Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gareth Edwards a prisoner at HMP Bullingdon on 11 December 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

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

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We are:

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

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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 Gareth Edwards was found hanged in his cell at HMP Bullingdon on 11 December 2015. He was 41 years old. I offer my condolences to Mr Edwards' family and friends.

Mr Edwards had a history of depression and had tried to take his life a number of times before he went to prison. He had been discharged from hospital after taking an overdose, the day before he arrived at Bullingdon in April 2015. Despite this, and other significant risk factors, no one identified him as at risk of suicide when he arrived. He was briefly monitored under suicide prevention procedures some weeks later but these procedures did not operate fully effectively. Mr Edwards was diagnosed with a personality disorder. While such disorders are difficult to manage, I am concerned that he did not get the type of support and interventions he needed from mental health services at the prison.

It is evident that Mr Edwards always had a long-term risk of suicide but he appeared to have settled at the prison and there was little to indicate to staff that he was at imminent and high risk at the time of his 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 **July 2016**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 6
Findings 14

Summary

Events

1. On 16 April 2015, Mr Gareth Edwards was arrested and, the next day, he was charged with attempted robbery. Mr Edwards had a history of mental health problems. He had a diagnosed personality disorder and suffered from depression. He had tried to kill himself several times and had taken an overdose, two days before he arrived at Bullingdon on 17 April. This was his first time in prison.

2. No one identified Mr Edwards as at risk of suicide and self-harm when he arrived but he lived in the prison's support and mentoring unit, which gives extra help for new and vulnerable prisoners identified as needing additional support for their first weeks at the prison. On 19 May, staff began monitoring him under suicide self-harm prevention procedures, known as ACCT when he said he had continuing thoughts of suicide. Monitoring ended on 5 June.

3. Mr Edwards appears to have settled at Bullingdon. He had a job in the prison laundry, which he enjoyed. He was supported by a prisoner mentor and had friends on his wing. Staff did not indentify any concerns about him and he never self-harmed at the prison. Although he was treated for depression and sometimes said his mood was low, staff did not subsequently consider that he needed to be monitored as a risk of suicide or self-harm.

4. On the morning of 11 December, an officer found Mr Edwards had hanged himself in his cell. Staff and paramedics tried to resuscitate him, but sadly, he was pronounced dead at 9.30am. The prison's family liaison officer asked the police to break the news of Mr Edwards' death to his brother.

Findings

5. Mr Edwards was a troubled man who had long history of depression, attempted suicide and continuing suicidal thoughts. We are concerned that despite a number of significant risk factors for suicide when Mr Edward arrived at Bullingdon, no one identified his risk. He was later monitored under ACCT suicide and self-harm prevention procedures for three weeks from the end of May, but none of the case reviews were multidisciplinary and they did not include relevant people who were involved in his care.

6. Subsequently, although he continued to suffer from depression, Mr Edwards seemed to settle. He had some good support from a prisoner mentor and other prisoners on his wing. Although he was always a long-term risk of suicide, and said he intended to kill himself after he was released from prison, there was little to indicate that he was at heightened or imminent risk in the period before his death. We consider that it would have been difficult for staff at the prison to have foreseen or prevented his actions on 11 December.

7. However, we are concerned that Mr Edwards did not receive the level of mental health support he needed for his conditions. The clinical reviewer found that support from the prison's mental health team was inadequate. There were delays responding to mental health referrals and the clinical reviewer was

concerned that services for prisoners with personality disorder did not reflect those available in the community.

8. On the morning Mr Edwards was found hanged, an officer did not check his welfare when she unlocked his cell but went back 25 minutes later to check him. A prisoner said he had spoken to Mr Edwards in the interim. However, the nurse who responded to the emergency medical code blue said that Mr Edwards was cool to the touch, pale and that his pupils had dilated. One of the officers who responded said that Mr Edwards' was cold and his skin was mottled. On balance, we cannot say for certain whether that prisoner's recollection of events was accurate. Although there was only a brief delay, the control room did not call an ambulance as soon as an emergency medical code was used. It would not however have changed the outcome for Mr Edwards if they had done so.

9. Mr Edwards received some good support from other prisoners and staff from the substance misuse team, but there was little evidence of engagement with his personal officer or other wing staff.

Recommendations

- The Governor should ensure that reception staff are aware of, consider and record all the known risk factors for suicide or self-harm when assessing newly arrived prisoners. They should open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.
- The Governor should ensure that all ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care. Healthcare staff should attend all first case reviews.
- NHS England – Thames Valley Area Team should ensure that mental health services commissioned for Bullingdon reflect the level of need, including for prisoners with personality disorders, and that prisoners have access to services equivalent to those available in the community.
- The Head of Healthcare should ensure that prisoners referred to the mental health teams have timely, appropriate, face- to-face assessments in private and that referrals for prisoners at risk of suicide or self-harm are prioritised.
- The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.
- The Governor should ensure that officers have meaningful contact with every prisoner through an effective personal officer scheme, which allows officers to get to know prisoners, identify their needs and make regular case history notes.
- The Governor should ensure that control room staff call an ambulance immediately a medical emergency code is received, without waiting for further confirmation.

