

**Prisons &
Probation**

Ombudsman
Independent Investigations

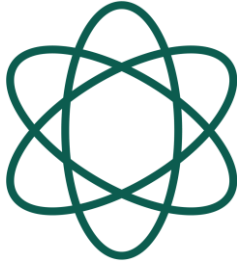
Independent investigation into the death of Mr Stephen Beadman, a prisoner at HMP Wakefield, on 8 April 2021

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

OGL

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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 Stephen Beadman died on 8 April 2021 in Pinderfields Hospital, having been found hanging in his cell in HMP Wakefield the previous day. Mr Beadman was 34 years old. I offer my condolences to Mr Beadman's family and friends.

Mr Beadman had been in Wakefield since 2016. He was subject to Prison Service suicide and self-harm support measures several times. Mr Beadman was bullied and victimised by other prisoners due to the nature of his offence. He also undertook an offender programme that stirred up difficult feelings for him. On 7 April, Mr Beadman cut himself, and staff again started procedures to support those at risk of suicide and self-harm. Less than three hours later staff found him hanging. We did not uncover evidence that suggested that staff should have anticipated such an escalation in his risk.

We found that prison staff responded to Mr Beadman's complaints of bullying and acted on them. This, however, did not stop him from feeling victimised, over a year after he first complained, and this is of concern. There was also a delay in staff using the correct emergency code when they found Mr Beadman hanging and staff did not automatically request an ambulance as they should have done.

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

June 2022

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Summary

Events

1. In November 2015, Mr Stephen Beadman was remanded to prison, charged with rape and murder. It was his first time in prison. In July 2016, he was sentenced to life imprisonment. Mr Beadman was supported under Prison Service procedures for those at risk of suicide and self-harm, known as ACCT. He was diagnosed with Mixed Personality Disorder (having traits of different personality disorders) for which he was prescribed medication.
2. In August 2016, Mr Beadman transferred to HMP Wakefield. He worked with mental health services until January 2018, when he was discharged from their caseload. In November 2019, he began an offender treatment intervention called the Kaizen Programme.
3. In January 2020, Mr Beadman self-harmed. He said that the Kaizen Programme had opened up feelings about his offence, so his participation was suspended. He also reported some concerns about his relationships with some other prisoners. Staff started ACCT procedures again.
4. Mr Beadman was supported by ACCT in July, August and October. He sometimes said that he was bullied by other prisoners due to the nature of his offence. Staff opened Challenge Support Intervention Plans (CSIP) to support Mr Beadman and three prisoners were moved to a different wing. In December, Mr Beadman recommenced the Kaizen Programme.
5. In January 2021, Mr Beadman said that he still felt under threat from other prisoners, but also told staff that he felt more settled and that his bullying issues had been resolved. He said he was content with the level of support he was receiving. In February, Mr Beadman said he had thoughts of killing a random prisoner. He said this was in response to people shouting things about him from another wing. He declined further help, saying he had support and would ask for more if needed.
6. On 30 March, Mr Beadman reported that something had been sprayed over his stereo and television. On 1 April, he retaliated by throwing urine into two other prisoners' cells and days after had a fight with one of those prisoners. Mr Beadman had said he felt under threat, although there was no supporting evidence for this.
7. On 7 April at 2.30pm, Mr Beadman barricaded his cell door and made a superficial cut to the right side of his neck. Staff took the blade, and a nurse treated his cuts. Staff started ACCT procedures, with checks at least every hour.
8. At 5.08pm, two officers went to Mr Beadman's cell and found him hanging. They entered the cell, called for assistance, and tried to resuscitate him. Medical staff joined them until ambulance paramedics took over and transferred him to hospital. Mr Beadman died the following morning.

Findings

Assessment of risk

9. Mr Beadman had a history of self-harm and was managed under ACCT several times. On 7 April, staff reacted swiftly, treated his cuts, and rightly opened ACCT procedures. Wing staff informed the mental health team that an ACCT had been opened but said that they did not need to see him urgently, so they arranged to see him the following day. There was nothing at the time to suggest that he needed urgent mental health intervention. We are satisfied that staff acted appropriately and could not have been expected to predict Mr Beadman's rapidly escalating risk to himself.

