Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Niven, a prisoner at HMP Bedford, on 15 June 2021

A report by the Prisons and Probation Ombudsman

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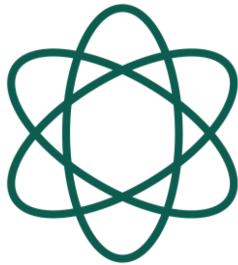
Our vision

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

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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 Paul Niven died on 15 June 2021, having been found hanging in his cell in HMP Bedford the previous day. Mr Niven was 40 years old. I offer my condolences to Mr Niven's family and friends.

Mr Niven's mental health had deteriorated while in HMP The Mount, and he was being managed under Prison Service procedures to manage those at risk of self-harm (known as ACCT) when he transferred to Bedford on 7 June 2021.

We are concerned that the level of observations for Mr Niven was reduced in reception at Bedford, with no input from healthcare staff at the ACCT review. We have previously made recommendations to Bedford about the operation of the ACCT process. There was a short delay in accessing Mr Niven's cell when he was found hanging as the night officer was not carrying a radio, as well as a delay in calling the ambulance.

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 **September 2022**

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Summary

Events

1. In March 2021, Mr Paul Niven was sentenced to 16 months imprisonment and taken to HMP Bedford. He had been in prison before and had been managed under Prison Service procedures to support those at risk of self-harm (known as ACCT). He had mental health issues and drank and misused drugs.

2. In April, Mr Niven transferred to HMP The Mount. In a mental health review, he reported no current mental health problems or thoughts of suicide and self-harm. At the end of April, he saw a psychiatrist and showed no signs of psychosis.

3. On 4 May, Mr Niven called prison officers in a highly agitated state, shouting there were spiders in his smoke alarm that were trying to get him. The following day he tied a ligature around his neck, and staff opened ACCT procedures. On 6 May, he pushed his way out of his cell and had to be restrained by prison officers. They took him to the Care and Separation Unit (CSU). He remained there until 1 June, when he said he had no issues and was looking forward to being on a standard wing. On 5 June, he again made delusional statements and threats to staff, and was taken back to the CSU. The mental health team made an urgent referral to the psychiatrist.

4. On 7 June, Mr Niven went to court then was taken to HMP Bedford. He was given a health screening and an ACCT review, where his level of observations was reduced. At a further review the following day, it was noted that he had a mental health review scheduled, so the ACCT remained open. That evening, Mr Niven told a prison officer some bizarre things, and she spoke to the mental health team. They assured her that someone was due to see him.

5. A community psychiatric nurse reviewed Mr Niven on 9 June. While he thought Mr Niven to be unwell, he knew that he was under ACCT management and did not think that he was at risk of harming himself. On 12 June, prison officers were concerned about his behaviour and a mental health nurse went to see him. Mr Niven appeared to be mentally unwell, and the nurse checked the availability of beds in the healthcare centre. None were available, but the nurse did not think that he was at imminent risk of suicide or self-harm or in urgent need of medical attention. He had an appointment with the psychiatrist pending and was under ACCT management.

6. Shortly after midnight on 14 June, the night officer found Mr Niven hanging. He did not have a radio so had to go to the office to raise the alarm. He returned to the cell but was unable to open the sealed pouch that contained a cell key. Other prison officers responded to the emergency call and went into the cell, lowered Mr Niven to the floor and attempted to revive him. Nurses responded to the emergency call but were unable to access emergency equipment on the wing so had to return to the healthcare office to fetch it. Staff continued to attempt to resuscitate Mr Niven until joined by paramedics, who transferred Mr Niven to hospital. Mr Niven did not regain consciousness and died at 12.24pm on 15 June.

Findings

Assessment of risk

7. Mr Niven was subject to ACCT procedures from 4 May until he died. When he returned to Bedford on 7 June, at an interim ACCT review his observation level was reduced, even though staff had not had the opportunity to assess him or how he settled after a transfer. The nurse who gave Mr Niven his reception health screening at Bedford was also unaware that he was under ACCT management.

Mr Niven's healthcare

8. The clinical reviewer noted no concerns regarding Mr Niven's physical healthcare. As his mental health deteriorated this was recognised by the mental health team, and he was referred to the psychiatrist for the next available appointment. No concerns were noted about any increased risk and overall mental health services responded appropriately.

