Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Towers a prisoner at HMP Bedford on 2 September 2017

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.

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

Mr Michael Towers was found hanged in his cell in the segregation unit at HMP Bedford on 2 September 2017. He was 31 years old. We offer our condolences to Mr Towers' family and friends.

Mr Towers had emotionally unstable personality disorder and was difficult to manage because of his violent and threatening behaviour towards others. As a result, he had been segregated for nearly two months when he died. Although we found some failings in the management of some aspects of his time in segregation, we are satisfied that staff appropriately attempted to reintegrate Mr Towers to a standard wing, and that he received appropriate mental health support during his time at Bedford.

Mr Towers had been very anxious about his upcoming release from prison. It is unfortunate that his community probation officer had not met Mr Towers, assessed him or referred him to support services in the community. This may have helped alleviate some of Mr Towers' anxiety.

Mr Towers was clearly a very challenging prisoner to manage. Staff at Bedford knew him well and there is little to suggest that he gave any particular indications of being at risk of suicide on 2 September. We believe that, in the circumstances, staff could not have been expected to predict or prevent Mr Tower's 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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **May 2018**

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Summary

Events

1. Mr Michael Towers was arrested on 30 August 2015. He had a history of attempted suicide and self-harm and was diagnosed with emotionally unstable personality disorder. He was remanded into custody and taken to HMP Bedford on 1 September. Staff started suicide and self-harm monitoring procedures, known as ACCT. He was prescribed quetiapine (an antipsychotic) and venlaflaxine (an antidepressant), was assessed by a psychiatrist and had regular sessions with a mental health nurse.

2. Mr Towers' behaviour was unpredictable and volatile. Sometimes staff assessed him as being a risk to himself and at other times as a risk to others. He threatened and assaulted staff and prisoners and damaged prison property. As a result, he spent periods of up to 12 days in segregation. In March 2016, Mr Towers was convicted. He also stopped taking his medication. In May, he was prescribed quetiapine for two weeks to assist with his emotional regulation.

3. In January 2017, Mr Towers was sentenced to four and a half years imprisonment. He regularly met with a mental health nurse and was assessed by a psychiatrist and psychologist on more than one occasion. Mr Towers was last managed under ACCT procedures in June 2017.

4. On 7 July, Mr Towers was segregated due to his threatening and violent behaviour. He remained segregated until he died nearly two months later. Staff made numerous attempts to reintegrate him to a standard wing, but Mr Towers assaulted or threatened others and was therefore returned to the segregation unit. During this time, he continued to see the mental health nurse and was assessed by a clinical psychologist and psychiatrist who prescribed a two-week course of quetiapine on 3 August.

5. On 2 September, officers said that Mr Towers appeared to have had a fairly good day and there was nothing out of the ordinary about his behaviour. Shortly before 9.00pm, during a routine roll check, prison staff found him hanged from the light fitting in his cell. They cut him down and began cardiopulmonary resuscitation (CPR). Due to a fault with the prison telephone line, there was a ten-minute delay in requesting an ambulance. Paramedics arrived and continued resuscitation attempts but pronounced Mr Towers dead at 9.30pm. A manager informed Mr Tower's mother that evening and the Governor held a debrief for some of the staff involved.

Findings

Assessment of risk of suicide and self-harm

6. Mr Towers was assessed as posing a risk to himself for periods of up to 16 days during his time in prison, most recently in June 2017. Nevertheless, all the staff we spoke to were shocked by Mr Towers' death. We are satisfied that there was nothing to suggest that staff could have predicted the risk Mr Towers presented to himself on 2 September.

Mental Health Care

7. Mr Towers had regular sessions with a mental health nurse and was assessed by a clinical psychologist and psychiatrist when his behaviour became more difficult. The clinical reviewer concludes that Mr Towers' mental health care was equitable to that which would have been provided in the community. We agree.

Prescription of quetiapine

8. During 2016-17, Mr Towers was prescribed quetiapine three times, each for periods of two weeks. This helped regulate his emotions during periods of crisis. We are concerned there is no robust system at Bedford for communicating when a prisoner refuses to take their medication, or for review when their prescription ends.

Emergency response

9. The member of staff who discovered Mr Towers was deeply shocked by what he saw and did not radio a code blue emergency. However, other staff responded quickly radioed the code. We are, therefore, satisfied that this did not result in a significant delay. Due to a faulty telephone there was, however, a delay of 10 minutes in calling the ambulance. Some prison staff did not know where the defibrillators were kept and nursing staff did not appear to lead in attempting to resuscitate Mr Towers in his cell.

Segregation

10. We are satisfied that Mr Towers was appropriately segregated and that efforts were made to reintegrate him to a standard wing. Staff clearly knew Mr Towers well but some of their work was not documented, and Mr Towers did not have a designated officer or a personal officer. Although there was a great deal of good practice evident in the segregation review boards, healthcare staff were not always present and commented that they were not given much notice to attend. Targets set for Mr Towers were often not very specific or meaningful, and a joint management plan between healthcare and prison staff would have assisted this. We also found that the authorisation of segregation over 42 days was four days late and only occurred after the IMB had commented that it was outstanding.

Community Probation Support

11. Mr Towers was anxious about his release. This was most likely exacerbated by having no contact with his community offender manager who also did not assess his needs in line with the National Probation Service's national standards.

Staff Support

12. Not all staff were able to attend the debrief after Mr Towers' death or felt they had been appropriately supported.

Recommendations

- The Head of Healthcare should ensure that appropriate systems are in place to review short term prescriptions of medication for mental health issues.
- The Governor should ensure that as part of contingency planning, telephone lines are regularly checked, with particular attention to those in the control room used to call the emergency services.
- The Governor and Head of Healthcare should ensure that the locations of defibrillators are clearly labelled and all staff are made aware of their location.
- The Head of Healthcare should ensure that medical staff take the lead in conducting CPR.
- The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:
    - prisoners have a designated officer who makes three quality entries on a daily history sheet;
    - the frequency of prisoners' observations are agreed by the person authorising segregation and clearly communicated to staff;
    - all segregation review board decisions are documented on the appropriate form and paperwork is retained;
    - healthcare staff are given sufficient notice to attend segregation review boards;
    - prisoners are set realistic, specific and timebound targets at segregation review boards;
    - prisoners who have been segregated for longer than 30 days have mental health care plans; and
    - appropriate authorisation is sought for prisoners being segregated beyond 42 days.