Allegations of bullying

10. Mr Beadman made allegations of bullying on several occasions. Staff opened CSIPs and provided support to Mr Beadman. Some prisoners were moved off the wing, and he did say that this alleviated his fears to a degree, but he continued to say that he felt victimised. Mr Beadman had regular contact with various agencies and at times he had additional support through ACCT. It is unfortunate that Mr Beadman still felt under threat, but evidence suggested that the prison took his fears seriously and addressed them in line with policy. A CSIP investigation had been opened days before Mr Beadman died but at the time the investigation was still underway. We are, nonetheless, concerned that Mr Beadman complained of bullying over such a long period without resolution.

Mr Beadman's healthcare

11. The clinical reviewer concluded that the healthcare given to Mr Beadman was of a good standard and equivalent to that which he could have expected in the community. While the Kaizen Programme was challenging, Mr Beadman was well supported through the process.

Emergency response

12. When staff found Mr Beadman hanging, there was a small delay before the correct emergency code was used and an ambulance called.

Recommendations

- The Governor should assess Wakefield's processes to address allegations of bullying, ensure that they are working as effectively as possible, relevant staff are aware of allegations of bullying and that all staff are vigilant to signs of bullying.
- The Governor should ensure that staff are aware of their responsibilities and the correct procedures in a medical emergency.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact him. He obtained copies of relevant extracts from Mr Beadman's prison and medical records.
14. The investigator interviewed seven members of staff at Wakefield. NHS England commissioned a clinical reviewer to review Mr Beadman's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
15. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Beadman's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Beadman's mother asked about Mr Beadman's medication and whether he was being bullied.

Background Information

HMP Wakefield

17. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).
18. Practice Plus Group provides healthcare. Service provision for psychiatry, recovery and psychology services are contracted from the Midlands Partnership Foundation Trust.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Wakefield was carried out in June 2018. Inspectors reported that the prison was calm, and the inspection was a positive one. The quality of ACCT documents was generally good and quality assurance processes were sound. Staff-prisoner relationships were generally good and enhanced by the keyworker scheme. Over 60% of prisoners reported some form of victimisation, usually verbal, by other prisoners. Inspectors said there had been an increase in low-level antisocial behaviour and insufficient challenge by staff. Overall living conditions and health services were good.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2021, the IMB reported that the CSIP violence reduction scheme had had limited impact as delivering intervention plans with meaningful targets was not possible due to COVID-19 restrictions and staffing levels. Generally, they found that staff and prisoner relationships were good. The Board said that Wakefield was generally a calm and safe prison.

Previous deaths at HMP Wakefield

21. Mr Beadman was the 21st prisoner at Wakefield to die since December 2018. Of the previous deaths, one was self-inflicted, and all the rest were from natural causes, including six from COVID-19. There have since been two further deaths, both due to natural causes. None of our investigations into these deaths raised issues relevant to this investigation.

Assessment, Care in Custody and Teamwork

22. 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.

23. 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.
24. 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.

Challenge, Support and Intervention Plan

25. Challenge, Support and Intervention Planning (CSIP) is a Prison Service scheme designed to address factors contributing to violence in prisons by managing the most violent prisoners and supporting the most vulnerable prisoners. Prisoners who are perpetrators of violence or who are vulnerable to violence or bullying are managed and supported on a plan with individualised targets and regular reviews.

Key Events

26. In November 2015, Mr Stephen Beadman was remanded to HMP Woodhill, charged with rape and murder. It was his first time in prison. He had a history of substance misuse and self-harm, and prison staff managed him under Assessment, Care in Custody and Teamwork (ACCT, Prison Service procedures for those assessed as at risk of suicide and self-harm) several times. He was diagnosed with Mixed Personality Disorder (having traits from different personality disorders) for which he was prescribed medication.
27. In May 2016, Mr Beadman was convicted of murder and in July sentenced to life imprisonment, to serve at least 34 years. Intelligence reports indicated that Mr Beadman often said he felt threatened by or wanted to attack other prisoners. When prison staff asked him about any problems, he said they had been dealt with.