Emergency response

9. The member of staff who found Mr Niven hanging did not have a radio with him when he made his ACCT check on Mr Niven. This caused a short delay in raising the alarm. When he tried to open the sealed key pouch to unlock Mr Niven's cell door, he struggled to do so.

10. We were unable to find evidence that an ambulance was requested immediately the emergency call was made, and there seems to have been a delay.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present;
  - all reception staff, including healthcare staff, are aware when a prisoner is on an ACCT; and
  - ACCT reviews are multidisciplinary wherever possible, particularly if a prisoner is under the care of the mental health team and observations are being reduced.
- The Governor should ensure that staff comply with radio guidance, in particular that:
  - staff making ACCT and wellbeing checks carry radios to enable emergency medical codes to be radioed promptly;
  - staff carry radios at all times after drawing them; and
  - staff are provided with the correct equipment to allow them to carry their radio.

- The Governor should ensure that all staff who may need to open sealed key pouches have received training in how to do so.
- The Governor should remind staff that an ambulance should be requested immediately on a code red or code blue emergency.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact him. There were no responses.

12. The investigator obtained copies of relevant extracts from Mr Niven's prison and medical records.

13. The investigator interviewed eight members of staff. Due to restrictions in place during the COVID-19 pandemic, these interviews were carried out using MS Teams or over the telephone. NHS England commissioned a clinical reviewer to review Mr Niven's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

14. We informed HM Coroner for Bedfordshire of the investigation. She gave us a copy of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Niven's brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any specific questions.

Background Information

HMP Bedford

16. HMP Bedford is a local prison with an operational capacity of 377 men. Northants Healthcare NHS Foundation Trust provides all healthcare services. There is a healthcare unit with ten single cells.

HM Inspectorate of Prisons

17. The most recent full inspection of HMP Bedford was in August to September 2018. Inspectors reported that the number of incidents of self-harm had increased substantially since their last inspection (in 2016) and was higher than in comparable prisons. There had also been five self-inflicted deaths since the last inspection in 2016. Inspectors also reported that ACCT processes were weak, including that some care plans failed to address issues of concern.

18. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State on 12 September 2018, setting out his significant concerns about the treatment of prisoners, including the management of prisoners at risk of suicide or self-harm.

19. In August 2019, HMIP carried out an Independent Review of Progress which followed up 13 of the 61 recommendations they had made after their 2018 inspection. Inspectors found that there had been no meaningful progress in the support of prisoners at risk of suicide or self-harm, and that the number of incidents of self-harm had increased dramatically. They found that ACCT caremaps were not used effectively and there were not enough ACCT case managers.

20. Inspectors carried out a scrutiny visit in February and March 2021. They had concerns about levels of safety in the prison. The ACCT process had too many weaknesses and lacked effective oversight by managers. Reviews were often not multidisciplinary. The Inspectorate recommended that prisoners' perception of safety at Bedford should be improved, staff-prisoner relationships should be improved and that support measures for vulnerable prisoners, including those at risk of self-harm should be improved.

Independent Monitoring Board

21. 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 2021 the IMB reported problems in the operation of the ACCT process.

Previous deaths at HMP Bedford

22. Mr Niven was the fourth Bedford prisoner to die since the end of 2019. One of these previous deaths was due to COVID-19, the other two were self-inflicted. We have previously made recommendations about the operation of ACCT. There have been two further deaths since, both apparently due to natural causes.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. 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 multidisciplinary review meetings involving the prisoner.

24. 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. 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.

Psychoactive Substances (PS)

25. Psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Key Events

HMP Bedford

27. On 23 March 2021, Mr Paul Niven was convicted of several offences including theft and burglary and sentenced to 16 months imprisonment. He was taken to HMP Bedford. He had been in prison before, and in the past had been managed under Prison Service procedures to support those at risk of self-harm (Assessment, Care in Custody and Teamwork, or ACCT).

28. At his initial health screen, Mr Niven said that he was taking medication for his mental health and the nurse referred him to the mental health team. He said that he drank high levels of alcohol and misused drugs. Mr Niven was agitated during the consultation and said all he wanted was to be prescribed methadone. He denied any thoughts of suicide or self-harm. He was referred to a doctor and said that he was prescribed pregabalin for nerve pain. A drug test was positive for opiates and diazepam. Mr Niven was put onto a detoxification regime, the doctor prescribed methadone and diazepam, and asked the mental health team to confirm Mr Niven's prescribed medication.

