Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Edwards a prisoner at HMP Bullingdon on 1 October 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Edwards was found hanged in his cell at HMP Bullingdon on 1 October 2015. He was 25 years old. I offer my condolences to Mr Edwards' family and friends.

Mr Edwards was recalled to prison and arrived at Bullingdon on 10 September. Reception staff did not fully consider his risk of suicide and self-harm. The next day, wing staff began to monitor Mr Edwards when he said he felt suicidal. I am not satisfied that the suicide and self-harm prevention procedures operated effectively to support Mr Edwards and monitoring ended without any consultation with mental health staff, who were involved in his care. Although this did not affect the outcome for Mr Edwards, there was a slight delay in calling an ambulance and the prison did not follow national instructions for informing and supporting families after a death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2016**

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Summary

Events

1. In April 2014, Mr Michael Edwards was remanded to prison. He was later convicted of robbery and sentenced to 30 months. Mr Edwards had longstanding mental health problems and a history of self-harm and suicide attempts. On 25 August 2015, he was released from HMP Winchester on conditional licence to live at Probation Service approved premises. On 9 September, his licence was revoked when he failed to sign in at the approved premises as his licence required. On 10 September, he was taken to HMP Bullingdon. No one assessed him as at risk of suicide and self-harm when he arrived.

2. On 11 September, Mr Edwards said he had suicidal thoughts. An officer began Prison Service suicide and self-harm prevention procedures, known as ACCT, and a mental health nurse assessed him. The next day, a case review, without any healthcare staff present, concluded Mr Edwards was at low risk of suicide and ended the ACCT monitoring. The mental health team continued to review Mr Edwards frequently.

3. At around 7.45pm on 1 October, Mr Edwards rang his cell bell and told an officer that he had broken his television aerial. He asked to move to another cell but there were none available at the time. Mr Edwards became upset and said he could not cope. The officer asked a Listener (a prisoner trained by the Samaritans) to speak to him but the Listener did not want to be locked in a cell with Mr Edwards, after he was warned he was a high risk of violence. The officer decided to give Mr Edwards a dedicated phone to ring the Samaritans and went to the wing office to begin ACCT procedures. Just after 8.40pm, two other staff took the telephone to Mr Edwards' cell and found him hanged by a ligature made from bedding. One of the officers radioed a medical emergency code and immediately began resuscitation, which nurses continued until paramedics arrived. Mr Edwards did not recover and, at 9.29pm, paramedics recorded that he had died.

Findings

4. The investigation found that probation staff took a very strict approach to enforcing Mr Edwards' licence conditions when they recommended his recall to prison but regarded him as a high risk at the time. Staff at Bullingdon did not manage Mr Edwards' risk of suicide and self-harm effectively. When he arrived at the prison, reception staff did not adequately assess his risk factors and consider whether he needed additional support. An officer began ACCT procedures, after Mr Edwards reported suicidal thoughts but the monitoring ended a day later without any effective support identified or healthcare involvement. Staff did not follow up Mr Edwards' comment that he had problems with some other prisoners. There was no post-closure review.

5. While we consider that Mr Edwards should have continued to receive ongoing support through ACCT procedures, we recognise that on the night he hanged himself it would have been very difficult for staff to have predicted his actions. There was little indication that he was at imminent and high risk of suicide and

we do not consider that staff could reasonably have anticipated or prevented his actions, which were sudden and unexpected.

6. We are satisfied that the Mr Edwards received an appropriate standard of healthcare at the prison. He received good consistent support from a mental health nurse.

7. Although it would not have affected the outcome, there was a short delay in calling an ambulance as, contrary to national instructions, the control room did not immediately call an ambulance after receiving an emergency code.

8. Prison staff did not personally inform Mr Edwards' next of kin of his death, or ask another prison to do so. They were notified by telephone, but no one arranged a follow-up visit to offer support.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular:

    - All known risk factors of newly arrived prisoners should be considered and recorded when determining their risk of self-harm or suicide, using all available information, such as from Person Escort Records.
    - Case reviews should be multidisciplinary and include all relevant people involved in a prisoner's care, with healthcare staff attending at least all first case reviews.
    - Case reviews should record and take into account all the known risk factors and triggers when considering the risk of suicide or self-harm.
    - Case reviews should set caremap actions, which are specific and meaningful, and ACCT monitoring should continue until the risk is reduced and all caremap actions have been completed.
    - Post-closure reviews should be held to check the prisoner's progress and to decide whether further monitoring is needed.