- The Head of the Local Delivery Unit for National Probation Service, South East and Eastern, Bedfordshire cluster, should ensure that OASys and initial sentence plans are completed for all prisoners within 16 weeks of sentencing, and community offender managers respond to communications from custody offender supervisors.

- The Governor should ensure that after a potentially traumatic incident or death all staff are appropriately supported.

The Investigation Process

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

14. The investigator visited HMP Bedford on 11 September 2017. She obtained copies of relevant extracts from Mr Towers' prison and medical records.

15. The investigator interviewed 13 members of staff and two prisoners at HMP Bedford in September, October and November.

16. NHS England commissioned a clinical reviewer to review Mr Towers' clinical care at the prison. She also attended the interviews with clinical staff.

17. We informed HM Coroner for Bedfordshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Towers' mother, to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. She asked:

    - was Mr Towers prescribed any medication?
    - was Mr Towers subject to suicide and self-harm prevention procedures?
    - why had prison staff not explained more about Mr Towers' death or come into her house when they broke the news?

19. Mr Towers' mother received a copy of the initial report. She did not make any comments.

20. HM Prison and Probation Service (HMPPS) also received a copy of the report. They accepted all the recommendations.

Background Information

HMP Bedford

21. HMP Bedford is a local prison holding 487 men. Northampton Healthcare Foundation Trust provides physical and mental health services at Bedford along with integrated drug treatment services. Psychiatrists work at the prison on Tuesday and Thursday mornings.

HM Inspectorate of Prisons

22. The most recent inspection of Bedford was conducted in May 2016. Inspectors found that staff did not manage ACCT procedures well, with poor assessments, insufficient and incomplete care plans, inconsistent case management at reviews, poor attendance by appropriate specialists at reviews and only observational contact rather than interaction between staff and prisoners. Inspectors found that the integrated mental health team provided a reasonably good level of secondary mental health care, although the range of treatment for primary mental health was limited and needed further development.

23. Inspectors also found that the use of segregation had reduced but was still higher than at other prisons. They commented that few prisoners were held in segregation for long periods and the introduction of exit planning and compacts for prisoners staying longer in segregation was showing promising results. Relationships between staff and prisoners were good, segregation reviews were timely and attended by a multidisciplinary team. They found that prisoners subject to suicide prevention measures were rarely located on the unit and good mental health support was provided for those who needed it in segregation.

Independent Monitoring Board

24. 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 June 2017, the IMB reported that staff shortages had made it difficult to run an effective regime and had contributed to a riot in November 2016. As a result, the prison had significantly reduced its capacity, and the care of prisoners had improved. However, the IMB remained concerned about the level of care that would be provided once Bedford was back to full capacity.

25. The IMB had concerns about suicide and self-harm prevention procedures and the way in which mental health services were provided, although they recognised that these were improving. Overall, they concluded that the segregation unit functioned well and segregation reviews were well conducted. They were concerned about the lack of an effective personal officer scheme.

Previous deaths at HMP Bedford

26. Mr Towers was the ninth prisoner to take his life at Bedford since 2013. In three of our investigations, we made recommendations to improve the prison's emergency response. One of these investigations also identified failings in the

support offered to staff after a death and, as Mr Towers' case shows, this continues to be an issue.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made 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. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Segregation Units

28. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air.

29. At Bedford the segregation unit is called the support and separation unit (SSU). It can accommodate up to nine prisoners and is split into two sections. One section is called the progression unit and is for those prisoners who are trying to reintegrate back to a normal wing. This is where Mr Towers lived when he was segregated.

Key Events

30. Police arrested Mr Michael Towers on 30 August 2015 for a number of offences, including burglary and theft. He had previously been released from prison at the end of June and told police he had tried to hang himself a year earlier but did not feel suicidal at present. On 1 September, Mr Towers was remanded into custody and taken to HMP Bedford. His person escort record (PER) noted that he had tried to hang himself in 2009 and 2010 and had cut his arms in 2005 and 2013. He also had post-traumatic stress disorder (PTSD – an anxiety disorder caused by very stressful, frightening or distressing events) and emotionally unstable personality disorder (EUPD – characterised by experiencing strong emotions which a person finds it difficult to cope with).

31. A nurse assessed Mr Towers on his arrival at Bedford. He said he had no thoughts of suicide or self-harm. He was prescribed medication for alcohol withdrawal symptoms as well as quetiapine (an antipsychotic) and venlafaxine (an antidepressant) which he had been prescribed in the community. Staff started suicide and self-harm monitoring procedures, known as ACCT. Over the next few days, Mr Towers was reviewed by mental health staff and substance misuse services because he said he had been using cannabis, crack cocaine and heroin in the community.

32. On 12 October, staff closed Mr Towers' ACCT as they no longer considered he posed a risk to himself. Mr Towers had regular sessions with a community psychiatric nurse (CPN). His behaviour was erratic, ranging from abusive and threatening to being down and withdrawn. On 26 October, a psychiatrist assessed Mr Towers. Mr Towers said his moods had been very changeable since coming into prison but he now felt better and more stable. The psychiatrist advised him to continue taking his medication and discharged him from his care.

2016

33. On 9 March 2016, Mr Towers was convicted at court. Sentencing was adjourned. On 15 March, Mr Towers said he no longer wanted to take any medication. Between 18 April and 26 April and 28 to 29 April, Mr Towers was segregated due to his threatening and violent behaviour towards staff and prisoners. On 7 May, staff began ACCT procedures. On 10 May, Mr Towers was aggressive towards staff. A prison GP prescribed Mr Towers quetiapine. The next day the psychiatrist assessed Mr Towers and concluded that he had no severe mental illness but had anger management and impulse control issues related to his personality. The psychiatrist indicated that Mr Towers' prescription of quetiapine should be restricted to two weeks to help reduce Mr Towers' aggression in the short-term. On 17 May, staff closed the ACCT.

34. On 7 June staff began ACCT procedures again. Due to his threatening behaviour, Mr Towers was segregated between 11 and 15 June. On 1 July, Mr Towers was transferred to HMP Thameside after being involved in a disturbance with a number of other prisoners at Bedford. On 16 July, staff closed Mr Towers' ACCT. During his time at Thameside, Mr Towers remained difficult to manage and was segregated for short periods. He set fire to his cell, threatened staff, took his cellmate hostage and was thought to be involved in drug distribution.