The Investigation Process

10. 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.

11. The investigator visited Bullingdon on 15 December 2015. He obtained copies of relevant extracts from Mr Edwards' prison and medical records.

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

13. The investigator interviewed fifteen members of staff and three prisoners at Bullingdon in February 2016. The clinical reviewer joined him for some staff interviews.

14. We informed HM Coroner for Oxfordshire of the investigation. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Edwards' family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Edwards' father asked whether staff had recognised his son's depression.

16. Mr Edwards' family received a copy of the draft report. They pointed out factual inaccuracy. This report has been amended accordingly. Mr Edwards' family also raised a number of questions that do not affect the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Bullingdon

17. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Virgin Care was the healthcare provider at the time of Mr Edwards' death, but this is now provided by Care UK. Cotswold Medicare Ltd. provides general practitioner services. Oxford Health NHS Foundation Trust provides care for those with severe and enduring mental illness and secondary mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Bullingdon was in June 2015. Inspectors found that the quality of personal officer work was inconsistent, and few prisoners knew who their personal officer was. There were few personal officer entries in prisoners' case notes. Inspectors noted that levels of self-harm were much lower than comparable prisons and that the support and mentoring unit was a good initiative to help prisoners identified as being likely to find life on a standard wing difficult.

19. Inspectors reported that the two primary mental health nurses provided good support to prisoners with mild-to-moderate anxiety and depression. However, the mental health service was not sufficiently multidisciplinary and did not support prisoners with wider mental health needs. Psychological interventions were limited, with only computer-based cognitive behavioural therapy. Counselling was available only through the chaplaincy. The inspectorate reported that the mental health team saw all new referrals within 72 hours, but there was no cover for staff absence, which reduced the provision of services.

Independent Monitoring Board

20. 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 published annual report for the year to 31 July 2015, IMB reported that the prison continued to have trouble recruiting staff, particularly nurses, A shortage of officers meant that they were often diverted from core functions, such as in the offender management unit.

Previous deaths at HMP Bullingdon

21. Mr Edwards' death was the fifth self-inflicted death at Bullingdon since January 2014. In previous investigations, we have found that reception staff did not identify and consider all risk factors for suicide and self-harm. We have previously identified the need for officers to check prisoners' welfare when unlocking cells, for an effective personal officer scheme and that the control room should call an ambulance immediately in an emergency. We repeat these concerns in this report.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners

assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. Mr Gareth Edwards had a history of attempted suicide, and, on 15 April 2015, he took an overdose of medication with alcohol. He was taken to hospital, where he spent the night. On 16 April, the police arrested Mr Edwards at the hospital for affray.

24. Mr Edwards told a police doctor that he had a personality disorder, depression and anxiety and was dependant on alcohol. He said that, as well as his overdose the previous day, he had last taken an overdose in January. Mr Edwards said he was taking medication for depression and anxiety but was not reliant on antidepressants. The doctor noted that a hospital psychiatrist had decided that Mr Edwards did not need to be admitted for treatment and had discharged him as he had no evident symptoms of withdrawal from alcohol or drugs. He spent the night in police custody and was checked every half an hour.

25. On 17 April 2015, Mr Edwards was remanded to HMP Bullingdon, charged with the attempted robbery of his mother. It was his first time in prison. He was due to appear in court on 1 May. His escort record noted his history of self-harm and that he had taken an overdose two days before. It also recorded that he had a personality disorder, depression and alcohol issues.

26. A substance misuse nurse assessed Mr Edwards and noted he had no evident symptoms of alcohol withdrawal. At an initial health screen, Mr Edwards told a nurse he had depression, had recently taken an overdose of antidepressants and had not seen his GP for several months. He said he had no current thoughts of suicide or self-harm. The nurse referred him to a GP. No one assessed him as at risk of suicide and self-harm, despite his recent overdose.

27. On 18 April, a prison GP reviewed Mr Edwards and recorded that his depression was a long term issue and that he had always had thoughts of suicide, which were not necessarily linked to his mood. Mr Edwards said he had no current plans to act on them. The GP noted that Mr Edwards was taking seroxat, an antidepressant. He prescribed paraxetine, an antidepressant, and medication to help Mr Edwards sleep but did not refer him to the prison's mental health team, as it did not provide a service for men with personality disorders.

