

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Garry Beadle a prisoner at HMP Durham on 11 February 2019

**A report by the Prisons and Probation Ombudsman**

## 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*



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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 Garry Beadle was found hanged in his cell on 7 February 2019 at HMP Durham. He was taken to hospital but died on 11 February. He was 36 years old. I offer my condolences to Mr Beadle's family and friends.

Mr Beadle had a number of risk factors that indicated that he was at high risk of suicide and self-harm. I am very concerned that important information about his current risk, sent from court to the prison, was disregarded during the reception process, and that staff appeared to make their risk assessment solely on how Mr Beadle came across and what he said about how he was feeling.

As we have noted many times in individual investigation reports, thematic reports and annual reports, staff too often focus on the prisoner's presentation and whether he says he has any thoughts of suicide or self-harm, and over-look known risk factors which might increase the prisoner's risk (such as a history of suicidal behaviour, or the circumstances of their offence). I am very concerned to see staff making this basic error again in Mr Beadle's case.

Suicide and self-harm monitoring procedures (known as ACCT) were later started by a senior nurse. Although individual staff were sensitive and proactive at ACCT reviews, they under-estimated Mr Beadle's level of risk, and the frequency of observations was set too low.

I am also concerned that when the prison received information on 3 February that Mr Beadle had said 'goodbye' to a close friend in a telephone call, this information was not passed to wing staff that night and did not lead to a review of Mr Beadle's level of risk, as it should have done.

It is very disappointing to find the same failings in suicide and self-harm monitoring procedures in Mr Beadle's case that we have found in previous investigations at Durham. The same failings were also identified by HM Inspectorate of Prisons in two recent inspections. A local investigation identified a significant training need in this area and I welcome the recent efforts to put this right. The Governor must ensure that improvements are now made and that frontline staff are clear about what is required.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**October 2019**

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# Summary

## Events

1. On 1 February 2019, Mr Garry Beadle was remanded to HMP Durham charged with possession of an offensive weapon, fraud, burglary, theft and common assault. Mr Beadle had not been in prison before.
2. Court escort staff completed a suicide and self-harm (SASH) warning form at court after Mr Beadle told them he had recently attempted to commit suicide twice and repeatedly said that he wanted to kill himself.
3. The Supervising Officer (SO) in reception at Durham, noted that Mr Beadle arrived with a SASH warning form but based his risk assessment on Mr Beadle's presentation and what he said. He did not begin Prison Service suicide and self-harm monitoring (known as ACCT).
4. Mr Beadle told a nurse at an initial health assessment that he was suffering from depression, had self-harmed or attempted suicide in the last year, attempted to hang himself the week before and that it was his first time in prison. The nurse did not begin ACCT procedures.
5. Mr Beadle then told a senior nurse that he felt very low and wanted to end his life because he was in prison. The senior nurse began ACCT monitoring and Mr Beadle was checked every hour pending assessment the following morning. Observations were reduced to one in the morning, one in the afternoon, one in the evening and four over-night at Mr Beadle's first review after his assessment. His risk to himself was assessed as low.
6. On 3 February, a friend of Mr Beadle's rang the police after Mr Beadle indicated during a telephone conversation that he was going to end his life. The police reassured him that Mr Beadle was fine.
7. On 6 February, Mr Beadle was moved to a standard wing with a new cellmate. Later that evening, Mr Beadle's cellmate was moved to another cell and Mr Beadle stayed on his own in the cell.
8. The next day, Mr Beadle was tearful at an ACCT review. The case manager proactively addressed his immediate anxieties about legal contact and prison work. Mr Beadle spoke to an officer twice between 12.30pm and 1.30pm and did not raise any concerns.
9. At 1.59pm, an officer found Mr Beadle hanged from the bed. Mr Beadle died in hospital on 11 February.
10. The post-mortem gave Mr Beadle's cause of death as hypoxic brain injury (lack of oxygen to the brain), due to cardio-respiratory arrest, due to hanging.