2017

35. On 2 January 2017, staff opened an ACCT as Mr Towers had attached a ligature to the light fitting in his cell. He said he was hearing voices, felt hopeless and wanted to die. On 11 January, officers noted that they were concerned that Mr Towers' mental health was deteriorating and he was hearing voices telling him to hurt others. They referred Mr Towers for a mental health assessment.

36. On 13 January, Mr Towers was sentenced to four and a half years in custody, with a conditional release date of 29 November that year. He went straight from court to Bedford, where he told staff he had no current thoughts of suicide or self-harm. He remained subject to suicide and self-harm prevention procedures until 18 January. Mental health nurses assessed Mr Towers and added him to the waiting list for a personality disorder group, which had not yet started.

37. Over the following months, Mr Towers was involved in fights with other prisoners, smashed his cell and was suspected of taking psychoactive substances. From March, a CPN met with Mr Towers on a regular basis. She noted that he was very angry and said he might hurt someone. As the personality disorder group had not yet started, she recorded that she would book him in for personality disorder education with herself. On 26 April, Mr Towers threatened to assault another prisoner and smashed items in his cell.

38. When the CPN saw Mr Towers on 28 April, he was aggressive, said he was hearing voices and, because he had stopped self-harming, felt he needed to kill someone. He asked for medication and asked why it had been stopped. She noted that she would meet with Mr Towers the following week, booked him an appointment with the psychiatrist, gave him a relaxation pack and completed a security form about Mr Towers' threat to kill someone.

39. On 5 May, the CPN met Mr Towers, along with the mental health team manager. From this point on, the mental health team always met with Mr Towers in pairs due to his volatile behaviour. Mr Towers spoke about his frustration about being in prison and his racing, intrusive thoughts. The CPN explained to Mr Towers that he was due to meet with a psychiatrist later that week and they could review his medication then. On 9 May, Mr Towers smashed items in his cell, headbutted a window and was segregated.

40. A probation officer was due to meet Mr Towers that afternoon. She had recently been allocated Mr Towers to her caseload from a colleague who had left the prison. She had not been given any handover and she did not know whether Mr Towers had had any previous contact with the probation service during this sentence. Due to Mr Towers' behaviour that morning, staff did not want to unlock Mr Towers, so his appointment with her was cancelled.

41. On 11 May, the psychiatrist assessed Mr Towers. Mr Towers said he understood he had personality difficulties and was feeling stressed. He noted that Mr Towers' symptoms were consistent with his diagnosis of EUPD. He prescribed quetiapine for two weeks and requested the CPN should review Mr Towers. Later that day, Mr Towers' behaviour became volatile. He asked for razor blades and to see a Listener (a prisoner trained by the Samaritans). He made a ligature and banged his head on the door. Staff opened an ACCT.

42. The next day, Mr Towers moved to D wing. On 13 May, Mr Towers climbed onto the beams of the landing. On 16 May, the CPN and the mental health team manager met with Mr Towers. He said he found it difficult being locked up for long periods and agreed to be assessed by a clinical psychologist. He said he felt sedated by taking quetiapine and had fleeting thoughts of self-harm. On 18 May, the CPN noted that due to his high level of impulsivity and thoughts of suicide and self-harm, Mr Towers represented a high risk of accidental suicide. He declined psychological support in relation to his personality disorder.

43. On 25 May, the psychiatrist reviewed Mr Towers. He said he was feeling much better although he thought his medication slowed him down. The psychiatrist noted that Mr Towers' prescription had finished anyway. He asked the CPN to discuss Mr Towers with the clinical psychologist to see if she could suggest any alternative ways of managing his volatile behaviour. The next day, Mr Towers assaulted an officer. Staff assessed he was no longer a risk of suicide and self-harm and closed his ACCT.

44. Over the next few days, Mr Towers threatened and assaulted staff. Following more disruptive behaviour, Mr Towers was segregated on 2 June. Staff also started new ACCT procedures as they were concerned that moving Mr Towers might increase his risk to himself and he was still in the post-closure period of the previous ACCT. On 7 June, a clinical psychologist met Mr Towers for the first time and began assessing him. The same day, staff closed Mr Towers' ACCT as they assessed he was not a risk to himself. He remained segregated until 12 June when he was relocated to B wing.

45. On 13 June, the probation officer met with Mr Towers. She noted that he had good insight into his behaviour and seemed motivated to change. Mr Towers was keen to discuss his release in around six months' time. They discussed accommodation and the possibility of Mr Towers having a mentor in the community. She also emailed Mr Towers' community probation officer. She said that the community probation officer had not completed Mr Towers' initial OASys (Offender Assessment System), meaning that the information she had about him was limited.

46. On 22 June, the clinical psychologist assessed Mr Towers for a second time. She did not have any concerns about his risk to himself and said he seemed calmer than at their first meeting. On 27 June, Mr Towers tried to assault an officer with a pool cue. The next day, he behaved erratically during education, kicking the door, throwing a stapler and threatening to punch someone. On 1 July, he threatened to kill an officer and assaulted another prisoner. Following further threats to staff and smashing items in his cell, staff segregated Mr Towers on 7 July under rule 45, in the name of good order or discipline (known as 'GOOD').

47. At an officer's request, the CPN saw Mr Towers that afternoon and spoke to him through the observation panel as there were insufficient officers to unlock him. He described his behaviour as a "blip" and did not wish to discuss it further. Mr Towers said he felt alright but was rather bored. The nurse said she would get him a distraction pack (involving activities to keep a prisoner occupied). He agreed to a psychiatric review.

48. Staff held a segregation review board, or GOOD review, on 10 July to decide where Mr Towers was best located. The Head of Safer Custody and Equalities, the CPN and an officer were present and Mr Towers said he was happy to remain in the SSU for a few more days before being moved back to a standard wing.

49. On 13 July, the clinical psychologist shared her report with Mr Towers. She did not assess Mr Towers as having a mental health issue but considered he was anxious about being released from prison and lacked the skills needed to live independently. She recommended that staff should assist Mr Towers' resettlement into the community. He was frustrated that he had not been supported well before. Mr Towers told her that he harmed himself or others as a way of regulating his own emotions. He said he did not want to take medication as he did not like the side effects. She also recommended that Mr Towers received psychological support to help him manage his racing thoughts, emotions and thoughts of suicide and self-harm (although he did not say he had any at the time). She noted that Mr Towers should continue to be supported by the mental health team and agreed that she would offer him psychological sessions from the end of August. She also noted that a psychiatrist should review him.