- The Governor should ensure that all indications of possible bullying or intimidation are taken seriously and investigated.

- The Governor should ensure that control room staff call an ambulance as soon as they receive an emergency medical code.

- The Governor should ensure that a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national guidance. Where it has not been possible for someone from the prison to inform the family, prison staff should arrange a visit as soon as possible afterwards.

The Investigation Process

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

10. The investigator visited Bullingdon on 9 October. He obtained copies of relevant extracts from Mr Edwards' prison and medical records and interviewed two prisoners.

11. NHS England commissioned a clinical reviewer to review Mr Edwards' clinical care at the prison.

12. The investigator interviewed 12 members of staff and six prisoners at Bullingdon. The clinical reviewer joined the investigator for interviews with healthcare staff. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations.

13. We informed HM Coroner for the County of Oxfordshire of the investigation who gave us the results of the post-mortem examination. The coroner commissioned additional toxicology tests in the light of information from our investigation. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Edwards' sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Edwards' sister was concerned about her brother's medical care at the prison, his recall to prison and wanted to know whether there was any evidence he was being bullied at Bullingdon. Mr Edwards' family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Bullingdon

15. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Virgin Care provides healthcare services. Oxford Health provides secondary mental health care. There is 24-hour healthcare cover with 21 in-patient beds

HM Inspectorate of Prisons

16. The most recent inspection of HMP Bullingdon was in June 2015. Inspectors reported that healthcare services, including secondary mental healthcare had improved from a relatively low base and was now reasonably good. Levels of self-harm were low compared to comparable prisons and prisoners managed under ACCT suicide and self-harm prevention procedures were mostly positive about their care. However, inspectors found that the prison did not effectively act on or review recommendations from Prisons and Probation Ombudsman reports into deaths at the prison. There was a need to improve record keeping, case management, care planning, and multidisciplinary input for ACCT cases.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2015, the IMB noted there had been improvements in mental healthcare. Urgent referrals were seen within 72 hours and routine referrals within 7 days. Patients were managed and supported through the Care Programme Approach. The IMB noted there had been a significant increase in the number of prisoners assessed as at risk of suicide and self-harm in 2015.

Previous deaths at HMP Bullingdon

18. There have been five self-inflicted deaths at Bullingdon since 2013. We have previously raised concerns about responses to emergencies and the management of the ACCT process.

Assessment, Care in Custody and Teamwork

19. ACCT is the Prison Service process for supporting and procedures prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

20. On 14 April 2014, Mr Michael Edwards was charged with robbery and remanded to HMP Winchester. On 8 September, he was convicted and sentenced to 30 months imprisonment. On 20 October, he was transferred to HMP Bullingdon and then returned to Winchester on 17 April 2015.

21. Mr Edwards had complex mental health problems. He was thought to have a psychotic mental illness and had an initial diagnosis of mixed personality disorder (symptoms that fit several personality disorder criteria). He had been under the care of prison mental health teams during previous prison sentences and had a long history of self-harm and suicide attempts. On 13 August, Mr Edwards received his monthly depot injection of aripiprazole. (A depot injection slowly releases antipsychotic medication into the body over a number of weeks.)

22. On 25 August, Mr Edwards was conditionally released from Winchester. As part of his licence conditions, he had to live at an approved premises. Mr Edwards was allowed to leave the approved premises but was required to sign in every two hours to safeguard social workers involved in the adoption of his children, whom he had threatened to kill.

23. On the morning of 9 September, during a phone call with his offender manager (probation officer), Mr Edwards said that he was worried about his antipsychotic medication wearing off and it was affecting his mental health. He described hearing voices, experiencing paranoia and believed people were reading his thoughts. He realised that it was a few days before his next dose of medication was due and he was trying to manage this.

24. At approximately 4.30pm on 9 September, a member of the public rang the police as Mr Edwards was acting bizarrely, running into the road and waving his arms in the air. An ambulance took him to the local hospital for a mental health assessment. However, he discharged himself before this was done.

25. At 5.00pm, Mr Edwards' offender supervisor tried to telephone him, as he had not returned to the approved premises to sign in. His mobile number was unavailable. Around 6.25pm, the offender supervisor telephoned the on-call manager, who advised him to begin recall procedures and inform the police. He began procedures to recall him to prison and informed the police. The police visited the approved premises and completed a missing persons report.