## Findings

11. The reception SO and reception nurse appear to have placed too much reliance on Mr Beadle's presentation and what he said when they considered his level of risk.
12. There is no evidence that Mr Beadle was checked after the prison received information from the police on 3 February that Mr Beadle had told a close friend to look after his children and that he would not see him again. When an officer did check Mr Beadle the next day, his level of risk and ACCT caremap were not reviewed as they should have been.
13. Given the nature and number of his risk factors for suicide and self-harm and the information contained in his SASH warning form we consider that Mr Beadle's level of risk to himself was underestimated, and the level of observations set did not reflect his risk.
14. Actions to reduce risk factors identified by the ACCT assessor were not captured in Mr Beadle's caremap as they should have been.
15. Court staff did not update the risk indicator page of Mr Beadle's person escort record (PER), as they should have done.

## Recommendations

- The Governor should ensure that reception staff:
  - have a clear understanding of their responsibilities and the need to share all relevant information about risk;
  - consider and record all the known risk-factors of a newly arrived prisoner when determining the risk of suicide and self-harm; and
  - open ACCT procedures when indicated.
- The Governor and Head of Healthcare should ensure that staff consider and record all known risk-factors of a newly arrived prisoner when determining his risk of suicide and self-harm.
- The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:
  - prisoners subject to ACCT procedures are reviewed when information is received that they are at risk of suicide or self-harm;
  - the level of observations should be set to reflect the level of risk; and
  - the caremap must address the issues identified in the ACCT assessment interview.
- The Area Business Manager for GEOamey should ensure that that court escort staff complete the risk indicator page of the PER in line with national guidance.

## The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator obtained copies of relevant extracts from Mr Beadle's prison and medical records. She watched CCTV and body-worn camera footage from 7 February and listened to the emergency radio traffic. She spoke to the prisoners in the cell next door to Mr Beadle, but they had not had any significant interaction with him.
18. NHS England commissioned a clinical reviewer to review Mr Beadle's clinical care at the prison. They interviewed six members of staff in March 2019. The investigator interviewed five members of staff on the telephone and obtained written information from another two. The solicitors representing Mr Beadle's mother provided a statement from a family friend who had called the police on 3 February.
19. We informed HM Coroner for Durham and Darlington of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. We contacted Mr Beadle's parents, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Beadle's mother asked:
  - What, if anything did the police tell HMP Durham about Mr Beadle's mental state on 1 February?
  - What steps were taken by HMP Durham after a close friend rang the prison out of concern for Mr Beadle's welfare on 3 February?
  - Why did no one see Mr Beadle at 1.00pm on 7 February after he rang his cell bell?
21. We have addressed these questions in this report and have sent a copy to Mr Beadle's family.

## Background Information

### HMP Durham

22. HMP Durham is a designated reception prison which holds up to 996 men who are on remand or recall, and serves the courts of Durham, Tyneside and Cumbria. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

### HM Inspectorate of Prisons

23. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Durham in September and October 2018. Inspectors found the prevalence and ready availability of illicit drugs, a high number of self-inflicted deaths, high levels of violence and self-harm. Initial risk assessments were inadequate and suicide and self-harm monitoring (ACCT) was “very poor” in too many cases. Inspectors were disappointed to see that recommendations from previous Ombudsman’s investigations had not been addressed with sufficient vigour or urgency.
24. An independent review of progress by HMIP in July 2019, found that the prison did not focus sufficiently on implementing PPO recommendations and ACCT case management was still far too poor in many cases. The level of risk of self-harm was sometimes underestimated and some care maps were weak. HMIP recommended that the management of prisoners at risk of suicide or self-harm should be given a high priority. More positively, prisoners who had been monitored on ACCT procedures spoke well of their experience and ACCT reviews were conducted sensitively.

### Independent Monitoring Board

25. 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 October 2018, the IMB noted that the violence which resulted from the trade in illicit drugs, and the use of those drugs, had led to an unstable prison. The number of prisoners subject to ACCT monitoring was high.