29. Mr Niven had to spend his first 14 days at Bedford isolating because of COVID-19. He did not display any symptoms. He told staff that he suffered from bipolar disorder and schizophrenia and had previously been sectioned under the Mental Health Act. He said he currently felt stable and had no thoughts of suicide or self-harm. He had misused drugs since the age of 13 and drank alcohol. His offending was mainly to fund his habits.

30. A multidisciplinary healthcare team meeting discussed Mr Niven on 9 April. He was currently stable in mood and mental state and would remain under the care of the mental health team with a psychiatric review planned.

HMP The Mount

31. On 9 April, Mr Niven transferred to HMP The Mount. The healthcare team at Bedford provided a handover, and Mr Niven was to remain under the care of the mental health team in The Mount.

32. A nurse reviewed Mr Niven's mental health on 14 April. He reported no current mental health problems, no depression and no thoughts of suicide or self-harm. He had a poor sleep pattern but had a good appetite. Mr Niven got on with his cellmate and socialised on the wing. He said he was not currently misusing substances. There was no evidence of thought disorder or psychosis, and the nurse judged that he was a low risk to himself. The mental health team planned to review him again two weeks later. On 26 April, Mr Niven saw a psychiatrist. He was calm and showed no signs of psychosis.

33. On 29 April, Mr Niven told a prison officer that he would like to speak to someone from the mental health team, as he was not receiving night medication to help him sleep. He had no other concerns at the time. The officer gave Mr Niven a healthcare appointment application form to complete and referred him to the mental health team.

34. On the afternoon of 4 May, Mr Niven pressed his cell bell and was highly agitated, shouting that he needed to get out of his cell. He said that there were spiders in his smoke alarm that were trying to get him. He was again referred to the mental health team. The following day, Mr Niven tied a ligature around his neck, and staff started ACCT procedures. Staff were to check on him at least once per hour. In his assessment interview and first ACCT review, Mr Niven spoke in the first-person plural, said he was hearing voices and talked of "sacrificing" himself to save the world. He felt that his medication was not working, and it was agreed that he should remain subject to ACCT measures until that had been addressed.

35. At his next ACCT review on 5 May, Mr Niven said that he would never self-harm again as he was scared and in pain. The next day he pushed his way out of his cell and had to be restrained by prison officers. They took him to the segregation unit, known as the Care and Separation Unit or CSU.

36. Mr Niven remained in the segregation unit until 1 June. During that time, he was regularly monitored under ACCT management as well as seen by healthcare staff, duty governors and chaplaincy staff on rounds of the unit.

37. On 13 May, Mr Niven told a member of the substance misuse team that he was not sure he was ready to come off his methadone prescription and was hearing voices. In the early hours of 14 May, Mr Niven had been shouting paranoid statements. At approximately 2.35am, he pressed his cell bell. When the night officer responded, Mr Niven said that something had climbed through his window and hit him in the face. On 16 May, the duty governor spoke to someone in the healthcare department about Mr Niven. They said that his behaviour could be down to PS withdrawal, although there is nothing in his records prior to this that indicates that he was using any PS. In the early hours of 21 May, Mr Niven told the night officer that he was hearing voices. At an ACCT review on 28 May, he said that he was still feeling paranoid and hearing voices but had no plans to harm himself. He admitted that in the past taking drugs had made him paranoid.

38. On 1 June, Mr Niven moved from the segregation to an ordinary wing. At an interim ACCT review he said he had no issues and was looking forward to settling into his new wing.

39. On the morning of 5 June, Mr Niven told a prison officer that he had 14 days to rescue a child stuck underground. He then became aggressive with her, saying that she was not helping him with the child, and she would be punished. He told another officer that he could hear children screaming for help. The following morning, in view of his behaviour and threats, staff relocated Mr Niven to the segregation unit. Mr Niven refused to go, so was taken there under restraint. On the way there, he said that he would be killed by the aliens in the segregation unit.

40. A nurse went to see Mr Niven in the segregation unit, but he refused to engage. A note in his ACCT document said that all alternative options for location had been considered but there was no safe alternative because he allegedly assaulted a member of staff. At an ACCT review, Mr Niven talked throughout, rarely making sense. He talked of a child under the floor, and said voices were telling him to hang himself, though he had no intention of doing so. That afternoon Mr Niven was displaying disturbing behaviour and saying strange things. The mental health team made an urgent referral to the psychiatrist.

