PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

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

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

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This is the final report of an investigation into the death of a male prisoner at HMP Bedford. He was on remand and had been in custody at Bedford. This was his first time in custody. I offer my condolence to his family and everyone touched by his death.

An investigator from my office conducted the investigation. NHS Bedfordshire commissioned a review of his medical care, which was completed by a Clinical reviewer. I am grateful to her for her report and contribution to this investigation. The Governor of Bedford and his staff co-operated fully with the investigation. I apologise for the delay in issuing this report caused by workload pressures.

The man had never been in custody prior to 3 January and had no offending history. While he was at court on 3 January, staff had raised concerns about his well-being, as he appeared distressed at being remanded. Staff at Bedford were told about the concerns prior to his arrival. On his arrival at the prison, nursing staff assessed him and recorded a full medical history. He told the nurse that he was on regular medication for migraine and disclosed that he had previously taken an overdose of prescribed medication.

Prison staff and nurses spoke with him regularly and, although he found the adjustment to prison life difficult, he frequently denied that he had any intention of harming himself. He was not considered to have any mental health problems, but staff from the mental health in-reach team (MHIRT) saw him regularly. The team considered that due to his age and his first time in custody, he would benefit from the additional support, although the services available at the time were limited.

In subsequent weeks, prison staff felt that he was coping better. He had begun to attend education and was apparently interacting more with his peers. It was therefore a shock to staff when he was found hanging from the window in his cell. Despite every effort by staff and paramedics, he could not be resuscitated.

The death of the man at such a young age is truly tragic. It is not possible to be clear why he took his own life, although it is known that he was worried that he might be given a lengthy sentence and he had recently been bereaved. In all the circumstances, the investigation concludes that staff could not reasonably have foreseen his intentions and that they responded appropriately, when they found him. However, the investigation did find a number of areas for improvement in the management of suicide and self-harm prevention procedures, staff support following emergency situations, prescribing, and provision of mental health services. It is to be hoped that action on these issues will help avert future tragedies

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Prisons and Probation Ombudsman **May 2012**

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SUMMARY

1. The man was remanded to HMP Bedford on 3 January 2011. It was his first time in custody.

2. Court staff had been concerned about his welfare, as he appeared tearful. The staff completed a self-harm warning form and telephoned Bedford, in advance of his arrival, to tell them of their concerns. A nurse assessed him on his arrival at Bedford and the form that had been completed at court was passed to reception staff. The nurse recorded that he appeared fit and well and denied any thoughts of wanting to harm himself. However, he told the nurse that he had previously taken an overdose of prescribed medication 12 months earlier.

3. Once all the reception procedures had been completed, he was given a cell on D wing, the detoxification unit. Although he was not undergoing detoxification, he was a Young Adult and had to share a cell with a prisoner of the same age. At the time, such a space was only available on D wing.

4. The day after the man arrived at Bedford, an Officer spoke to him as his aunt had contacted the prison to express concerns about him. He told the Officer that he was all right, but had not been given his medication. The officer spoke with healthcare staff and the problems were rectified. The Officer also recorded that he was very young and it was his first time in custody.

5. On 5 January, a nurse assessed him for a secondary health screen and completed a more in depth medical history. The nurse also completed an assessment of his mental health. The assessment indicated that he was mildly depressed, which the nurse considered was probably a reaction to his situation.

6. The man submitted a request to speak to a member of the Mental Health In Reach Team (MHIRT) on 10 January, saying that he was feeling low. A nurse from the MHIRT spoke with him later that day. He told her that he had no history of depression. She recorded that he might benefit from relaxation therapy and arranged for his previous medical history to be requested from his community general practitioner (GP). He was also seen by the prison GP who prescribed medication to help him sleep.

7. The information from the man's GP was received on 11 January and a full mental health assessment was completed with him on 12 January. Staff considered that, while he had no signs of mental illness, he would benefit from the additional support of the MHIRT. They continued to see and engage with him during his time at Bedford. He also attended relaxation classes to help him cope with the stresses of prison life.

8. Although the man made no complaints and appeared to be coping, staff became concerned about him on 16 January due to his age and the fact it was his first time in custody. As a precaution, they put in place additional monitoring under the suicide prevention and self-harm management procedures and opened an Assessment, Custody, Care and Teamwork (ACCT) document. During the first assessment after the ACCT was opened, he said that items had

been taken from his cell and he was feeling low. When asked about harming himself, he said that he had these thoughts, but had not intended to act on them.

9. He was monitored until 19 January, when he said that he was feeling better and staff decided to close the ACCT plan. He also moved to a different wing. He continued to have contact with the MHIRT and began attending education where he was completing an anger management course.

10. He spoke to staff about his court case and his concerns about the possible sentence, but was considered to have settled well and had a good rapport with staff and his peers.

11. On 23 March, another prisoner, who was a friend of the man, moved into his cell. Staff said that the two young men got on well together and he was considered a good influence as his cellmate was himself subject to ACCT monitoring. Staff said that before the decision to place the two young men together was made, he was spoken to, to ensure that he was happy for this to happen. He attended court again on 25 March and was convicted. As the sentence was likely to be over 12 months, the sentencing was referred to the crown court and he returned to Bedford to await another court appearance.

12. On the evening of 27 March, the man and his cellmate watched television in their cell and talked about the bible. His cellmate said that he appeared to be his usual self. At 4.10am, on 28 March, an officer went to the cell occupied by the man in order to carry out a routine ACCT observation on his cellmate. As the officer looked into the cell via the observation panel, he saw him suspended from the window at the back of the cell, by a ligature.

13. The officer immediately radioed for assistance and as other staff arrived, he entered the cell. Staff supported him while the ligature was removed from the window and he was then laid on the floor. Officers and nursing staff carried out cardio pulmonary resuscitation until the arrival of paramedics, who took over treatment. However, despite their best efforts, he did not respond and was pronounced dead at 4.40am.

14. After his death, there was some delay in notifying his relatives, however, this was largely due to circumstances beyond the control of prison staff. Debriefs were held and staff subsequently attended his funeral, to which the prison contributed financially. Staff spoke to all prisoners who were subject to ACCT monitoring at the time of his death. Although he was managed appropriately during his time at Bedford, there are 16 recommendations for improvements at the prison. These relate to ACCT procedures, mental health provision, prescribing medication and staff support.

THE INVESTIGATION PROCESS

15. The investigator opened the investigation at HMP Bedford on 29 March and the prison provided him with all documentation relating to the man. Notices were issued informing staff and prisoners of the investigation. These asked anyone who had information, relevant to the investigation, to contact the investigator but no responses were received.

16. NHS Bedfordshire conducted a review of the medical care given to the man while in custody. The Clinical reviewer completed the review and subsequent report.

17. The investigator wrote to the Coroner, to inform him of the investigation and, to request a copy of the post mortem report. The final post mortem attributed the cause of the man's death to hanging.

18. ,A family liaison officer (FLO) from our office, contacted the man's aunt, who was the family's agreed point of contact. She explained the role of this office and the purpose of the investigation. The family liaison officer and the investigator visited his aunt, at her request, on 28 April, discussed the investigation and the issues raised by the family. The man's aunt expressed concerns about the way she was told of her nephew's death. At the family's request, the man is referred to by his Christian name in the report.

19. The investigator visited Bedford on 14 and 16 June, to conduct interviews with staff. After he had completed the interviews, he met with the Governor to discuss his emerging findings and followed this up in writing.

20. Following the issue of the draft report, both the Prison Service and the man's family were asked to provide feedback. A response from the Prison Service was received and commented on in this final report. Unfortunately, at the time of publishing this report, no response had been received from his family.

HMP BEDFORD

21. HMP Bedford is a local prison. The prison accepts sentenced and remanded male prisoners serving all local Courts, as well as sentenced prisoners sent there because of overcrowding in London prisons. It has an operational capacity of 506 prisoners. In addition, the prison also accommodates young adults (YAs).

22. NHS Bedfordshire, formerly Bedfordshire Primary Care NHS Trust, commissions healthcare services at Bedford. The provider arm of NHS Bedfordshire is Bedfordshire Community Health Services (BCHS). BCHS provides a healthcare team based in the prison. Doctors, nurses and nurse managers make up the team. It provides diagnostics including blood services, in-patient care and an integrated drug treatment service (IDTS) and other primary care services. The South Essex Partnership Foundation University NHS Trust provides a mental health in-reach team. However, there is currently no primary mental healthcare provision. Bedford's healthcare unit can accommodate up to 13 in-patients.

23. Since the Ombudsman was given responsibility for investigating deaths in custody, in April 2004, there have been eleven deaths at Bedford, including that of this man. Recommendations resulting from earlier investigations are not relevant in this report.