50. A GOOD review on 13 July noted that staff would attempt to reintegrate Mr Towers back to a standard wing from 17 July. On 14 July, Mr Towers told the CPN that he would prefer to remain in the SSU. He said he had no thoughts of suicide or self-harm. On 17 July, Mr Towers threatened a prison GP. During a GOOD review, staff and Mr Towers discussed a reintegration plan to move him back to a standard wing. They decided that he would participate in association on C wing that day and the next, with a view to transferring there if it went well.

51. On 18 July, the CPN completed a mental health care plan for Mr Towers. This noted that Mr Towers would be supported by the mental health team, complete psycho-educational work with them, be assessed by the psychiatrist as required and engage in meaningful activities during the day to keep him distracted. She told the investigator that during this time she tried to complete problem-solving and decision-making work with Mr Towers but he was often reluctant, saying he had already covered it all. She said he was very changeable from one appointment to the next and he became increasingly anxious about his forthcoming release at the end of 2017. She also said he seemed to get increasingly frustrated about being in prison.

52. On 20 July, during a GOOD review, Mr Towers said he did not want to move to C wing until 24 July but was happy to continue to go for association there. He said if prisoners made him angry or "wound him up", he would harm them. Mr Towers refused to sign the reintegration plan which set out the behaviour expected of him on C wing, including taking responsibility for his actions and refraining from violence. Over the next few days he was volatile and, at times, agitated and aggressive.

53. On 25 July, Mr Towers signed the reintegration plan. Staff agreed with Mr Towers that he would gradually reintegrate to C wing, spending an hour a day there at first and gradually increasing this until he was spending all day on C

wing and the night in the SSU. On 27 July, an officer asked the probation officer if she would see Mr Towers, as they were concerned about his behaviour. She did so and Mr Towers told her that he did not have his property and was annoyed about this. He said he also did not know who his probation officer was in the community.

54. Having had some association periods on C wing, on 28 July, Mr Towers told the CPN that he felt "all right" about moving there and said he had no mental health concerns at present. On 29 July, Mr Towers moved to C wing. Within a short time, he assaulted an officer and refused to return to the SSU. Staff restrained Mr Towers and escorted him back to SSU.

55. On 31 July, during a GOOD review, the Head of Safer Custody and Equalities discussed Mr Towers' reintegration with him, indicating that they needed to start this process again. Mr Towers said he was anxious about his release and staff assured him that they would do all they could to support him. Staff considered that the most recent assaults committed by Mr Towers may have been a deliberate attempt to get days added onto his sentence due to his anxiety about release. She emailed staff in the offender management unit and the Head of Reducing Reoffending about Mr Towers' concerns. Those present were also keen to ensure that Mr Towers' continued segregation was not adversely affecting his mental health. After discussion with the CPN, they agreed that the psychiatrist would review Mr Towers on 3 August to ensure this was not the case.

56. On 1 August, the probation officer spoke to an officer on B wing about Mr Towers' property. She was told she should check with D wing staff which she did by email. She did not receive a reply. She spoke to Mr Towers on 2 August. He said he only wanted to move to D wing as the cells were newer and nicer. On 3 August, the psychiatrist assessed Mr Towers through his observation panel as there were no officers available to unlock him. Mr Towers said that he had been "doing fine" and was "happy in himself". Mr Towers became upset when talking about his release and said he had been struggling to control his anger. He agreed to take quetiapine for two weeks. The psychiatrist noted that the CPN would follow this up and that Mr Towers should also be reviewed in two weeks. He was not specific about who would do this.

57. The clinical psychologist also spoke to Mr Towers though his observation panel that afternoon. He said he would be willing to start emotional management sessions at the end of August. The psychologist said she wanted to wait until then to see if the medication Mr Towers had been prescribed was helpful, if his mood had stabilised and if he was back on a standard wing.

58. Mr Towers took his quetiapine that afternoon. He was prescribed the medication until 16 August. On 4 August, Mr Towers told the CPN that he felt sedated by the medication but thought it would help him. They discussed his need to improve his behaviour and cooperate with staff if he wanted to return to a standard wing. Mr Towers said he had no thoughts of suicide or self-harm. On 7 August, Mr Towers threatened a manager and staff decided he was not ready to return to a standard wing. On 9 August, after mistakenly being allowed a period of association, he assaulted another prisoner.

59. On 11 August, the CPN met with Mr Towers. They discussed his behaviour and how he would reintegrate to a standard wing. Mr Towers said that he had punched a prisoner on C wing as he thought he was talking about him. He said that as he had spent a lot of time in the SSU, when he went to a standard wing he became anxious. He thought quetiapine was making him drowsy and he did not like taking it as he feared becoming addicted and building an increased tolerance. He said he had no thoughts of suicide or self-harm. Mr Towers had been taking the quetiapine as prescribed, but refused doses on the morning of 6 August, the morning of 9 August, both doses on 10 August and all doses between 13 and 16 August. There is no note of a pharmacist informing the CPN that he had refused this medication. The mental health team leader said she would have expected this to occur.

60. On 14 August, during a GOOD review, staff and Mr Towers agreed that he would reintegrate to D wing gradually – overnight at first, then for association periods and then move there completely. A pharmacist spoke to the CPN, who confirmed that Mr Towers' quetiapine did not need to be re-prescribed and the mental health team would review Mr Towers as required. On 15 August, Mr Towers telephoned his mother. The investigator listened to the last month of Mr Towers' telephone calls. He told his mother he had had a misunderstanding with someone and was back in "the block". He told her that "I would rather be dead than back in the block" and had started taking his medication again. He said he wanted to get out of prison and move forward but was anxious about his release.

61. On 16 August, staff noted that they were waiting for an appropriate cell for Mr Towers to relocate to D wing. On 18 August, Mr Towers rang his mother. They spoke about her potentially visiting him and about his release. The CPN also reviewed him and Mr Towers said he was frustrated and bored in the SSU but understood that he was waiting for an appropriate cell on D wing. He told her that he felt "okay" without taking quetiapine.

