIONS

1. The Governor of Woodhill and the Governor of Bedford should ensure that appropriate safeguards are in place to mitigate the significant risk associated with prisoners who have committed domestic homicide, in line with the requirements of PSO 2700.

**Woodhill accepted the recommendation and provided the following commentary:**

“This is something that is considered on Reception and during First Night procedures. Staff conducting First Night interviews are aware of index offences and will encourage prisoners to explore any concerns. Staff will always be extra vigilant to this type of offending and the use of ACCT procedures in line with PSI 64/2011 will always be considered.”

**Bedford accepted the recommendation and provided the following commentary:**

- “The Induction passport has a prompt for staff to ask if the prisoner is charged with offences of domestic violence or murder against a family member and for the staff to refer to the PER.
- A system will be put in place to Identify personal officers to ensure that prisoners Identified as significant risk or high profile have regular c-Nomis entries recorded in their case notes.
- Prisoners will be discussed by the internal risk management Team and the Safer Custody Manager will use this process as a tool to identify those at risk.”

2. The National Offender Management Service should ensure that prisoners charged with domestic homicide are referred for a mental health assessment.

**The National Offender Management Service rejected the recommendation and provided the following commentary:**

“PSI64/2011 highlights that prisoners charged with domestic violence are at a higher risk of suicide however, the aim is that prisoners are triaged and not automatically referred for a MH assessment. The reason for this is to ensure that prisoners are treated as individuals and therefore given individualised care. Establishments may choose to do this automatically based on their need.”

3. The Governor of Woodhill should ensure that PERs are completed in line with PSO 1025, particularly with regard to risk information.

**Woodhill accepted the recommendation and provided the following commentary:**

“All staff completing PERS are trained to cross reference CNomis information with information on the security file. This gives the extra

assurance that any information regarding self-harm risk will be picked up, even if the prisoner is not on an open ACCT, or had never been

4. The Head of Healthcare at Woodhill should ensure that all prisoners should be seen by a member of the healthcare staff and declared fit for transfer.

**Woodhill accepted the recommendation and provided the following commentary:**

“A system is in place to ensure that all prisoners are seen by a member of healthcare staff in reception and the PER endorsed to indicate that the prisoner is fit for transfer.”

5. The Head of Healthcare at Bedford should ensure healthcare staff are aware how they can retrieve records on the clinical system.

**Bedford accepted the recommendation and provided the following commentary:**

“Head of Healthcare is in discussion with the management company for system one to establish how to retrieve records for prisoners that have been transferred from another establishment. This information will have to be passed on to all Nursing staff as a training requirement.”