Her Majesty's Inspectorate of Prisons

24. The most recent inspection was unannounced and took place in March 2009. The inspection report noted that Bedford was '… a well-run prison with positive staff attitudes, which serves to mitigate some of its problems and difficulties.' Also, '… a small local prison where good relationships and effective use of limited resources were able to mitigate some of the inherent problems of space, design, and population …'

25. One recommendation in the report is relevant to the findings of this investigation:

> "Staff should be reminded of the need to identify trigger points in assessment, care in custody and teamwork (ACCT) documents and the need for unpredictable observations. (3.29)"

Independent Monitoring Board (IMB)

26. Each prison in England and Wales has an Independent Monitoring Board, 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 2009-2010 published by the IMB at Bedford contains no issues that are relevant to the man's care.

Critical incident and hot debriefs

27. A critical incident debrief normally takes place two weeks after a serious incident. It gives the staff the opportunity to understand the incident in detail, identify any learning points, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment. A 'hot debrief' takes place immediately after a serious incident, allowing staff to receive immediate support.

Cut-down tools

28. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons that have contact with prisoners must be provided with and carry, when on duty, their own personal issue tool.

Emergency response codes

29. Emergency codes are used to summon staff to deal with a particular situation. In most prisons, the common coding system is 'Blue' to indicate a prisoner with respiratory problems, or who is unconscious and 'Red' to indicate a prisoner who is bleeding. The benefit of such codes is to allow medical staff to attend the emergency with the correct equipment and to minimise delays to treatment.

Listeners

30. Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected, and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.

Reception and induction

31. A Cell Sharing Risk Assessment (CSRA) of every prisoner is completed on his or her reception into custody. The document has recently changed and now requires decisions to be evidence-based. This requires staff to check the prisoner's previous convictions to identify potential risks to them sharing a cell. The CSRA rates a prisoner as either a low or a high level of risk. If high risk and considered unsuitable to share, a multi-disciplinary team must review the assessment frequently.

32. Reception staff do not routinely have access to a prisoner's past records, so at this point the prisoner is the main source of information. All prisoners will also have a Person Escort Record (PER) form. This document is used when escorting a prisoner between prisons, courts and police stations. It includes risk pertinent information, such as risk to others or themselves.

33. The initial healthcare screen concentrates on the prisoner's immediate well-being, mental health, risk of self-harm or suicide and any drug or alcohol withdrawal or detoxification issues.

34. All new prisoners are located on the induction wing. If staff consider that a prisoner is vulnerable, they will be given accommodation on other more appropriate wings, to receive their induction. Staff ask about any immediate concerns, such as disability, their offence, and general well-being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Staff ensure that prisoners have a new reception pack, pin numbers to access the prisoner telephone system and explain visiting arrangements.

35. At Bedford where Young Adults (YA) are integrated with adult prisoners the policy is that YA's can only share a cell with each other.

Counselling Assessment Referral Advice and Throughcare service (CARATs)

36. The Counselling Assessment Referral Advice and Throughcare service (CARATs) provide a substance misuse service for prisoners, assessed as having serious drug and alcohol problems. The team work in partnership with the healthcare service and officers, to provide a service within the prison and as a referral agency for ongoing support to prisoners on their release.

Suicide and self-harm monitoring

37. ACCT has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

KEY EVENTS

38. A local Magistrate remanded him into custody on 3 January 2011. He has not been in custody previously.

39. While at court, a custody officer raised concerns about his well-being, as he appeared upset. As a precaution, the custody officer completed a self-harm warning form and observed him while in the court cells. The officer also contacted HMP Bedford to tell them that they had completed the form. Court or escort staff complete self-harm warning forms where there is a concern about an individual's well-being. In most cases, staff will make a call to the receiving prison to tell them that they consider a prisoner to be at risk and will be arriving at the prison later that day. On arrival, escort staff pass the document to reception staff. They, along with nursing staff, complete an assessment of the prisoner, to ascertain whether further monitoring is required.

40. On his arrival at Bedford, the self-harm warning form was passed to reception staff that completed the initial documentation. Staff then passed it to Staff Nurse who completed a health screening with him. Nurses complete initial health screens on all prisoners on their reception into custody. The Staff Nurse recorded that he appeared fit and stable with good eye contact. He denied any thoughts of harming himself when the nurse asked him. However, he admitted that he had previously taken an overdose of prescribed medication 12 months earlier. The Staff Nurse recorded that he was on regular medication for epilepsy (Epilim) and used an inhaler to treat his asthma. Details of his community doctor were recorded and he signed to indicate that he was happy for his previous medical information to be requested. The Staff Nurse referred him for an assessment by the doctor in view of his existing medication.

41. At interview, the investigator asked the Staff Nurse to clarify the procedure when receiving a warning form. He said that the normal procedure would be for the reception nurse to speak to the individual. He added that the nurse would make observations but it is also very much based on what the prisoner tells them. If the prisoner said they were all right, as the man had, then the nurse would take no further action. The Staff Nurse explained that he follows this procedure, but had not actually seen it written down and was unable to confirm whether it was an agreed policy.

42. Despite the Staff Nurse completing a referral, the doctor did not assess the man. The investigator asked why this did not happen. The Staff Nurse replied that if a person arrives into custody with no immediate problems but is on existing medication, the doctor will review the nurse's entries in the documents and write a prescription for that patient.

43. As previously mentioned, the man had taken an overdose of his prescribed medication 12 months earlier. The Staff Nurse was asked whether such a history would have been a concern when considered with factors such as the warning form and the man's first time in custody. The Staff Nurse explained that it would have been considered, but it is also based on the individual's state

of mind at the time. So, if there are no thoughts of self-harm and there is no indication to the nurse that this would be a problem, then medication would still be prescribed. The Staff Nurse went on to explain that, as a nurse, he has feelings when something is not right and in such cases he would act on them. He never had any concerns during his assessment with him.

44. Following completion of the reception procedures, staff escorted him to a cell on a residential wing. There is no evidence that he raised any concerns at this time. The safer custody team at Bedford received a call the following day from his aunt, who expressed concern that the man had been remanded into custody. She asked the Senior Officer (SO), the Safer Custody Manager, if he would check on him. So The Staff Nurse contacted his wing. He asked the Officer who works with the MHIRT and spoke to the man's aunt if she could speak to him to ensure that he was all right.

45. The Officer spoke with him and recorded that he had denied any thoughts of self-harm when she spoke with him. He did raise concerns about his medication and the Officer spoke with nursing staff to get this resolved. She also made an entry in the wing observation book, 'very young, first time in custody. Staff to be aware and monitor progress.' The wing observation book is similar to a daily diary, where staff can record significant events or other information that needs to be relayed to other staff. The wing manager will usually review the observation book and inform staff about issues as part of staff briefings. In addition, staff are encouraged to read the book before starting their duty.

46. The officer who works with the MHIRT told the investigator that her initial perception of the man was that he was young and described him as, 'not the usual clientele,' He seemed to stand out from other prisoners. The Officer said that after her first meeting with him, her concern was about his young age and appearance and she had decided that she would check on him, as part of her daily duties, to see how he was doing. This was also the reason for her entry in the observation book.

47. The health screen completed on reception is in two parts, with a secondary screen carried out a day or two after arrival into custody. The purpose of the secondary screen is to record a more in-depth medical history and provide further health information. Another Nurse completed the secondary screening with the man on 5 January. The Nurse recorded that he was a smoker and that he had no desire to give up. Information was provided on health issues, including blood borne viruses, and when asked he said that he would like to be screened for both hepatitis C and human immunodeficiency virus (HIV). (Hepatitis C is an infection that causes inflammation of the liver, HIV causes progressive failure of the immune system The nurse also recorded that while he was not epileptic, he suffered from severe migraines, and this was the reason why he had originally been prescribed Epilim.

48. As part of the secondary screening process, the Nurse completed an assessment to gauge whether he was depressed, known as a PHQ9 questionnaire, and an Audit C score, which is used to assess a patient's alcohol

intake and any potential health risks. The PHQ9 questionnaire uses nine statements and, for each, there are four possible answers depending on how relevant the prisoner feels the statement is to them. For each answer, a score is assigned between 0-3, with a potential maximum score of 27. The severity of depression is indicated by the score, 0-4 none, 5-9 mild depression, 10-14 moderate depression, 15-19 moderately severe depression and 20-27 severe depression. He scored six, indicating that he was potentially suffering from mild depression.

49. The Audit C score has the same format, but uses a series of seven questions, each with scores between 0-4. 0-7 indicates low risk, 8-15 increased risk, 16-19 higher risk and 20 or more possible dependence. For the Audit C score he scored 10, indicating an increased risk. The assessments completed by the Nurse were handwritten and did not appear to be available on the medical computer system (SystmOne), along with all other medical information.