28. On 21 April, a nurse from the prison's substance misuse team reviewed Mr Edwards and referred him to the primary mental health team, as he said he had depression and felt low. An officer also made a mental health referral that day, after Mr Edwards said he had attempted suicide six times in the past. He said that he did not currently feel suicidal but was pleased about his referral.

29. On 22 April, a key worker from the Rehabilitation for Addicted Prisoners Trust (RAPt), which provides interventions and services for prisoners with drug and alcohol problems, assessed Mr Edwards. Mr Edwards told him about his history of drug and alcohol use and that he had been due to see his community mental health team for depression and anxiety. He also referred Mr Edwards to the prison's primary mental health team, and to the prison's chaplaincy team for counselling.

30. On 23 April, Mr Edwards moved to the prison's support and mentoring unit which holds 60 prisoners, with seven prisoner mentors who support and encourage prisoners new to prison or going through a period of crisis.

31. On 30 April, a nurse from the prison's primary mental health team saw Mr Edwards. The nurse told the investigator that he had seen Mr Edwards for a "welfare check" to find out how he felt, whether he had any issues and if he needed an immediate mental health assessment. The nurse noted that Mr Edwards appeared calm, mentally stable, and normal. He said he had no current thoughts of self-harm. Mr Edwards told the nurse about his alcohol abuse, how he sometimes felt low and had felt detached from an early age. The nurse noted no concerns but considered that Mr Edwards should continue to receive support from the prison's RAPt team. (The clinical reviewer noted during our investigation that the welfare check was an adequate assessment.)

32. Healthcare staff obtained Mr Edwards' community mental health records, which were discussed at the weekly mental health in-reach team meeting on 30 April. The in-reach team decided that Mr Edwards did not meet their criteria, as he did not have a severe and enduing mental illness. They noted that he could be referred again if his health deteriorated.

33. On 1 May, Mr Edwards was convicted and remanded for sentencing on 4 June. On 5 May, a RAPt drug and alcohol practitioner and a trainee counsellor from the prisons chaplaincy team had her first counselling session with Mr Edwards. On 11 May, a prison GP saw Mr Edwards and increased his dosage of antidepressants.

34. On 19 May, the trainee counsellor had a counselling session with Mr Edwards and he told her that he had suicidal thoughts all the time. He said that as he had tried to kill himself many times before and needed more support. She began ACCT procedures.

35. On 20 May, an officer assessed Mr Edwards as part of the ACCT process and noted that Mr Edwards had attempted suicide many times. He noted that suicidal thoughts were normal for Mr Edwards, and that Mr Edwards said that it was not a question of whether he would kill himself, but when. Mr Edwards said he felt fine, but did not care if he lived or died, and saw no future for himself. He said his thoughts had recently turned to hanging and cutting. He said he was afraid about being released, as he felt he was getting the help he needed in prison.

36. That day, a Supervising Officer (SO) held Mr Edwards' first ACCT case review with an officer. No one from the prison's mental health team was present or any other member of healthcare staff. Mr Edwards said he had been in a low mood for about thirty years. He said he struggled to use the Listeners scheme and the Samaritans, but he had a supportive cellmate and was happy to talk to staff. The SO referred him to the mental health team again and to a GP to review his medication. She noted as actions in Mr Edwards' caremap that he had been referred to the mental health team, that he should communicate more with staff and that the GP should review his medication.

37. On 27 May, a custodial manager held an ACCT case review with a SO. Mr Edwards said that he had a more positive outlook and got on well with his

cellmate. The case review team decided to continue ACCT monitoring until after Mr Edwards was sentenced on 4 June.

38. On 28 May, a nurse, recorded that the primary mental health team had received referrals for Mr Edwards from officers and nurses and noted that Mr Edwards had a provisional diagnosis of personality disorder. He recorded that he had seen Mr Edwards on 30 April, and as he had not appeared psychotic or disturbed, he had decided that Mr Edwards should remain under the care of RAPt, the psychosocial team, to help him 'deal with his drug habit'. The nurse noted that Mr Edwards had no ongoing mental health issues and could be referred again if there was a real need for intervention.

39. On 29 May, a mental health nurse discussed Mr Edwards' referral with the previous nurse and noted that she had explained to the key worker from the RAPt team that he did not meet their criteria for intervention. She noted he had a diagnosis of personality disorder and substance misuse and that a community mental heath professional had discharged Mr Edwards on 25 March because he had no significant needs and did not have depression. She recorded that the primary mental health team would therefore not see Mr Edwards.

40. On 4 June, Mr Edwards was sentenced to two years in prison. His Home Detention Curfew (HDC) date, the earliest time that he could be considered for release with an electronic tag, was 4 December 2015; otherwise, he would be relapsed on 16 April 2016.