26. At around 7.00pm, probation staff at Slough telephoned the approved premises and said Mr Edwards had just visited their office and intended to get the next bus back to the approved premises. The oncall manager decided to continue with the recall procedures as she was concerned that he had been absent for a number of hours; there was uncertainty about his current whereabouts and whether he would come back. An Assistant Chief Officer from another probation area approved this.

27. At around 8.35pm, Mr Edwards arrived at the approved premises. He said that he had been stung by a bee, then chased by a swarm of bees and had been taken to hospital. (In a later interview in prison, he said he had a phobia of bees.) Staff told Mr Edwards that he had breached his licence and he would be

recalled to prison. The police took Mr Edwards from the approved premises at around 9.15pm.

28. Mr Edwards spent the night in police custody and was taken to HMP Bullingdon the next day, 10 September. His Person Escort Record (PER – a document which accompanies all prisoners when they move between police stations, courts and prisons and communicates risks) noted that he had superficial burns, had self-harmed by cutting and that he had been diagnosed with an unstable personality disorder. At an initial health screen that evening, a nurse recorded that Mr Edwards had a history of self-harm, but no current thoughts of harming himself and appeared settled. An officer also interviewed him that night. The officer said Mr Edwards appeared quite agitated, as he did not believe he should have been recalled and said he had tried everything to stay out of prison. No one assessed him as at risk of suicide and self-harm when he arrived at Bullingdon.

29. Just before 11.00am, on 11 September, Mr Edwards pressed his cell bell and told an officer that he was hearing voices and had thoughts of suicide. He asked to see someone from the mental health team. The officer noted he was agitated, upset, and appeared to be having a panic attack. He noticed Mr Edwards had scars from previous acts of self-harm and began ACCT suicide and self-harm prevention procedures. The officer telephoned a mental health nurse, who agreed to see Mr Edwards. A Supervising Officer (SO) decided staff should observe Mr Edwards hourly, until his first ACCT case review.

30. At around midday, the mental health nurse assessed Mr Edwards and recorded that he appeared restless, anxious and upset. Mr Edwards said he had been doing well in the community, but had experienced problems in the days leading up to his recall as his medication had started to wear off. He showed her a red swollen mark on his hand and said he believed he had been stung and chased by bees, but he was not sure if it was real. Mr Edwards accepted he had breached his licence conditions and was worried about how long he would have to stay in prison. They discussed his strategies to cope with his thoughts of suicide and self-harm, including watching the television and reading the Bible. She told him that it would not be possible to prescribe any medication until a psychiatrist reviewed his medication.

31. A little later, the mental health nurse and the Offender Manager had a telephone conversation to discuss the background to the recall and Mr Edwards' management. The Offender Manager then completed the recall papers and started to prepare a report to support Mr Edwards' release after 28 days. (After a recall, the Parole Board will decide, within 28 days, whether to order immediate release on licence, order release at a future date, make no recommendation or send their case to an oral hearing at which the prisoner can give evidence and call witnesses.)

32. On 12 September, an officer assessed Mr Edwards as part of ACCT procedures. He recorded that Mr Edwards was a prolific self-harmer. Mr Edwards told him about the events that had led to his recall and that he felt optimistic after speaking to his offender manager the previous day. He said that his medication

had started to wear off, so he had begun to hear voices, but he did not have any thoughts of suicide or self-harm.

33. A custodial manager held the first ACCT case review with an officer and a SO. She recorded that Mr Edwards was lucid and positive and said he had never acted on voices and planned to spend his time in prison constructively. He said that he had previously had some problems with other prisoners at Bullingdon and was concerned about this. She noted a plan to ask wing staff to check the location of these prisoners before Mr Edwards moved to a residential wing. There was no evidence that this was done.

34. No general healthcare or mental health staff were invited to the case review, although this is a mandatory requirement of ACCT procedures. The custodial manager told the investigator that she had received verbal briefing from healthcare staff, but there is no record of this in the ACCT document or in Mr Edwards' medical record. She said that Mr Edwards told her that he was happy and receiving support from the mental health team. The review concluded that Mr Edwards' risk of suicide and self-harm was low and they decided to end ACCT monitoring. There was no ACCT caremap setting out Mr Edwards' issues, arising from the ACCT assessment and how they would be addressed to reduce his risk. A post-closure review was scheduled for 19 September, but this did not take place.