50. The Nurse has since retired and was unavailable for interview during the investigation. However, the investigator asked the Staff Nurse who completed a health screening with the man about the scoring used in the assessments. The staff Nurse explained that it was his understanding that, at the time of assessments, certain documents were still in the process of being moved to SystmOne and therefore still had to be completed by hand. He confirmed that all documents are now completed electronically. Also, that the scores on both the PHQ9 and Audit C would not always result in a referral to either the Mental Health In-Reach Team (MHIRT) or the detoxification unit. Even if a referral had been made to mental health as his scores indicated mild depression, The Staff nurse said it was unlikely that they would have offered any treatment or considered him as part of their caseload.

51. The nurse who completed the secondary screening recorded that the man needed help for his low mood and a referral was made for him to be assessed by the prison doctor. In relation to his alcohol intake no referral was made, but he was seen the same day by a member of the prison's Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) team, , who recorded that his offending was linked to alcohol. She made a further referral for him to have a more in depth assessment by the CARATs team. A member of CARATs contact with the man was as part of his standard induction, rather than because of the assessment by the nurse who completed the secondary screening. CARATs teams are in all prisons and provide a range of interventions including:

- Initial assessment following referral;
- Advice to prisoners with substance misuse problems;
- Liaison with health care both in prison and in the community;
- Care plan assessments;
- Drawing up a care plan for the prisoner;
- One-to-one counselling and group work services;
- Assessment for intensive treatment programmes in prison;
- Throughcare linking with community drug treatment services;

- Ensuring, where required, prisoners are offered post release support for up to a maximum of 8 weeks.

52. On 6 January, a doctor assessed the man in response to the referral made by the nurse who completed the secondary screening. The doctor recorded that he was feeling low but this was mainly due to being in custody for the first time. He prescribed a ten-day course of promethazine, which is used in the treatment of allergic reactions as well as motion sickness. In addition, it can also be used as a sedative and it is was for this reason that the doctor prescribed its use. However, guidance for the use of promethazine indicates that there are a number of pre-existing conditions, which should be considered before the medication is prescribed. These include asthma and a history of seizures. The man was recorded as asthmatic. There is no evidence that the doctor considered his medical history before he prescribed the medication. In addition, there is no entry on his prescription chart showing that the medication had been prescribed. The clinical reviewer sought clarification on this.

53. The doctor told the clinical reviewer, , that he was aware of the man's medical history and the guidance for prescribing promethazine. He said that as he was prescribing it for a short period he had no concerns. The doctor confirmed that he had prescribed the medication, but was unable to confirm whether he had received it or account for why no entry was made on the prescription chart.

54. The man submitted a request to speak to someone from the MHIRT on 10 January, in which he said that he had a 'low mood.' Community Psychiatric Nurse (CPN) assessed him because of his self-referral. The nurse recorded on the medical notes that he said that he had no previous history of depression and he agreed that his current feelings might be as a reaction to his current situation. The Community Psychiatric Nurse, also recorded that the man might benefit from relaxation therapy in order to teach him some ways of coping. She arranged for information to be requested from his community doctor and a referral was made for the relaxation therapy.

55. The investigator asked the Nurse whether she had access to his full medical information, including the earlier assessments completed by the nurse who completed the secondary screening, when she assessed him on 10 January. She replied that she had not seen any other information at the time. When asked whether having the PHQ9 score would have been beneficial to her, she said that while it would have proved useful as an indicator and help with diagnoses, it still has to be confirmed by observations and the individual explaining why they feel the way they do.

56. When asked about her initial view and concerns about the man, the community Psychiatric Nurse's opinion was that his age made him vulnerable, also it was his first time in custody. She added that while she felt that there were some psychological problems, this was only an assumption and she had requested further information from his community GP. The request for his medical information was sent the same day and a response was received by the prison the following day. The Community Psychiatric Nurse said that she would await a response before going back to see a patient.

57. Prison Service Order (PSO) 3050 relates to provision of healthcare for prisoners. It is a requirement of the PSO that every effort is made to retrieve any information required from a prisoner's GP or other service with which they may have recently had contact.

58. The response from his GP, received on 11 January, detailed all his previous medical treatment. The manager of the MHIRT at Bedford, recorded on the medical notes that he had been treated at the Hospital in May 2010, following a suicide attempt. There was no evidence of mental illness and it had been suggested that he attend counselling to overcome loneliness and low mood.

59. At interview, The manager of the MRIRT at Bedford was asked whether he thought that the information recorded initially by the Community Psychiatric Nurse indicated any immediate concerns about the man's well-being. He said that the entry made by the Nurse would suggest that she had developed a good rapport with him and that he had been forthcoming about his issues. The manager of the MRIRT at Bedford confirmed that requesting a patient's medical notes from their outside GP is standard practice and would not suggest any undue concern.

60. The Community Psychiatric Nurse carried out a mental health assessment with the man on 12 January. During the assessment, he spoke of issues relating to his childhood and family and said that he had always 'bottled' his feelings up. He explained to the nurse that at the time of his alleged offence he felt that he had experienced a breakdown. He openly discussed two previous suicide attempts and said that both involved him taking an overdose of his prescribed medication. The nurse talked with him about his previous alcohol and drug use. He said that he would often binge drink and had started drinking when he was 14 years old. He viewed his drinking as mainly being down to, 'student party life,' but it would affect his behaviour when he did so with his prescribed medication.

61. During the assessment, he complained of insomnia (not being able to sleep) and said that he had been taking prescribed sleeping tablets for four days. Although these were helping, he said that he was still pre-occupied with worries about his court case and job. The medication he mentioned would suggest that he was in receipt of the promethazine that the doctor had prescribed.

62. Prior to custody, he aspired to become a teacher and had been working as a teaching assistant. He told the Community Psychiatric Nurse that he was getting on well with his cellmate and was trying to get used to the prison regime and had applied for education and work. She encouraged him to complete the alcohol awareness course that was available through the education department. It was recorded that he was keen to engage with cognitive behavioural therapy (CBT) also referred to as talking therapy, to help with his worries and to learn coping strategies. The nurse recorded that he would be assessed for his suitability to attend by someone from the MHIRT.

63. CBT describes a number of therapies that all have a similar approach to solving problems. These can range from sleeping difficulties, relationship problems, drug and alcohol abuse or anxiety and depression. The therapies focus on thoughts, images, beliefs and attitudes, when dealing with emotional problems. During her assessment with him, the nurse recorded that he made good eye contact, had a good rapport, his speech was normal and, although he appeared shy, he was pleasant and polite.

64. The Community Psychiatric Nurse told the investigator that she was aware that the man would be seen by the doctor, who would consider whether there was a need for medication, but she was looking at other interventions, such as therapy. Information received from his community GP suggested that the type of interventions being considered had been beneficial to him in the past. The doctor assessed him later that day and held another 'pep' talk with him. They discussed the benefits of dealing with his issues by way of psychological treatments rather than medication.

65. The Clinical Reviewer asked the doctor if he could explain the comment about having a 'pep talk.' He explained that when talking to younger prisoners he is very conscious of encouraging them to pursue the therapeutic interventions offered and is reluctant to start them on medication. He refers to such contacts as 'pep talks' as he is offering advice and encouragement.

66. The assessment for CBT was completed that afternoon and he was shown a video about the therapy and what it involved. The course facilitators recorded that, although a quiet young man, participated well and was observed to be able to start building a rapport with the facilitators.'

67. Unfortunately, there is a high demand for therapies such as CBT so during his time at Bedford, he did not begin the course. The investigator asked the Officer who works with the MHIRT, about the problems with delivering the course. She explained that to facilitate the course, the team needed her to be available to provide the security. However, due to staff shortages, she was often assigned work elsewhere, resulting in courses and group work being cancelled at short notice. Despite not being able to complete the CBT, he did attend relaxation classes and these began on 13 January.

68. Another member of the CARATs team, spoke with him on 14 January. She said that she had seen him as a follow up to his earlier discussion with a CARATs worker. Her aim was to ensure that he was happy with the work to be done and, following that, he would complete alcohol and drug awareness work in his cell. In addition to the in-cell work, he was also invited to attend Alcoholics Anonymous (AA) meetings. She said that she only had one meeting with him. Her impression of him was that he was not 'cocky', as some young offenders can be, and he was not familiar with the prison system, but did not seem anxious. He appeared comfortable during their conversation.

69. Little is documented about his movements or interactions on the residential wing. However, on 15 January, he went to collect his medication and while doing so asked for someone from the MHIRT to come and speak with him. It is

documented that a member of the team was informed, but there is no evidence that he was seen that day.