### Previous deaths at HMP Durham

26. Mr Beadle was the ninth prisoner to die at Durham in the last two years. Five of the previous deaths were self-inflicted and three were drug-related. In four of these deaths we identified inadequate risk assessment and operation of ACCT procedures, as we have done in this case. In one of these we also recommended that the Governor ensure that all wing staff are provided with radios for use in emergencies. Two prisoners have hanged themselves in Durham since Mr Beadle died.
27. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Durham on 24 September to 5 October 2018. Inspectors found illicit drugs prevalent and readily available, a high number of self-inflicted deaths, and high levels of violence and self-harm. Initial risk assessments were inadequate and suicide and self-harm monitoring (ACCT) was “very poor” in too many cases.

Inspectors were disappointed to see that recommendations from previous Ombudsman's investigations had not been addressed with sufficient vigour or urgency.

28. A follow up inspection, in June 2019, found that the prison did not focus sufficiently on implementing PPO recommendations and ACCT case management was still far too poor in many cases. The level of risk of self-harm was sometimes underestimated and some care maps were weak. HMIP recommended that the management of prisoners at risk of suicide or self-harm should be given a high priority. More positively, prisoners who had been monitored on ACCT procedures spoke well of their experience and ACCT reviews were conducted sensitively.

## **ACCT**

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
30. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
31. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

32. On 1 February 2019, Mr Garry Beadle was remanded to HMP Durham charged with possession of an offensive weapon, fraud, burglary, theft and common assault. His charges related to incidents with his partner and at their home. Mr Beadle had not been in prison before.
33. Mr Beadle's person escort record (PER) showed that a suicide and self-harm (SASH) warning form was completed at court at 2.30pm. Durham were unable to find a copy of this warning form, which accompanied Mr Beadle's PER. The investigator obtained a copy from the escort services. The form recorded that:

"Mr Beadle states he tried to hang himself and take an overdose in the last 2 weeks."

And:

"After Mr Beadle was remanded in custody, he stated numerous times to the Magistrates and his solicitor that he would not last 2 days in prison. He repeatedly stated he would kill himself. He stated to me that he had mental health problems."
34. Mr Beadle arrived at Durham an hour and a quarter later, at 3.45pm. The risk indicator page recorded Mr Beadle presented "No known risk."

### Assessment in reception

35. A Custodial Manager (CM), then the reception supervising officer (SO), noted in Mr Beadle's prison record that he arrived with a SASH warning form. He said that Mr Beadle was annoyed to be in custody but denied current thoughts of suicide or self-harm. The CM did not begin Prison Service suicide and self-harm monitoring procedures (known as ACCT). The CM completed Mr Beadle's first night in prison assessment (FNIP). He noted on the form that Mr Beadle had no issues with suicide or self-harm and no recent attempted suicide or self-harm, no history of attempted suicide or self-harm, offences against a member of his family or restrictions on contact with his family.
36. A nurse and a healthcare assistant, completed Mr Beadle's initial health assessment. Mr Beadle tested positive for amphetamines, but he denied he had issues with alcohol or drugs and declined a referral to substance misuse services. He said that he was suffering from depression, had self-harmed or attempted suicide in the last year, attempted to hang himself a week ago and that it was his first time in prison. Mr Beadle denied current thoughts of suicide and self-harm. The nurse referred Mr Beadle the senior nurse in reception, because he could not remember what his anti-depressants were called. She also referred Mr Beadle to the mental health team, but she did not begin ACCT procedures as she should have done.
37. Immediately following this assessment, Mr Beadle told the advanced nurse practitioner, that he felt very low and wanted to end his life because he was in prison. He said he had taken an overdose of paracetamol 11 days previously and had also attempted to hang himself. He began ACCT procedures and

completed a concern and keep safe form. The SO completed the immediate action plan and they agreed Mr Beadle should remain in a double cell and be checked hourly pending an assessment and case review the next morning.