62. On 21 August, during a GOOD review, staff informed Mr Towers that he would not be able to move to D wing as a prisoner who he had previously assaulted was located there. Mr Towers said he did not want to go to any other wing in the prison and wanted to be transferred to another prison. Staff did not think this would assist Mr Towers in controlling his behaviour and planned to reintegrate him elsewhere in the prison. If this took too long, they noted that transferring Mr Towers to another prison would be considered. Mr Towers asked to start stronger medication. The mental health team manager, who was present at the review, agreed to discuss the prescription of quetiapine with the psychiatrist. She told the investigator that she thought she had discussed this with the CPN after the review although this is not documented in Mr Towers' medical record. She said it would then be up to the CPN whether she thought Mr Towers needed to be reviewed by the psychiatrist.

63. An IMB rota report noted concern that there was no effective plan to move Mr Towers out of the SSU. They were concerned about Mr Towers' mental health which they considered was deteriorating. The IMB also noted that the Deputy Director of Custody had not authorised the segregation of Mr Towers beyond 42 days, in line with national instructions. The Head of Safer Custody and Equalities completed this request for authorisation later that day, noting that staff at Bedford

were still trying to reintegrate Mr Towers to a standard wing but if this was not successful they would consider transferring him to another prison. The Operations Manager for the region authorised Mr Towers' continued segregation. He noted that it would be preferable to reintegrate Mr Towers to another wing at Bedford.

64. The probation officer was also due to meet Mr Towers that day. This meeting did not go ahead, but she did not know why this was the case. She rearranged the appointment for 23 August but Mr Towers refused to attend on that day. She wanted to find out how Mr Towers was feeling and discuss his release. On 25 August, the managing chaplain noted that he had been visiting Mr Towers regularly in the SSU. He was concerned that Mr Tower's mental health was deteriorating and he was struggling to manage his anger.

65. The assistant psychologist and the CPN reviewed Mr Towers. He said he was frustrated at remaining in the SSU and had thought he was going to move to D wing. He said he was having difficulty sleeping but did not want any medication. After Mr Towers left the assessment, they noted that they would review his reintegration plan with safer custody staff. The psychologist assessed his behaviour was due to anxiety rather than paranoia.

66. On 28 August, Mr Towers told a manager that he was sleeping better and was exercising but was frustrated about having no association. They discussed his risk to others and considered other alternatives such as Mr Towers choosing a friend to spend some time exercising with. However, he did not identify anyone.

67. On 29 August, the Head of Reducing Reoffending spoke to Mr Towers, noting that he was in a better mood than the previous week. They discussed why he was not allowed access to the gym because of his random assaults on other prisoners and confirmed that he had a gym ball in his cell to assist with exercise.

68. Mr Towers' mother said that she spoke to him during the morning of 29 August. There is no record of this on his PIN phone record. Nor did the call take place from the SSU office telephone. She said that Mr Towers was a little down at the start of the call but by the end his mood had improved and he was looking forward to being released.

69. On 30 August, staff discussed Mr Towers at the weekly complex needs meeting. This is attended by most departments in the prison, including safer custody, healthcare, substance misuse, mental health and security. Those present agreed that someone from the substance misuse team should speak to Mr Towers to see if he wanted their support and to ensure his volatile behaviour was not due to substance misuse. A support and wellbeing practitioner in the substance misuse team arranged to attend his GOOD review the following day.

70. The CPN saw Mr Towers when passing through the SSU. He said he was fed up with being in prison, and particularly the SSU, and wanted to transfer to another prison. He said he was keeping busy in his cell and declined a distraction pack. They discussed Mr Towers writing a list of goals he wanted to achieve when he was released. Mr Towers said he had no thoughts of suicide and self-harm.

71. On 31 August, the IMB Vice Chair spoke to the Head of Interventions about his concerns about Mr Towers' mental health. He was due to chair Mr Tower's GOOD review later that day. The Head of Interventions advised him to speak to the mental health team manager, which he did. The manager assured the IMB Vice Chair that Mr Towers had been seen regularly by the mental health team and had also been assessed by a psychologist and psychiatrist. The IMB Vice Chair later wrote an email at 1.54pm, to the IMB Chair and Governor regarding his concerns about Mr Towers, his treatment and diagnosis.

72. Later that afternoon, the Head of Interventions chaired a GOOD review. The support and wellbeing practitioner introduced herself and offered the support of the substance misuse team. Mr Towers said he had no issues and therefore declined this intervention. She told Mr Towers she would return to see him on an individual basis in a week's time, in case he changed his mind. Mr Towers became increasingly angry during the course of the review, said that no one was helping him and refused to answer questions. He said that if he could not move within the prison he would like to transfer to another prison. He would not acknowledge that the reason he was still in the SSU was due to his own behaviour since being segregated. Mr Towers became aggressive and threatening to the Head of Interventions, demanding to be transferred to another prison or else he would assault people. The Head terminated the review.

73. Later that day, the clinical psychologist spoke to Mr Towers through his observation panel to see if he was ready to start psychology sessions. Officers had been unwilling to unlock his door due to Mr Towers' behaviour in his GOOD review. She agreed she would attend the next GOOD review on 7 September. She planned to assess him individually afterwards to see if he was ready for psychological intervention. The psychologist had no concern that he presented a risk of harm to himself and Mr Towers said he would see her the following week.

74. On 1 September, Mr Towers spoke to two chaplaincy staff. He said he was feeling okay and they discussed his recent behaviour. Officer A worked in the SSU on a regular basis. He told the police that the only difference in Mr Towers' recent behaviour was that he had been tidying his cell more recently and burning rubbish in his toilet.

2 September

75. On 2 September, Officer A said that Mr Towers seemed to have a "fairly good" day. He said Mr Towers had extra servings at each meal which usually implied he was having a better day. The officer spoke to him around ten times throughout the day. They discussed a film that Mr Towers liked and the only thing the officer considered unusual was that Mr Towers asked what date he had come to prison. The Head of Reducing Reoffending checked on Mr Towers around 2.00pm. He raised no issues with her.

76. Shortly before Officer A finished his shift at 5.20pm, Mr Towers asked for some extra coffee which he gave him. He had no concerns that Mr Towers presented a risk to himself.

77. Officer B was also working in the segregation unit on 2 September. He said that Mr Towers was his usual self throughout the day. After lunch, he had a shower,

took exercise and joked with him and Officer A about the football score. Around 5.45pm, as Officer B was leaving the SSU, Mr Towers asked him if there was a newspaper available. He replied that there was not as the library was shut on a Saturday. Mr Towers thanked him. This was the last interaction that Mr Towers had with staff.