70. Later on 15 January, he had a visit from his family. After returning to the unit, he spoke to an Officer who made a record of their conversation. He said that he had received a letter from his solicitor and had concerns about his possible sentence and how long he would serve. He told the Officer that the letter indicated that he could possibly be sentenced to a life term. The Officer said that he had the letter with him, but she did not read it herself. The man asked her whether he could speak to someone from the MHIRT and she telephoned and left another message.

71. The following day, due to her continued concerns about him, the Officer started the procedure for monitoring him under the suicide and self-harm prevention procedures by opening an Assessment, Care, Custody and Teamwork (ACCT) document. The ACCT process is used nationally by the Prison Service to provide additional support and monitoring for any prisoner considered to be at risk of either self-harm or suicide. Additionally, the process might also be used when neither of these are an immediate concern, but to provide an individual with additional support during a difficult period.

72. The Officer recorded on the ACCT that her reasons for putting in place the process were, "the man appears to be fairly low and apprehensive. He is vulnerable due to his age and his offence and the sentence it carries. He has been getting a lot of unwanted attention from older prisoners." The investigator asked the officer to expand on what she had written. She said a few older prisoners had told her that he looked a bit scared and had asked her to speak with him. She was also aware that some prisoners were going to his cell and she was unsure what was going on, so this was another reason for her going to see him to make sure he was all right. The man told her that he was feeling down and she recorded this on the ACCT.

73. When asked whether he had mentioned that other prisoners on the wing were bullying him, the Officer said that he had not said anything to her. Older prisoners on the wing told her that the man had been approached and offered drugs. He had not mentioned this to her, but it was another reason for her opening the ACCT to give additional support. She also reported what she had been told to the security department.

74. Once an ACCT document has been opened, a trained assessor carries out an assessment with the prisoner. A trained assessor Officer did this with him. The assessment aims to identify the prisoner's problems, potential risk of them harming themselves and to identify a plan that will help them to deal with their difficulties. The trained assessor Officer recorded:

> "concerned about legal case and letter from solicitor. Photo of nephew has been stolen from his cell. No recent self-harm, previous overdose 12 months ago. Had been at a friend's house and was taken to hospital. This was due to an argument with family, but has not done anything since. The man feels low at the moment and has disturbed

> sleep. Has feelings of wanting to die, but is dealing with these. No suicide plan. Coping by thoughts of getting out of prison and carrying on with life. Has good contact with family and getting visits has money sent in. He has said that his legal team are coming to see him this week, has spoken to mum about letter, and has a bail hearing this week. Applied for education and gymnasium induction."

75. The assessor Officer was asked about his impressions of him and said that initially his opinion was that he seemed very out of place. He added that he was a, 'young lad, very sheepish, not talking much, and looking very withdrawn, and unhappy.' The ACCT assessment took between an hour to an hour and a half. During the discussion, he said that he was feeling all right and the only thing that was on his mind was his bail hearing. The Officer said that as well as his concerns about his bail hearing, he was also concerned that he was on D wing and a photo of his nephew had been taken from his cell.

76. Although he was looking very out of place and very withdrawn, he was still positive and appeared to be pinning a lot of hope on his bail hearing. Due to his apparent concern about his bail hearing, the officer recorded this as a potential 'trigger' on the inside cover of the ACCT document. Triggers are issues that are identified as potentially increasing a prisoner's level of risk. They may be significant dates, such as court appearances and are recorded on the ACCT to notify anyone who might be dealing with the prisoner that particular attention is to be made around these times. Triggers should also be reviewed as part of any subsequent case review.

77. Once the assessment was completed, the Officer and the man had a meeting with a Senior Officer (SO), the wing SO, who recorded:

> "The man is very withdrawn and quiet, but is feeling alright, no suicidal ideation or thoughts of self-harm, but in my opinion and the assessors he is a very vulnerable young man. He recently had his tobacco, and some personal effects, stolen and is quite low because of this."

He was considered to be a 'low' risk of harming himself. His level of observations were set at hourly, with staff instructed to interact with him at least twice in the morning, afternoon and evening and to record these interactions.

78. The review team are also required to complete a Caremap as part of the ACCT procedures. The Caremap lists the prisoner's problems and what can be done to deal with them. A 'live' document can be added to at anytime, but should be reviewed as part of every subsequent case review. An entry on his ACCT, on 17 January, by the Deputy Governor indicated that no Caremap had been completed in his ACCT following the assessment. The Caremap was subsequently completed, but was dated 18 January. The actions listed were for him to contact his legal team and to be referred to MHIRT as he had feelings of despair at being in prison. It is recorded that both actions were also completed on 18 January. However, there is no evidence of a referral to MHIRT in relation to the ACCT.

79. On 17 January, the manager of the MHIRT at Bedford and the Officer who works with MHIRTspoke with him as part of a follow up with the MHIRT. The manager of the MHIRT at Bedford recorded that the man had said that he was obsessing about his crime and subsequent trial. He also made a note that he had reported this to wing staff, but they had thought he was hearing voices. He clarified that this was not the case. He told the manager of the MHIRT at Bedford that he was isolating himself in his cell in order to 'keep his head down.' The manager advised him to keep busy and take part in the prison regime and activities and contact MHIRT if he required further support. He agreed to attend the relaxation classes already arranged. The manager explained that he saw him for a routine follow-up and not because of the ACCT monitoring.

80. The manager explained that while he was being offered support from his team he was not part of their normal caseload. He had not been diagnosed as having a mental health problem and would not normally fit their criteria. In most prisons, a Primary Care Mental Health Team (PCMHT) would provide support for patients such as him. However, at the time of this investigation no such provision was available at Bedford. The manager said that this issue had been discussed, but he considered that if the MHIRT had not provided the input with him in this instance, there was no other provision. At the time of the investigation, Bedfordshire PCT was in the process of conducting interviews with a view to providing a PCMHT at Bedford.

81. Later that day, he was moved from D to B wing, one of the main wings. This was seen as a positive move as he was not on detoxification, unlike others on D wing. During the investigation, the investigator was told he had been initially placed on D wing because he was a young adult (YA) and the availability of space on that wing. YAs do not share a cell with an adult prisoner, only with one another. This means that they are dispersed throughout the prison, depending on where there is a space. When he arrived at Bedford, the only space available with another YA was on D wing, therefore his location had nothing to do with him requiring detoxification.

82. Over the next couple of days, he was monitored regularly as part of the ACCT procedures and he interacted with other prisoners and staff. Although it is not documented, it is also believed that he had his bail hearing during that week. The assessor told the investigator that it had taken place. He had spoken with him on B wing who had told him that his bail application had not been successful, but his legal team were still working on things. The officer's impression of him at that time was that he had a positive outlook.

83. On 19 January, a review of the ACCT monitoring was carried out. The guidance for such reviews says that they should be multi-disciplinary; and anyone who has been engaging with the prisoner should be invited to take part, as well as any other person who might be able to offer useful support.

84. His case review was only attended by a Senior Officer and a Temporary Senior Officer. The record of the review says:

> "The man is a very quiet and polite individual; we talked about the issues raised in his assessment and his care map. He said that he was feeling much better, and his confidence has improved. The Officer who works with MHIRT has arranged education and alcohol awareness, which he is very happy about. He said that he gets on well with cell mate and has a good rapport with wing staff. We are agreed this document can be closed. He is fully aware of support available. ACCT closed with post closure interview on 26 January."

85. The investigator asked the temporary senior officer who attended the man's case review about the review and whether she had interacted with him prior to 19 January. She had not had any contact with him prior to the case review, but had read his ACCT document and was aware of the reasons he was subject to monitoring. When asked whether any other staff had been invited to attend or asked for input, the temporary senior officer said that she was not sure, but it was usual for someone from the MHIRT to be invited.

86. The investigator told the temporary senior officer that during the ACCT assessment, the man had said he had, 'feelings of wanting to die'. The temporary senior officer was asked whether this had been discussed with him as part of the review. She replied that she would have asked him direct questions about any thoughts of self-harm or suicide and that if she or the other senior office who attended the case review had any intimation that those thoughts were still with him the ACCT document would have remained open.

87. The officer was also asked whether the triggers were discussed during the review. She confirmed that she was aware of the triggers as she had read the document and they had been discussed with him. She said that he had explained that, although he was not looking forward to going back to court, he just wanted everything dealt with. Unfortunately, the record of the review does not show that the triggers were discussed with him, or that he was asked directly about thoughts of wanting to die, as he had previously mentioned during his assessment.

88. The officer was on temporary promotion. When asked whether she had received the necessary training to act as a case manager, she said no. During other interviews, the investigation heard that other members of staff had not received ACCT training.

89. Over the next few weeks, little is documented on either his wing history or his medical record. However, there is evidence that during this time he was receiving regular visits from his family and friends. He also took part in education and started alcohol awareness and anger management classes.