41. On 5 June, a SO and an officer held an ACCT case review. Mr Edwards said that the length of his sentence was what he expected. He said he had no thoughts of suicide or self-harm, was in good spirits and felt well supported in the support and mentoring unit. The SO decided to end ACCT monitoring, and the caremap actions were noted as complete on 27 May. On 14 June, at an ACCT post-closure review, Mr Edwards told her he was happy that his court case had finished. He said he had the support of family, friends and his prisoner mentor.

42. Mr Edwards worked in the laundry at Bullingdon. He was polite to staff and complied with the prison's regime. Officers told the investigator that Mr Edwards had mixed well with other prisoners, but sometimes preferred to be alone in his cell.

43. On 24 June, Mr Edwards told a nurse that he was feeling anxious and depressed and that his medication had not helped him. He asked to see the GP to discuss other options that might help him.

44. On 6 July, a GP saw Mr Edwards and noted that the increased dose of antidepressants was not working, as Mr Edwards appeared to have continuing depression and anxiety. He changed his antidepressant to sertraline. He recorded that Mr Edwards said he had suicidal thoughts and, while he had no current plans to act on them, said he intended to kill himself when he left prison. Mr Edwards told the GP that his counselling sessions with the trainee counsellor were 'okay'.

45. On 20 July, the GP reviewed Mr Edwards and noted that his symptoms of depression had improved, but he still had suicidal thoughts and said he planned

to 'end it all' when he was released from prison. Mr Edwards said that when he had been monitored under ACCT procedures, he was told he had been referred to the mental health team but had heard nothing. The GP increased the dose of sertraline and referred him to the primary mental health team the following day.

46. On 21 July, a nurse noted that the GP had referred Mr Edwards to the primary mental health team because he had persistent suicidal thoughts, which he intended to act on when he was released. He arranged another welfare check to decide whether the mental health team should take Mr Edwards' case.

47. On 25 July, a nurse from the mental health team went to Mr Edwards' wing to see him but he was at work. On 29 July, she saw him in the prison laundry for a welfare check. She noted that Mr Edwards said he had no current thoughts of suicide, but was overwhelmed by thoughts of harming himself when he got out of prison. She noted his earlier diagnosis of personality disorder and that he had a mental and behavioural disorder due to his use of alcohol. She noted that Mr Edwards was seeing a counsellor weekly. They agreed that there was no need for a further mental health assessment, but she arranged to see him to monitor his mental wellbeing four weeks later. She told the investigator that the primary mental health team would not normally take on their caseload prisoners who were already seeing a counsellor.

48. On 4 August, the trainee counsellor had her last counselling session with Mr Edwards as he wanted to see a psychologist and the prison's mental health team policy was that prisoners could not work with a counsellor and a psychologist at the same time. She told Mr Edwards that his decision would not affect a future request for counselling.

49. On 3 September, a nurse recorded that she had tried to see Mr Edwards as she had agreed with him on 25 July, but was unable to because he was at work.

50. On 7 September, Mr Edwards started a four week RAPt Stepping Stones programme. (This is a programme designed to support people using drugs or drinking at harmful or dependent levels, as preparation for receiving further support or long-term treatment in prison or after release.) During a session on 24 September, Mr Edwards said he was not getting appropriate mental health support. On 29 September, he said that sometimes he did not see a future, and found it difficult to deal with negative thoughts. However, he felt well supported by other prisoners in the support and mentoring unit. He again said that he felt he was not getting support from the prison's mental health team, as he did not present as someone who was depressed.

51. On 29 September, a nurse saw Mr Edwards for a welfare check. She noted that he continued to work with RAPt, but was no longer receiving counselling. Mr Edwards had said he wanted to complete the computer-based cognitive behavioural therapy course. He did the first module of the course on 23 October, and finished after five sessions on 7 December. (She said that, on 6 October, she had added Mr Edwards to the primary mental health team's caseload because she had facilitated the computerised cognitive behavioural therapy course and did so after Mr Edwards had watched the introductory DVD about it.)

52. On 8 October, the RAPt key worker talked to Mr Edwards about accessing rehabilitation services when he was released. On 22 October, the key worker asked the prison's offender management unit (OMU) to send Mr Edwards the relevant forms about home detention curfew (HDC) so that probation staff could help him access community rehabilitation services before his release.

53. Mr Edwards had been told he would be eligible for release on HDC from 4 December 2015. However, on 5 November, when Mr Edwards returned the HDC application, staff concluded that, because of a previous offence many years before, Mr Edwards was not eligible for HDC release and would have to appeal if he wanted to be released sooner than 16 April 2016.

54. On 9 November, Mr Edwards told a SO at an offender management unit clinic that he had been told earlier that he was eligible for release on HDC. She noted that his prison record said that he was not eligible due to the nature of his earlier offence. She asked an officer from the probation team to look into this as she was experienced in HDC matters. The next day, the officer apologised to Mr Edwards for the confusion and explained why his HDC application was not eligible, but that he could appeal. She said Mr Edwards was intelligent and she was confident he understood the situation.