35. On 15 September, Mr Edwards had an appointment arranged with a psychiatrist, but due to unforeseen circumstances, she was not available that day. When the mental health nurse told Mr Edwards the assessment was not taking place, he became agitated and said he would not be released until he had a psychiatric assessment. She emailed the psychiatrist to ask about the possibility of medication and she agreed to change Mr Edwards' prescription to the tablet form of aripiprazole. (Mr Edwards received this on 18 September.)

36. On 16 September, the mental health nurse reviewed Mr Edwards. She recorded that he had spoken at length about his anger and frustration at being recalled to prison. He said he would not act on his thoughts of harming himself and he had recently handed some razors to officers in order to keep himself safe. (There was no record of this in the wing observation book or in Mr Edwards' prison record.) She agreed to find out when the Offender Manager was going to visit Mr Edwards.

37. On the morning of 21 September, the mental health nurse saw Mr Edwards briefly and told him that his Offender Manager would visit him later in the day. Mr Edwards said that the aripiprazole tablets were effective and had made him feel calmer. He was considering remaining on them rather than the depot injection. The Offender Manager visited Mr Edwards in the afternoon and accompanied him to a review with the mental health nurse. He told Mr Edwards he intended to recommend releasing him after he had served 28 days and that the psychiatrist, the mental health nurse and the approved premises manager supported this. He said Mr Edwards was very happy about this and seemed very positive - even at the prospect that he might not be released at the 28-day point.

38. On 22 September, the psychiatrist assessed Mr Edwards, who described experiencing commanding hallucination which ordered him to harm others. He

said his medication was very helpful in controlling his emotions, but his monthly injection was only effective for 25 days and then wore off. He had no thoughts of self-harm, but was still hearing voices, which he knew, were not real. However, he said he was better equipped to manage this with cognitive behaviour therapy. She recorded that she had no serious concerns about Mr Edwards' mental state. She considered that his risk of self-harm was low and his risk to others was lower than when they last met, the previous time he had been at Bullingdon.

39. On 25 September, a custodial manager allowed Mr Edwards to use an office telephone to contact his Offender Manager. He said that after the call Mr Edwards was quite positive.

40. On 28 September, the mental health nurse reviewed Mr Edwards, who seemed calm. However, he said he felt quite depressed about being in prison. He had been in contact with his ex-partner, who was supportive. Mr Edwards said that he had not self-harmed since his recall but he had injured his knuckles before their meeting. He said that he sometimes became frustrated and punched his mattress and pillows, but he had missed the mattress and grazed his knuckle on the bed. He was keen to continue taking aripiprazole, as he found the tablets were effective during the day, and he did not have to worry about the effect running out, as he did with the depot injection. (Anxiety about reduced efficacy of depot injections in the period just before and just after an injection is a well-known phenomenon, but there is usually no pharmacological basis for this.)

41. During the day, Mr Edwards telephoned his Offender Manager to talk about his possible release. He seemed very positive and spoke about plans for the future.

42. At around 5.30pm that afternoon, a nurse gave Mr Edwards some paracetamol for a cold. She knew Mr Edwards from previous sentences. She noticed that his scars from cutting himself had now all healed. When she asked him about this, he said he had got past that stage in his life and had grown up.

43. At lunchtime on 30 September, a member of the prison chaplaincy went to see Mr Edwards in his cell. In a statement, she said he was playing loud music and sobbing hysterically, while holding a picture of one of his children. Mr Edwards told her that he would not see his children again, as they were being adopted. She spent some time reassuring him that they would be looked after. She said she informed a wing officer about Mr Edwards' emotional state.

44. In the afternoon, a wing officer contacted the mental health team, at Mr Edwards' request, to ask if someone could see him as he had received some difficult news about his children and did not feel good. The mental health nurse told the officer that Mr Edwards' children were a painful topic for him and said to let him know that she could not see him that afternoon, but planned to see him the next morning.

45. At around 8.15pm, Mr Edwards said that he had had two fits and might have hit his head. The duty nurse examined him and recorded that he was alert, communicative and his clinical observations were normal. However, he was worried and did not feel physically well. She admitted him to the inpatient unit for observation overnight.