90. A tutor at Bedford, during the investigation, was asked for her view of the man and to explain the interaction that she had with him. The tutor said that the first time she saw him she had been struck by how young he looked and due to this, she had been quite protective of him. He had told her that he had wanted to be a teacher and he now felt that his life was over. She reassured him that this was not the case and he would still be able to teach. While the tutor tried to

reassure him and advised him to be open about any convictions with employers, she said that there were others in the class who were telling him not to do this and never tell anyone about previous convictions. This was another reason she felt protective towards him.

91. The anger management course provides prisoners with workbooks to be completed during the course. They are given an anger diary to record their thoughts and how they are feeling day to day. The tutor said that during the last week of the course he had taken his workbook away. His court case was coming up on the Friday. The tutor thought that because of this, he was struggling to balance everything and that was why she had agreed to him taking his book back to his cell to complete. He was keen to complete the course and for the tutor to write a reference for the court to say that he had completed it. They had agreed that the workbook would be returned that afternoon via another prisoner, but that did not happen.

92. Amongst the documentation provided to the investigator was the anger diary completed by him. The feelings expressed in the diary indicated that he was still struggling with being in prison and had many issues on his mind. The tutor explained that the anger diaries are given out in either the first or the second week of the course with advice on how the diaries should be completed. The tutor said that often prisoners would record their feelings rather than their thoughts. Prisoners are reminded about the diaries, as they are required to complete the course. When asked whether she had seen his diary, the tutor said that she had not. She said that he had told her that he had lost it and she gave him another one, but he had never given that back as he did not attend on the last session due to his court case. The tutor said that he had never mentioned harming himself in her interactions with him and she had never had those concerns.

93. On 18 February, the Community Psychiatric Nurse spoke with him on B wing. She recorded that she had been unable to facilitate the relaxation class due to the long waiting list and the unavailability of an officer over the previous few weeks. The Nurse said that he appeared to be coping better and he was less pre-occupied with his court case.

94. He was involved in an incident on B wing on 28 February, when another prisoner was discovered hiding in his cell. The temporary Senior Officer was the wing manager on the day. She recorded that she had placed him and the other prisoner's involved on the 'basic' level of the Incentives and Earned Privileges scheme. The prison service uses an incentives system whereby prisoners are placed on one of three levels depending on their behaviour. The purpose of the incentive levels is to encourage and reward good behaviour. 'Basic' level is the lowest and means that a prisoner will receive minimal privileges, including less time out of their cell and no access to in-cell television, amongst others. 'Standard' is the level that all prisoners are placed on when they arrive into custody and means that they receive the normal range of privileges. The highest level is 'Enhanced' and prisoners who are rewarded with this level are able to have additional visits, amongst other benefits.

95. The temporary Senior Officer said that there had been a problem during the lunchtime when staff had been unable to account for a prisoner. Staff had searched other areas of the prison for the individual and they eventually found him hiding in the cell occupied by the man and his cell mate. She interviewed both the man and his cell mate and asked them whether the prisoner had forced himself into their cell. They said 'no' and they were aware that it was wrong. As a result, both prisoners were placed on the basic regime. He remained on basic until 11 March, when he returned to the standard privileges.

96. While on the basic level, he asked the temporary Senior Officer whether it would be possible for him to have an extended visit with his family, as his aunt was very ill. The officer told the investgator that she arranged this and he had thanked her. During the first two weeks of March, he had a number of social visits from his family. He had also begun attending bible study groups facilitated by the chaplaincy team at Bedford.

97. On 10 March, the Community Psychiatric Nurse spoke to him again. She had heard from wing staff that he had been notified about a family bereavement and she decided that she should speak with him again. She recorded that he was low in mood and tearful. The chaplaincy team had discussed further bereavement counselling with him. He told the Nurse that he was able to talk to his mother about his grief and had plans and strategies to cope. He described these strategies as his spiritual beliefs, continuing to attend education and having a supportive cell mate. The Nurse recorded that, when asked, he denied any thoughts of self-harm and he appeared settled following their conversation.

98. He wanted to attend his aunt's funeral, but her family indicated that they would rather he did not attend as he would need to be escorted by prison staff. He recorded in his anger management course workbook that he felt angry and powerless because of this.

99. On 16 March, an external therapist who attended Bedford to deliver relaxation classes saw him. It was recorded on his medical record that he was shown breathing and relaxation techniques and given a brief Indian head massage. Following the session with the therapist, the Community Psychiatric Nurse spoke to him. He said that he had been unable to attend his aunt's funeral, but was coping by keeping busy and interacting with others. She asked about any feelings of self-harm which he denied. He said that he was in contact with his mother and the chaplaincy team and able to discuss his feelings. He also indicated that he was aware of the other sources of support available to him and that he could speak to someone if required. The Nurse recorded that his mood had improved since her last contact with him.

100. He had visits from his solicitor on 17 and 18 March. He was told that he was to have an additional charge made against him of affray. As a likely result of the visits from his solicitor, he asked to speak to the MHIRT. The Nurse and the Officer who works with the MHIRT spoke with him on 20 March.

101. He explained that he was to be charged with affray. The Nurse recorded that he appeared preoccupied with not being able to remember the incident. She reminded him of his strengths and positive coping methods, such as engaging in activities and talking to others as well as the support available and the ACCT if he felt that thoughts of self-harm were strong. He denied having such thoughts and was encouraged to continue with relaxation techniques. Another relaxation session took place with the external therapist on 23 March and it was recorded that he engaged well.

102. The same day, a new cell mate, moved in with him. The new cell mate was subject to ACCT monitoring and the investigator asked the man's personal officer about the reasons for the move. A regular officer on B wing was his personal officer also. A personal officer is assigned to every prisoner as a point of contact and provides support and advice to those assigned to them. The Officer also deals with young adults when they arrive on the wing.

103. The man's personal officer said that she did not have any initial concerns about him, although he had got himself in with 'the wrong crowd' and this had led to him being placed on basic. However, he had picked himself up and began mixing with different prisoners and attending anger management. She said that his new cell mate was someone who he had begun socialising with and they had developed a friendship. It was believed that they had some distant family connection and had actually asked to share a cell. Staff considered that it would be beneficial as it would get him away from the cell mate who they thought had been leading him astray.

104. The Officer was asked whether there were any concerns about him and his new cell mate sharing a cell given that he was subject to ACCT monitoring. She said that it was actually considered a positive move as a support network for each other, they had also become quite close friends. The officer said that both young men had asked to share a cell together, and the man had been spoken to before cell mate was located with him, to ensure that he was happy.

105. He attended local Magistrates' Court on 25 March. He pleaded guilty to the charges. As a result, he returned to Bedford with his remand status changed to indicate that he had been convicted but was awaiting sentence. He would appear at Crown Court on a date to be fixed. The maximum sentence that can be passed by a Magistrates' Court is 12 months.

106. His cell mate gave a statement to police in which he said that when he returned from court he was unhappy. He had told him that he had seen his mother crying in court and he seemed quite down. He reassured him and told him that he was lucky to have a family that supported him.

107. On 26 March, he had a visit from his family. He spoke with his mother and his aunt on the telephone the following day. During the investigation, the investigator listened to a recording of the telephone calls. In the course of the telephone conversations, he mentioned having a bad headache and described it as 'screaming' in his head. He told his family that he was now considered a convicted prisoner and appeared concerned that he would get fewer visits. As

a remand prisoner, there is no restriction on the number of visits a prisoner may receive. However, convicted prisoners are allowed three visits per month, one of which can be taken on a weekend. During the conversation with his mother, he says that he had been told that he could expect a substantial sentence. Both his mother and aunt tell him to stay strong. He also spoke about not seeing his stepfather, who had a terminal illness again and sounded very low.

108. His cell mate said in his statement that he had an appointment with the MHIRT on 27 March. When he was escorted back to his cell, he asked the nurse whether he could see someone from the MHIRT and was told to make an appointment on Monday. He said that he did not seem to be in the best of moods. He was quiet, seemed scared and was shaking. His cell mate tried to talk to him, but he did not want to talk. He said that during the afternoon,the man telephoned his mother before returning to the cell. He then seemed to be his normal self again.

109. Both young men collected their evening meal and returned to their cell. His cell mate said that during the evening they watched television and talked about various things, including sections from the bible that he was reading. According to the statement by the cell mate, he was also cutting strips of his sheet and asked him how to make a plait, so he showed him. He said that he joked with him, that he had better not do anything stupid with it, to which he replied that it would not be possible. He then says that he told the man that it was and described how it would be possible to harm himself using the plait. The cell mate told the police that he only said this in conversation, as he never had any indication that he might harm himself.