### **ACCT assessment and first review**

38. At 9.30am on 2 February, an officer completed the ACCT assessment. Mr Beadle said he missed his children and had problems with his partner. He said he had not attempted to harm himself in the previous 48 hours, but he wanted to end his life and had tied a ligature with the intention of killing himself three weeks previously. More recently, he said that he took 36 paracetamol tablets when his partner left him and took their children with her. He said that he did not have current plans to kill himself. The officer noted Mr Beadle was “very down and teary”. Mr Beadle said he would like to start work and stay with his current cellmate because he found talking to him helpful.
39. The officer summarised Mr Beadle’s key issues in bullet points:
- mental health appointment;
  - Through the Gate;
  - speak to partner;
  - start work; and
  - remain with current cellmate.
40. Mr Beadle attended his first ACCT case review with a SO and a mental health nurse immediately after his assessment. He said it was his first time in prison and he was worried about being in custody. His cellmate was helping him but every time he thought about his partner and children, he became anxious and depressed. Mr Beadle said had never come to terms with the death of his baby daughter in 2004, and felt that a lot of his problems were because of not grieving for her. He said he regularly heard her voice and children’s voices in his head. Mr Beadle also said that he was on anti-depressants in the community and wanted to continue taking them in prison. The mental health nurse said he would look at Mr Beadle’s GP summary when it arrived and see if these could be re-prescribed. He did not think Mr Beadle was at immediate risk of harming himself.
41. Mr Beadle’s risk was marked as “low” and observations were reduced to one in the morning, one in the afternoon, one in the evening and four over-night. Staff were required to have three conversations with Mr Beadle every day and record them on his ACCT record. The SO added three actions to Mr Beadle’s caremap:
- to contact the Chaplaincy to explore grief counselling;
  - to review his medication with a view to prescribing anti-depressants; and
  - to refer Mr Beadle to Nepacs (a charity in the North East that provides practical and emotional help for prisoners).

42. The mental health nurse said that he planned to keep Mr Beadle on his caseload because he had risk factors for suicide and self-harm and because he said he was hearing voices. He also planned to attend Mr Beadle's further ACCT reviews but was not in the prison when they took place. (Mr Beadle was subsequently added to the secondary mental health team caseload but did not see the mental health nurse again before he died.)

### 3 February 2019

43. A close friend of Mr Beadle, said Mr Beadle rang him every day from prison. On 3 February, Mr Beadle said goodbye to him and asked him to look after his children. Mr Beadle said, "I have everything I need to do what I am going to do". He said Mr Beadle was very upset and said he would not hear from him again. He called the police immediately after the phone call. Eventually, he received a call back from Northumbria police who told him that Mr Beadle was okay but distressed. There is no record that Durham staff checked Mr Beadle in response to the police enquiries.

### 4 February

44. The next day, 4 February, an officer noted that the close friend had raised concerns and he asked Mr Beadle how he was feeling. Mr Beadle said he felt a little low and that it might take a few days for him to settle into prison life. He denied current suicidal thoughts or plans to harm himself. There is no record that Mr Beadle's level of risk or ACCT caremap was reviewed in the light of his friend's concerns, as it should have been.
45. Later the same day, Mr Beadle asked the pharmacist, using the kiosk facility (interactive information portal), whether his anti-depressants had been prescribed. A pharmacy technician replied that the prison needed confirmation from Mr Beadle's GP and this might take up to seven days. Mr Beadle's GP record was requested and received that afternoon and a GP prescribed Mr Beadle citalopram (an antidepressant) at 5.43pm.
46. Also on 4 February, a CM completed a management check of Mr Beadle's ACCT and changed his level of risk from 'low' to 'raised' because of Mr Beadle's mental health issues. The CM said he would contact the case manager about future reviews. The CM said he could not remember speaking to a SO about this and thought it was because she was probably not on duty at the time.
47. Mr Beadle telephoned a close friend. He said he knew his friend had called the police and that he was "on suicide watch". The friend said Mr Beadle sounded okay and he agreed that Mr Beadle could live with him to increase his chances of being released on bail. He said he told Mr Beadle that he would not be able to contact him for the next two days because of prior commitments.