55. On 11 November, Mr Edwards had an application to attend rehabilitation services in the community after he was released, rejected because of the nature of his earlier offence. The RAPt key worker told Mr Edwards that another service had accepted him in principle and that he would make a formal application to that service in January 2016, a few months before his release.

56. On 12 November, after he had attended a computer-based cognitive behavioural therapy session, Mr Edwards told a nurse that his mood had been low for a week. He had said that he did not know what had triggered it, as he had felt that way before he had heard that his HDC application had been rejected. He said his medication was still not working and he would ask the GP whether he could increase it.

57. On 13 November, a GP reviewed Mr Edwards and noted that his mood often dipped and that he often thought about suicide, but had no current plans to act on these thoughts. He noted that Mr Edwards had been diagnosed with a personality disorder and was due to see the complex needs team in the community before his arrest. The GP gave him some suggestions to help deal with day-to-day problems, but noted that Mr Edwards was unsure how to deal with the dips in his mood, as he did not know what triggered them. The GP did not increase the dosage of Mr Edwards' antidepressants but advised him to continue with the cognitive behavioural therapy. He planned to write to community mental health services to tell them that Mr Edwards was due for release in April and told Mr Edwards he would monitor his mood and was happy to see him at any time.

58. On 7 December, Mr Edwards attended his last computer-based cognitive behavioural therapy session and told a nurse he had benefited from the sessions. They agreed she would check on his wellbeing in four weeks. She said he was upbeat and she would have noted in his record if he had said he had any

thoughts of suicide or self-harm. She made a diary note for 31 December to set a review date for Mr Edwards in January.

59. On 10 December, Mr Edward's cellmate went to court and did not come back to the prison, which meant that Mr Edwards was left alone in his cell. Another prisoner in the support and mentoring unit told the investigator that Mr Edwards had been in good spirits that evening. Another prisoner said Mr Edwards was laughing and joking with other prisoners. The investigator spoke to prisoners in the cells on either side of Mr Edwards' cell. None of them had heard anything during the night. The prisoners who shared one of the cells said that they had not noticed anything unusual about his behaviour when they had last seen him the previous evening.

60. An operational support grade (OSG) patrolled the unit on the night of 10 December. He arrived shortly before 9.00pm and no one raised any concerns about Mr Edwards with him during the handover with day staff. He carried out a check of all cells to establish that all prisoners were present.

11 December 2015

61. The OSG had no contact with Mr Edwards during the night. Around 5.00am, he did a morning roll check of all prisoners again. He told the investigator that he could not recall anything specific about Mr Edwards when he did the check, but he had had no concerns about any of the prisoners at the time.

62. At approximately 8.10am, an officer unlocked Mr Edwards' cell so he could go to work. She told the investigator that she could not recall whether she had seen Mr Edwards at the time, but thought it likely that she had not.

63. At around 8.15am, a prisoner said he had gone to speak to Mr Edwards' cellmate, as he did not know he had not come back from court the day before. He said the cell door was ajar and he could see the back of Mr Edwards, standing at the toilet in his underpants. He told the investigator that he did not know what Mr Edwards was doing behind the toilet door, but Mr Edwards had told him he was going to the toilet. He said he would see Mr Edwards later and then went back to his cell. He told the investigator he was confident that he had spoken to Mr Edwards at the time.

64. After she had unlocked the cells of the prisoners who were due to go to work, an officer helped other officers mark them off as they left the wing. As Mr Edwards did not appear, she went back to his cell to check him. She got to Mr Edwards' cell at 8.36am. She saw someone was in the toilet area and that the toilet door was ajar. She went into the cell and found Mr Edwards hanged from a nylon cord, tied around the top of the toilet door.

65. The officer left the cell and radioed an emergency medical code blue (which indicates situations such as when a prisoner is unconscious or not breathing). She shouted to another prisoner to press the general alarm and then went back into the cell. An officer who was close by noticed she looked very upset and followed her. He supported Mr Edwards' weight while she cut the cord and laid Mr Edwards on the floor. The officer said Mr Edwards was naked, his body felt

cold, and his skin appeared slightly mottled. He could not find a pulse and he immediately started cardiopulmonary resuscitation.

66. Other officers responded to the code blue and a nurse, who was in the unit at the time, brought emergency response equipment. He and an officer continued with cardiopulmonary resuscitation. The nurse attached a defibrillator, which found no shockable heart rhythm so they continued to try resuscitation. The nurse said Mr Edwards was cool to the touch, pale and his pupils had dilated.

67. At 8.39am, an OSG who was working in the control room called an ambulance when a custodial manager contacted her to check whether an ambulance had been called.