HMP Bedford

41. On 7 June, Mr Niven went to court for a plea hearing. After his appearance, he was taken to HMP Bedford. A nurse gave Mr Niven a health screening in reception. Mr Niven said he was okay but seemed confused. The nurse referred him to the substance misuse and mental health teams. She said in interview that she was not aware that he was under ACCT management but that she had no concerns that he would harm himself. He saw a doctor, who re-prescribed his medication. He had to self-isolate for another 14 days due to COVID-19. A Supervising Officer (SO) chaired an interim ACCT review. Mr Niven said that he was happy to be back in Bedford. He was tired and said that he had no thoughts of suicide or self-harm. Observation levels were reduced to one conversation each morning, afternoon and evening, and five random observations during the night.

42. On 8 June, a nurse completed a substance misuse assessment. Mr Niven denied any thoughts of suicide or self-harm. He admitted to misusing drugs and alcohol when out of prison. As part of his care plan, he agreed to comply with medication and engage with the substance misuse team. The same day, he refused a secondary health screen and would not let a nurse take his medical observations. He was referred for an urgent mental health review.

43. That afternoon, a SO chaired an ACCT review, attended by Mr Niven, two Community Psychiatric Nurses (CPNs) from the mental health team, a member of the substance misuse team and a member of the chaplaincy. Mr Niven seemed to be in a good mood, though he said he was still not content that his medication was correct, and he was still suffering from hallucinations. One CPN said that he had a mental health review scheduled and that he could discuss it then. Mr Niven said that he did not want to self-harm, but sometimes had thoughts about it and could not say that he would not. It was agreed that his observations would remain as three quality conversations throughout the day and five random checks overnight.

44. That evening, an officer saw Mr Niven for a key work wellbeing check. She noted that his behaviour was bizarre, and that he said strange things including that he was a vampire. He said that he only had 13 days to live but would not explain what made him think that. She spoke to a CPN in the mental health team, who said that they were aware that someone needed to see Mr Niven as soon as possible.

45. On 9 June, a CPN saw Mr Niven. He showed signs of thought disorder and did not appear well. He was hallucinating and expressing delusional thoughts. The CPN noted that his medication should be reviewed and referred him to the psychiatrist. He told the wing SO that he was unwell and should remain under ACCT monitoring. The CPN said in interview that he did not consider Mr Niven to be at particular risk of harming himself.

46. On 11 June, Mr Niven told a clinical support worker that he was still hearing voices. He admitted to some drug use, though it was not clear if he meant at that time or in the past. He said that he had no current thoughts of self-harm. On 12 June, Mr Niven refused a COVID-19 swab and his afternoon medication. The following morning, he again refused his medication. Officers were concerned about Mr Niven's behaviour, and a nurse from the mental health team went to the wing. He spoke to a CM (Custodial Manager), and she said that Mr Niven had refused his medication, and been exhibiting bizarre behaviour, talking about dragon's eggs and making threats to eat female staff.

47. Mr Niven had not been unlocked from his cell that morning because he had been aggressive, so a nurse went to his cell and spoke to Mr Niven through the observation panel with the door shut. He appeared mentally unwell. The nurse thought that Mr Niven would benefit from a period of observation and went to the healthcare centre to check the availability of beds but there were none. He went back to the wing and explained this to a CM. Mr Niven was being managed under ACCT procedures and had a scheduled appointment with the psychiatrist two days later. In the circumstances, the nurse felt that officers could manage Mr Niven on the wing. In interview, the nurse said that there were no indications that Mr Niven was at risk of suicide or self-harm at the time, or in need of urgent medical intervention. He assessed that Mr Niven was displaying symptoms of psychosis and diminished mental capacity.

48. On the evening of 13 June, an Operational Support Grade (OSG) was on duty on Mr Niven's wing. He made an ACCT check on Mr Niven at 9.30pm, when Mr Niven was lying on his bed watching television. Later that evening, Mr Niven pressed his cell bell. (In his statement, the OSG said that this was at 11.45pm, but cell bell records show that the last time Mr Niven used his bell was at 9.45pm. The OSG said in interview that he had most likely noted the time incorrectly.) When the OSG responded, Mr Niven was talking to himself and did not properly engage with him. He suggested that Mr Niven opened a window for some fresh air, and Mr Niven replied "Alright Gov". He checked him again at 11.45pm, when he was lying on his bed watching television.

49. The OSG returned for the next check at 12.31am on 14 June, and saw Mr Niven hanging from a ligature made from a bed sheet attached to the curtain rail. He ran to the office and called a code blue emergency (meaning a prisoner is not, or is having difficulty, breathing). This prompted the control room to call for an ambulance.