Thursday 1 October

46. At 4.55am on 1 October, a nurse recorded that Mr Edwards had slept throughout the night, with no further seizures.

47. At 9.13am, a prison GP noted that Mr Edwards felt better. He had been shouting and confrontational with officers, but was calm and cooperative when the GP examined him. Mr Edwards told the doctor that he had had similar fits in the past, but had not seen a neurologist or received any anticonvulsant medication. The GP referred Mr Edwards to a neurology clinic. He advised Mr Edwards to stay in the healthcare centre for observation for another 24 hours, but Mr Edwards insisted on going back to D Wing. The GP explained the risks of further seizures and that he would have to be readmitted to the healthcare centre if there were any further episodes.

48. At around 11.30am, the mental health nurse saw Mr Edwards and recorded that he appeared pleased to see her and had joked about his admission to the inpatient unit. Mr Edwards said he understood why staff had wanted him to stay in the inpatient unit, but he wanted to mix with his friends on the wing and smoke, which he could not do in the inpatient unit. He said he was pleased the doctor had referred him to a neurology clinic, as he was concerned about the fits.

49. Mr Edwards said he had felt depressed the day before, but currently felt positive and he hoped this would continue. He said he had been trying to contact his ex-partner to help him access his money in the community and to get more photographs of his children. He said that he had been testing himself the day before, by holding a razor blade in his hands, but said he did not want to use it as he did not want more scars on his arms and he was “resisting temptation”. He said that a member of the chaplaincy team had visited him at that point and he had taken this as a sign that he should not harm himself. Mr Edwards said he knew that there were healthier ways to express emotion.

50. Mr Edwards told the mental health nurse that he felt comfortable about speaking to officers if he had any thoughts of suicide or self-harm and said he would hand in his razors and any sharp items if thoughts of harming himself became too intense. He had no current thoughts of suicide or self-harm. They discussed the ongoing support he would need in the community after he was released and he suggested continuing therapies to help him change his patterns of behaviour, such as self-harm, suicidal thinking and substance misuse. He said that he wanted to understand and validate his emotions rather than dismiss them, as he had done in the past, as this did not help him move forward from any crises.

51. The mental health nurse told Mr Edwards she would be on leave the next week, but would see him when she got back. She advised him to ask officers if he needed to see someone else from the mental health team, but said they would have to fit him in around their other appointments. She noted that he understood this and thanked her for coming to see him. She booked an appointment for Mr Edwards to have an annual physical health check on 13 October.

52. At 4.45pm, the prisoners on D Wing were unlocked for an association period, when prisoners can mix with each other, make phone calls, take showers and complete other domestic tasks. Around 5.30pm, Mr Edwards collected his medication from a nurse and apologised for being late as he had overslept. She asked him why he had discharged himself from the inpatient unit and he said he had not been happy there and had wanted to be back on D Wing. She did not notice anything about Mr Edwards that concerned her. At 6.15pm, the prisoners were locked back in their cells.

53. Around 7.45pm, Officer A responded to Mr Edwards' cell bell and spoke to him through the door observation panel. Mr Edwards said that he felt stressed. He had pulled the television aerial out of the socket and could not get a picture. She telephoned the night manager and asked whether Mr Edwards could move to another cell with a working television. He told her to contact other wings for available cells. She found that the only empty cells were on the induction wing, F Wing, but staff did not yet know how many new prisoners would arrive that evening. The night manager therefore decided that Mr Edwards could not move until the morning.

54. When Officer A told Mr Edwards, he became annoyed and angry. He said he did not think he would be able to cope without a television. He was pacing the cell, then put both hands on the cell door and started to rock backwards and forwards. She asked whether he wanted to speak to a Listener (prisoners trained by the Samaritans to help other prisoners in emotional distress). Mr Edwards said he did and she telephoned the night manager, who arranged for a Listener to be brought from another wing.

55. Mr Edwards rang his cell bell again and Officer A went back and told him she had asked for a Listener. Mr Edwards showed her a small cut he had made on his right arm. He told her about his children being adopted and held up a picture of one of them. He asked her if she would come into the cell and talk to him but she explained she could not do this. She said this appeared to make him angrier and she told him she would check about the Listener.

56. When Officer A got back to the wing office, the Listener arrived, escorted by a SO and Officer B. Officer A told the Listener that Mr Edwards was a high-risk prisoner who was in a double cell by himself and was quite agitated. Because of the risk, he decided not to see him and the staff took him back to his cell. (Mr Edwards had been assessed as high risk for cell sharing due to a previous offence of arson and on the advice of the mental health nurse.) Officer A then told Mr Edwards that the Listener was busy and Mr Edwards agreed to use a Samaritans telephone instead. (A portable dedicated phone which prisoners can use in their cells to speak to the Samaritans.)