HMP Wakefield

28. On 12 August 2016, Mr Beadman transferred to HMP Wakefield while subject to ACCT monitoring. After ten days, staff judged that he was no longer at risk of suicide or self-harm and closed his ACCT. In April 2017, a television programme about Mr Beadman's crime was aired, and staff started ACCT procedures. He worked with mental health services until January 2018, when he was discharged from their caseload as there were no concerns about his mental state and he had not harmed himself for some time. In November 2019, he began a new part of the Sex Offender Treatment Pathway called the Kaizen Programme, which helps prisoners explore their thinking processes and how this affects their behaviour.
29. In January 2020, Mr Beadman self-harmed. He said that the Kaizen Programme had opened up feelings about his offence, so his participation in the programme was suspended. He also reported concerns about other prisoners. He had been part of an arrangement whereby several prisoners pooled their resources to allow them to have a wider range of food. Mr Beadman had occasionally been cooking the food for the group, but they were pressing him to do so more often, and he had started to feel uncomfortable. He was subject to ACCT monitoring until the end of February.
30. In July, Mr Beadman started the Kaizen Programme again. However, on 26 July staff were worried about his behaviour, so monitored him through ACCT procedures again. He said that participating in the programme had made him think about his offence and he temporarily withdrew from the course. He also told staff that he had been struggling with restrictions during the COVID-19 pandemic. On 29 July, he tied a ligature around his neck and staff intervened. They also removed a blade that he was holding. He said that another programme about his offence had been on television, and whenever this happened, he was abused by other prisoners. Mr Beadman was moved to the healthcare inpatient department. He remained there until 3 August, and subject to ACCT management until the end of August.
31. In September, Mr Beadman said that he wanted to start the Kaizen Programme again as he felt that he had unresolved issues to address. On 8 October, he handed a ligature he had made to an officer. Mr Beadman said that he had no intention of using it, but was frustrated with not seeing his keyworker, about

adjustments to his medication, and a general feeling of paranoia. The officer informed the Safer Custody department and Mr Beadman's Recovery Worker of what had happened. She arranged for him to see the GP. Later that day, staff noted damage to his hand and head, and Mr Beadman said that he had hit the walls in frustration. He said he was having trouble coping, so staff began ACCT procedures.

32. Mr Beadman told staff during the ACCT review on 9 October that he was again struggling with the Kaizen Programme. He also said he had written to the Safer Custody department saying that he was being bullied by other prisoners and they had agreed to investigate. The following day, staff found Mr Beadman with a ligature around his neck. Staff cut the ligature and healthcare staff attended, but he did not need treatment. He said that he was struggling with the thought that he would spend another 30 years in prison. Staff found improvised weapons in his cell.
33. On 14 October, Mr Beadman said that his life was under threat, and that he wanted a move to the segregation unit or the healthcare unit otherwise he would take matters into his own hands. That afternoon, staff found Mr Beadman with a ligature made from a bed sheet around his neck, tied to the window. He had barricaded his door. Staff forced entry and cut the ligature. Mr Beadman was moved to a cell with minimal ligature points and put into anti-ligature clothing.
34. Staff interviewed Mr Beadman under Challenge, Support and Intervention Plan (CSIP) procedures. He said that three prisoners from the group that he had previously been cooking food for had been to his cell door accusing him of being "a grass". He refused to name the individual prisoners. He said that he had cooked for the group as he hoped they would give him protection in view of the high-profile nature of his offence. Mr Beadman said he had become scared of them and had recently written an anonymous letter implicating several of them in dealing in drugs and mobile telephones. He was concerned that they knew he had done so. Staff agreed that Mr Beadman would be supported through the CSIP process as well as through ACCT and he continued to engage in the Kaizen Programme.
35. At an ACCT review on 16 October, Mr Beadman said that he was content with being in isolation behind his cell door but was concerned about going out for showers and phone calls. Staff arranged for him to have these alone, while the wing was out in the exercise yard. On 19 October, Mr Beadman saw a psychiatrist, who noted that Mr Beadman presented an ongoing risk to himself, as well as to others if he felt under threat. Partly, as a result of CSIP investigations, some prisoners had been moved off the wing and he no longer felt as threatened.
36. Later that day, Mr Beadman told his Offender Supervisor that he had a price on his head from other prisoners on the wing. They discussed coping strategies, but he said that sometimes he felt that the only way to cope was by taking his life. They discussed the possibility of a transfer to another prison once he had completed the Kaizen Programme.
37. On 26 October, the Distance Learning Co-ordinator received a letter from Mr Beadman which said that he had been bullied by a prisoner for the previous 12 months. He had written that along with the stress of taking the Kaizen Programme, pandemic restrictions and his own anxiety and depression, it was all too much, and he had tried to kill himself three times. He said that the prison was not interested in