50. Bedford's daily briefing sheet shows that the OSG called a code blue at 12.31am. Although it is not recorded when the ambulance was called, Ambulance Service records show that the request was received at 12.36am.

51. CCTV footage showed the OSG got back to the cell within a minute of leaving. He was carrying a cell key in a sealed pouch but could not open the pouch. Other staff arrived in response to the emergency call. Officer A used his key to try to open the door, but the lock was stiff. Officer B managed to get the door open and the officers, along with two more officers, went into the cell around a minute after the OSG had returned to the cell. They cut the ligature, lowered Mr Niven to the floor, and began to perform cardiopulmonary resuscitation (CPR).

52. Two nurses were in their office when they heard the emergency call. Nurse A took a small emergency bag with her to the wing. She got to Mr Niven's cell 35 seconds after staff had gone into the cell, realised she needed more equipment and left straight away. She went to the medical room on the wing to get the equipment, but this was locked so she returned to the office to get it. On her way she passed Nurse B, who was on his way to the wing. Officer A had gone to collect a defibrillator (a machine that monitors and, in some cases restarts, the heart) and oxygen, and brought them to the cell. CCTV footage showed that Nurse B arrived at the cell three minutes after Nurse A had first arrived. He joined the officers performing CPR until paramedics took over. At 2.10am they transferred Mr Niven to hospital. He was placed on a ventilator and put into an induced coma.

53. Hertfordshire Police identified Mr Niven’s brother as his next of kin and contacted him. A SO was appointed as the prison’s family liaison officer (FLO) and went to Mr Niven’s brother’s home to collect him and take him to the hospital.

54. Following discussion with Mr Niven’s brother, doctors withdrew treatment. Mr Niven died at 12.24pm on 15 June.

Contact with Mr Niven’s family

55. Having spoken to Mr Niven’s brother while he was in hospital, the FLO remained in contact with him. In line with Prison Service guidance, Bedford offered a contribution to the costs of Mr Niven’s funeral.

Support for prisoners and staff

56. After Mr Niven had gone to hospital, the Head of Security and Operations 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. When Mr Niven died, support was offered to prison officers who had been in the hospital with him.

57. The prison posted notices informing other prisoners of Mr Niven’s 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 Niven’s death.

After Mr Niven’s death

58. On the afternoon of 14 June, prison staff were clearing Mr Niven’s cell. Body worn video camera footage shows a member of staff picking up something that they said could be suicide notes and put them into evidence bags that were passed to the police. At the time of publication, we have not been able to see a copy of these notes, but the police confirmed that the content did not constitute a suicide note.

Post-mortem report

59. Post-mortem tests showed that Mr Niven died from a brain injury caused by hanging. The toxicology report did not show the presence of any illicit drugs in his system.

60. Mr Niven had several fractured ribs on his right side and a probably fractured sternum. There were no other injuries reported, and it is reasonable to assume that these were caused by the CPR attempts to resuscitate Mr Niven.

Findings

Assessment of risk

61. Mr Niven was subject to ACCT procedures from 4 May until he died. The clinical reviewer noted good evidence that mental health and substance misuse staff fully participated in the ACCT process. We have focussed on the management of Mr Niven's ACCT after he returned to Bedford and, while there was evidence of staff engaging with Mr Niven and trying to reduce his risk, we are concerned about some aspects of his ACCT management.

62. Before Mr Niven returned to Bedford subject to ACCT management, he had been in segregation in The Mount. He was allocated to a standard wing in Bedford, although he had to isolate for 14 days in line with COVID-19 protocols. A SO chaired an ACCT review and decided to reduce the observation levels on Mr Niven.

63. PSI 64/2011, Safer Custody, contains guidance on the operation of ACCT. The PSI requires case reviews to be multidisciplinary where possible. Other than Mr Niven, the review contained just a SO and an officer. Healthcare staff had seen him in reception and noted no concerns that he might harm himself but were not represented in the review. Mr Niven told those at the ACCT review that he had no intention of harming himself, but it would appear to have been a premature decision to reduce the level of observation.

64. Staff had not had time to assess him, how he would settle after the transfer, and whether he would need additional support in isolation. Moreover, bearing in mind that Mr Niven had been under the care of the mental health team in The Mount, there were no healthcare staff involved in the decision to reduce the level of observation. We have commented previously on multidisciplinary attendance at ACCT reviews in Bedford.