57. The Listener told the investigator that staff have a duty of care towards Listeners and are obliged to tell them about possible risks and dangers of being locked in a cell with another prisoner. When Officer A had told him that Mr Edwards was violent and volatile, he had decided that he did not want to take the risk of personal harm to himself. He said he had previously had a bad experience with a violent prisoner who had taken a new psychoactive substance (NPS) and he was particularly concerned about the prevalence NPS and the effect on

prisoners' behaviour. He said that as he was leaving the wing, staff were going to get the Samaritans telephone.

58. Officer A telephoned the night manager and told him that the Samaritans telephone was not working. He sent a replacement, which also seemed to be faulty but eventually began to work. Officer A decided to start ACCT procedures, but there were no ACCT forms in the wing office, so Officer B went to get some from another unit. She then began to complete the form, while the SO and Officer B took the telephone to Mr Edwards' cell.

59. When they arrived at the cell, the SO looked through the observation panel and saw Mr Edwards hanging from a piece of torn bedding, attached to the bed.

60. The SO unlocked the cell and, at 8.44pm, Officer B radioed a code blue medical emergency message (which indicates circumstances such as when a prisoner is unconscious or not breathing). The officer supported Mr Edwards' weight while the SO cut the material from around his neck. They lowered him to the floor and the SO began chest compressions while the Officer A gave rescue breaths. Another officer joined them and took over the chest compressions. Two nurses then arrived and continued cardiopulmonary resuscitation.

61. The night manager responded to the code blue. On his way to D Wing, he asked the control room to call an ambulance. The control room and ambulance service records show that the call was made at 8.46pm, after he requested one, rather than in response to the code blue.

62. Around 9.00pm, paramedics arrived and took over the emergency treatment. Mr Edwards did not recover. At 9.29pm, the paramedics recorded that he had died. Mr Edwards had left a note in his cell to his family, children, and partner, apologising and said that he could not take the pain any longer.

Contact with Mr Edwards' family

63. Mr Edwards had given his ex-partner as his next of kin, at an address in Southampton. His brother was also listed in his records. No telephone numbers were recorded, but the duty governor obtained their telephone numbers from Mr Edwards' call records. She asked a prison chaplain to telephone Hampshire Police and ask them to inform Mr Edwards' family of his death. The chaplain called at around 10.30pm. At 3.30am, the police called back and said that they had spoken to Mr Edwards' brother, but he had refused to disclose where he was at that time. They had therefore been obliged to inform him of his brother's death over the phone.

64. The Head of Corporate Services acted as the prison's family liaison officer. At 9.55am, he telephoned Mr Edwards' ex-partner to offer condolences and support and to explain procedures. The prison paid funeral costs, in line with Prison Service instructions.

Support for prisoners and staff

65. The prison posted notices informing prisoners of Mr Edwards' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Edwards' death.

66. The night manager debriefed the wing staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and offered his support and that of the care team. Healthcare staff involved in the emergency response received support when they were next on duty.

Post-mortem report

67. A post-mortem examination found that the cause of Mr Edwards' death was hanging. Toxicology tests found therapeutic levels of his prescribed medication, aripiprazole and showed low levels of aspirin and paracetamol. The toxicology tests produced negative results for all other substances, including new psychoactive substances.

Findings

Mr Edwards' recall to prison

68. The events leading up to Mr Edwards' recall to prison were unusual. He had been at the approved premises for just over two weeks and was fully compliant with the requirement to sign in every two hours. He appeared settled and staff had raised no concerns. During the afternoon of 9 September, he went to a job centre and was then taken to hospital after a member of the public rang the police to report that he was behaving oddly. After discharging himself from hospital, Mr Edwards went to Slough Probation Office to ask them to contact the approved premises on his behalf, but he had not tried to contact staff before this to tell them what happened. He had missed two signing-in periods.

69. Mr Edwards had a history of violent offences. Due to his risk of harm to others, and the uncertainty around his failure to return to the approved premises, out of hours probation staff, who were unfamiliar with Mr Edwards, decided to recommend his recall to prison and this was agreed by the National Offender Management Service. The Offender Manager was confident that Mr Edwards would not have to serve his complete sentence. Additional measures would be put in place to manage his risk, such as mental heath support in the community and the change from a depot injection to tablet medication would help reassure Mr Edwards that the effects would not wear off. He told Mr Edwards he would recommend release after he had served 28 days. The psychiatrist, the mental health nurse and the approved premises manager all supported this course of action so it was likely that Mr Edwards would have been released again shortly afterwards.