### 5 February

48. The next day on 5 February, a SO held a review with Mr Beadle and a mental health nurse. Mr Beadle said he was struggling to cope and wanted to die. He had not yet seen the Chaplain but still had the same cellmate and was hoping they would be able to move to a new wing together. He also said that he had started some medication but was not sure what it was. The mental health nurse

said he would check and make sure Mr Beadle was receiving his antidepressants. The SO said that the Chaplaincy had promised to support Mr Beadle. Mr Beadle said that he was keen to start work but he needed to move to a standard wing first. He had applied to Nepacs about contact with his children. Mr Beadle remained on the same number of observations.

49. Later the same day, Mr Beadle told a resettlement worker he had tried to kill himself the week before he arrived in Durham, but he had no current plans to harm himself. He said he had bi-polar disorder and was working with the prison mental health team.
50. At 5.00pm Mr Beadle was moved to cell 4-12 on B Wing, a standard prison wing. His cellmate moved to B Wing at the same time but there were no empty cells and so both men began sharing with different prisoners. There is no evidence that consideration was given to Mr Beadle remaining with his cellmate at this time, a protective factor identified at his ACCT assessment.

## 6 February

51. At 9.55am on 6 February, a safer custody hub manager completed a quality assurance check on Mr Beadle's ACCT. He said he discussed with a SO the need to update the caremap and to include issues that had been identified at the assessment but were not captured in it. However, as Mr Beadle had already moved to B Wing by this time, the SO would not be chairing his next ACCT review.
52. At about 5.00pm, an officer contacted the duty mental health nurse because Mr Beadle had threatened to kill himself if he did not speak to a member of the mental health team. The duty mental health nurse said she checked Mr Beadle's medical record and then went to B Wing with a nurse. She spoke to the officer and read Mr Beadle's ACCT document before speaking to Mr Beadle through the observation panel in his door.
53. Mr Beadle said that he was very stressed because he was unhappy with his new cellmate. He said he wanted to share with the man he had met on the induction unit as promised by staff. The duty mental health nurse explained that she could not make a decision on who he shared a cell with. She said she would speak to the officers and explain his issue. She said she asked Mr Beadle a few questions to assess his risk of suicide and self-harm. He said he had plans to start work, he was pleased she had come to see him and relieved she would talk to staff for him. He accepted her offer of a distraction pack of puzzles to do in his cell. She said she did not think Mr Beadle's risk was raised and decided that his observations did not need to be increased.
54. The duty mental health nurse said that she spoke to the officer and he promised her he would address the issue of Mr Beadle's cellmate. (The investigator tried to speak to the officer by telephone, but this proved difficult to arrange within our timescales.)
55. The investigator asked an officer from safer custody to speak to Mr Beadle's original cellmate. He said he had been asked (presumably by the officer) if he

wanted to move in with Mr Beadle on B wing but had told the officer that he was now sharing with someone from his home area and did not want to move.

56. At 6.30pm, Mr Beadle asked the officer if he could have a different cellmate instead. The officer told him it was too late to move people around. About 45 minutes later, Mr Beadle's cellmate was moved to a different cell because of a fault with his bed. Mr Beadle stayed in the cell on his own. Twenty-five minutes after his cellmate was moved, the officer noticed Mr Beadle had obscured his observation panel and asked him to uncover it. Mr Beadle appeared to be asleep during the over-night checks.