110. He said that they continued watching television. At around midnight, the man who died turned the light on and said that he needed to write a letter to his aunt. He said that he only spoke to him after this to ask if he had finished so that the light could be turned off, which he did at around 1.00am.

111. As mentioned previously, he was not subject to any additional monitoring, but his cell mate was being monitored under the ACCT provisions. As a result, staff observed him at regular intervals during the night. At 4.10am, an Officer went to cell B3-10, to carry out a routine ACCT observation on the cell mate. As she looked into the cell via the observation panel, she saw the man suspended by a ligature from the window at the back of the cell. The Officer immediately used her radio to call for urgent medical assistance.

112. The majority of prisons have a coding system, which is used in a medical emergency. The coding system often consists of two codes red and blue. Red indicating a patient who is bleeding and blue for those with breathing difficulties. The purpose of the coding system is to enable medical staff to attend with the correct equipment for the type of emergency. Bedford does not use the coding system. The Governor told the investigator that the reason Bedford does not use such a system is that every emergency is treated with the same urgency and all equipment is taken regardless.

113. The Officer broke the seal on her key pouch and, along with an Officer, who had arrived on the landing, entered the cell. During the night, only the officer in charge carries keys. All other staff patrolling the wings have sealed pouches, which contain a single cell key. In the event that they need access to a cell in an emergency, the seal can be broken. The officer who had arrived on the landing took hold of the man and lifted him so that another officer could cut the ligature from the window with her cut-down tool. (A cut-down tool is carried by discipline staff as part of their issued uniform.)

114. Once the ligature was cut, staff laid him on the cell floor and placed him in the recovery position. Other staff arrived in response to the emergency call. The officer who cut the ligature from the window was now in the cell and assisted the officer had arrived on the landing in removing the ligature from around his neck. The Officer said that as the officer who had arrived on the landing lifted the ligature so that he could cut it, it came apart. The officer checked to see if he had a pulse or if there were any sign of breathing but there was neither. The officers then placed him on his back and administered cardio pulmonary resuscitation (CPR), with one of the officers delivering chest compressions and the other Officer creating an airway.

115. Two nurses had been in the healthcare wing when they heard the emergency call. They immediately went to C wing with a bag containing medical equipment. One of the nurses told the investigator that the bag contains all the equipment that is required, apart from a defibrillator, which is located in the treatment room on every wing. When the nurses arrived on C wing, she said that the other nurse had collected the defibrillator and taken to the cell. (A defibrillator or AED is a device that can deliver a controlled shock to a heart by electrodes placed on a patient's chest. By delivering a controlled shock, the defibrillator can put a heart back into a normal rhythm, but cannot restart a heart.)

116. The nurses took over CPR from the officers. The nurse who collected the defibrillator continued chest compressions and the nurse who spoke to the investigator delivered breaths to the man via a 'bag valve and mask', also known as a BVM or Ambu bag. (This is a hand held device, used to provide ventilation to a patient who has stopped breathing.) The CPR was delivered in line with NHS guidelines, at a rate of 30 chest compressions to 2 breaths.

117. CPR continued and the nurse who collected the defibrillator attached the defibrillator to him. The defibrillator is automated and instructed the nurses to stand clear. However, no rhythm could be detected and the nurses were instructed to continue CPR. Both nurses continued to administer treatment until the arrival of emergency paramedics, at approximately 4.30am. Resuscitation attempts continued, with paramedics doing further checks on him, while the nurses continued CPR. However, he did not respond and at 4.40am, paramedics pronounced him dead.

Actions following the man's death

118. The man's cell mate had already been taken to another cell, prior to the arrival of the paramedics and, following his death, received support from a Listener. (Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners experiencing periods of crisis.) All other prisoners who were subject to ACCT monitoring were also reviewed by staff.

119. As with all deaths in custody, the police were notified and arrived at the prison at around 5.00am and carried out a brief search of the cell. During the search, a letter was found, addressed to the man's aunt, which indicated that he had intended to take his own life. The letter was later passed to his family.

120. Prison Service Order (PSO) 2710 gives instructions to prison governors and staff on the actions that should be taken following a death in custody. This also covers family liaison. The PSO instructs that the prison must appoint a family liaison officer and a deputy to cover any absence. They must also arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible and in a suitable manner, giving an accurate factual account of what has happened. Bedford appointed a Governor as family liaison officer and a Senior Officer as his deputy.

121. When the man first arrived at Bedford, he was asked to provide the name of his nominated next of kin. This was recorded as an aunt. He was also asked for the name of any other person that he would want to be contacted in an emergency, this was recorded as his other aunt.

122. A Governor told the investigator that Bedford's first priority was to notify the man's aunt nominated next of kin in. However, due to the distance from Bedford, he had asked HMP Norwich if they could send their family liaison officer to the address and they agreed. A Governor who is, the family liaison officer at Norwich spoke with Governor that Bedford appointed as family liaison officer at 7.30am and told him that she would visit the man's aunt with the prison chaplain. The family liaison officer from HMP Norwich arrived at around 11.30am, but there was no one at home. She spoke with neighbours who told her that they did not know what time the family would be home. She therefore left a note with her contact details, asking the family to contact her as soon as possible. She updated the Governor who informed the investigator that Bedford's first priority was to notify the man's aunt on her actions.

123. In the meantime, the family liaison officer for HMP Bedford and, the Roman Catholic priest at Bedford, had left the prison at 9.45am to travel,in order to notify the man's aunt who had been nominated as an emergency contact. They arrived at the address at 11.05am. However, there was no response and the family liaison officer telephoned the prison to update them. The prison told the officer that another address had been obtained from the man's record for his mother and, as time was passing, the officer made the decision to go to that address. When they arrived at the home of the man's mother, her husband

said she had left for work. The officer and the Roman Catholic priest made their way to her work address, only to find that she was not due at work until 1.30pm. After making another visit to the home of the man's aunt and finding that she was still not there, the officer decided that he would have to contact the man's mother by telephone. The prison supplied a mobile number and the officer called and arranged to meet her at her place of work.

124. The family liaison officer and the Roman Catholic priest met his mother at 1.10pm and notified her of her son's death. However, they still needed to speak to his aunt aunt who had been nominated as an emergency contact,and his mother said that she would be upset. She agreed to go with them to his aunt's place of work. They arrived at 2.40pm and the family liaison officer and the Roman Catholic priest broke the news to his aunt. His aunt explained that he had lived with her from the age of six and that she was in fact his next of kin. She explained that the only reason he had given the address for his other aunt in Norfolk was that it was to be his bail address.

125. Later in the afternoon, the family liaison officer for HMP Bedford spoke with the family liaison officer for HMP Norwich. She told him that the man's aunt had contacted her and had been told of his death. Tthe family liaison officer for HMP Norwich said that, understandably, the aunt was very upset. She had then spoken to the man's uncle and told him that the family liaison officer for HMP Bedford would get in touch with them the next day; and provided contact details for Bedford.

126. All staff involved in finding and treating the man on attended a debrief before finishing their duties and were offered support. Members of the senior management team and the Officer who works with the MHIRIT subsequently attended his funeral service. The prison also contributed to funeral costs.

ISSUES

Suicide prevention and self-harm monitoring procedures

127. Although he had been monitored under the ACCT procedures shortly after he arrived at Bedford, he was not subject to such monitoring at the time of his death. The investigation has not found sufficient reason to conclude that monitoring should have been in place at this time. However, some staff including nurses said that they had not received any training in ACCT procedures. In addition, the investigator found deficiencies in the management of the monitoring of the man that had taken place. The investigator was told that ACCT training had not been delivered in recent months due to the delivery of mandatory training on new computer systems.

128. PSO 2700, Suicide Prevention and Self-Harm Management, says that:

> "… All staff in contact with prisoners must be trained to at least ACCT Foundation level …"

129. All those staff spoken to during the investigation demonstrated knowledge of ACCT procedures, but there is clearly a need for priority to be given to this in order to meet the requirements of the PSO. The following recommendation is made:

The Governor should ensure that all staff with direct prisoner contact are appropriately trained in ACCT procedures and that the ACCT Foundation training is given priority as part of Bedford's training schedule.

130. Staff that are expected to fulfil the role of case manager must be at least the minimum grade of senior officer. One of the officers was temporarily promoted and, although she may well have been capable of fulfilling the task, had not received adequate training.

131. PSO 2700 says that case managers must be of the rank of senior officer or above and have completed case manager training. In addition, when an officer is temporarily promoted they should also be provided with case manager training before covering such duties. When a temporarily promoted officer reverts to their substantive grade, they should no longer carry out the case manager role. The following recommendation is made:

The Governor should ensure that managers at all levels, including those on temporary promotion, have completed the necessary ACCT training before fulfilling the role of case manager.