68. The ambulance arrived at Bullingdon at 8.57am. At 9.05am, the paramedics reached Mr Edwards's cell and took over emergency treatment. Mr Edwards could not be resuscitated and, at 9.30am, the senior paramedic recorded his death.

69. Mr Edwards had left a note in his cell, in which he said, "This is nice, quiet and comfortable; the perfect environment to commit an act always on my mind. You have given me the reasons and the opportunity to do this but you are not to be held accountable. No one is. The truth is I am obsessed with the idea of ending what I believe is a sickening pointless exercise".

70. The investigator spoke to a number of prisoners in the unit. They said Mr Edwards mixed with other prisoners and was well liked, but generally kept himself to himself. Some said he had a deep side. The investigator noted that Mr Edwards had a drawn a number of pictures with a theme of death, which were displayed in his cell. A prisoner on the wing said that the pictures had been there for a long time. He said that Mr Edwards often spoke about his daughter and his forthcoming release. Another prisoner described Mr Edwards as not being angry but deep, always analysing things, but not necessarily in a negative way. Both said that Mr Edwards' death had come as a shock.

71. Mr Edward's mentor in the previous weeks said that he never spoke about suicide. He described the pictures in Mr Edwards' cell, as dark and gothic. (One picture was of a series of images of a man hanged from a tree, with the words, "We are watching" and "You will fail".) He said that the pictures of crosses and skulls were not unusual in prison, but that Mr Edwards' were really dark. He said he did not talk to Mr Edwards about the pictures. After Mr Edwards' death, other pictures were found in his cell. One was of a noose with the words, "Insert Head Here", printed in the middle.

72. Mr Edwards' cellmate said that Mr Edwards had always supported him, especially during his first couple of weeks in prison. He told the investigator that he did not think "too much" of the pictures that Mr Edwards had on display, and that not all his pictures were like that.

Contact with Mr Edwards' family

73. Mr Edwards had named his brother as his next of kin. The prison's family liaison officer tried to get a family liaison officer from a prison to go to see Mr Edwards' brother and inform him of his death, but the prisons she contacted had no one

available. She therefore asked the police to inform him. The prison later contacted other members of his family and offered condolences and support. The prison's family liaison officer visited Mr Edwards' parents on 17 December. The prison offered to contribute to the cost of Mr Edwards' funeral in line with national policy.

Support for prisoners and staff

74. Managers debriefed the staff involved in the emergency response and offered support. Prisoners were notified of Mr Edwards' death and offered support if they needed it. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Edwards' death had affected them.

Post-mortem report

75. The post-mortem report gave the cause of death as hanging. Toxicology tests showed that Mr Edwards had no illicit substances in his bloodstream at the time he died. Therapeutic levels of sertraline were detected and paracetamol at above therapeutic levels.

Findings

Assessment of risk of suicide and self-harm

76. Mr Edwards did not kill himself until some months after he arrived at the prison. However, because of the high proportion of self-inflicted deaths in the early days of custody, we are concerned that no one identified Mr Edwards' risk of suicide when he first arrived at the prison. In a recent learning lessons bulletin about deaths in the early days and weeks in custody, we found that nearly a third of the self-inflicted deaths in prisons between April 2012 to March 2014, occurred in the first 30 days, and half of these were within the first week. The most common theme was that prison staff did not identify risk factors for suicide when prisoners first arrived.

77. 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 beginning ACCT procedures if necessary. Risk factors are listed in the PSI and in PSI 64/2011, which covers safer custody.

78. When Mr Edwards arrived at Bullingdon on 17 April, he had been discharged from hospital just the day before, after taking an overdose. He had a history of suicide attempts, mental health problems and alcohol problems. He had been charged with a violent offence against a close family member and this was his first time in prison. These are all individual risk factors for suicide or self-harm but collectively they should have indicated a significant risk. Prison staff have to weigh these risk factors against an individual's presentation when assessing their risk, but there is no evidence than this was done. The staff seemed to rely on Mr Edwards' statement that he had no thoughts of suicide or self-harm. We have identified inadequate reception risk assessments at Bullingdon in previous investigations. We make the following recommendation:

    The Governor should ensure that reception staff are aware of, consider and record all the known risk factors for suicide or self-harm when assessing newly arrived prisoners. They should open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.

79. Prison Service Instruction (PSI) 64/2011 says that all staff in contact with prisoners must be aware of the risk factors and triggers that might increase a prisoner's risk of suicide or self-harm, and take appropriate action. Mr Edwards was managed under ACCT suicide and self-harm prevention procedures for just three weeks at the end of May and the beginning of June, six months before his death. We have considered whether staff at Bullingdon should have recognised Mr Edwards as at risk of suicide and self-harm at the time of his death in December 2015.