helping him. She submitted an intelligence report and referred the letter to the Safer Custody and Security departments. The following day, Mr Beadman had a CSIP review. The note of the review said that the reasons for being under ACCT management were related to the CSIP issues. The plan was for him to engage with the issues identified in the ACCT process to address his problems, engaging with staff whenever issues arose.

38. On 29 October, ACCT procedures were closed. Mr Beadman said he had plans for the future, was hoping for a transfer to a different unit, and had support networks. Having been temporarily taken off the Kaizen Programme, he now wanted to re-join it.
39. On 6 November, Mr Beadman told two officers in a Safer Custody check that he felt that there were still threats against him on the wing. They asked if he wanted them to investigate this, but he said that the Security Department already knew about it.
40. On 9 November, Mr Beadman told workers from the Kaizen team that he wanted to re-join the programme. He recognised that the next steps involved detailed consideration of his offence, and that he would need a period of stability before he could resume the course.
41. On 26 November, Mr Beadman told an Offender Supervisor that he was in a much better place now that the bullying situation had been resolved. He felt ready to move forward.
42. On 1 December, workers from the Kaizen team discussed re-engaging with the Kaizen Programme with Mr Beadman. This was initially on a one-to-one basis. Mr Beadman was happy with this.
43. On 3 December, Mr Beadman had a CSIP review. He was self-isolating as part of the COVID-19 pandemic but said that doing so helped avoid the bullying issues. The perpetrators had been moved off the wing, and Mr Beadman said that he was more comfortable and there were no prisoners that caused him any worries. He was looking forward to re-engaging with the Kaizen Programme, which he felt raised his confidence and reduced his feelings of vulnerability. He was encouraged to engage with staff over any concerns at an early stage.
44. Later that day, Mr Beadman had an altercation with another prisoner. When interviewed about this, Mr Beadman said that it was heat of the moment and he regarded it as finished. The following day he told his Offender Supervisor that he had not retaliated. He was due to resume the Kaizen Programme and said that he would apply to undertake a PIPE course (Psychologically Informed Planned Environments, specialist units for people with personality disorders).
45. On 21 December, Mr Beadman told two officers that his altercation on 3 December had stemmed from the issues he had had with other prisoners who had since moved off the wing. Another prisoner had called him “a grass” and threatened to assault him. He challenged the individual and they each threw punches. He said that since the incident they ignored each other, and he regarded the issue as over.
46. On 22 December, Mr Beadman resumed the Kaizen Programme.
47. On 5 January 2021, Mr Beadman told a worker from the Kaizen team that a prisoner had said that his cell was going to be smeared with excrement because he

had provided staff with information about prisoners involved in the prison drug culture. He felt that he had done the right thing but was now being told that staff could not do anything to maintain his safety until something happened. He felt let down. He repeated this to his Offender Supervisor on 8 January, but said he felt that he had reacted properly to the threat by informing staff. He had applied to move to a PIPE unit, but said that even if he was unsuccessful, he would like to transfer to a different prison.