78. A daily sheet is completed in the SSU which indicates what applications a prisoner has made that day, what their meal choices are and has a space to sign that their hourly monitoring has been completed, 24 hours a day. The investigator received these documents for the last period Mr Towers spent in the SSU. The majority have been completely filled in although a number of daily sheets have monitoring sections missing for up to a few hours. On 2 September, the monitoring form was filled in on an hourly basis from 7.00am until 5.00pm. After this, no further observations were marked as completed.

79. Officer C started working in the SSU at 5.45pm that evening. He checked all the cell doors were locked and, in doing so, noticed that Mr Towers' television or radio was on. He was unaware that all segregated prisoners should be observed hourly and therefore did not complete Mr Towers' observations that evening.

80. At 8.51pm (according to the time on the CCTV), the Operational Support Grade (OSG) looked through Mr Towers' observation panel. He saw Mr Towers was suspended from the light fitting by bed sheets and a towel. He can be seen struggling with the radio on his belt. He shouted to Officer D that Mr Towers was hanging. About 30 seconds after the officer looked in, Officer C reached Mr Towers' cell, looked in and immediately unlocked the door. Officer D pressed the general alarm button which signifies an emergency and the control room confirmed to all staff via radio the location of the emergency.

81. Officer C went into Mr Towers' cell and cut him down, supporting his body and laying him down on the floor. He cut the ligature from Mr Towers' neck. Two other members of staff arrived. An officer radioed a code blue emergency. (This indicates a medical emergency in circumstances where a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.)

82. Officer D also radioed that urgent medical assistance was needed. Staff checked for signs of life and started chest compressions. He recalled that Mr Towers was pale and cold to the touch. Around three minutes after they had first unlocked the door, an officer arrived with a defibrillator. A custodial manager also arrived and radioed the control room staff to check that an ambulance had been called. The control room operator confirmed that he was trying to request an ambulance at that time. Officers went to the healthcare centre to collect the nurses, who did not have keys.

83. Six minutes after staff had unlocked Mr Towers' door, two nurses arrived and assisted with chest compressions. A nurse used an Ambu-bag (a mask with a bag and valve attached) to administer oxygen to Mr Towers.

84. Officer C said that as soon as he heard the code blue, he tried to telephone an ambulance. However, when he dialled 999 on any of the telephones in the

control room, they all diverted to another telephone in the control room and rang there. He then tried to use the dedicated telephone for calling the police but they were unable to redirect his call to the ambulance service. The CM then advised him to get a mobile telephone from the main gate (about 20 metres from the control room) and telephone an ambulance with this. He did so.

85. Paramedics arrived at the prison gate at nearly three minutes into the 999 call, meaning the fault on the telephone lines had caused a ten minute delay in requesting an ambulance. The CM escorted the paramedics to Mr Towers' cell. 17 minutes after Officer D had first looked in the cell, paramedics arrived and took over Mr Towers' care. Mr Towers was pronounced dead at 9.30pm.

Contact with Mr Towers' family

86. At 9.35pm, the Head of Reducing Reoffending was appointed family liaison officer and came into the prison immediately. Having waited for a police escort (at the request of the police), she left the prison around 12.00am, arriving at Mr Towers' mother's address 30 minutes later. She informed Mr Towers' mother of her son's death, explaining that he had taken his own life and said he had used a ligature. Mr Towers' brother was angry and upset and left the house. She noted that Mr Towers' mother was sitting on the doorstep and did not want to go inside. She was then advised by the police to leave the property due to a potential risk to herself. She provided Mr Towers' mother with information and her contact number, and said she would be in contact the next day.

87. The family liaison officer stayed in contact with Mr Towers' mother over the next few days and offered a contribution to Mr Towers' funeral expenses in line with prison service instructions. She arranged for Mr Towers' family to visit the prison and his cell, on 8 September.

Support for prisoners and staff

88. After Mr Towers' death, a governor debriefed some of the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

89. Officer D and the emergency response nurses were unable to attend the debrief that evening as they had to continue working in their respective locations. Staff also reported a mixed experience of the support they were subsequently offered. Some felt they had been adequately supported, while others, such as the emergency response nurses, the CPN and Officer D said that they would have liked more consideration to be given to the support they had been offered in the days after Mr Towers' death. The probation officer also said that her manager had not checked on her welfare, although she had felt well supported by colleagues.

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

Post-mortem report

91. The post-mortem report indicated the cause of death as hanging. There were no drugs detected in Mr Towers' system.

Findings

Assessment of risk of suicide and self-harm

92. Mr Towers had been assessed as a risk of suicide and self-harm for short periods during his time in custody, most recently in June 2017. Since that time, he had consistently said he had no thoughts of suicide or self-harm. Mr Towers had been assessed by a psychologist, a psychiatrist and a CPN on numerous occasions. No healthcare staff had any concerns that Mr Towers was a risk to himself or that his mental health was deteriorating due to being segregated. Both prison and healthcare staff said that they thought that Mr Towers was a risk to others or prison property, rather than a risk to himself. The clinical psychologist and psychiatrist both recognised that Mr Towers' behaviour had recently been more "agitated" and "hyper". They associated this type of behaviour as being a potential risk to others, rather than a risk to himself - when he was more commonly self-isolating, hopeless and low in mood. Staff were all shocked by his death.

93. Staff judgement is fundamental to suicide and self-harm prevention, which relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. There are recognised risk factors that raise the risk of suicide and self-harm which are set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*. Some of those relevant to Mr Towers were his history of self-harm and attempted suicide, his mental health issues and personality disorder diagnosis, his impulsiveness, segregation and recent contact with psychiatric services. However, we are satisfied that there was nothing to suggest that staff could have predicted the risk Mr Towers presented to himself on 2 September or prevented his death.

Clinical Care

94. The clinical reviewer concluded that overall the clinical care provided to Mr Towers was equivalent to that which would have been provided in the community. We agree with this view.