70. Probation staff have a difficult task and heavy responsibility when supervising offenders released on licence. They must put public protection at the forefront when reaching decisions about whether to recommend that an offender is recalled to prison. The Offender Manager, who knew Mr Edwards best, was not involved in the decision as it was taken out of hours. However, he considered that the action to recall Mr Edwards to prison was correct, as Mr Edwards had discharged himself from hospital, was behaving erratically and there had been some reports of him drinking alcohol in Slough.

71. We understand that when the staff began to initiate recall proceedings they were rightly concerned because Mr Edwards was missing and had been assessed as a high risk of harm to others. It seems likely that Mr Edwards experienced some sort of psychotic episode but afterwards he had gone to the probation office at Slough and reported his whereabouts. He later returned to the approved premises and it would have been possible to abort the recall process at that point, but the staff decided to continue. In making this decision, we consider they adopted a risk-averse approach but we accept that, based on the information available to them at the time, this was not an unreasonable decision; Mr Edwards had breached his licence condition and the decision was based on an assessment of risk and the need to prioritise public protection.

Assessing and managing the risk of suicide and self-harm

72. Mr Edwards had been managed under suicide and self-harm prevention procedures many times during previous sentences. On 10 September 2015, when he arrived at Bullingdon, he had a number of factors known to increase the risk of suicide and self-harm, including a history of self-harm, recall to prison and complex mental health problems. His escort record noted that he had deliberately cut himself.

73. PSI 07/2015 (Early Days In Custody) requires staff to be alert to the increased risk of suicide and self-harm among new prisoners. They are required to interview all new arrivals to assess the risk of suicide and self-harm and act appropriately to address any concerns, including opening an ACCT if necessary. There is no evidence that staff at Bullingdon took Mr Edwards risk factors into account, or considered starting ACCT suicide and self-harm prevention procedures when he arrived. No one began ACCT procedures.

74. The next day, an officer began ACCT procedures, when Mr Edwards reported feeling suicidal. We are concerned that these were not managed effectively to support Mr Edwards. The procedures were not fully in line with Prison Service Instruction (PSI) 64/2011, which expects case reviews to be multidisciplinary where possible and there is a mandatory requirement that healthcare staff must attend the first case review. There were no healthcare or mental health representatives at the first case review and no member of staff from any other prison department. The custodial manager said she had spoken to the mental health team before the review, but there is no record of this in the ACCT document or Mr Edwards' medical record.

75. We are concerned that staff decided to end ACCT monitoring within 24 hours, without any proper consideration of Mr Edwards risk factors and without the involvement of anyone from the mental health team, despite his acknowledged mental health problems. Mr Edwards mentioned some concerns about other prisoners but this was not followed up. (See potential bullying below.) No one drew up a caremap with identified actions to help reduce his risk. It seems that the case review placed a lot of reliance on Mr Edwards' apparent mood, rather than an objective assessment of his outstanding risk factors. In addition to those already identified, he had voiced suicidal thoughts just the day before, he had been hearing voices and he had told staff that his antipsychotic medication was not effective.

76. One of the lessons we identified in our thematic report, published in January 2016, about prisoner mental health, based on our investigations into self-inflicted deaths in prisons, was that someone from the mental health team needed to attend or contribute to all ACCT reviews for prisoners under their care, and should be fully involved in any important decisions about their location, observations and risk. We are concerned that the mental health team were not appropriately involved in the case review process and in the decision to close the ACCT.

77. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular:

- **All known risk factors of newly-arrived prisoners should be considered and recorded when determining their risk of self-harm or suicide, using all available information, such as from Person Escort Records.**
- **Case reviews should be multidisciplinary and include all relevant people involved in a prisoner's care, with healthcare staff attending at least all first case reviews.**
- **Case reviews should record and take into account all the known risk factors and triggers when considering the risk of suicide or self-harm.**
- **Case reviews should set caremap actions, which are specific and meaningful, and ACCT monitoring should continue until the risk is reduced and all caremap actions have been completed.**
- **Post-closure reviews should be held to check the prisoner's progress and to decide whether further monitoring is needed.**

78. We consider that the ACCT was closed prematurely and Mr Edwards should have continued to receive ongoing support through ACCT procedures. However, we recognise that, on the night he hanged himself, it would have been very difficult for staff to have predicted his actions. An officer had identified he was at increased risk of suicide and self-harm and was beginning ACCT procedures at the time he was found hanged. However, there was little to indicate that he was at imminent and high risk of suicide. We do not consider that staff could reasonably have anticipated or prevented his actions, which were sudden and unexpected.