48. On 11 January, a Custodial Manager (CM) opened a further CSIP as a result of Mr Beadman's fight on 3 December. She noted that the Safer Custody Department would investigate.
49. On 21 January, Mr Beadman told an officer that he was more settled now that "negative people" had moved off his wing. On 25 January, he told the psychiatrist that he felt much better now that his bullying issues had been resolved. He said that he had occasional thoughts of self-harm but managed them without acting on them. The psychiatrist noted that there was no evidence of mental illness and discharged him from their caseload. That day Mr Beadman's CSIP form was closed. It noted that he was receiving extra support from the Safer Custody Department with regular visits so he could raise any issues. Mr Beadman said he was content with the level of support he was receiving at that time and did not currently need anything further.
50. In early February, Mr Beadman finished the Kaizen Programme. He felt that it had gone well, and he was proud of his efforts. He sometimes felt paranoia but said that he was able to manage this.
51. On 17 February, Mr Beadman told a Kaizen worker that he had thoughts of killing another prisoner. He said that he had gone into an empty cell and hidden under the bed with the intention of attacking the prisoner when he returned. While waiting he had changed his mind and left. This was not a specific prisoner's cell but chosen at random. She submitted an intelligence report and told the wing Supervising Officer that she thought his movements on the wing should be monitored. She checked on him the following day, and he seemed calmer.
52. On 22 February, Mr Beadman told staff that a television programme about his crime was being aired. He said that he did not want to watch it, as this had previously triggered mental health issues for him. On 24 February, Mr Beadman told a Kaizen worker that he had made his threats to kill someone in response to people shouting things about him from another wing. He had asked officers for a cell move but had not yet had a response. He realised that his actions had been stupid, and he did not want to do anything to jeopardise his future.
53. On 4 March, Mr Beadman told an officer that he felt like he was progressing. His next step would be the PIPE unit at HMP Frankland. He said that he had no issues with bullying, was enjoying studying and did not feel under pressure.
54. On 5 March, the Offender Supervisor spoke to Mr Beadman. He said that he was paranoid as prisoners had been shouting at him from outside his window. He had asked for a cell move but had been refused due to the pandemic. He was keen to transfer out of Wakefield. She emailed the Security Department to register Mr Beadman's interest in a transfer.

55. On 11 March, an officer and a CM spoke to Mr Beadman about the reports of his thoughts of harming another prisoner. He said that he had been in a bad place when he said that, but knew it was wrong and was now coping better. They offered support from CSIP, but he said he did not feel this was necessary. He was supported in weekly sessions with the officer and would seek any further support he needed from wing staff.
56. On 16 March, Mr Beadman told a recovery worker that he wanted to stop working with substance misuse services. He said that he was feeling positive and focused. They agreed to gradually reduce his recovery support over a three-month period.
57. On 18 March, Mr Beadman tested positive for COVID-19. He had to isolate for 10 days.
58. On 30 March, Mr Beadman reported that something had been sprayed over his stereo and television. Staff found a bottle with an unknown substance in it, likely to be some form of human waste. The issue was referred to the Security Department to check CCTV footage.
59. On 1 April, Mr Beadman threw urine into two other prisoners' cells. He then climbed over the railings onto the netting before going back to his cell. In view of recent events, staff submitted a further CSIP referral. On Sunday 4 April, he had a fight with one of those prisoners. He was segregated in his cell pending disciplinary procedures. An intelligence report noted that Mr Beadman had said that prisoners on the wing were going to "get" him and he was concerned for his safety. The report said that there was no supporting evidence for this.
60. On 5 April, an officer spoke to Mr Beadman. He said he was "okay" but his issues with other prisoners on the wing had not been resolved and his cell had been "dirtied" by someone paid to do so. He said that he had no thoughts of harming himself, and did not need the support of ACCT. She made a note in the wing observation book asking staff to be aware. That night, Mr Beadman pressed his cell bell and handed over an improvised weapon.
61. On 6 April, the Offender Supervisor spoke to Mr Beadman about the incidents that had occurred over the weekend. He said that he felt under threat but did not know what else to do so had resorted to "prison rules" to protect himself. He had previously been friends with the prisoner he had fought with, but he had subsequently been paid with drugs to throw urine into Mr Beadman's cell. He had made a weapon to protect himself, as he did not feel safe. He had handed it over as he did not want to use it. She encouraged him to use staff support, his own support network, and said that she would speak to him again.
62. At 2.30pm on 7 April, Mr Beadman barricaded his cell door and made a cut to the right side of his neck. He then began to smash the contents in his cell. Prison officers tried to talk to him and, after refusing to engage for some 20 minutes, he handed over his blade and allowed staff to clear the debris. A CM asked him what had made him self-harm, and Mr Beadman said that he had issues with some other prisoners. A nurse went to see him, and Mr Beadman said that there were ongoing issues on the wing with bullying, which staff knew about. She applied steri-strips to his neck and his arm. Mr Beadman did not want dressings, so the nurse left three in his cell and told him how to apply them if he changed his mind.