The Governor should ensure that staff who have been temporarily promoted to senior officer do not continue to act as case managers when they revert to their substantive grade.

132. When the Officer, trained as an assessor carried out the ACCT assessment, he recorded on the inside cover that a potential trigger for increasing the man's

level of risk was his forthcoming bail hearing. Unfortunately, the date of the bail hearing was not recorded. This would have been useful, but staff should have still been aware of the trigger from staff briefings and reading the document. Staff would have also known when he was attending court or a video link. Annex 8G of PSO 2700 says that:

> "Where an ACCT trigger/warning signal is activated or there are other concerns such as increases in frequency or lethality of repetitive self-harm, changes in mood, and other factors or events which may increase risk of suicide, the ACCT Plan must be referred to and the planned course of action followed. The concern and the action taken must be noted on the ACCT Plan, and the Case Manager must be informed about the raised risk."

133. There is no indication that his risk had increased after the bail hearing, as he told the trained assessor that he was all right and his legal team were working on other things. However, there is no evidence that the trigger was followed up as part of the ACCT procedures as it should have been. HM Chief Inspector of Prisons recommended, in the most recent inspection of Bedford, that staff are reminded about the importance of identifying triggers. The trigger was identified, but it was not followed up, therefore the following recommendation is made:

The Governor should ensure that significant dates or triggers identified in the ACCT process, which might increase a prisoner's risk, are also recorded in wing observation books; and that the safer custody team have a system for monitoring that enables them to provide reminders to unit managers.

134. The initial ACCT case review uses a Caremap to record the issues that have been identified as causing the prisoner to feel suicidal or are responsible for the period of crisis. The aim is that these issues will be broken down on the Caremap, each will be discussed, and the goal for the prisoner will be recorded as well as the actions required for them to achieve it. The Caremap also has a note of the name of the member of staff identified as being able to oversee or ensure that a particular goal is achieved.

135. Additional items can be added to the Caremap at anytime, but should be reviewed at every subsequent case review. The man's Caremap was not completed following his assessment as instructed in PSO 2700, which says that the first case review must:

> "… Identify the most urgent precipitating problems of the prisoner (that is, the problems leading the prisoner to feel suicidal or to self-harm) and specify actions in the CAREMAP to address these. Be alert that these may include problems arising from disabilities or from bullying or harassment linked to race or homophobia.
>
> "Decide on how best the prisoner should be supported (consistent with the level of risk posed by the individual to themselves and others) –

that is, where he/she will be located, what access to activities will be provided during the day (e.g. day-care, education, work) and what people (e.g. friends, family, staff, chaplain, Listeners) will be asked to provide support. Activities, which distract from painful thoughts and worries, are a particularly important part of the care of a prisoner who uses self-harm as a coping strategy. These decisions must be set out in the CAREMAP …"

136. The Caremap completed for him on 18 January also records that the actions had been completed that same day. However, there is no named person responsible for the actions and no evidence that the referral to the MHIRT was made. The, MHIRT Manager, said that he saw him on 17 January, but this was a routine follow up and not related to the ACCT document. The next time he was reviewed by anyone from MHIRT was 18 February, when the Community Psychiatric Nurse spoke with him about being unable to facilitate the relaxation course. The following recommendation is made:

The Governor should ensure that all case managers complete Caremaps as instructed in Annex 1A, PSO 2700.

137. The Senior Officer on temporary promotion, the Senior officer, and the man attended the case review on 19 January. No other persons were present and there is no evidence of input being sought from any other person before it took place. The chaplaincy team at Bedford attend most ACCT reviews and this makes up a large part of their workload. No one from the chaplaincy attended his review. Although he had had recent contact with the MHIRT, they were not present at the review.

138. The Senior Officer on temporary promotion recorded that issues raised during his assessment were discussed, but does not say what direct questions he was asked or his response. He had said during his initial assessment with the trained assessor Officer, that he had feelings of wanting to die. The record of the case review does not provide any indication that he was asked directly about this or what his response was. The trained assessor recorded his bail hearing as a trigger, but there is no evidence that he was asked about this either. The Senior Officer on temporary promotion said that she would have had these discussions with him.

139. The investigation heard from The Senior Officer on temporary promotion that neither she, nor the Senior Officer who attended the case review had concerns about him during the review; and if they had, the monitoring would have continued. However, decisions about the management of a prisoner's ACCT should not be made in isolation and staff should not be expected to take such decisions on their own. This is why all case reviews should be multi-disciplinary. The following recommendation is made:

All ACCT case reviews should be multi-disciplinary. When staff are unable to attend, they should provide relevant information in writing or by telephone to the case manager, which should be recorded as part of the review.

Chaplaincy

140. The man had been attending bereavement counselling following the death of his aunt, but this information was not widely known. The chaplaincy team at Bedford told the investigator that it was not routine to inform wing staff that a prisoner was receiving such support. Given the nature of the counselling and that, it may cause the individual to face difficult issues I feel that wing staff should be made aware so that they can monitor and provide further support if required.

The chaplaincy team should ensure that wing staff are made aware of any prisoner that is receiving bereavement counselling, to enable them to follow up on return to the residential wing and provide support if required.

Clinical care

Prescribing

141. The doctor prescribed medication to help him to sleep. When the clinical reviewer spoke to him, the doctor confirmed that he had been aware of his medical history and had discussed the medication with him. However, this was not recorded as part of the assessment. The doctor was also unable to explain why the medication that he had prescribed was not recorded on the prescription chart or his medical record.

142. The General Medical Council (GMC) guidelines set out the expectations for GPs and details good practice. On prescribing medication, the GMC says:

> "… Doctors must be in possession of, or take, an adequate history from the patient, including any previous adverse reactions to medications, current medical conditions, and concurrent or recent use of medicines, including non-prescription medicines …
>
> "… Make a clear, accurate, legible and contemporaneous record of all medicines prescribed …"

143. It is apparent that the records made for the man did not follow the GMC guidelines and the following recommendations are made:

The Head of Healthcare should ensure that all GPs record information about a patient's medical history before prescribing, in line with General Medical Council guidelines.

The Head of Healthcare should ensure that when medication is prescribed, this is recorded in line with the General Medical Council guidelines.

Mental health provision

144. tThe clinical reviewer, comments on the provision of mental health care at Bedford. She says that all prisoners should have access to primary mental healthcare and that such interventions would meet the majority of the mental health need. She also says that the provision of a primary care service would ensure that the more specialist services could focus on those with severe and enduring mental illness.

145. The investigation found that the management arrangements for the MHIRT at Bedford were unusual, as the MHIRT manager does not report to the Head of Healthcare. However,the clinical reviewer says in her report that the working relationships appeared satisfactory.

146. The MHIRT saw the man, although he had not been considered to have any mental illness. The clinical reviewer comments on the difficulties in understanding the nature of the MHIRT involvement with The man. He had been recommended for Cognitive Behavioural Therapy (CBT) but this never took place due to the unavailability of an officer. The clinical reviewer says that such regular cancellations are unacceptable.

147. During the investigation, prison staff also said that they felt better understanding/updating of mental health issues would be valuable in their work. the clinical reviewer comments that Bedford had not provided mental health awareness training for staff due to a lack of capacity in the MHIRT and pressure on officers to take part in other initiatives.

148. The clinical reviewer makes a number of recommendations in relation to mental health provision. Five of these have been slightly recast below:

The Governor and Head of Healthcare should establish a Primary Mental Health Service as a priority.

The Head of Healthcare should be designated to provide strategic representation in the development of healthcare services. Given the increase in multiple providers, this is essential to ensure that robust procedures are in place to provide integrated development of such services.

The Head of Healthcare should develop clinical pathways that show the interface between Primary Mental Health and In Reach Services. Criteria for referral to the services should be clear, understood by all healthcare staff and reflected in the service specification.

The Head of Healthcare should review and agree the role of the discipline officer within the In Reach team so that prisoners receive a comprehensive range of services. If this cannot be resolved, the Mental Health Team should no longer offer CBT or relaxation.

The Head of Healthcare should develop a programme of mental health awareness for prison staff which should be built into the prison's training programme.

Staff support

149. Following the man's death, support for staff was available from the staff care team. A hot debrief was conducted and arrangements were made for a critical incident debrief to take place. Although all staff involved on 28 March were adequately supported and the debrief process took place, the investigation found that it was not always possible for staff to attend such debriefs; and it was less likely that support and learning for nursing staff would be available. Any death in custody is traumatic for those involved so support for all staff should be available as well as opportunities to share learning from such events. The following recommendations are made:

The Governor should ensure that prison managers invite all staff who have been involved in a serious incident to attend the hot debrief and the critical incident debrief. Nursing staff should have the opportunity to attend a clinical debrief.