Mental Health Care

95. Mr Towers was assessed by the mental health team on numerous occasions, was under the care of a CPN after his return to Bedford in January 2017 and was assessed and reviewed by a psychiatrist and psychologist a number of times. He was consistently diagnosed with EUPD. The clinical reviewer comments that the usual treatment for EUPD is psychotherapy with the use of medication to treat any associated depression or anxiety or as a mood stabiliser. Therapeutic groups for those with personality disorder were planned at Bedford, but had not started. We agree with the clinical reviewer's recommendation that such a service should be introduced. In the meantime, the CPN was doing one-to-one work with Mr Towers.

96. The clinical reviewer concludes that:

> "Mr Towers was receiving individual psychosocial intervention work from the CPN with support from the clinical psychologist and overview from a

psychiatrist for diagnosis and medication prescribing as required. This approach is in line with the recommended support for people with personality disorder."

97. We are therefore satisfied that Mr Towers received an adequate level of mental health care.

Prescription of Quetiapine

98. Mr Towers was prescribed quetiapine, an antipsychotic, for the first few months he was at Bedford. He stopped taking it of his own accord. The psychiatrist next prescribed it at a low dosage for two weeks at a time in May 2016, May 2017 and on 3 August 2017. He said that quetiapine can be prescribed at a low dosage to assist with emotional regulation for prisoners with personality disorder. However, the medication becomes less effective, the longer a person takes it.

99. Mr Towers did not take the last four days of his prescription of quetiapine in August 2017. The psychiatrist was not informed of this, although he said it would not hugely concern him and Mr Towers was capable of making such decisions himself. Mr Towers had previously told the psychiatrist that he did not like taking the medication as it made him sleepy. He did not review Mr Towers again. He said it would be up to a member of the mental health team to book him an appointment if necessary. On 11 August, Mr Towers told the CPN that he did not like taking quetiapine but did not tell her he had been refusing it. A pharmacist contacted the CPN on 14 August to tell her that the prescription had finished. On 18 August, Mr Towers told the CPN that his medication had stopped and this was okay with him.

100. On 21 August, the mental health team manager had agreed to talk to the psychiatrist about the potential prescription of medication. She said she thought she spoke to the CPN about this. On 25 August, Mr Towers told the CPN he did not want any medication. It is likely that not taking the last four days of his medication made no difference for Mr Towers, nevertheless, we are concerned that there is not a robust system in place at Bedford to ensure those taking medication for mental health issues are formally reviewed and that any refusal to take medication is communicated and considered. We make the following recommendation:

The Head of Healthcare should ensure that appropriate systems are in place to review short term prescriptions of medication for mental health issues.

Emergency response

101. When Officer D discovered Mr Towers, he was deeply shocked. CCTV shows him attempting to use his radio but having difficulty doing so. He pressed the emergency alarm and other staff arrived very quickly and immediately entered Mr Towers' cell. One of these officers also radioed a code blue emergency. He was aware that he should have radioed an emergency code. In some situations, the failure to do so could make a difference to the outcome. We are, however, satisfied that this did not cause a significant delay in Mr Towers' case. Other

staff reacted calmly and competently, checking for signs of life before starting chest compressions.

102. In line with policy, Officer D tried to call an ambulance as soon as he heard the code blue. However, due to a telephone fault there was a delay of around ten minutes before the ambulance was called. Officer D reported the fault to the external contractor but was unsure whose responsibility it was to check that the fault had been repaired and that no further difficulties occurred. We therefore make the following recommendation:

The Governor should ensure that as part of contingency planning, telephone lines are regularly checked, with particular attention to those in the control room used to call the emergency services.

103. Several members of staff commented that there was not a defibrillator on every wing and their location was not clearly labelled. Some staff working in Bedford that evening had been deployed from other prisoners and were unsure where they were located. Around four minutes after the officer first discovered Mr Towers, staff arrived with a defibrillator. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the locations of defibrillators are clearly labelled and all staff are made aware of their location.

104. Once Mr Towers was discovered, prison staff commenced chest compressions immediately. Not all of these staff had been first aid trained. Once nurses arrived they did not appear to take the lead role in CPR. One officer said he did not think nurses had assisted with chest compressions. We therefore endorse the clinical reviewer's recommendation that:

The Head of Healthcare should ensure that the most senior clinician responding to emergency calls should take the lead role in overseeing basic life support.

Mr Towers' segregation

105. We published a learning lessons bulletin in June 2015 based on learning from self-inflicted deaths of prisoners in segregation. This concluded that it was crucial for staff working in segregation units to be fully aware of the instructions in the relevant Prison Service Instructions relating to segregation and safer custody. Prisoners must also be given the means to occupy themselves. We also found that staff should consider a prisoner's full history when assessing their ability to cope in segregation, not just their current demeanour. Finally, we noted that lengthy periods of segregation should be avoided if possible and when unavoidable regular review boards should be held to assess how well the prisoner is coping, plan their relocation and to develop a careplan to help prevent a deterioration in their mental health.

Reason for segregation

106. Mr Towers was segregated on a number of occasions for up to ten days. However, on the last occasion, he was segregated from 7 July until he died on 2 September - a significantly longer period of segregation. He had always been segregated under rule 45 (for the maintenance of Good Order or Discipline) as he threatened, or assaulted, staff and prisoners and damaged prison property.

107. Since Mr Towers' assaults and threats against others were seemingly carried out at random and Mr Towers himself was reluctant to give any reason for his actions, it is difficult to know what alternative arrangements, other than segregation, could be made for Mr Towers. We consider that the reasons for segregating Mr Towers were reasonable and complied with Prison Service Order (PSO) 1700, *Segregation,* which indicates that prisoners must only be segregated under rule 45 when: "*there are reasonable grounds for believing that the prisoner's behaviour is likely to be so disruptive or cause disruption that keeping the prisoner on ordinary location is unsafe*".

Management of the SSU

108. PSO 1700 indicates that prisoners in segregation must have a designated officer who records three quality entries daily on a segregation history sheet. This does not need to be the same person every day. Prisoners should also have a personal officer on the wing so that they do not solely become a management issue for the segregation unit. Prisoners should be encouraged to change their behaviour and this should be recorded. While it was clear from our discussions with staff that they had a lot of daily interactions with Mr Towers, these have not been recorded as the PSO instructs, nor did Mr Towers have a designated or personal officer.

109. In addition, the history sheet annexed to the PSO was not being used at Bedford. The document in use had no space for interactions to be recorded, nor was it possible to tell who had visited Mr Towers' each day. The Head of Safer Custody and Equalities said she expected staff to record this on a prisoner's computerised record although she acknowledged that this did not always occur. She said that the history sheet annexed to the PSO is now being used at Bedford and staff are expected to make three quality entries on the sheet.