63. A Supervising Officer (SO), the A Wing manager that afternoon, opened ACCT procedures. He noted that Mr Beadman would not tell staff why he had self-harmed that afternoon. He completed the immediate action plan, noting that Mr Beadman should stay in his own cell, and be given access to Listeners (prisoners trained by the Samaritans to provide peer support) and/or Samaritans if he requested it. Staff were to check on Mr Beadman at least once per hour.
64. The SO checked Mr Beadman at 3.30pm. He had calmed down and asked if he could have a shower and be able to clean his cell. At 4.30pm, another officer checked Mr Beadman, and he was looking out of his cell window.
65. At 4.30pm, a nurse answered a telephone call from a member of staff on the wing, telling her that he had opened ACCT procedures on Mr Beadman. She said in interview that she did not know who the member of staff was, and in interview the SO said he did not recall making the call. The member of staff said that Mr Beadman had cut himself and described the self-harm as “minimal”. The nurse asked if the situation was serious and whether Mr Beadman needed to be assessed by the mental health team that day. She was told that it was not serious, and he did not need to be seen that day. An appointment was made for the next day.
66. Two officers went to Mr Beadman’s cell to let him out for a shower. In his statement, Officer A said that this was at approximately 5.08pm. Officer B opened the observation panel and saw Mr Beadman hanging by a ligature made from strips of bedding attached to the window. He told Officer A to call an emergency on the radio, as he unlocked the door. They went into the cell, cut the ligature and lowered Mr Beadman to the floor. Officer A began cardiopulmonary resuscitation (CPR).
67. Other staff arrived, and one of them radioed a code blue emergency (Indicating a prisoner is unconscious or having breathing difficulties). The Control Room emergency log noted this at 5.06pm. At 5.08pm, another member of staff radioed that an ambulance was required. Records showed that the ambulance was requested at 5.08pm.
68. Nurses responded to the emergency calls and joined the prison officers in attempting to resuscitate Mr Beadman until paramedics arrived and took over. They transferred Mr Beadman to Pinderfields General Hospital. The prison appointed a family liaison officer, who contacted Mr Beadman’s mother.
69. When he got to hospital, Mr Beadman remained in an induced coma, but his condition deteriorated, and he died at 10.55am the following morning.

Contact with Mr Beadman’s next of kin

70. After informing Mr Beadman’s mother of his admission to hospital over the telephone, the prison family liaison officer met her at the hospital. They remained in contact in the weeks that followed. In line with Prison Service guidance, Wakefield offered a contribution to the costs of Mr Beadman’s funeral.

Support for prisoners and staff

71. After Mr Beadman’s death, staff were offered support. The prison posted notices informing other prisoners of Mr Beadman’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 Beadman's death.

Post-mortem report

72. The post-mortem report showed that Mr Beadman died as a result of hypoxic ischaemic encephalopathy (lack of oxygen to the brain) as a result of cardiac arrest, caused by hanging.

Findings

Assessment of risk

73. 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.
74. We have considered whether staff at Wakefield used ACCT procedures appropriately to support Mr Beadman throughout his time at the prison and the day he was found hanging.
75. Mr Beadman had a history of self-harm and making ligatures at Wakefield. We are satisfied that prison staff identified Mr Beadman's risk on previous occasions and managed to de-escalate his risk through a multidisciplinary approach to supporting him, reducing his risk and encouraging him to plan for the future.
76. When Mr Beadman barricaded his cell and cut himself on 7 April, staff reacted swiftly and negotiated with him to remove the barricade. The SO rightly opened ACCT procedures and telephoned the mental health team (although he could not specifically recall the conversation at interview) and said that Mr Beadman did not need an urgent mental health assessment.
77. PSI 64/2011 requires that prisoners assessed as at risk of suicide and self-harm should have a formal ACCT assessment and a case review to discuss how best to support them within 24 hours. The SO completed the Immediate Action Plan until Mr Beadman could be properly assessed. He told the investigator that he could not remember speaking to Mr Beadman that afternoon or how he seemed when he checked him later. He told the investigator that he did not think that Mr Beadman's self-harm was "anything more significant than superficial harming", so did not assess him as at particularly high risk of suicide or self-harm or in need of an urgent mental health assessment, as he told the nurse.
78. While we are concerned that the SO did not remember speaking to Mr Beadman just hours before he was found hanging, we do not consider his assessment of Mr Beadman's risk after his self-harm was itself unreasonable. Mr Beadman saw a nurse, ACCT procedures were opened, and support was in place. In these circumstances, we do not make a recommendation.