## 7 February

57. At 10.55am, Mr Beadle attended an ACCT review with a CM and a mental health nurse. The CM held the review in her office because it was private and comfortable. She said she asked Mr Beadle a lot of questions and he responded very openly.
58. Mr Beadle said that he was still feeling low and had not had any contact with his family. He was hoping to be released at his court appearance on 1 March but had not spoken to his solicitor which was making him anxious. The CM allowed Mr Beadle to phone his solicitor from her office during the review. He said he felt much better afterwards. Mr Beadle also said he was keen to work to take his mind off his situation. The CM put him on the list to attend Choices, the prisons work assessment programme, that afternoon. The mental health nurse attended the review because she was the duty mental health nurse. She said she read Mr Beadle's medical notes and ACCT before the review. She was aware that Mr Beadle had attempted suicide and was low in mood. She said Mr Beadle appeared low in mood because of his circumstances, which was an appropriate response. She did not detect any sign that Mr Beadle was mentally unwell or needed further assessment by the mental health team.
59. The CM and the mental health nurse said that Mr Beadle appeared brighter and more positive by the end of the review. CM Richards told him that if he needed anything, he should press his cell bell and ask to speak to her. After Mr Beadle had returned to his cell, the CM and mental health nurse discussed Mr Beadle's level of risk and decided to reduce it from raised back to low. They did not reduce the level of observations, which remained at one in the morning, one in the afternoon, one in the evening and four overnight. The CM was on an early shift that day and finished work at 12.30pm.
60. An officer arrived on B Wing for lunch time patrol duty at about 12.30pm. He received a handover from wing staff and looked at the open ACCT documents. The officer said he remembered reading Mr Beadle's ACCT because he knew that Mr Beadle was new to the wing and had attended a review that morning. He said Mr Beadle was on "normal obs" by which he meant one observation during every duty during the day and four overnight. He then checked all the prisoners on ACCT monitoring.
61. The cell bell record shows Mr Beadle pressed his cell bell at 12.31pm and an officer answered less than a minute later. (CCTV shows the officer at Mr Beadle's door at 12.37pm.) He said Mr Beadle was lying on his bed. He said

'hello' and explained he was the lunch patrol and told Mr Beadle to let him know if he needed anything. Mr Beadle asked him to repeat what he said and then gave the officer a 'thumbs up' sign. The officer could not remember whether Mr Beadle's cell bell light was on but said he was not aware that Mr Beadle had pressed his bell.

62. The cell bell record shows Mr Beadle pressed his cell bell again at 12.53pm. The officer answered the bell less than a minute later. (CCTV shows this happened at 1.00pm.) Mr Beadle asked to speak to a CM. The officer said that he was the only member of staff on the wing and asked Mr Beadle if there was anything he could help with. He said he tried to find out what Mr Beadle wanted but Mr Beadle only said he wanted to talk to a CM. The officer said Mr Beadle did not appear agitated, upset or distressed. He assumed it was something to do with Mr Beadle's ACCT review that morning. He said Mr Beadle's response when he explained that he would have to see the CM later was, "Ok, no problem I'll speak to her later". The officer told the investigator that was not concerned for Mr Beadle's welfare at the time.

### Emergency response

63. At 1.59pm, CCTV shows that an officer unlocked Mr Beadle to go to Choices. She found him sitting slumped on the floor with his legs stretched out in front of him. His shoe laces were tied to the side bar of the top bunk bed and around his neck. The officer did not have a radio because there are only four radios available for officers on B Wing and they were all in use when the officer came on duty. She shouted 'code blue' to the other landing staff and then used her cut down tool (known as a fish knife) to cut the shoe laces from the bed and from around Mr Beadle's neck. CCTV shows her entered Mr Beadle cell at 2.00pm, immediately after she shouted code blue.
64. A second officer said she was unlocking prisoners on B3 landing for the afternoon workshops when she heard the officer shout. She went immediately to Mr Beadle's cell and arrived as the officer cut the ligature from the top bunk bed. CCTV shows the second officer entered Mr Beadle's cell 19 seconds after the officer. She shouted to a nearby prisoner to press the general alarm bell, which he did. Both officers then laid Mr Beadle flat on the floor of the cell. Mr Beadle was not breathing so an officer began cardio-pulmonary resuscitation (CPR).
65. A third officer was unlocking the prisoners on B2 landing when he heard the officer shout code blue. He said he knew she did not have a radio and so he radioed the control room immediately and then went to Mr Beadle's cell. The control room log shows the code blue was called at 1.58pm.
66. Ambulance service records show the prison called an ambulance at 1.59pm. CCTV shows the third officer entered Mr Beadle's cell at 2.00pm. He found both officers were moving Mr Beadle to the floor. As soon as the third officer established Mr Beadle was not breathing, he radioed the control room again to update them. He took turns with an officer to give Mr Beadle CPR.
67. Two nurses and a Healthcare Support Worker arrived. A defibrillator was already in the cell and an officer was struggling to open the pads. A nurse took over, but the defibrillator did not work, and they attached the defibrillator brought by the