Potential bullying

79. Mr Edwards' sister was concerned that Mr Edwards might have been a target for bullying for a tobacco or drug debt. Intelligence reports completed at Bullingdon in March 2015 suggested that Mr Edwards might have been in debt at the time, but there was no further information about this.

80. At his ACCT case review on 12 September 2015, Mr Edwards mentioned some prisoners he had problems with. A custodial manager made a note that wing staff should follow this up but there is no record that this was done. There is no evidence from either staff or prisoners to indicate that Mr Edwards was in debt to other prisoners after he returned to Bullingdon in September 2015. The fact that he did not want to stay in the inpatient unit when he was admitted, but wanted to go back to his wing, suggests he had no fears on the wing. However, we are concerned that staff did not establish whether there was an ongoing problem when he raised it at an ACCT review. We make the following recommendation:

The Governor should ensure that all indications of possible bullying or intimidation are taken seriously and investigated.

Clinical care

81. The clinical reviewer noted that Mr Edwards was well known to the specialist mental health team at Bullingdon. A member of the team assessed him within 24 hours of his return to prison and reviewed him nine times in the three weeks before his death. We consider he received good and consistent support from the mental health team.

82. Mr Edwards had been due to receive an aripiprazole injection, prescribed to help control his mood, on 13 September. His prescription was changed to the tablet form of the medication on 15 September, but he did not receive this until 18 September. The clinical reviewer concluded that the delay in the continuity of medication did not contribute to Mr Edwards' death. Toxicology tests showed no evidence of over or under usage of this medication. He was satisfied that Mr Edwards' healthcare was equivalent to that he could have expected to receive in the community.

Emergency response

83. When the SO and Officer B discovered that Mr Edwards had hanged himself, the officer immediately radioed a code blue emergency. Control room staff logged the time as 8.44pm and they called an ambulance at 8.46pm.

84. PSI 03/2013, which covers medical emergency response codes, contains mandatory instructions for prisons to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. The PSI makes it clear that the control room should call an ambulance immediately an emergency medical code is received and should not wait to be instructed to call one by a manager or member of healthcare staff at the scene. It notes that an ambulance can be cancelled if it is later assessed that it is not required. In 2013, Bullingdon issued a notice to staff which made it clear that an ambulance should be called immediately when an emergency code is used.

85. Control room staff did not call an ambulance until the night manager specifically asked them to call one. In all other respects the emergency response was quick and effective. The officers who found Mr Edwards hanged immediately began cardiopulmonary resuscitation and nurse arrived promptly and took over his care until paramedics arrive. While there was only a slight delay in calling an ambulance, and there is no indication this would have affected the outcome for Mr Edwards, control room staff need to understand that they should call an ambulance immediately and automatically when they receive a medical emergency code, as in other emergencies any delay could be critical. We make the following recommendation:

    The Governor should ensure that control room staff call an ambulance as soon as they receive an emergency medical code.

Family liaison

86. Prison Rule 22 requires that the governor should inform families at once when a prisoner dies. PSI 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. It notes that time will be of the essence in order to try to ensure that the family do not find out about the death from another source. It states that the police should be informed before a visit and, if necessary, be asked to escort the team or remain nearby. If the next of kin live a long distance away, consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.

87. At 10.30pm, an hour after Mr Edwards' death, prison staff asked the police to notify Mr Edwards' next of kin of his death and gave them details of his ex-partner and brother. At 3.30am, the police confirmed that they had notified his brother by telephone as he would not tell them where he was when they called. Mr Edwards' family lived around an hour and a half away from the prison. It is unclear why staff from Bullingdon did not try to visit Mr Edwards' next of kin or arrange for someone from another prison to do so.

88. The instruction also states that if the prisoner's next of kin is not informed in person, or is told by another prison or the police, a follow-up visit by the prison must be arranged as soon as practicable. There is no evidence that the prison tried to arrange such a visit after the initial notification by the police. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's family quickly and in person of their death, in line with national guidance. Where it has not been possible for someone from the prison to inform the family, prison staff should arrange a visit as soon as possible afterwards.

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