Allegations of bullying

79. Mr Beadman's offence was high profile and continued to receive coverage in the national media, which he felt put him at risk from other prisoners. Mr Beadman first mentioned that he was concerned about bullying in January 2020. He was subject to ACCT procedures at the time. Thereafter, while he said that abuse from other prisoners increased when his case was referred to in the press, he did not complain of further bullying until October.
80. Prison Service procedures to address bullying are addressed via CSIP. The emphasis is on the individual, focusing on their specific needs so the right support

can be given. It should work alongside other interventions, such as ACCT and substance misuse services.

81. Staff referred Mr Beadman for CSIP four times between October 2020 and April 2021. In October, the alleged perpetrators were interviewed, and subsequently moved off the wing. Mr Beadman was under ACCT management, and his issues were addressed jointly with the CSIP process. It was agreed that he would re-engage with the Kaizen Programme, which he did. When he asked for help in December, he was interviewed, and support was agreed at wing level. When referred in January after a fight in December, Mr Beadman said he was being visited by Safer Custody staff weekly and did not need any further support. When Mr Beadman soiled the cells of two other prisoners in April, a CSIP referral was made and was in progress when he died.
82. Mr Beadman was a Category A prisoner, which meant that he could only be moved to certain areas of the prison. The prison does not have a Vulnerable Prisoners Unit. He hoped to transfer out of Wakefield but did not want to do so before finishing the Kaizen Programme. Once he had done so, his offender supervisor started to enquire about him transferring to another prison, but she had not secured a transfer before he died.
83. Mr Beadman complained of bullying on more than one occasion, although also often told staff that he felt that the problems had been dealt with. Sadly, the basic problem did not seem to be eradicated, and Mr Beadman again complained of problems with other prisoners in the days leading up to his death. Staff had again started a CSIP when Mr Beadman died. It is of concern that over a year after first complaining of bullying, Mr Beadman was on the same wing complaining of the same problem. It is of further concern that the SO said in interview that he was unaware of the bullying problems. We make the following recommendation:

The Governor should assess Wakefield's processes to address allegations of bullying, ensure that they are working as effectively as possible, relevant staff are aware of allegations of bullying and that all staff are vigilant to signs of bullying.

Mr Beadman's healthcare

84. The clinical reviewer said that the healthcare given to Mr Beadman was of a good standard and equivalent to that which he could have expected in the community. When he tested positive for COVID-19 he isolated in line with government guidance, and later appeared symptom free. Mental health services were responsive and proactive. He was in regular contact with his recovery worker, who engaged well in providing support, including while he was under ACCT management.
85. The clinical reviewer noted that while the Kaizen Programme appeared to have been very challenging for Mr Beadman, he was well supported through the process. When he found it too challenging his participation was suspended, and only reinstated when he was keen to do so.

Emergency response

86. Wakefield has an emergency code system whereby calling code blue means a prisoner is not breathing or is having difficulty breathing and code red means a prisoner is bleeding. Each of these should prompt the control room to automatically call an ambulance, as well as alerting other staff, including medical staff, to the nature of the emergency.
87. When Officer B found Mr Beadman hanging, he opened the cell and told Officer A to raise the alarm. Not knowing what the emergency was, Officer A activated his personal alarm but did not call a code blue.
88. A code blue was not called until other staff arrived, and an ambulance not called until another officer asked for one. We cannot be certain how much time elapsed between Officer B finding Mr Beadman hanging and an ambulance being requested, although it is likely to have been minimal. Nevertheless, any such delay can be critical in a medical emergency. We make the following recommendation:

The Governor should ensure that staff are aware of their responsibilities and the correct procedures in a medical emergency.

Inquest

89. The inquest, held from 19 to 21 June 2023, concluded that Mr Beadman died by suicide.

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100