110. At the time of Mr Towers' death, the policy at Bedford was for all prisoners in the SSU to be observed hourly. The Head of Safer Custody and Equalities' understanding was that this was instructed by the PSO. This is not the case, and practice at Bedford has since been amended to reflect the national instructions that all segregated prisoners are observed by an officer at a frequency which is individually assessed by the prisoner's needs and circumstances. This frequency is decided by the person authorising segregation. In these circumstances, we are not critical of Officer C, who had not been informed that Mr Towers should be observed hourly and therefore did not observe him during his evening shift. Given that this situation has now been addressed we make no recommendation.

111. The prison was unable to provide the investigator with the paperwork from the last two GOOD reviews. Although some details were recorded elsewhere in Mr Towers' notes, it is essential that these reviews are recorded appropriately and are available for staff to review when working with a prisoner, so that there is a clear plan and issues are documented.

112. Segregation review boards should consist of, among others, a chairperson, healthcare representative and segregation officer. In general, mental health staff did attend Mr Towers' GOOD reviews although there were at least two instances, on 21 July and 31 August, when they did not. The CPN and the mental health team manager told us that they always try to prioritise attendance at these reviews but they are often not given much notice of them occurring.

113. PSO 1700 instructs that the prisoner should be set targets at segregation reviews which demonstrate a willingness and ability to change their behaviour. We found that Mr Towers' targets were often not specific or timebound for example "engage with staff and regime, take medication as prescribed and continue to work with mental health team". We agree with the clinical reviewer's conclusion that a joint management plan between healthcare and prison staff may have assisted Mr Towers' reintegration to a standard wing. PSO 1700 also instructs that those in segregation for more than 30 days should be subject to care plans as to how to support their mental health. Staff were unaware of this requirement and although the CPN had completed a care plan on 18 July, this needed updating and sharing with the team on a wider basis.

114. The Deputy Director of Custody (now Prison Group Director) has to authorise prisoners' segregation beyond 42 days. In Mr Towers' case, this should have occurred on 17 August, but did not take place until 21 August when the prison completed the required documentation.

Progression from the SSU

115. During his last period of segregation, staff made several efforts to reintegrate Mr Towers back to a standard wing. When allowed onto other wings, he assaulted or threatened prisoners and staff virtually straight away and was taken back to the SSU. At one point, he also refused to sign a reintegration plan, which included an agreement he would not be violent. Mr Towers was keen to move to D wing but this was considered inappropriate because another prisoner he had assaulted living there.

116. During the GOOD review on 21 August, staff discussed a potential transfer to another prison for Mr Towers if a suitable location could not be found at Bedford. However, the Head of Safer Custody and Equalities said that this would have been a last resort as there was no guarantee that his behaviour would improve if he was transferred, and he was due for local release within a few months. PSO 1700 instructs that the GOOD review board should consider whether a prisoner needs to be transferred to another prison. This may be the case if a prisoner has become so disruptive, dangerous or notorious that they would not be able to return to a standard wing in their current prison or if they have not made any progress in segregation.

117. We recognise that Mr Towers was a volatile and difficult prisoner to manage. His risk to others had to be balanced against his own safety and welfare. We consider that staff at Bedford took reasonable steps to try to move Mr Towers from the SSU. They had also begun to consider his transfer to another prison.

118. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:

- **prisoners have a designated officer who makes three quality entries on a daily history sheet;**
- **the frequency of prisoners' observations are agreed by the person authorising segregation and clearly communicated to staff;**
- **all segregation review board decisions are documented on the appropriate form and paperwork is retained;**
- **healthcare staff are given sufficient notice to attend segregation review boards;**
- **prisoners are set realistic, specific and timebound targets at segregation review boards;**
- **prisoners who have been segregated for longer than 30 days have mental health care plans; and**
- **appropriate authorisation is sought for prisoners being segregated beyond 42 days.**

Community Probation Support

119. A senior probation officer said that Mr Towers should have been assessed by his community probation officer within 16 weeks of being sentenced, in line with national *OASys Practice Guidance* published in January 2016. This would have involved a one-to-one interaction either in person or via videolink and may have also involved the custodial probation officer. From this, an initial sentence plan would have been made, and appropriate referrals to services, such as accommodation and mental health, completed. He acknowledged that workload pressures meant that often these assessments were not being done within the timescales and those offenders who came to the probation office in person were often given priority over those in custody.

120. The senior probation officer also considered that the long period Mr Towers had spent on remand (from September 2015 until January 2017) meant that his team had not realised he was due for release in 2017. *National Standards* for the National Probation Service also indicate that there should have been a level of contact both between Mr Towers and his custodial probation officer and between his community probation officer and custodial probation officer to properly assess his behaviour and plan his release. Mr Towers' community probation officer did not respond to the probation officer's email in June about putting together a resettlement plan.

121. Mr Towers' was extremely anxious about being released from prison. He was concerned that he would not be able to support himself on release or have somewhere to live, and that he would return to prison, as he had done in the past. Not knowing who his offender manager was or having a coherent sentence or release plan must have further exacerbated this anxiety. We make the following recommendation.

The Head of the Local Delivery Unit for the National Probation Service, South East and Eastern, Bedfordshire cluster, should ensure that OASys and initial sentence plans are completed for all prisoners within 16 weeks of sentencing and community offender managers respond to communications from custody offender supervisors.

Staff support

122. A governor held a debrief for some staff on the night of Mr Towers' death. Neither of the emergency response nurses or Officer D were able to attend this debrief. They have not had the opportunity to attend a debrief since that time. We recognise the difficulty in supporting staff while maintaining the security and running of the prison at night. However, these staff members should have at least been given the opportunity to attend a debrief since 2 September. PSI 8/2010, *Post Incident Care*, indicates that a critical incident debrief should have taken place between five to ten days after Mr Towers' died so that staff could discuss the personal impact of Mr Towers' death and potential coping strategies.

123. Officer D described being deeply affected by what he had seen and was left to work all night on the SSU on his own. Other staff, such as the CPN and the probation officer also said that they could have been better supported since Mr Towers' death. We therefore make the following recommendation:

The Governor should ensure that after a potentially traumatic incident or death all staff are appropriately supported.

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