The Governor and Head of Healthcare should ensure that all action plans developed following a death in custody are shared with staff who provide care for prisoners to encourage their involvement in the service review and development process.

Family liaison

150. The man's family raised concerns with the investigator about the way in which the news of his death was broken. In particularly, his aunt was concerned that the prison had not identified her as the man's next of kin.

151. When he arrived at Bedford, he gave an address for his next of kin, which was his aunt in. In addition, he was also asked for the name and address of any other person he would wish to be contacted in an emergency, He gave the details of his other aunt. The investigation has heard that the reason for him providing the address of his other aunt was that it was to be a bail address. The prison would not have been aware of this.

152. It is recorded that his aunt had telephoned the prison to express her concerns about her nephew and, during the conversation, she had said that she was his next of kin. However, prisons are unable to change such information unless it comes from the prisoner.

153. On 28 March, the prison arranged for both aunts to be notified and hoped that this would happen at the same time. However, staff obtained no answer from either address. The Governor that Bedford appointed as family liaison officer and the Roman Catholic Priest had attempted twice to contact the man's aunt who he nominated as an emergency contact and the family liaiason officer at HMP Norwich had left a note at the address. It was essential that a family

member was notified of his death and the decision was taken to contact his mother.

154. The investigation has found that Bedford followed Prison Service Order 2710 in their attempts to notify his next of kin as soon as possible, albeit that there was some confusion over who was the immediate next of kin. The events that unfolded could not have been foreseen and the prison's actions ensured that the family were told without further delay.

CONCLUSION

155. During the investigation, many staff described the man as ‘a fish out of water.’ Adjusting to prison must have been very difficult for him and probably more so due to his young appearance and age. Despite this, he engaged fully with the regime and had a good rapport with both staff and fellow prisoners.

156. Staff placed him on monitoring under the suicide and self-harm prevention provisions, as a precaution, not long after he had arrived at Bedford. Staff from the Mental Health In Reach Team also assessed him. It is clear that he benefited from having this contact and at the first review of his ACCT plan, he spoke about being more positive. Concern about the possible length of any sentence he might be given evidently played on his mind and his legal team’s advice, to expect a significant sentence, probably did little to ease these concerns.

157. The man was also dealing with the death of his aunt and the serious illness of his stepfather in addition to his court case. His faith appears to have been an important factor in helping him deal with these issues and he attended chapel and bible study class regularly.

158. Indeed, despite these possible reasons for upset, staff who dealt with him on a daily basis described his outlook as positive. He attended education and offending behaviour courses, apparently interacted well with prisoners, and gave no substantive cause for staff to be concerned about his well-being. During the investigation, it became clear that he was a popular young man both with staff and his peers and his death was felt by all those that knew him at Bedford.

159. The investigation concludes that, in all the circumstances, his actions could not have been reasonably foreseen and that, when he was discovered, staff carried out the emergency procedures appropriately. Nevertheless, a number of recommendations have been made regarding required improvements to the management and clinical care of prisoners at Bedford.

RECOMMENDATIONS

1. The Governor should ensure that all staff with direct prisoner contact are appropriately trained in ACCT procedures and that the ACCT Foundation training is given priority as part of Bedford's training schedule.

   The Prison Service accepted this recommendation and said:

   Training is to be part of induction where appropriate and diaried into the Bedford training plan. Target date for completion 30 April 2012.

2. The Governor should ensure that managers at all levels, including those on temporary promotion, have completed the necessary ACCT training before fulfilling the role of case manager.

   The Prison Service accepted this recommendation and said:

   Line managers are to ensure that training pathways are updated prior to promotion. Instruction to all managers that ACCT case manager work must not be conducted by any manager that has not completed ACCT Case Manager training. Target date for completion 31 March 2012.

3. The Governor should ensure that staff who have been temporarily promoted to senior officer do not continue to act as case managers when they revert to their substantive grade.

   The Prison Service accepted this recommendation and said:

   To be actioned as part of No. 2 above

4. The Governor should ensure that significant dates or triggers identified in the ACCT process, which might increase a prisoner's risk, are also recorded in wing observation books; and that the safer custody team have a system for monitoring that enables them to provide reminders to unit managers.

   The Prison Service accepted this recommendation and said:

   Safer Custody Manager to inform Unit Managers of significant dates or triggers by e-mail. Target date for completion 30 April 2012.

5. The Governor should ensure that all case managers complete Caremaps as instructed in Annex 1A, PSO 2700.

   The Prison Service accepted this recommendation and said:

   Safer Custody Manager to provide all Case Managers with instructions of how Caremaps should be completed as per Annex 1A, PSO 2700. Target date for completion 31 March 2012.

6. All ACCT case reviews should be multi-disciplinary. When staff are unable to attend, they should provide relevant information in writing or by telephone to the case manager, which should be recorded as part of the review.

The Prison Service accepted this recommendation and said:

Safer Custody Manager to advise all Case Managers regarding the requirement that Case Reviews should be multi-disciplinary. This to include what should happen where relevant staff are unable to attend. Target date for completion 31 March 2012.

7. The chaplaincy team should ensure that wing staff are made aware of any prisoner that is receiving bereavement counselling, to enable them to follow up on return to the residential wing and provide support if required

The Prison Service accepted this recommendation and said:

Head of Chaplains team to issue instruction to team members and Bereavement Counsellors re the need to inform staff of any prisoners receiving bereavement counselling. This to include a protocol as to how this information should be shared. Target date for completion 31 March 2012.

8. The Head of Healthcare should ensure that all GPs record information about a patient's medical history before prescribing, in line with General Medical Council guidelines.

The Prison Service accepted this recommendation and said:

System in place, the GP surgeries are faxed for Long Term Medication and past medical history. Any prescribing completed in reception is based on clinical need after assessment.

9. The Head of Healthcare should ensure that when medication is prescribed, this is recorded in line with the General Medical Council guidelines.

The Prison Service accepted this recommendation and said:

All medications should be recorded in SytemOne; work is currently in progress that handwritten prescriptions by locum GPs are added to the System. Target date for completion 1 April 2012.

10. The Governor and Head of Healthcare should establish a Primary Mental Health Service as a priority.

The Prison Service accepted this recommendation and said:

Two staff employed at Band 6 level, service being developed

11. The Head of Healthcare should be designated to provide strategic representation in the development of healthcare services. Given the increase in multiple providers, this is essential to ensure that robust procedures are in place to provide integrated development of such services.

The Prison Service accepted this recommendation and said:

Head of Healthcare does provide strategic representation of healthcare services.

12. The Head of Healthcare should develop clinical pathways that show the interface between Primary Mental Health and In Reach Services. Criteria for referral to the services should be clear, understood by all healthcare staff and reflected in the service specification.

The Prison Service accepted this recommendation and said:

Referral criteria have been developed and is utilised.
Stepped Care Pathway model is being led by commissioners. Target date for completion 1 May 2012.

13. The Head of Healthcare should review and agree the role of the discipline officer within the In Reach team so that prisoners receive a comprehensive range of services. If this cannot be resolved, the Mental Health Team should no longer offer CBT or relaxation.

The Prison Service partially accepted this recommendation and said:

The Head of Primary Healthcare at HMP Bedford is responsible only for the delivery of primary care services and as such has no oversight of the Inreach discipline officer role.

The role of the discipline officer is reviewed and agreed by the Integrated Clinical Lead for SEPT secure services.

A Job Description is currently being actioned and will be discussed and agreed with the governor & HR business partner at HMP Bedford upon completion. Target date for completion 30 April 2012.

14. The Head of Healthcare should develop a programme of mental health awareness for prison staff which should be built into the prison's training programme.

The Prison Service partially accepted this recommendation and said:

The Head of Primary Healthcare at HMP Bedford is responsible only for the delivery of primary care services and as such has no oversight of mental health training & development

Mental health awareness training is delivered by the mental health inreach team to operational staff on a rolling programme arranged by the HMP Bedford training manager. This training is also extended to local Police & Magistrates colleagues.

15. The Governor should ensure that prison managers invite all staff who have been involved in a serious incident to attend the hot debrief and the critical incident debrief. Nursing staff should have the opportunity to attend a clinical debrief. This will enable all staff to be supported, reflect on and review practice and inform future developments for the prison and healthcare team.

The Prison Service accepted this recommendation and said:

Nurses will be given opportunity to attend clinical debriefs, as part of developing service .Takes place informally, will formalise process. Target date for completion 1 May 2012.

16. The Governor and Head of Healthcare should ensure that all action plans developed following a death in custody are shared with staff who provide care for prisoners to encourage their involvement in the service review and development process.

The Prison Service accepted this recommendation ans said:

Staff meetings being utilised to feedback to Healthcare staff, staff views actively sought for development of service.