80. As noted above, Mr Edwards had a number of risk factors for suicide and self-harm, including personality disorder, depression, and substance misuse issues. He told mental health nurses many times that he had had suicidal thoughts for many years. He said he intended to kill himself after he was released from prison. His bleak thoughts were reflected in his artwork, many of which had a theme of death. However, he constantly maintained that he had no plans to kill himself in prison. He received support from substance misuse workers and had counselling. While he was not under the care of the prison's mental health team (other than taking part in the cognitive behavioural therapy course), nurses checked on him regularly. In the six months before his death, none of the professionals who had regular contact with him considered he was at imminent risk of suicide.

81. In November, Mr Edwards said his mood was low, but the GP who reviewed him noted that this was not unusual. Mr Edwards completed his last cognitive behavioural therapy session on 7 December and said he had benefitted from the programme. Although there was some confusion about his eligibility for home detention curfew, this does not appear to have been the trigger for his actions and Mr Edwards said his mood had dropped before that. A nurse and prisoners who knew him said that his mood had improved and he appeared as usual in the days before his death. We accept that there was little to indicate that Mr Edwards was at imminent and heightened risk of suicide at the time of his death.

82. While it is apparent that Mr Edwards was always a long-term risk of suicide, ACCT procedures are designed to support and manage prisoners during short periods of crisis. We have some concerns about whether mental health services at Bullingdon, sufficiently meet the need of prisoners with personality disorders (see below) but we are satisfied, despite his underlying risk factors, that there was little reason for staff to consider beginning ACCT procedures in the weeks before his death. It is very difficult to prevent someone determined on suicide from carrying out that plan without making living conditions extremely restrictive. Had Mr Edwards been managed under ACCT procedures at the time of his death, it is unlikely that monitoring levels would have been sufficiently frequent to prevent his suicide, if he had planned it. We consider it would have been difficult for staff at Bullingdon to have predicted prevented his actions.

ACCT procedures

83. Although we do not consider that the management of ACCT suicide and self-harm prevention procedures in May and June 2015 was connected with Mr Edwards' death, we were concerned that none of the ACCT case reviews was multidisciplinary.

84. PSI 64/2011 says that ACCT case reviews should be multidisciplinary where possible, and it is a mandatory requirement that a member of healthcare staff should attend at least the first ACCT case review and the person who initially raised the concern. Other members of staff who will have contact with the prisoner and who can contribute to their support and care should also attend reviews.

85. This did not happen. There was no member of healthcare staff at the first case review or any other review and his counsellor, who had begun ACCT procedures,

was not involved. Neither was Mr Edwards' key worker from the substance misuse team. We make the following recommendation:

The Governor should ensure that all ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care. Healthcare staff should attend all first case reviews.

Mental health

Service provision

86. Bullingdon does not have a complex needs service for prisoners diagnosed with a personality disorder. Prisoners with personality disorders are not accepted on the caseload of either the primary mental health team or the mental health in-reach team, unless they have another mental health diagnosis, which would fit the eligibility criteria. However, the clinical reviewer noted that this need had been identified as a GP had referred Mr Edwards to the complex needs service in the community for after he was released. He therefore concluded that this aspect of Mr Edwards' care was not equivalent to what he could expect to receive in the community, as he was unable to benefit from such as service while he was in prison. We are concerned that despite his complex needs, Mr Edwards did not meet the criteria to receive care from mental health services in prison, although he would have been eligible for such support in the community. We also note (see below) that there was an apparent lack of capacity in the primary mental health team. We make the following recommendation:

NHS England – Thames Valley Area Team should ensure that mental health services commissioned for Bullingdon reflect the level of need, including for prisoners with personality disorders, and that prisoners have access to services equivalent to those available in the community.

Mental health referrals and assessments

87. Mr Edwards was referred to the mental health team at his first ACCT case review on 20 May 2015, after he had been identified as at risk of suicide and self-harm. We would expect such assessments for prisoners at risk to take place promptly but this did not happen. On 29 May, two nurses decided not to accept Mr Edwards on the mental health team's caseload without properly assessing him or seeing him and without considering the information in his ACCT record. Although one nurse had seen Mr Edwards for a welfare check, that was a month earlier before he had been assessed as at risk of suicide and self-harm and there had been a number of referrals from officers and nurse who were concerned about Mr Edwards. We consider that the decision not to accept Mr Edwards on the mental health team case load was not adequately informed, particularly in light of his risk of suicide, the multiple referrals, the increase in his antidepressants, his complaint of low mood and his request to see the mental health team.

88. A GP referred Mr Edwards to the mental health team again after he saw him on 20 July and Mr Edwards told him that he has still not seem anyone from the mental health team since being referred on 20 May. A nurse then did not see him until 29 July, in the prison laundry.