Healthcare Support Worker. The nurse inserted an airway and the second nurse gave Mr Beadle oxygen while officers continued CPR. The defibrillator recorded a non-shockable heart rhythm and advised to continue CPR.

68. CCTV shows paramedics arrived at 2.12pm. They took over from the nurses and found some cardiac output, but Mr Beadle was unable to breathe on his own. He was taken to hospital but died on 11 February.

### **Contact with Mr Beadle's family**

69. On 7 February, a prison chaplain telephoned Mr Beadle's father to tell them he had been taken to hospital. Mr Beadle's father was with him when he died. The prison contributed to the cost of the funeral in line with national guidance.

### **Support for prisoners and staff**

70. After Mr Beadle was taken to hospital on 7 February, the deputy governor debriefed 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.
71. The prison posted notices informing other prisoners of Mr Beadle's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Beadle's death.

### **Post-mortem report**

72. The pathologist concluded Mr Beadle died from:
  - 1a Hypoxic brain injury due to;
  - 1b Cardio-respiratory arrest; due to
  - 1c Hanging.
73. Toxicology tests showed therapeutic levels of citalopram (the antidepressant prescribed to Mr Beadle) and no illicit substances.

# Findings

## Identifying risk of suicide and self-harm

74. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. The PSI also says that, all relevant information available about the prisoner must be noted in the appropriate record and shared with other staff as necessary.
75. Mr Beadle had a number of risk factors that indicated he was at high risk of suicide and self-harm, including: first time in prison, domestic offences, the breakdown of family relationships, depression and suicidal ideation. Most significantly, he had recently attempted suicide on two occasions. His SASH warning form referred to his two recent suicide attempts and noted Mr Beadle had said repeatedly in court that he wanted to kill himself.
76. The reception officer told the investigator that he did not remember either Mr Beadle or his SASH warning form but said that, regardless of any previously identified risk factors, he based his risk assessment on the prisoner's presentation and his response to questions. During his initial health assessment Mr Beadle said that it was his first time in prison, he had depression and had attempted to hang himself a week before. Despite this evidence of risk, neither a SO nor a nurse began ACCT monitoring procedures as they should have done.
77. We are very concerned that the SO disregarded Mr Beadle's very significant risk factors and based his assessment exclusively on what Mr Beadle said to him at the time. We are also concerned that the SO did not record Mr Beadle's risk factors on his first night in prison assessment or prison record. These are important tools in communicating identified risk to colleagues responsible for the prisoner's ongoing care. Mr Beadle's first night in prison assessment recorded, wrongly, that he had no recent attempted suicide or self-harm and no domestic offences. The nurse also appears to have placed too much weight on Mr Beadle's presentation.
78. In our thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that reception assessments often place too much weight on staff's perception of the prisoner and they do not always consider all relevant information about risk factors. We reinforced these messages in a learning lessons bulletin, issued in February 2016, about early days and weeks in custody. We have continued to reinforce these messages repeatedly in individual investigation reports and annual reports. It is very disappointing to see such a basic failing being repeated yet again in this case.