65. Furthermore, it is of concern that a nurse gave Mr Niven his reception health screening without knowing that he was under ACCT management. Prison staff did not inform her, nor did she note this information from Mr Niven's medical record. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

    - **staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present;**
    - **all reception staff, including healthcare staff, are aware when a prisoner is on an ACCT; and**
    - **ACCT reviews are multidisciplinary wherever possible, particularly if a prisoner is under the care of the mental health team and observations are being reduced.**

Mr Niven's healthcare

66. The clinical reviewer noted no concerns regarding Mr Niven's physical healthcare. His mental health problems were noted on arrival in prison. His mental health deteriorated prior to his return to Bedford on 7 June. This was recognised by the mental health team in Bedford, and he was referred to the psychiatrist for the next available appointment. No concerns were noted about any increased risk in Bedford and the clinical reviewer said that overall mental health services responded appropriately.

Substance misuse services

67. Mr Niven had a history of substance misuse. On 16 May, a member of healthcare staff said that his behaviour could be due to PS withdrawal. At an ACCT review on 28 May, he said he was paranoid and admitted that in the past taking drugs had made him so. The prison's Quick Time Learning Review contains a note that there was a smell of drugs in the cell at the time of the emergency, though it is not clear who reported this.

68. Despite his sometimes bizarre behaviour, there are no reports from staff in his records that they suspected Mr Niven of PS use. Post-mortem reports showed no drugs in his system. There were no reports of any drug paraphernalia in his cell.

69. Mr Niven was referred to substance misuse services in prison and engaged with the support offered. The clinical reviewer had no concerns about the substance misuse support given to Mr Niven. Mr Niven's cause of death was not ascribed to drug misuse, and we have no evidence to suggest otherwise.

Emergency response

Radios

70. The OSG did not have a radio with him when he made his ACCT check on Mr Niven. He told the investigator that he had not been issued with a belt to carry his work equipment. When he found Mr Niven hanging, he had to run back to the office to raise the emergency call. CCTV footage shows that he was back at Mr Niven's door within a minute. We cannot say how much difference this made to the outcome, but we do know that in emergency situations time is essential.

71. Local guidance on radio procedures is contained in a Governor's Order. This says that for staff drawing them "radios must be attached to your person at all times via the use of a radio pouch (available from the Security Department)". We are concerned that the OSG did not have a radio with him. As the point of ACCT checks is to confirm prisoners' wellbeing this is one of the times when they will potentially need a radio to call an emergency medical code. We make the following recommendation:

The Governor should ensure that staff comply with radio guidance, in particular that:

- **staff making ACCT and wellbeing checks carry radios to enable emergency medical codes to be radioed promptly;**

- **staff carry radios at all times after drawing them; and**
- **staff are provided with the correct equipment to allow them to carry their radio.**

Access to cells

72. When the OSG tried to open the sealed key pouch to unlock Mr Niven's cell door, he struggled to do so. He said in interview that it was the first time he had had to break the seal on the pouch. We cannot say whether the short delay in entering the cell affected the outcome for Mr Niven, but delays could be critical in other life-threatening situations. We make the following recommendation:

    The Governor should ensure that all staff who may need to open sealed key pouches have received training in how to do so.

73. The note of the debrief said that staff had trouble opening the lock on Mr Niven's cell door, and that this had been previously reported but nothing had been done. The prison's facilities manager, however, confirmed that no reports of a faulty lock had been received before Mr Niven died. A report was received on 21 June.

Ambulance request

74. Prison Service Instruction (PSI) 03/2013 says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly says that control room staff should automatically call an ambulance whenever there is an emergency code.

75. Bedford recorded the code blue call at 12.31am. The Ambulance Service recorded a request at 12.36am. Bedford recorded paramedics were with Mr Niven at 12.52am, the Ambulance Service recorded it as 12.49am. It is therefore possible that the clocks used were a few minutes apart. Even so, we are unable to be sure that an ambulance was called immediately, and we do know that even a short delay can make a significant difference in a medical emergency. We make the following recommendation:

    The Governor should remind staff that an ambulance should be requested immediately on a code red or code blue emergency.

76. When Nurse A went to the wing, she could not access the emergency equipment which was locked in a healthcare suite for which nurses do not carry keys at night. The prison identified this in an early learning review and relocated emergency equipment on wings to the wing offices, where they are readily available. Consequently, we do not make a recommendation.

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