89. While the clinical reviewer concluded that this delay might have been understandable in the light of pressures on the mental health team and the nature of Mr Edwards' risk, there was then a further two-month gap before a nurse next saw Mr Edwards on 29 September. This was too long. The clinical reviewer was concerned that this might reflect a lack of capacity in the primary mental health team. We are concerned that mental health referrals, particularly for prisoners at risk of suicide and self-harm, need to be actioned quickly. We make the following recommendation:

The Head of Healthcare should ensure that prisoners referred to the mental health teams have timely, appropriate, face- to-face assessments in private and that referrals for prisoners at risk of suicide or self-harm are prioritised.

Computerised cognitive behavioural therapy programme

90. The clinical reviewer noted that the computerised cognitive behavioural therapy programme Mr Edwards attended, generated a progress report at the end of each session, which in the community, would be reviewed by a patient's GP. A suicidal score of three or more would prompt a GP in the community to review a patient in person. Mr Edwards' score at his fifth session was seven out of eight, which indicated he had serious thoughts about ending his life at the time. Although Mr Edwards' score improved in later sessions, a nurse was unaware of this peak as it was not routine to review the computerised cognitive behavioural therapy reports. The prison's primary mental health team accepted that this was a shortcoming and agreed to change its practice. We have therefore not made a recommendation.

Unlock procedures

91. The Prison Officer Entry Level Training (POELT) manual says that before unlocking a cell, staff should physically check the presence of the occupants. It says that staff must ensure that they receive a positive response from them by knocking on the door and waiting for a sign of acknowledgment. The manual says that if staff do not get a response, they may need to open the cell to check that the prisoner has not escaped, is not ill or dead. After a previous investigation into a death at the prison, the Governor issued a notice to staff in May 2015, reminding officers to check prisoners' welfare when locking and unlocking cells. It is evident that this is still not happening.

92. An officer said that when she unlocked Mr Edwards' cell at 8.10am, she could not recall whether she had seen Mr Edwards or got a response from him. She thought that she had probably not. A prisoner said that he spoke to Mr Edwards shortly afterwards, on the morning of 11 December.

93. Although the officer might not have checked Mr Edwards when she unlocked his cell, she went back to check him 25 minutes later, when he did not turn up to go to work and found him hanged. In light of the note Mr Edwards left in his cell and an officer's and nurse's description of how Mr Edwards looked when they responded to the emergency, we consider it is likely that he had hanged himself before the officer unlocked his cell. It appears that earlier intervention in this case would not have helped. Nevertheless, officers should always check a prisoner's welfare, as early intervention in an emergency can save lives. We

repeat our previous recommendation:

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Personal Officer Scheme

94. Officers made few entries about Mr Edwards' welfare in his case notes in his prison record. His personal officer made none. She told the investigator that she had introduced herself to Mr Edwards around mid-September but she did not record this. She said she had not been aware at the time that she was expected to make entries in his case history.

95. The investigator asked the officer about the drawings Mr Edwards had displayed in his cell. She said she had thought they were strange, but did not ask Mr Edwards about them or discuss this with other staff. Other officers would have seen the pictures during cell checks, but no one discussed them with Mr Edwards or anyone else. We are concerned that no one considered that they might be a potential indicator of Mr Edwards' risk.

96. In a previous investigation into the death of a man at Bullingdon in May 2015, we found very few personal officer entries in case notes. Although we acknowledged the difficulties for staff in a busy, local prison, such as Bullingdon, this is still a concern. We note that at the inspection of Bullingdon in June 2015, inspectors found few personal officer entries in prisoners' records. We repeat our previous recommendation which the prison accepted on 31 March 2016 and said they had implemented:

The Governor should ensure that officers have meaningful contact with every prisoner through an effective personal officer scheme, which allows officers to get to know prisoners, identify their needs and make regular case history notes.

Emergency code

97. PSI 03/2013 on Medical Emergency Response Codes says that a code blue (or equivalent) emergency code must be used in a medical emergency such as when a prisoner is unconscious or not breathing. It says that when a medical emergency code is called, the control room must call an ambulance immediately and should not wait for healthcare staff or a duty manager to make that decision. The PSI makes it clear that ambulances can be cancelled if it is later found that they are not needed.

98. The officer was in a state of shock when she found Mr Edwards hanged. Although she did not cut the ligature at once, she called an emergency code blue immediately. An officer who was nearby was there very quickly and both officers cut Mr Edwards down. However, we are concerned that the control room operator did not call an ambulance automatically when she received the code blue call, but waited until a custodial manager called her. While in this case, there was a delay of only three minutes, and it would not have altered the outcome for Mr Edwards, in other emergencies, any delay could be critical. We

make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately a medical emergency code is received, without waiting for further confirmation.

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