79. Staff judgement is fundamental to the ACCT system but, while a prisoner's presentation is obviously important and shows something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.
80. We accept that ACCT procedures were started by another nurse shortly after Mr Beadle had spoken to a nurse. However, if Mr Beadle had been able to remember the name of his antidepressants he might not have been referred a nurse at all.
81. After Mr Beadle's death, the Group Safer Custody lead identified that case managers at Durham needed refresher training in risk identification and defensible decision-making. A regionally managed training resource was put in place and identified a number of immediate training needs at Durham. At the time of writing over 100 staff in Durham have now received Prison Service SASH modules 1-6 (which covers identification of risk), ACCT assessor and ACCT case manager training.
82. Although we welcome this new training initiative, we are concerned that such a significant training need was allowed to develop. Given the importance of this issue in reducing suicide and self-harm, we recommend:

**The Governor should ensure that reception staff:**

- **have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm; and**
- **open ACCT procedures when indicated.**

**The Governor and Head of Healthcare should ensure that staff consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.**

### **ACCT procedures**

83. We have also identified some weaknesses in the ACCT process from which the prison can learn. PSI 64/2011 sets out a number of mandatory actions including:
- agree the level of risk posed by the prisoner to themselves, taking into consideration all available sources of information; and
  - the caremap must reflect the prisoner's needs, level of risk and the triggers of their distress. It must aim to address the issues identified in the ACCT assessment interview.
84. Mr Beadle had a number of significant, risk factors that indicated he was at high risk of suicide and self-harm. He was assessed as low risk at all his ACCT reviews despite the unchanged nature of his risk factors. We consider that he should have been assessed as high risk, at least until after he had been to court for the first time.

85. We also consider that Mr Beadle's level of observations was too low and did not reflect the nature of his risk. During the investigation several staff said that ACCT observations at Durham were usually set at the level of those applied to Mr Beadle. We are concerned that this level has become the norm and does not properly reflect the level of risk. During the investigation the number of open ACCT documents at Durham was twice the national average for a local prison. This is unmanageably high and we consider there is a risk that quantity is overwhelming quality.
86. Mr Beadle's ACCT assessor identified a number of issues, including that he wanted to start work and he wanted to remain with his cellmate. Neither of these were reflected in the caremap completed at Mr Beadle's first review. We understand that the number of prisoners received at Durham means it is not possible to ensure that all those on the induction unit attend the Choices group. While we recognise the pressure that Durham is under as the only reception prison for the North East, if this had been a caremap objective, consideration could have been given to prioritising Mr Beadle's attendance at Choices to reduce the risk factors associated with his current circumstances.
87. Similarly, if remaining with his current cellmate had been one of his caremap actions, Mr Beadle might not have been put in a different cell when he was moved to B Wing. This should also have meant that, when Mr Beadle's new cellmate moved to a different cell because of a problem with the bed, Mr Beadle was not left alone. Twenty-five minutes after the removal of this protective factor Mr Beadle obscured his observation panel. The next day he hanged himself.
88. The security department completed an information report on receipt of information that Mr Beadle had indicated on the telephone that he intended to kill himself. We have not seen any evidence that this information was passed to wing staff that night (although the information given to the close friend by the police implies that this did happen). It is possible that the information was passed to the wing the following morning and that was why an officer checked Mr Beadle. In either case, this information should have resulted in a review of Mr Beadle's level of risk and ACCT caremap, but did not. There is no information about the close friends concern in Mr Beadle's ACCT plan and therefore when he moved to B wing, none of the staff there knew about it.
89. We recommend that:

**The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:**

- **prisoners subject to ACCT procedures are reviewed when information is received that they are at risk of suicide or self-harm;**
- **the level of observations should be set to reflect the level of risk; and**
- **the caremap must address the issues identified in the ACCT assessment interview.**

## Person Escort Record (PER)

90. The risk indicator guidance notes contained within the PER require staff from any agency to complete the suicide and self-harm section if the person in custody has self-harmed or has attempted to self-harm or has threatened to self-harm. The Prisoner Custody Officer who completed the SASH warning form at court did not complete this section as they should have done. The risk indicator page is often the only information about risk available to prison reception staff and it is crucial that all information about risk is properly recorded and does not become lost when a prisoner transfers from one agency to another. We recommend:

**The Area Business Manager for GEOamey should ensure that court escort staff complete the risk indicator page of the PER in line with national guidance.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations