Report of an Independent Investigation into the Case of AB commissioned by the Secretary of State for Justice in accordance with Article 2 of the European Convention on Human Rights

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GLOSSARY

ACCT	Assessment, Care in Custody and Teamwork: Care planning system used to help identify and care for prisoners at risk of suicide or self-harm
ASCA	Area Safer Custody Adviser
Association	Prisoners' recreation period / time out of cell
BME	black and minority ethnic
Category A	The category of prisoners whose escape would be highly dangerous to the public or the police or the security of the state, no matter how unlikely that escape might be, and for whom the aim must be to make escape impossible.
Category B	The category of prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult.
CNA	Certified Normal Accommodation. (Uncrowded capacity is the Prison Service's own measure of accommodation. CNA represents the good, decent standard of accommodation that the Service aspires to provide all prisoners.)
CPR	Cardiopulmonary resuscitation
Constant Supervision	Where a prisoner is supervised by a designated member of staff on a one-to-one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly. The term "Constant Watch" is also used.
CSRA	Cell Sharing Risk Assessment
ECHR	European Convention on Human Rights
F2050	A Prisoner's Personal Record
F2050A	Information of Special Importance in a Prisoner's Record
GSL	Global Solutions Ltd (a company which provides escorts to and from prisons
HMCIP	Her Majesty's Chief Inspector of Prisons
IMB	Independent Monitoring Board (formerly Board of Visitors)

IMR	Inmate Medical Record
IPCC	Independent Police Complaints Commission
Listeners	Prisoners who are selected, trained and supported by the Samaritans to listen in confidence to fellow prisoners who may be experiencing feelings of distress or despair
Operational Capacity	The operational capacity of a prison is the total number of prisoners that an establishment can hold taking into account control, security and the proper operation of the planned regime.
Orderly Officer	Principal Officer responsible for ensuring the prison regime is running correctly. Responsible for the management of incidents
PER	Prisoner Escort Record
PO	Principal Officer
POA	Prison Officers' Association (Trade Union)
PSI	Public Service Instruction
PSO	Prison Service Order
Rule 45	The Prison Rule under which a prisoner may be segregated or removed from association for reasons of maintaining good order and discipline or for the prisoner's own protection
SIR	Security Information Report
SMART	Systematic Monitoring and Analysing of Race Equality Template
SN	Staff Nurse
SO	Senior Officer

Executive Summary, List of Findings and Recommendations

AB, a young man aged twenty-one, was remanded to HMP Bedford on 5th June 2008 after he had killed his former girlfriend. AB had come to the UK as a sixteen-year-old asylum-seeker and had been in the care of a London borough's Children's Services Department. He had been studying at university but appears to have become very disturbed after his girlfriend ended their relationship. The case attracted considerable media attention.

When AB arrived at Bedford, the paperwork given to Reception staff made no reference to a risk of self-harm. This is despite the fact that AB had been arrested on a bridge having told the 999 operator that he was going to kill himself and after his arrest had swallowed a chain while in Police custody.

The Duty Governor placed AB in a room on his own after assessing his potential to be classified as a Category A prisoner - that is a prisoner for whom the aim must be to make escape impossible. In this room, AB made a ligature from his tracksuit top and was discovered hanging by a member of staff who had come on duty shortly beforehand. He was resuscitated and suffered no lasting ill effects. An ACCT document was opened to plan his care and AB spent the next week in the Health Care Centre, initially on constant supervision and then on twice-hourly observations. He was seen by a psychiatrist and was not found to be mentally ill.

AB became bored and on 13th June he was moved to F Wing which accommodates vulnerable prisoners. Because of the nature of his alleged crime, AB was placed on Rule 45 which meant he was held separately from most other prisoners. The prisoner with whom AB initially shared a cell was unable to cope with AB's threats to kill himself. AB was moved to a cell closer to the staff office. His cellmate there also could not cope and asked to be moved. AB was regularly reviewed as part of the ACCT process which plans the care of at-risk prisoners, but his management was somewhat superficial. Not all of the decisions made were followed up, for example his need for reading glasses which had been taken from him by the Police. AB became very concerned about contacting the mother of his former girlfriend and angry and frustrated when he was not permitted to do so by prison staff. AB spent a lot of time in his cell writing and drawing.

On 24th June 2008, AB was found hanging from his cell window at about 7 pm. Staff responded rapidly to the incident and were able to resuscitate him before an ambulance arrived to take him to hospital. AB sustained significant damage to his brain and was managed in intensive care for a period. AB's condition improved but he remained in hospital until 23rd September 2008 when he returned to Bedford, where he was located in the Health Care Centre. He was transferred to a hospital setting on 10th December 2008, where he remains at the time of writing.

AB did not have the mental capacity to participate in a trial. On 20th May 2009, a trial of the facts was heard at the Central Criminal Court, known as the Old Bailey. AB was found to have committed the act of homicide and was ordered to be held

indefinitely under the Mental Health Act. An assessment carried out in July 2010 found that because of his acquired brain injury and the severity of his impairments, AB lacked the capacity to participate directly in this Article 2 investigation.

Findings

1. We consider that on 5th June 2008, the staff [in Reception] generally acted in accordance with procedures and the decision to place AB in a holding cell was not unreasonable. We think that the form given by the Police to the escorting personnel should have noted that AB was at risk of self-harm.

2. We think it would have been better had AB been seen first by Health Care staff in Reception prior to the Category A assessment, so that any risk of self-harm could have been assessed.

3. It is not at all clear what decision was made about AB's security status following the assessment. Consideration should have been given to segregating AB for his own protection under Rule 45 at the same time.

4. It would have been better had a clear instruction been given as to how often AB should have been checked after he had been placed in the side room in Reception.

5. We think that it was not appropriate forcibly to take a photograph of AB immediately after his attempted hanging in Reception. It could have been taken a little later, with AB returning in the morning for an electronic image to be used in the documentation. A Police photograph could have been used in the meantime.

6. We think that when undertaking Cell Sharing Risk Assessments, it is important not to confuse risk of self-harm (which was clearly established in AB's case) with risk of assaulting a cellmate; but in the circumstances the decision to assess AB as "high risk at this time" was not unreasonable.

7. Much greater priority should have been given to obtaining AB's spectacles which had been retained by the Police. Given his need for these, a temporary pair might have been obtained.

8. We question the decision to treat AB as a Potential Category A Prisoner. The question should have been settled much more quickly and, until it was, the consequences for AB should have been managed as part of the ACCT process, perhaps by the involvement of security staff at reviews. It was unnecessary for two officers to have to unlock AB in the Health Care Unit, notwithstanding his Potential Category A status at the time.

9. Greater efforts should have been made to identify AB's next of kin.

10. Given the progress that AB had made and his wish to enjoy a more normal regime, the decision to move him to F Wing seems a sensible one. Decisions

about location within F Wing and the sharing of cells should have been managed as part of the ACCT process.

11. The spirit of the Suicide and Self-Harm Management Strategy in place at the time was not adhered to in the way the decisions about AB's cell allocation were made on F Wing. On successive days, 20th and 21st June, prisoners told staff that they were unable to share a cell with AB and that AB was actively suicidal. There is, however, no record of the reasons for prisoners feeling that they were unable to share with AB being properly fed into the ACCT review process.

12. Despite some examples of good practice, the ACCT process was not managed as well as it could have been, with too many Case Managers and a failure to involve the most relevant personnel, consider all relevant information and follow up the CAREMAP in the Case Reviews.

13. Continuity of care more generally would have been improved by a functioning Personal Officer scheme and greater involvement from mental health services.

14. A more thorough assessment of possible trigger points relating to AB's alleged offence should have been undertaken.

15. The views of AB's cellmates about his risk should have been fed into the risk management process.

16. Although AB may not have been in the right frame of mind to work in F Wing, we think opportunities to occupy him out of his cell should have been more vigorously pursued so that he spent less time in his cell, and was able to experience a more positive environment during the day.

17. While staff were right to be cautious about AB's wish to contact the mother of his victim, his reasons for wanting to do so should have been explored and, if appropriate, some contact facilitated with an intermediary.

18. We do not think that the broader problems on F Wing directly contributed to AB's attempted suicide but they may reflect a lack of management attention being given to a small unit.

19. It seems possible that had AB been checked at 18.50 on 24th June 2008, his attempt at self-harm might have been prevented or frustrated. The interaction between an officer and AB which took place between 18.30 and 18.50 should have been recorded in the ACCT On-Going Record.

20. Once AB was discovered on 24th June, staff responded as well as they could have.

21. A log should have been taken at the time of the incident and statements should have been taken from all of those involved shortly afterwards.

22. The Security Incident Report is not the most appropriate vehicle for reporting on serious incidents of self-harm.

23. Several of the findings identified in this investigation may reflect wider weaknesses in Bedford's approach to suicide prevention at the time.

24. We consider that the Near Miss Investigation of the Incident in Reception on 5th June 2008 was a speedy and appropriate investigation, identifying important changes which were implemented.

25. While an immediate debrief was important, we think that there might have been a more considered opportunity to learn lessons in the days after the incident on 24th June.

26. Action plans should contain more detailed methods of how recommendations might be put into practice and for proposing indicators for measuring progress in their implementation.

Recommendations

A. The Police and the Prison Service should use the same scale and terms when assessing risk of self-harm.

B. Prisoners who are remanded for crimes which have attracted high media interest should be processed in Reception as a priority after those who have been assessed as being at risk of self-harm.

C. The Procedure for Rule 45 should be reviewed to ensure that high profile cases are proactively managed.

D. Although there is now CCTV, staff should check prisoners in the holding room every ten minutes.

E. Better documentation should be used for assessing prisoners for Potential "Cat A" status. A written algorithm should be produced to show the decision made to either submit or not and why. A copy should be placed in the prisoner's record.

F. If a prisoner is initially considered for Potential "Cat A" status, but is subsequently downgraded, his closed visit status should be considered at the same time. The prisoner should be informed of the outcome of the review promptly.

G. More resources should be used to establish next of kin swiftly, especially in foreign national cases. Enquiries could be made through Police intelligence officers, the UK Border Agency and any church or community groups with whom a prisoner had been associated.

H. We recommend that a more detailed policy is developed about the allocation of cells. For prisoners subject to ACCT monitoring, any cell moves should be

agreed as part of the reviewing process, other than in an emergency when they should be reported to the Case Review.

I. Cell moves in F Wing should be better documented and countersigned by management. If prisoners are moved for their safety and wellbeing, it should be noted in their prison files and ACCT document.

J. Managers must ensure that any downgrading in Cell Sharing Risk Assessment is documented correctly, giving valid reasons for any decision.

K. Either higher priority should be given to case management or more realistic Guidance about ACCT Case management needs to be produced. There should be continuity of Case Manager in ACCT reviews, with consideration given to whether a review deadline might be relaxed if that permits a Case Manager to attend, thus forming a more meaningful review.

L. Greater priority should be given to ensuring that prisoners with open ACCTs are allocated to a Personal Officer who attends or reports to all ACCT reviews.

M. Greater efforts should be made to involve in ACCT reviews any of those who work in a prison who know a prisoner well, and to obtain their contributions if they cannot attend.

N. All action points in ACCT documents should be time-bound and the use of “ASAP” discouraged.

O. Further investigation of trigger points should be made where possible, such as the funeral of a victim, or events which carry particular significance in different cultures.

P. Training should be given to ACCT Case Managers to develop skills for use whenever prisoners are unwilling to discuss the trigger points or circumstances surrounding their self-harming.

Q. Mechanisms should be developed so that in appropriate cases the views of cellmates can contribute to the assessment of risk.

R. Given the growing number of foreign national prisoners, we recommend that the Prison Service initiates research into how murder / killing is perceived and dealt with in other countries, particularly in relation to cultural expectations within communities.

S. Establishments holding foreign national prisoners should be assisted in understanding cultural differences in respect to attitudes to death, murder and taking one’s own life.

T. Performance on Suicide and Self-Harm Prevention should continue to be a high priority element in the audit of prisons.

U. In cases of near death or serious injury, the Governor should initiate an investigation as a matter of urgency, securing all relevant documents and evidence.

V. When a case of near death occurs, the scene, documentation and any files should be secured in the same way as follows a death.

W. A clearer policy should be developed about the nature and extent of investigations which should take place following incidents of self-harm, so that prisons know when a local investigation within the prison is likely to be adequate, when an internal Prison Service investigation by the Area Manager is needed and the circumstances in which an independent Article 2 investigation is likely to be commissioned.

Part One The Investigation

Chapter One

How we conducted the Investigation

The Investigation was carried out by Rob Allen, former Director of the International Centre for Prison Studies, assisted by Andy Barber, a retired Governor from the Prison Service. A clinical review was conducted by Dr Ian Cumming.

The Investigation was commissioned on 7th September 2010. The terms of reference were:

- to examine the management of AB by HMP Bedford from the date of reception on 5th June 2008 until the date of his life-threatening attempted suicide on 24th June 2008, and in the light of the policies and procedures applicable to AB at the relevant time;

- to examine relevant health issues during the period spent in custody from 5th June 2008 until 24th June 2008, including mental health assessments and AB’s clinical care up to the point of his attempted suicide on 24th June 2008; and

- to consider, within the operational context of the Prison Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved.

In the initial stages of the investigation, Andy Barber and I visited Bedford Prison on 30th September 2010. We analysed an initial set of documents which was disclosed to us. This included the report of an internal Prison Service investigation into the circumstances surrounding the case of AB undertaken by the Governor of another prison in 2008 at the request of the Area Manager of the Prison Service; and a variety of other material relating to AB’s time at Bedford.

We met with AB and a family member on 15th October 2010. Before the Investigation was commissioned, the Ministry of Justice had obtained a medical assessment of AB’s mental capacity. The assessment concluded that AB “lacks capacity to make decisions about matters that affect him and to participate directly in the investigation.” Nevertheless we considered it important to try to tell AB himself about our investigation as well as involving the relative who is his next of kin. Following our meeting, we drew up a short paper setting out the sequence of events and the issues which we wished to explore in the investigation. We shared this with AB’s next of kin, who responded by setting out some general concerns about whether the authorities were sufficiently alert to her relative’s risk of suicide and a particular concern about the length of time that it took for the ambulance to arrive after the incident of self-harm on 24th June 2008. These matters are explored fully in our report.

We undertook a total of ten formal interviews with present and former members of staff at Bedford, on 22nd and 23rd November and on 15th December 2008. We also undertook four telephone interviews with staff members, a telephone interview with a former prisoner who had shared a cell with AB and a face to face interview with another of AB's former cellmates. We also interviewed AB's former social worker at the Children's Services Department in whose care AB had been.

During the investigation we identified a number of additional documents and records from the prison that we thought might assist us. While we successfully obtained a number of these, there were some records that we were unable to see. For example, we were told that the records of telephone calls made by AB had not been kept, nor the list of people whom he was permitted to call. We were not able to track down all of the information that was obtained in the course of the internal Prison Service investigation, nor any documentation about a review undertaken by the Area Safer Custody Adviser in 2008. We discuss the issues relating to Investigation procedure in Chapter 21.

Chapter Two

HMP Bedford

HMP Bedford is a small, mainly Victorian, Category B local prison in the centre of town. It takes male prisoners from Luton Crown Court and magistrates' courts in Bedfordshire. It is managed as part of the Eastern Area of the Prison Service. In 2008 it was used to take prisoners from the London courts when there were not enough cell places available in the London prisons.

The Certified Normal Accommodation for the Prison in June 2008 was 324 and the Operational Capacity 506. In June 2008 the population was 502, very close to the limit of its capacity.

The prison comprises six wings. F Wing, where AB was located when he attempted suicide on 24th June 2008, is a small, Victorian, two-storey wing with gallery landings. It is the designated vulnerable prisoners' wing. The Health Care Centre, where AB spent his first eight days in Bedford, is situated on the second floor of a new purpose-built building.

Bedford was subject to inspections by HM Chief Inspector of Prisons in April 2006 and in March 2009. The 2009 inspection report described Bedford as having "all the problems associated with such local prisons: a transient and often needy population, and insufficient space for work and activities". It found Bedford to be "a well-run prison with positive staff attitudes, which serves to mitigate some of these problems and difficulties". The 2006 report was also generally positive. Both reports commented on the good relationships between staff and prisoners. Both reports also noted, however, the need for improvements in the management of foreign national prisoners.

Part Two The Background and Events in Detail

Chapter Three

Background

AB was born on 15th February 1987 and spent his early life in Eritrea. He arrived as an unaccompanied asylum-seeker at Heathrow Airport in December 2003. AB's mother had died when he was young and his father and elder brother had apparently been arrested as opponents of the government. His uncle had bought AB a ticket to London so that AB would avoid the same fate. As a sixteen-year-old, AB became "a looked after child" under the care of a London Borough Children's Services Department. He had no prior connection with that particular area but was allocated as a part of a rota system operating among London boroughs. AB was not thought to have any relatives in the United Kingdom, although it turned out that he has a relative in the north of England and he mentioned two other relatives in a paper he wrote in prison.

AB initially lived in an outer London suburb but then moved to a neighbouring borough, where he shared a flat. He moved back to the suburb on 12th May 2008. After undertaking an English language course, AB started a degree course in Civil Engineering at university in 2006. He passed the first year but failed one part of his second year course. AB told his social worker this when she saw him on 28th May 2008, a few days before he committed the crime which led to his remand to prison. As a care leaver, AB was entitled to support up to the age of 24 as he was doing a degree course.

AB told a psychiatrist whom he saw on 10th June in Bedford that he was a keen footballer and did voluntary work with young people. He also said that he liked to draw and write poems and had many friends. He further said that he was frustrated by not being able to work because of a lack of official documents. AB's status in this regard is not entirely clear. According to the Children's Services Department, the Home Office had told AB that he would be told the outcome of his asylum claim by the end of 2012 but that in the meantime he could claim benefits and obtain a student loan.

AB had some physical health problems, wearing glasses for a lazy eye and refractive error and suffering gastric problems. He was thinly-built and looked younger than his age. He had no criminal record apart from a warning for fare evasion. AB was a Christian and attended a church which is much frequented by people from Eritrea.

Chapter Four

The Offence

While attending church, AB met S, a girl also from Eritrea, whom he eventually killed in June 2008. S was some six years younger than AB, although AB wrote in a letter recovered from his prison cell that she was in fact older and was claiming to be 15 in order to attend school. It appears that she started a friendship with AB in 2006. AB appears to have become close not only to S, but to her family. He describes S's mother as "like my mum". After a while AB became very controlling of S, most likely thinking that she would one day become his wife. On 16th April 2008, S was with friends at a McDonalds in London, when AB joined them, reportedly very angry. A friend said that when she saw S the next day, S had a black eye and S had told her friend that AB did it. After the assault AB went to S's house on several occasions, but he was not welcome and was eventually advised to stay away by a neighbour.

S, her mother and cousin reported their concerns about AB to the Police on 30th April 2008. The Police recorded that "the suspect frightens the victim, that he is constantly ringing her and her mother and texting the cousin." The Police maintain that the family wanted AB to be warned, then later retracted this by saying they did not want anything done. The family dispute this and say that the Police told them that there was not enough evidence to prove the allegation. The Independent Police Complaints Commission (IPCC), who investigated the way the Police dealt with the case, found that the Police failed to seize potential evidence, failed to record the name and contact details of S's cousin and, through confusion and misunderstanding, failed to appreciate the nature of the threat that the family were telling them about. AB was not questioned about the assault.

On 2nd June 2008, the day that AB referred to as "the Day of Evil", AB killed S at the block of flats where she lived. CCTV cameras showed AB following S, walking a few feet behind her before confronting her either at the doorway or inside the block. Although nobody saw the attack, neighbours overheard an argument between a young girl and a man, then a scream. After the event, the court heard that AB dialled 999 and that during the call he told the Police operator that he had stabbed S to death because she was cheating on him. It seems that S had ended the relationship approximately two months before she met her death and that AB found it impossible to accept that. He was gripped by jealousy and possessiveness, reportedly saying to S, "Do you love me? Because if you don't love me, I will kill you." AB wrote a detailed account of the breakup of the relationship and the devastation it caused him - not only intense feelings of rejection, but failing his exams and starting drinking and smoking.

The Police managed to trace the 999 call after the operator kept AB on the line for more than 30 minutes, while he threatened to "finish it". Police officers found AB covered in blood, standing on the edge of a bridge over the River Thames, and arrested him.

AB was held at London Police Station for three days and appeared at court on 5th June where he was remanded to prison.

AB did not have the capacity to participate in a trial, because of the damage to his brain sustained in the incident of life-threatening self-harm on 24th June 2008. On 20th May 2009 his case was tried at the Central Criminal Court in London. The facts of the case were heard and on the basis of the evidence presented the jury decided that AB had committed the act of homicide. The Judge ordered that AB should be held indefinitely under the Mental Health Act.

Chapter Five

AB's arrest, court appearance and arrival at HMP Bedford

AB arrived at HMP Bedford on 5th June 2008 at about 4.30 in the afternoon. He was brought by a SERCO escort vehicle from Camberwell Magistrates Court where he had been remanded in custody on a charge of murder. His case had been adjourned until 21st August when he was due to appear at the Central Criminal Court - the Old Bailey.

AB had been arrested on 2nd June and held at a London Police Station. According to the Police records, shortly after his arrest AB collapsed in custody and attempted to swallow a chain. A doctor records him as being in a state of catatonia [a state in which a person becomes mute or adopts a bizarre, rigid pose] and suggested an urgent psychiatric assessment. His risk of self-harm on the evening of 2nd June was recorded as "high". He was not deemed fit for interview and a review was scheduled for the following morning.

There is no record of any medical examination until the evening of the 3rd when AB was given Rennies (tablets for the treatment of heartburn, indigestion or trapped wind.) to deal with pains in his chest. AB was still deemed as being at "medium" risk of self-harm, as he was the next morning. His chest pain was diagnosed as muscular. A Mental Health Act assessment was reportedly carried out on the 4th June 2008 but AB was not transferred to hospital. [This Article 2 investigation has not seen this assessment.] The social worker involved in the assessment made contact with the Children's Services Department in whose care AB had been. A doctor was called again in the early hours of 5th June because AB was still complaining of chest pains; further painkillers and a sleeping pill were given. His risk of self-harm at 12.52 a.m. was recorded as "medium".

At 9 o'clock in the morning of 5th June AB was taken to Camberwell Magistrates Court. A Prisoner Escort Record was prepared by the Police on the evening before. This ticked four boxes on the form: Medical condition, Violence, Stalker/Harasser and No Known Risk. The boxes for the categories of Suicide/Self-Harm and Vulnerable were not ticked. The Police officer completing the form did write in the box inviting further information about risk, "Violence - Nature of Offence; Stalker - Nature of offence; High Media Interest".

AB appeared before Magistrates for five minutes at 11.23 a.m. and, after accepting a meal and drink, he was back in an escort vehicle at 12 noon. A newspaper reported that AB "seemed bemused and distant before magistrates".

It is not clear why the 60 mile journey to Bedford from London took four and a half hours. The Internal Prison Service Investigation report into AB's case says that the van arrived at 15.29. A Near Miss Investigation report prepared by Governor M about what happened in Reception that afternoon says AB was received at approximately 16.30. In normal circumstances a defendant remanded at Camberwell would have been accommodated in one of the London prisons.

It appears that because of population pressures, a number of prisoners were sent instead to Bedford on an overcrowding draft. Governor N told us that this was commonplace at the time. A psychiatrist writing some four months later said he believed that AB was remanded to Bedford "in part because the prison was outside London and the case was of a high local and national profile", but there is no other suggestion that the decision to remand AB to Bedford was made on the grounds of his alleged offence. The Senior Officer (SO) who was in charge of Reception when AB arrived told us, "We weren't told from the court that we were receiving AB, or receiving the prisoner in relation to that crime, that was obviously in the news at that time." The SO who took over later that afternoon remembers differently, telling us "We knew we were going to get him. I mean he was quite a high-profile prisoner because of … there'd been a lot of media interest."

AB arrived at HMP Bedford at 16.30 hours on 5th June. He was wearing a white tracksuit top and jogging bottoms provided by the Police, according to the SO who was in charge of Reception. AB had no property with him.

There were a large number of arrivals at Bedford that afternoon. According to the internal Near Miss Investigation undertaken by Governor M into what happened in Reception that afternoon, 22 prisoners were received, 13 of whom were new, including AB. Three of the intake were deemed at risk and had ACCT plans opened on them; it is not clear if AB is included in these three. The Prisoner Escort Record (PER) made no reference to self-harm or suicide risk. In consequence, consideration was not given at this stage to opening an ACCT for AB, that is a plan for managing prisoners at risk of suicide or self-harm.

AB and the other prisoners were placed in a holding area, waiting to be processed. Because of the nature of AB's alleged offence which was detailed in the paperwork, the Reception SO telephoned the Duty Governor to tell him that AB was a Potential Category A Prisoner. In these circumstances it is for a Governor Grade to assess whether a prisoner meets the criteria for Category A. Those prisoners that did so would be transferred immediately to Woodhill Prison or held in one of a few particularly secure cells at Bedford.

The Duty Governor came to Reception and saw AB sitting "on his own, fairly quietly in a room with other prisoners. And initially I thought he looked a bit vulnerable". He interviewed AB in the office used by the Senior Officers. The Duty Governor said he did not know much about AB as he had not been reading the papers. The process required him to ask questions related to the alleged offence, to establish whether the criteria for Category A were met. Initially, AB was fairly reluctant to answer questions. The Duty Governor assured AB that he was not "trying to find out whether you did it or not, I just need to know whether or not I can locate you at Bedford tonight." At that point the Duty Governor reported that AB "became quite tearful and said he did know the victim. He said there was a weapon involved, stated the weapon … I think it was a knife. He, I think he then said it was his girlfriend and he began sort of sobbing and becoming very tearful."

AB's answers lowered his risk as far as his eligibility for Category A was concerned, so the Duty Governor decided not to submit him for consideration. The "Record of Potential CAT A Prisoners Received in Reception", the paper record of such assessments, was not completed however and it seems that the possibility of submitting him was in fact left open. The entry in the ACCT Observation Record at 17.15 on 6th June says, "AB to be dealt with as a Pot Cat A."

The Duty Governor did decide that AB should be placed on his own in a small holding room separate from the rest of the prisoners to await the reception process. He told us that "because he was so tearful and he was a very small lad and ... I felt could be prone to being bullied, I said, 'Look, let's put you in a little holding room on your own so that you'll, you know, you can compose yourself and get back on track.'" The Reception SO said that the main holding room was quite full at that time.

The Duty Governor said that AB was happy with that so he put him in the side room, and although he cannot remember exactly, thinks that he would have explained to the Reception SO what had gone, "that he hadn't made Cat A, that he was upset, tearful; just to check on him and then move, locate him accordingly."

The Duty Governor could not remember what questions he asked of AB and in particular whether AB was feeling suicidal or not. "I think I would've, but I can't remember 100%." It appears that the staff in Reception did not give consideration to opening an ACCT at this point. Nor did they have any discussion of whether because of the nature of his offence AB might be considered in need of segregation for his own protection under Rule 45 of the Prison Rules. The Duty Governor left Reception to return to other duties.

It is not exactly clear how long AB remained in the room. The Duty Governor thought that it could have been between 15 minutes and two hours before he heard an alarm which had been raised when AB was discovered.

It does not seem that AB had been processed at this stage. The Reception SO told us that she and other members of staff had looked in on him. But she explained, "There was no way of checking him, his welfare 'cause you can't see him without going to the door and looking, which was done on a few occasions." The SO does not think that AB had been seen by Health Care and may have only been seen by the Governor but she couldn't be 100% sure. The Senior Officer who arrived at Reception at teatime to take over was certain that nothing had been done.

It is not exactly certain when the second Senior Officer arrived to relieve her colleague. According to Governor M's report it was 17.50. The SO herself told us it was earlier, at 17.15.

The SO who had been in charge briefed her colleague about what was going on. She told us that "I had to give her a handover, which included Mr AB and where he was and why he was there; to which, obviously because she was taking over from me, she then went to check Mr AB herself and found that he had obviously, had self-harmed or was hanging."

The incoming Senior Officer confirms that the handover "straightaway ... raised to me of concern that we'd got Mr AB. And she said he'd been very tearful, so I said to her straightaway, 'Oh, I'll check him now'. She said he was checked a couple of minutes ago and I said, 'Well, I'll check him now again just to make sure he's all right.'" The SO who had been in charge did not confirm however that AB had been checked "a couple of minutes" before her colleague went in. She told us that it was no more than ten minutes previously.

When the newly-arrived Senior Officer looked through the observation hatch at approximately 17.55 she saw AB hanging from a noose made from his sweatshirt tied around the window bars at the rear of the cell. She shouted for help and an alarm was raised. Staff from the reception area and the rest of the prison arrived. A nurse based in Reception brought oxygen and AB was resuscitated. The SO thinks that "he was not breathing when we first found him" and this is confirmed in a note by the nurse and her entry in the medical record made later that night. The Patient Record states that "Found with shirt around his neck .. No responding. Lips blue and not breathing on arrival. Pulse present. Shirt removed and placed to floor as shirt removed he started to breathe. Oxygen applied and placed in recovery position".

After AB regained consciousness it was decided that he should be moved to the Health Care Unit. Staff undertook "a minimal reception process" with the "bare minimum of paperwork". The reception process included taking a photograph of AB, which required someone to support AB's head because, according to the SO who was now in charge, he "didn't have all his faculties". The other SO (who had remained in Reception to help out) told us that at this point AB "didn't want to have his photo taken".

An ACCT was opened at 18.15 and AB was taken to Health Care. One of the Senior Officers told us that AB "was moved to the Health Care and placed in the constant watch cell - I think initially he was dazed. But after that I believe he would have walked to the Health Care, but I don't remember". Initially, in the immediate action plan AB was made subject to intermittent watch, but within the next hour this was raised to constant supervision. AB was placed in the gated constant watch cell in the Health Care Unit. This cell is specifically designed for prisoners who need to be supervised 24 hours a day.

A Cell Sharing Risk Assessment (CRSA) was completed by the Senior Officer who had been in charge when AB arrived and the Reception nurse who had treated AB after his suicide attempt. He was assessed as representing a high risk of harm to others, which the form clarifies as meaning "a clear indication of high level of risk that prisoner might assault cellmate". The SO wrote that "Due to Self Harm and un-cooperation – high risk at this time." The nurse has ticked boxes indicating that "you feel something is wrong" and "Insufficient evidence to give opinion". She also ticked the box indicating that he may be at risk of harming others because of "Previous Behaviour".

Chapter Six

AB in the Health Care Centre, 5th - 13th June

AB spent the next week in the Health Care Unit. From 6th to 10th June he was subject to constant observation. During the first few days AB was highly suicidal. On the morning of 6th June he was seen first by a doctor who recorded that AB maintained some self-harm ideation: "states that he doesn't know why he is here and that he didn't know if would try another attempt at self-harm." A Community Psychiatric Nurse reports AB being "adamant that he wants to die as he sees no future ahead of him" and that he appears depressed and remorseful. AB was also interviewed by an officer undertaking the assessment interview which forms a key part of the ACCT process. The officer recorded that AB would commit suicide given the chance, "that he has no reason for living and no coping mechanisms."

AB's first ACCT review was held later that morning, chaired by the Head of Health Care. AB stated that he wanted to take his own life. A CAREMAP was produced. This is the name for the Care and Management Plan that forms part of each ACCT Plan for the care of at-risk prisoners. The CAREMAP recorded that AB should have mental health assessment "asap", be referred to the Chaplaincy and remain on constant supervision.

For the rest of the day, the ACCT On-Going Record of observations shows AB to be very upset and tearful. At 5.15 in the afternoon, the record states that AB is "now to be dealt with as a Pot Cat A" but it is not clear who or what triggered this decision and what this entailed in practice. There is reference to AB wearing special clothing in the form of an "E list suit". The Security Department sent AB a form telling him that he would be placed on closed visits.

There are no entries in the ACCT On-Going Record of observations between 17.45 and 23.14 on 6th June. In the morning of the 7th AB stayed on his bed asleep or awake, crying and groaning from time to time. At 09.45 a Case Review was held chaired by Governor M who was the Head of Safer Custody. AB's risk remained "high". Steps were taken to enable AB to read and write and to have a shower, all of which was recorded in the updated CAREMAP. AB asked for his glasses and Reception was to be contacted to see if they were there.

At 10.15 AB returned to his cell. The Observation records show that AB was still upset and tearful but that he showered, took exercise, watched TV in the Association Room - his own cell did not have TV. He also read newspapers and spent time writing. He ate lunch and dinner and cleaned his cell. AB told an officer that he was writing a love story in his native language. On two occasions, he told officers who were watching him not to worry about him.

After what appears to have been a good night's sleep, on 8th June AB ate breakfast, filled in his menu choice and went to see induction staff in the day room; shortly afterwards his third ACCT review was held. Governor M, the Case Manager, noted

a more positive review with AB showing “us that he is progressing”. AB asked to watch football; the European Championships were on and he was keen to see the matches. The updated CAREMAP records that AB could wear his own clothes in and out of the cell, could be issued with a telephone PIN so that he could ring his solicitor and engage in more of the normal regime. The CAREMAP also notes that the constant supervision might be reduced to intermittent at the next review the following day as long as there were no further incidents of self-harm.

During the rest of the day AB stayed in his cell and watched TV during the afternoon. He was noted as becoming very upset at lunchtime. AB spent the evening writing in his cell and was given pyjamas at 11.30 at night. He appears to have slept well.

The following morning, 9th June, AB asked to see a doctor who told him his chest pains were due to anxiety. It is also noted in the Health Centre record that he was “not able to read due to needing spectacles”. After a period of exercise in which AB is recorded as staring into space, his ACCT review was held at 11.10 a.m.

Although AB seemed positive, the panel agreed that he remained “high” risk and stayed on constant supervision, notwithstanding the suggestion in the CAREMAP that this might be reduced to intermittent. AB agreed to join in education and asked once more for his glasses which the Case Manager said she would pursue with his solicitor, having established that the glasses had been retained by the Police, presumably as possible evidence.

In the afternoon, AB was not permitted to watch TV but he joined in education classes before returning to his cell and he spent the rest of the day reading, writing and drawing. At 3.10 p.m. he was told that he was not to be made Category A and was then noted to be crying. AB had visits from a Chaplain and the Independent Monitoring Board. He asked again about his glasses and was given a large print book because “small print strains his eyes”.

The following morning, 10th June, AB was seen by a psychiatrist at just after 10 a.m. The psychiatrist took a life history from AB but AB would not talk about his self-strangulation attempt. He said he had been very scared on arrival at Bedford but had taken a decision to deal with the issues using his inner strength. He was disappointed that he could not watch football on TV and he wanted pen and paper to write stories and poems. The doctor planned no psychiatric intervention. Two hours later AB was reviewed under the ACCT scheme and, although his risk remained “high”, it was decided to move him from the constant watch cell to a safer cell and reduce observations to intermittent. He seemed “much better today”.

The records do not say when exactly AB moved cells but it seems to have been sometime that afternoon. Observations continued to be recorded six times an hour. AB is recorded as being reluctant to change into a blue gown at night and “acting angry, this man shows clearly he can be very stubborn with attitude.” He was also frustrated at not always being able to watch TV. He was subject to a two-man unlock, meaning that he could not be allowed out of his cell without two officers present, which sometimes led to delays. If a prisoner is a Potential “Cat A” then it is

normal for two officers to be present when he moves out of a unit to another, but it is not usual for two officers to be required when unlocking a "Cat A" within a unit.

On the morning of 11th June, AB complained of feeling unwell and stayed in his cell, later complaining of boredom; and at 1.30 in the afternoon he is recorded as hitting his head on the window having blocked the spy hole on the hatch. At his ACCT review in the afternoon, he is recorded as being fed up, wanting to be treated as normal. Plans were put in place to allow him his own clothes at night, TV in his cell until 8.30 at night and to explore a transfer to F Wing. The requirement for two officers to unlock his cell was lifted and his observations reduced to half-hourly. These changes, reflecting the reduction of level of risk from "high" to "raised", were included in the CAREMAP. AB spent the evening writing a letter, asking for more paper at ten to midnight.

On the morning of 12th June AB visited the library, where he tried to take a newspaper away which had an article in it about his case. An officer removed the newspaper. AB is recorded as being a bit low at lunchtime but the ACCT Case review held at 2.15 p.m. found him to be about the same as the day before. AB asked again about his glasses and the record says that "Officer will try and find out". The summary also refers to the assessment by the psychiatrist finding "no mental health issues", although this finding had been made two days before.

AB spent the rest of the day in education and in the day room watching TV, before returning to his cell where he wrote.

On the morning of 13th June AB had a visit from his solicitor and in the afternoon a further ACCT review, immediately before which he is recorded as asking an officer what F Wing was like. At the review, AB's risk was assessed as "low" and he was reassured about the wing being friendly. He said he was happy to go and to share a cell.

Chapter Seven

AB in F Wing, 13th - 23rd June

AB's move to F Wing was made immediately after the review on 13th June and AB was located at Cell F2-006, sharing with a Mr X. He spent the evening watching TV. The paperwork for Rule 45 was completed, with AB applying for separation from the main core of prisoners for his own protection because of the huge media coverage and fear of taunting from other prisoners. The Cell Sharing Risk Assessment was not reviewed until the next day, when AB's risk of harming a cellmate was noted as "medium". A Cell Sharing Risk Minimisation Plan quotes AB as saying that he is happy to share a cell and that his cellmate is a good man.

AB appears to have settled reasonably well over the weekend, although he was initially reluctant to join in association on 14th June. After that, the observations record him playing pool, watching TV and not giving any cause for concern. Indeed, on the morning of Monday 16th June he told an officer that he no longer needed to be on the ACCT document.

An ACCT review was held a little later that day and AB said he had settled in well, got on with his cellmate and had no thoughts of suicide. He had applied for work, education and gym. Observations and interactions were to continue to be made and recorded half-hourly and, despite the positive picture, the risk level was ticked as "raised" whereas it had been "low" on Friday 13th June. A Senior Officer had seen AB on the Saturday and an entry at 10.30 on 14th June in the ACCT On-Going Record states that his risk assessment was now "medium". This change does not appear to have made any real difference to AB's supervision and care.

The CAREMAP was completed, setting goals of finding work to combat boredom, to have emergency credit to use the pin phone and to use the gym. The Senior Officer who chaired the review told us that, as far as he could recall, the emergency credit was to assist AB in contacting his solicitor.

Over the next three days, the observations record little in the way of issues or problems. AB continues to write a good deal, to use the gym and to make telephone calls. However on 17th June, a Chaplain records a pastoral visit to AB, "v emotional. Please look after him Thank you". The Chaplain told us that AB was always tearful when she saw him. She told us that she had not been surprised when she found out about the incident of life-threatening self-harm after it had occurred.

On the same day, 17th June, AB made a telephone call to a social worker at the Children's Services Department by whom he had been looked after. He said he had no future and asked if he died what would happen to his remains - would they be returned to Eritrea? Governor M was alerted to the call by the social worker. Governor M came to talk to AB on the 18th June, who he records as being embarrassed that he, the Governor, knew about the conversation he had had with the social workers. AB told the Governor that he was settled although "he did have

thoughts going round in his head". AB also told a Chaplain that he tended to keep feelings to himself.

Although the observations during 19th June record AB as OK, the ACCT review held in the afternoon found AB to be "very low in mood". But he denied thoughts of suicide and self-harm. Risk remained "raised", half-hourly checks stayed in place and a further review was scheduled for the following day so that a Community Psychiatric Nurse could attend. After the review on 19th June, AB made a telephone call, following which he was very tearful. It is not known whom AB had telephoned. It is noted that his cellmate would keep an eye on him.

We have been unable to interview the cellmate in question, Mr X, but he was interviewed in the internal Prison Service investigation into the case in 2008. Mr X told the internal Prison Service investigation that he had been asked to keep an eye on AB when AB first came to share the cell on 13th June, although he was not told that AB was on suicide watch. Mr X said that he guessed something was not right because of the frequency of the checks made on AB by staff. Mr X said that at night AB did not sleep, kept writing letters and would cry. AB talked about why he was in prison and said that he wanted to talk to the victim's mother, with whom he said he had had a good relationship, and "she had given him everything". AB "continually tried to get in contact with the mother".

AB reportedly told Mr X that he had tried to kill himself and that his life was over and he had nothing to live for. Mr X also said that AB would often be cowering in the corner during exercise and was generally withdrawn and would not shower. There was no work on the wing and AB would sleep during the day and cry at night, sobbing and distressed.

Keeping an eye on AB became too much for Mr X who asked to move cell. In fact it was AB who moved cell on the afternoon of 20th June after the ACCT Review meeting. The Review found AB to be very down and depressed when mentioning his call on the day before. He walked out of the review at one point.

The Senior Officer who chaired the meeting told us that she could not remember about the call but that "he said that he wanted to call or to write to the alleged victim's family; and obviously we said that he couldn't do that, right? Which is when he got up and walked out." The CPN went after AB and, persuaded him to come back into the review. The SO told us, "I don't know whether it was a look or something that gave me the impression that he was actually in contact with the family; and I asked him this and he denied it." She suggested that perhaps he was writing to them via somebody else or via a mobile phone. While this was purely her opinion, she said, "it was just the way he looked, you know, like when we said, you know, 'You can't contact the family', it was just … he gave me the impression that he already was although he denied it."

The review felt that AB was not really communicating, although AB said that he "will talk to staff", presumably about his feelings and problems. The review concluded that if AB were to get worse, they would recommend a move back to the Health Care Centre. This possibility was discussed at the meeting but, according to the Senior

Officer who chaired it, “everyone was of the opinion that moving him to Health Care would have made him worse, because then you were going to take his access to the TV away from him”. Also, AB himself did not wish to move.

Although AB was not moved to the Health Care Centre, he did move to a new cell on F Wing shortly after the meeting on 20th June. The note of the ACCT review does not refer to this. The ACCT On-Going Record of observations states that “Review completed is moving cells from F 2-6 to F 3-3 to be closer to the office as still on half hour observation.” At 15.45 it is noted that AB was not happy with move but after a talk he has now understood the reasons for the move.

When we interviewed the officer who made these entries, he could not remember the cell move or whether he had played a role in the decision. He had told the internal Prison Service investigation that AB had been removed from his cell with Mr X because he was actively seeking to harm himself and this was upsetting Mr X. The officer said he deliberately put him in with Mr Z because he thought it might help him as Mr Z had recovered from a tendency to self-harm and could be a role model. The officer reportedly told the internal Prison Service investigation that he did not record that he discussed this with other officers and that, more generally, history sheets had an absence of entries.

Mr X, with whom AB had been sharing in F 2-6, said to the internal Prison Service investigation that when AB was told that he was moving cells AB broke down and cried uncontrollably. He calmed down “but was still really upset at being moved”.

In his new cell AB shared with a Mr Z who was also interviewed by the internal Prison Service investigation and during this Article 2 investigation. Mr Z told the internal Prison Service investigation that he was uncomfortable about sharing with someone subject to an ACCT but he never told the staff this – nor did they ask.

Mr Z also said to the internal Prison Service investigation that during the night of 20th/21st June AB spent a long time talking about killing himself. AB looked for somewhere to hang himself and Mr Z found a noose AB made under his pillow which was braided and had taken some time to make. Mr Z told us that the rope had fallen out of AB’s bedding and that he, Mr Z, had thrown it away which had angered AB. AB had said to Mr Z that if he was his friend he would let him kill himself. Mr Z managed to talk him down and AB went to sleep at 2 a.m., but Mr Z could not relax and watched TV until 5 a.m. The next morning Mr Z told an officer he could not cope with AB and another prisoner, Mr Y, moved into F 3-3 with AB. Mr Y had previously occupied this cell and told us that he offered to return there when he heard that Mr Z wanted to move.

The ACCT On-Going Record confirms that AB was sitting talking to his cellmate at 22.45 on the 21st and that until 02.40 the next morning AB was observed either writing at his desk or watching TV before going off to sleep.

On 21st June AB told an officer he was feeling fine. There is no reference to Mr Z moving out of the cell and AB getting a new cellmate. AB is recorded spending the day sleeping, writing and joining association, with no issues or problems noted by

staff. Once again, AB stayed awake until late, still watching TV at 2.15 a.m. the next morning.

On the morning of 22nd June, AB declined the opportunity to attend chapel and stayed in his cell. He was noted as “a very quiet individual”. He joined association for half an hour before returning to his cell to write and to draw pictures of love hearts. He then went out for a longer period of association and was noted to be mixing well and in good spirits. He watched TV in the evening before going to sleep by 00.20. AB’s cellmate, Mr Y, told us that on that day a newspaper carried a piece about the funeral ceremony for AB’s victim which had taken place the day before. (There were two funerals: one in London on 21st June, the second in Eritrea on 24th June.) Some prisoners drew it to Mr Y’s attention, telling him that he should know who he was sharing with. They then left the article out on a table at the bottom of the stairs in F Wing where prisoners, including AB, could see it. Mr Y is certain that AB did see it. Mr Y informed staff who withdrew the newspaper from circulation. The article described how “the anguished mother of murdered choir girl was overcome with grief”.

On the morning of 23rd June, an ACCT Review was held. This was recorded as starting well, but AB stormed out when told he could not write to his victim’s mother. He returned and apologised, saying that he was impatient about things and just wanted everything sorted. The Senior Officer who chaired this review told us that “He came to the – I remember him coming to the review with a letter. Initially, we talked about how he was, how he was feeling, that he’d settled and he was quite open, talking, he had good eye contact and initially I thought he was doing very well. And then he produced a letter, and I remember him passing it to the CPN at the time ... and saying, ‘Could this go to my – could the letter be sent on?’ And he didn’t say where it was going and obviously the CPN has checked the address and recognised through her dealings with AB, I’d imagine, that this was his victim’s mother. And she stated, ‘I don’t think that you will be allowed to send that. It would have to be checked.’ And at that point he become quite agitated and just walked out.”

The Senior Officer “gave it probably about a minute and went towards his cell and he came back towards me, and he apologised, he said, ‘I’m sorry, I’m sorry.’ I said, ‘Well, do you want to come in and we’ll continue?’ And he did, and he picked up really before the incident with the letter. He sort of calmed down; explained to him, you know, we’ll have to check things out, we’re not sure, and he seemed to calm down again at that point.”

A further review was scheduled for the next day. AB was next observed reading a newspaper before returning to his cell. He refused his lunch and spent the next two hours in bed with his head under the sheets. He appears to have stayed on his bed for much of the rest of the day, apart from making a number of telephone calls, some of which did not successfully connect.

In the evening AB was observed chatting to his cellmate, before being seen asleep at 01.05.

Chapter Eight

The Day of the Incident of Self-Harm, 24th June

On the morning of 24th June, AB did not reply when spoken to at 07.30 but at 9 a.m. he was telling an officer that he was OK. He was told his social worker would be visiting the next day. He then went to the gym where his mood was noted as being a little subdued.

AB collected and ate his lunch at 12.30, one of only five (out of 28) prisoners to do so. Many of the F Wing prisoners believed that the food had been contaminated. Officer C told us that "It's not unusual to have issues with food on the wing, because of what type of prisoner is on there. Some issues are raised up by the prisoners themselves, some are raised by staff. Sometimes some of the stuff looks like it may have been adulterated; sometimes maybe the prisoners just think it." On this occasion, the same officer noted in the wing observation book that the fear of contamination "stemmed from shouting between B and F Wings". Verbal abuse had been noted in the wing observation log on the 19th and 20th June, and on the 20th prisoners in the chapel's Muslim prayers were "not only shouting abuse they are now spitting down onto the prisoners on the exercise yard". One of the Senior Officers and the Orderly Officer held a meeting at 14.30 to discuss the food and abuse issues with the F Wing prisoners. AB attended. The officers offered to sample the food themselves and said that the prisoners who had been shouting from B Wing had been dealt with.

AB then had his ACCT review at 14.50. This noted AB to be still very "emotive". He cried a couple of times and said he still could not understand why he could not write to the victim's mother. He also said he was finding it difficult speaking to staff. He said he was looking forward to starting IT class in the morning. The level of risk remained at "raised" and twice-hourly observations were to continue.

The Senior Officer who chaired the meeting was concerned about AB and rang Governor M who came to see AB at about 15.30. The SO told us that "AB wouldn't really communicate with me and I think he was crying and was very non-responsive ... and I asked for a second opinion from Governor M who was then the Head of the Safer Custody … 'cause he wasn't really talking to me and I know that he used to sometimes talk to Governor M a bit more ... sometimes you just get this niggling feeling and it's hard to say why. And I think in that case it's because he wasn't … although there was bits and pieces wrote down there, he wasn't communicating brilliantly with me."

Before Governor M arrived to see AB, AB is noted as making a phone call. Governor M spoke to AB and noted that he gets upset with issues relating to the crime but is settled on F Wing, gets on with his cellmate and is starting an IT course and expecting a visit the next day. AB's spectacles were also discussed. These had not been located and he was put on the waiting list to see an optician.

Governor M told us that he had received a call from the Senior Officer who had chaired the review, who said that AB had been tearful and “she wanted my opinion as to if he should he remain on F Wing.”

Chapter Nine

The Incident of Self-Harm on 24th June

Officer C told us that he and Officer T were detailed to work on the evening of 24th June. When unlocking the prisoners for association, which would have happened at 6.15 p.m., Officer C had noticed quite a number of cell cards had been missing. These are the cards placed outside each cell which give the name and basic information about the prisoner located in it. He decided to type up and replace the missing cell cards. He remembers having a jokey exchange with AB when he was replacing his card about whether AB was a smoker.

Officer C told us, “We had a laugh, I patted him on the back and he went into his cell. I then went down and did another two cell cards down on the 2s, I had a quick look into the Association Room and then went back upstairs. I went past AB’s cell, I noticed the door was closed, I went into the office and looked on the ACCT document, ‘cause what I’d actually done, although I’d spoken to him, I hadn’t recorded that in the ACCT document. When I went in I’d pencilled in a half hour when the half hour was up. I looked at that and went straight back out.”

Governor D, who was the Duty Governor, happened to be on the wing. She had seen Officer C and thought that he had been looking for someone.

Officer C opened AB’s door flap and found that the cell was in darkness. He opened the door and could see a shadow, standing at the window, and then became aware of the ligature behind the figure. “I turned round, called for assistance, went in and lifted him up. He was extremely heavy. I tried to lift him up a bit more and I lifted up my right knee to further support him.” Officer T came in, and he got a fish knife out from Officer C’s belt and they cut him down. Officer T started heart massage, and a nurse arrived soon after. She had responded to an alarm. Officer C thought it was a general call for assistance.

Officer T, who was the second on the scene, had been with Governor D in the office which is a few metres from the cell. He remembers Officer C “saying that as a result of one of these half-hourly obs, that’s when he found him, yeah. I remember now. Yeah, yeah, yeah, that’s what it was. That’s what it was. He said, ‘I’m going to check on AB.’” Shortly afterwards Officer T heard Officer C shouting; Officer T thought that Officer C had shouted “Staff”, whereas Officer C recalls shouting “assistance”. Officer T thought his colleague was “either in some kind of trouble, you know maybe the prisoner was acting up a bit or something.” He admits he “didn’t figure exactly immediately what was happening. So I took hold of his arm, right, and the other Officer said to me, ‘He’s hanging, he’s hanging. Lift him up.’ or ‘Keep him’ or ‘cut him down’, something like that. So anyway, we did cut him down. We used one of those fish knives. We cut him down and I said, ‘Let’s get him on the floor’, you know, and I think by that time [Governor D] must have twigged on to what was going on, she realised something was happening. So she must have summoned the nurse or Health Care help or something.”

Once the two officers had got AB on to the floor, Officer T undid the ligature that had been made from a plaited bed sheet, which took a few seconds. According to Officer C, "It wasn't a slip knot, shall we say. It wasn't meant for undoing."

After this the two officers started cardiopulmonary resuscitation (CPR). Officer T recalls that when he had first tried for a pulse, there was none. When the nurse arrived she took over from Officer C. She recorded that on her arrival AB was in full cardiac arrest. The Incident Report attached to the Security Incident Report says that when AB was cut down there was no pulse so CPR was conducted. On the arrival of the nurse AB again stopped breathing and CPR was again performed until the paramedics arrived and stabilised him". A newspaper report of the incident quotes the Prison Service as saying, "Staff .... revived this prisoner twice before paramedics took him to an outside hospital."

The nurse recorded in the medical record that after about six minutes there was a pulse present, although Officer T told us that he "had a pulse by the time ... she turned up". Officer T "was quite sort of shocked 'cause it's not that often that happens. Got a pulse, kept him going, bagging him with the Ambu bag [a self-inflating resuscitator bag used to assist ventilation] and then, when the ambulance people turned up, we told them exactly what we'd done. We got a pulse, very slow pulse, but it was strong, steady." The Incident Log records that at 19.15 "informed AB breathing".

Officer C told us that when the nurse arrived she had to ask for other equipment to be sent over but Officer C is not sure if this was oxygen. Officer T recalled that the nurse did have an Ambu bag when she arrived.

Governor D broadly confirms what happened. She had entered the wing from the external door, walked through the Association area onto the wing. She saw Officer C, who appeared to be looking for someone. After talking to prisoners, Governor D made her way upstairs where she went to the wing office and talked to Officer T. Governor D thinks she may have looked through some documents, but after a short period Officer C shouted out for assistance. He had entered AB's cell and seen AB hanging from the windows, partly obscured by curtains. Officer T hurried to the cell to provide assistance. A radio call was made for urgent medical assistance; Governor D cannot remember if it was she or one of the officers that made the radio call. Governor D moved to outside the cell, but, having seen that the officers were doing what was required to get AB down, she concentrated on getting the other prisoners back into their cells. Other staff arrived quickly, including the Orderly Officer, Principal Officer M. Governor D briefed PO M about what had happened and he then took charge at the scene. Governor D made her way to the Control Room where she prepared a security risk assessment for the officers who would be escorting AB to hospital. After the ambulance had taken AB to hospital, Governor D made some telephone calls, including to the Governing Governor who came to the prison. She arranged for the cell to be sealed but the Police were not called at this stage.

There is some discrepancy about the exact timing of the events. The ACCT On-Going Record notes that AB was found hanging at approximately 18.50, whereas the

incident report compiled by Officer T says he was found at approx 19.00. The Incident Log has the call for assistance timed at 19.02. The medical record notes the call for urgent assistance to F Wing at 19.00, which is also the time noted in the wing observation log. Officer C told us that he had already pencilled in 18.50 as it was half an hour after the last check.

There is also a minor discrepancy about precisely what alarm call was made. The Incident Log says, “Papa 2. Assistance Required F Wing Radio Alert sounded” [the call sign for medical assistance]. The medical record notes “Hotel 2 call for urgent assistance”. The incident report by Officer T, the second Officer on the scene, says, “we called for urgent medical assistance”.

Officer C, the first officer on the scene, recalls that, after the nurse had relieved him, he “carried on the wing sorting out, ‘cause some of the prisoners had been doubled up in the wrong cells, they’d just been put behind their doors because I believe a general alarm had gone out, as opposed to … because I’d called for assistance, and I didn’t identify what assistance I wanted – I just wanted assistance, and apparently they called … sent out a general alarm. So we had a lot of staff there and the situation was then carried on and dealt with from there.” It is not known for certain who made the alarm call.

There is some doubt about exactly how the ambulance was called. The report on the management of the incident by the Orderly Officer, Principal Officer M, says that the nurse who was in attendance “request an ambulance at once”. The Incident Log says that the ambulance was requested by “O”, i.e. the Orderly Officer. It is possible that the nurse asked for the ambulance to be called and the Orderly Officer actually made the radio call for it.

Finally, there is a question about precisely how long the ambulance took to arrive at the prison and leave. The Incident Log says that the ambulance was requested at 19.05 and arrived at 19.06. The log also says “Paramedic Arrived” at 19.23. Officer T, the second on scene told us that he thought the ambulance came within six or seven minutes of being called.

As for leaving, the Incident Log notes “Paramedic Leave” at 19.33 and the ambulance “en route to S/Wing” [South Wing Hospital] at 19.40. The Prisoner Escort Record form notes that AB was discharged from F Wing at 19.30 and that he arrived at S Wing at 19.40.

Chapter Ten

AB since the Incident on 24th June 2008

AB remained at South Wing Hospital where he was placed in intensive care. He was on a ventilator until 2nd July 2008 when he was able to breathe spontaneously. He sustained damage to his brain due to asphyxia during the hanging.

His condition gradually improved and on 23rd September 2008 he returned to HMP Bedford. AB still had difficulty walking, his speech was limited and he was difficult to understand. He was located in the Health Care Centre and continued to be subject to ACCT monitoring.

Doctors decided that AB should be transferred to a hospital setting and this appears to have taken some time to arrange. He was assessed by staff from a hospital in the Midlands on October 23rd 2008. Although a place was offered he was not transferred there. An assessment carried out in December 2008 found AB to have a complex combination of physical, neurological, neuropsychological, neuropsychiatric problems following the brain damage sustained during the hanging on June 24th 2008.

On 10th December 2008, AB was transferred under Section 48/49 of the Mental Health Act to a hospital that provides rehabilitation programmes for patients with acquired brain injury. This is a medium secure unit where AB is still living at the time of writing.

On 20th May 2009 a jury at the Old Bailey decided that AB was responsible for killing S. AB was not fit to plead or take part in a conventional trial. He was ordered to be detained under the Mental Health Act.

Part Three Issues examined in the Investigation

Chapter Eleven

Could anything have been done which might have prevented the incident of self-harm in Reception on 5th June 2008?

The Reception area at Bedford was undoubtedly a busy place on Thursday 5th June 2008. As the Duty Governor put it, "When I had to go to see AB so it was all a bit, you know, as it is in a local it's kind of quite manic. So you run around from one area to another."

When AB arrived at Bedford there was nothing in the paperwork to suggest that he was at risk of suicide or self-harm. AB had been arrested on a Thames bridge having threatened to kill himself. He had tried to harm himself in the police station when he was first detained there on 2nd June but his risk of self-harm was assessed by the Police as "standard" on 4th June and as "medium" in the early hours of 5th June. It is not clear exactly what the terms are in the scale of risk which is used by the Police.

Recommendation A: The Police and the Prison Service should use the same scale and terms when assessing risk of self-harm.

If there had been an indication of risk on the Prisoner Escort Record form (PER form), a report would have been attached. The Senior Officer told us that if they had received such a report "... that form is given to the Health Care staff in Reception straightaway and they're asked to see the prisoners that come in with that form sooner than any other prisoners, to give them priority in case they are at risk." Dr Cumming considers that had the prison been informed about the earlier self-harm in the police station and the Mental Health Act assessment undertaken there, this might have led to "a greater or more sustained input from the mental health team in the prison."

The Prisoner Escort Record form did alert the staff to the fact that the offence was one of violence and stalking and that there was high media interest. There was no requirement that in such a case a prisoner should have been processed as a priority. In many cases of this kind, the prisoner concerned is likely to be of particular interest to, and perhaps at risk from, other prisoners in Reception. AB told the psychiatrist who assessed him on 10th June that on his arrival in prison he was very scared.

Recommendation B: Prisoners who are remanded for crimes which have attracted high media interest should be processed in Reception as a priority after those who have been assessed as being at risk of self-harm.

The nature of the AB's offence did lead to an assessment being undertaken of his security status. The Duty Governor who undertook the assessment told us that this process involved "getting the basic information we can. And I've always had a

problem with it because it's - you are almost asking a person to admit guilt or not to a crime that they've been charged with, and that's always felt a little bit awkward. And we've had to sort of stress to them, 'Well, what we're trying to do is assess your risk.'"

The Duty Governor told us that AB looked vulnerable from the start. "By the time I'd finished talking with him he was tearful, sobbing, and I just felt it was the humane and decent thing to do was to put him on his own. You know, that's something we, again, we routinely do with prisoners who are vulnerable. So if somebody's clearly in for a sex offence or whatever, they will go into a separate holding cell. Now he was - or a vulnerable prisoner, so that's … it wasn't unusual". Placing AB on his own would have protected him from the possibility of bullying, but provided the opportunity for him to harm himself. There was no way to observe a person in the small side room without opening the flap on the door. The Duty Governor told us that AB was happy with being placed in the side room so he put him in there. Although he cannot remember exactly, the Duty Governor thinks that he would have explained to the Senior Officer what had gone on, "that he hadn't made Cat A, that he was upset, tearful; just to check on him and then move, locate him accordingly." The Duty Governor does not appear to have completed the "Record of Potential CAT A Prisoners Received in Reception". It is not clear what AB's security status actually was at this point.

The Duty Governor did not at that point consider either opening an ACCT, nor the question of Rule 45, for AB. He told us that "that could have been done at the same time really or on the same day. He would need to be signed up, again by me as the Duty Governor, for Rule 45; and that would be based on his, usually on his offence, or at his request. If he said, 'Look, I don't want to be on the main wing, mixing with mainstream prisoners', we would then try and explore the reasons why, and go from there. But it's generally fairly easy to identify those who will not cope in sort of mainstream population." But AB was not so identified at that point.

Governor M's Near Miss Investigation into the incident of self-harm on 5th June says that AB's location in a holding cell on his own may have resulted from confusion as to whether or not AB was applying for Rule 45 status. The staff in Reception do not appear, however, to have considered Rule 45 at this stage. But Governor M told us, "I think that when AB arrived it was quite a high profile case and it was, I believe, an offence against a young girl and I think at the time, if I can recall he had been kept separate from other prisoners by the escorting company if I remember rightly, and when he arrived in the prison we weren't sure that - the Reception staff weren't sure whether or not this man was going to be going onto Rule 45 for his own protection in light of the case or not. And that just highlighted to me on the investigation that there wasn't really a protocol in place in Reception for the monitoring of prisoners who are kept separate."

There was a "Protocol for the Location of Rule 45 Prisoners" (dated 16th April 2008) in operation at the time. This applied "when a prisoner has requested to apply for Rule 45 status and the Duty Manager has endorsed this …", suggesting that the process is initiated by the prisoner himself. But this is not always how prisoners were made subject to Rule 45. HMP Bedford's Independent Monitoring Board, in its

report for 2007-8, had concerns that prisoners were committed to F Wing, the vulnerable prisoners unit, "when it may not be necessary through misplaced advice from solicitors or GSL staff", namely the staff escorting prisoners from court. Whether misplaced or not, no advice about Rule 45 appears to have been given in respect of AB.

Recommendation C: The Procedure for Rule 45 should be reviewed to ensure that high profile cases are proactively managed.

The internal Prison Service investigation was critical of the decision to put AB in a single holding cell without adequate supervision, immediately after AB had broken down, crying, in front of a Governor. "There was no need to isolate AB due to the nature of his offence, particularly if he wasn't made Category A, and if a prisoner was tearful isolation may not be the best option for him, or if it is then it needs to be properly written up."

It is true that HMP Bedford's Suicide and Self-Harm Management Strategy says at 5.2 that at-risk prisoners should not be isolated and should be kept in association wherever possible. But AB had not been identified as being at risk at that time. The decision seems to have been designed to help AB.

The Reception Senior Officer told us that while AB was in that holding room, "myself and members of my staff did make regular checks on him in there to make … 'cause he was in there on his own." But "there was no way of checking him, his welfare 'cause you can't see him without going to the door and looking, which was done on a few occasions." She thought this was done about every ten minutes. Her briefing of the Senior Officer who came to replace her when she was due to go off duty prompted the new SO to check on AB almost immediately and this was when AB was found hanging.

Finding 1: We consider that on 5th June 2008, the staff [in Reception] generally acted in accordance with procedures and the decision to place AB in a holding cell was not unreasonable. We think that the form given by the Police to the escorting personnel should have noted that AB was at risk of self-harm.

Finding 2: We think it would have been better had AB been seen first by Health Care staff in Reception prior to the Category A assessment, so that any risk of self-harm could have been assessed.

Finding 3: It is not at all clear what decision was made about AB's security status following the assessment. Consideration should have been given to segregating AB for his own protection under Rule 45 at the same time.

Finding 4: It would have been better had a clear instruction been given as to how often AB should have been checked after he had been placed in the side room in Reception.

Recommendation D: Although there is now CCTV, staff should check prisoners in the holding room every ten minutes.

Recommendation E: Better documentation should be used for assessing prisoners for Potential "Cat A" status. A written algorithm should be produced to show the decision made to either submit or not and why. A copy should be placed in the prisoner's record.

Chapter Twelve

How did staff respond to AB's incident of self-harm in Reception?

The immediate response to AB was prompt and efficient and the two staff directly involved were rightly recognised for their actions in saving AB's life.

The internal Prison Service investigation was critical of two aspects of AB's management after the incident. First, he considered that it was inappropriate that someone held AB's head up so that a photograph could be taken before he was moved to Health Care. He thought that "Sensitivity and discretion should be used to ensure the dignity of the prisoner in such a situation". We asked a number of staff members about this. The Senior Officer in charge at the time the photograph was taken told us, "I know that wasn't ideal, but it was imperative to have a photo before we moved him because we do need that for every prisoner's record and because obviously by then he was placed on an open ACCT document and that also needs it." She was not prepared to delay the taking of a photograph until later "Because he was on an ACCT we couldn't … well, I wasn't prepared to do that and I know it didn't seem ideal, but we need to identify, like, prisoners that are on an ACCT". The Senior Officer who had been in charge earlier on, when AB first arrived, told us that his head was held because AB didn't want to have his photo taken; he was therefore assisted. She said that the Health Care staff were there and that a photo of his face was necessary because "he was a suicide risk and therefore we needed it for his ACCT document and also we would have needed it had he been potentially a Cat A anyway".

Governor D considers that taking a photograph is a key part of the reception process and, while a balance must be struck with the needs of individuals, on a busy evening in Reception if it were not taken at that time it might not have been done later. At the time, the fixed electronic camera in Reception generated sufficient photographs for all the necessary paperwork. An alternative Polaroid for use when the digital system broke down created much more work. We were told that there is now a free-standing digital camera which means that a photograph producing a digital image could be taken anywhere in the prison, for example in Health Care.

Finding 5: We think that it was not appropriate forcibly to take a photograph of AB immediately after his attempted hanging in Reception. It could have been taken a little later, with AB returning in the morning for an electronic image to be used in the documentation. A Police photograph could have been used in the meantime.

The second decision criticised by the internal Prison Service investigation was to make AB high risk for single cell-sharing purposes. The investigation accepted that the Cell Sharing Risk Assessment was undertaken when AB was on his way to the constant watch cell, so this made no material difference in the case itself. Its main concern seems to have been that staff are not signing up other prisoners in similar situations as high risk, when in fact the sharing of a cell may be an appropriate support mechanism. It was also critical of the Duty Governor's decision not to return

to Reception to check the form and sign it personally. The Duty Governor gave his agreement by telephone to the Senior Officer who, along with the nurse from Health Care, completed the CSRA.

This was clearly an unusual situation in which to complete a Cell Sharing Risk Assessment. The staff completing the CSRA had just been involved in a near-death incident which, apart from the impact on them, meant that AB could not communicate with them. The Senior Officer who completed the CSRA told us she could not recall doing so. The reception process had necessarily been minimal and there was little information available. As Nurse G wrote on the CSRA, "Unable to assess properly". The Prisoner Escort Record form did say, "Violent, Stalker and High Media Interest", and the consideration of Category A status was still under way.

Finding 6: We think that when undertaking Cell Sharing Risk Assessments, it is important not to confuse risk of self-harm (which was clearly established in AB's case) with risk of assaulting a cellmate; but in the circumstances the decision to assess AB as "high risk at this time" was not unreasonable.

Chapter Thirteen

How was AB's period in the Health Care Centre from 5th - 13th June managed?

From Thursday 5th to Tuesday 10th June 2008, AB remained on constant watch in the Health Care Centre. He stayed in the cell which is specifically designed for constant observation. The In-Patient Manager at the time explained what this meant: "Constant supervision is a process that anyone who is deemed to be of high risk of either suicide or self-harm, they have a member of staff sitting outside the door 24 hours a day, and they … it is recorded every ten or so minutes the actions of that person. They are watched if they shower, they're never left on their own."

AB seems to have got bored and did not like being under constant surveillance. There was no television in the constant supervision cell. The In-Patient Manager told us that "In the gated cell it wouldn't be appropriate to put a TV in there. When people are on suicide watch and they're on constant watch, you know, it would give them ammunition, if you like, to harm themselves".

AB made progress during this period and was reviewed every 24 hours. On 10th June the frequency of AB's observations was reduced from constant to intermittent and he moved to Cell 2 across the corridor. From 11th June AB's risk was assessed as "raised" rather than "high" and observations were further reduced to half-hourly day and night. Dr Cumming considers that the Health Care Centre "was used appropriately in the initial period of his remand and when he was most obviously distressed."

There are three matters which might have affected AB's progress in this period. These relate to AB's glasses; his security status and the attempt to obtain information about his next of kin.

a) AB's Glasses. The first is the issue of AB's glasses. The CAREMAP written at the first ACCT Case Review mentions the need to get the glasses. AB spent a good deal of time reading and, while the absence of glasses did not seem to prevent him doing so, it is likely to have put strain on his eyes and may well have caused him distress. It emerged that AB's glasses were not in Reception and had been removed by the Police. Efforts were made to retrieve them and then to obtain a prescription from the Children's Services Department in whose care AB had previously been. Eventually AB was put on a waiting list to see an optician. By the time of his life-threatening self-harm on 24th June, AB still did not have a pair of glasses, two and a half weeks after arriving in prison. Indeed, his Patient Record notes him receiving his spectacles on 7th November 2008 when he was back in the Health Care Centre after his return to Bedford from South Wing Hospital.

Governor M told us that "in hindsight now, I think perhaps what we should have done initially was just gone through the process of booking him an eye test, and at least tackled it on a couple of fronts, sort of, you know, that we might have got it resolved – well, we might have resolved it before the incident."

Finding 7: Much greater priority should have been given to obtaining AB's spectacles which had been retained by the Police. Given his need for these, a temporary pair might have been obtained.

b) AB's Security Status. The second issue relates to the decision made on the day after AB arrived that he was, after all, to be treated as a Potential Category A Prisoner. This seems puzzling. The Duty Governor told us that the factors which AB disclosed to him lowered the likelihood of AB being made a Category A, and it is not clear what further information could have been considered subsequently to justify AB's treatment as a Potential Category A Prisoner.

AB received a notification on the 6th June that he was being placed on closed visits for up to three months. This is in line with Bedford's Policy on Potential Category A Prisoners which says that visits should be "in closed conditions until such time as the visits are approved .." At this time he was in the Health Care Centre under constant supervision due to being at "high risk" of suicide and self-harm. As the internal Prison Service investigation pointed out, "there is no mention that being on an ACCT document has been taken into consideration and how this information should be conveyed to AB. This may not be unreasonable, but is hardly likely to have improved his state of mental health. Many prisoners who are potentially category A, who have committed very serious offences and are likely to be depressed and potentially suicidal, may be tipped over the edge by this piece of information".

Other matters that resulted from the decision to deal with AB as a Potential Category A Prisoner, namely that he should wear a particular uniform and that he should be unlocked only with two officers present, were discussed as part of the ACCT reviewing process. The question of closed visits is not recorded as having been discussed. There is no evidence that AB's mental health was adversely affected by the restrictions imposed as a result of his security status, but it is reasonable to think that it might have been. It is not clear from the paperwork at what point it was decided that AB was definitely not to be a Category A prisoner. Presumably this decision was taken by the time AB was moved from the gated cell on 10th June.

Finding 8: We question the decision to treat AB as a Potential Category A Prisoner. The question should have been settled much more quickly and, until it was, the consequences for AB should have been managed as part of the ACCT process, perhaps by the involvement of security staff at reviews. It was unnecessary for two officers to have to unlock AB in the Health Care Unit, notwithstanding his Potential Category A status at the time.

Recommendation F: If a prisoner is initially considered for Potential "Cat A" status, but is subsequently downgraded, his closed visit status should be considered at the same time. The prisoner should be informed of the outcome of the review promptly.

c) Information about AB's Next of Kin. The third issue relates to the gathering of information about AB's next of kin. The summary sheet on the core record has no details. The ACCT document has in the Next of Kin Details section, "Non stated"

(sic). No proactive efforts seem to have been made to identify a next of kin. On 8th June a staff member on the Health Care wing undertook a housing needs assessment which noted that AB "was renting a property that social services had set up" and proposed a further assessment. Contact with Social Services was only established after AB telephoned his social worker on 17th June. She then wrote to the prison on the following day and also telephoned Governor M.

Given that every prisoner is given an opportunity to make a phone call and the fact that ACCT Case Reviews should review progress "in increasing the strength of protective factors and the need to take further action, e.g. contact with friends and supportive family", the failure on the part of the prison to seek to identify a next of kin is an omission.

Finding 9: Greater efforts should have been made to identify AB's next of kin.

Recommendation G: More resources should be used to establish next of kin swiftly, especially in foreign national cases. Enquiries could be made through Police intelligence officers, the UK Border Agency and any church or community groups with whom a prisoner had been associated.

Chapter Fourteen

Was it appropriate to move AB to F Wing on 13th June? Were decisions made properly about which cell AB should have on F Wing and with whom he should share?

AB grew frustrated with the restricted regime in the Health Care Centre. On 11th June he told his ACCT review that he was fed up and wanted to be treated as a normal prisoner. The review decided to start looking for a bed for him on F Wing. This seems appropriate. Puzzlingly, there was no mention of a move to F Wing at the following day's review held on Thursday 12th June. This review scheduled a further review for the Monday four days later. In fact, the next review was held the next day, on Friday 13th June. Presumably this was because a vacancy had become available in F Wing; an officer is recorded as having made a "verbal contribution regarding vacancy" and the summary of the review is almost entirely about the move to F Wing. Dr Cumming considers that AB's "discharge to the main prison did not seem precipitous and the rationale and benefits were developed with AB".

Finding 10: Given the progress that AB had made and his wish to enjoy a more normal regime, the decision to move him to F Wing seems a sensible one. Decisions about location within F Wing and the sharing of cells should have been managed as part of the ACCT process.

As for AB's exact location on F Wing, he was initially placed in Cell F2-006 on the ground floor. Mr X had been in the cell on his own and he told the internal Prison Service investigation that his "door was opened and" he was told that he "would be having a new cell mate in 10 minutes." Mr X "had had some difficulty with a previous cell mate as he had ended up arguing with him and was then given a cell on his own. It was his first time in prison."

A week later, on the afternoon of the 20th June, AB was moved to Cell 3-3. Although the move was made directly after the ACCT review held on that day, the note of that review makes no reference to the cell move. The summary, however, recommends a move to the Health Care Centre if AB gets worse. An officer told the internal Prison Service investigation that he deliberately put AB in with a Mr Z because he thought it might help AB as Mr Z had recovered from a tendency to self-harm and could be a role model. Mr Z told us that he was not subject to ACCT monitoring at the time. Mr Z also said to us that he was not asked, but told, he would be sharing with AB.

The next day Mr Z said to an officer that he could not cope after AB had spent much of the night threatening to kill himself. Mr Z told us that he had found a noose in AB's bedding and confronted AB about this, telling him that he was not going to harm himself while in his cell. On this occasion it was not AB, but Mr Z, who was moved; and a third cellmate, Mr Y, moved into 3-3.

We asked a number of witnesses how cell allocations were decided. Senior Officer P said, "I'm led to believe that was dealt with by management at a higher level, and through the ACCT process that was in place. I had no dealings with where he would be located or if he'd be located with prisoners." In fact, it seems that the moves were decided at a lower level, by the officers on F Wing.

None of the detailed cell moves affecting AB were mentioned in the ACCT reviews. The Suicide and Self Harm Strategy in force at Bedford in June 2008 says that Case Reviews should decide on how best the prisoner should be supported - that is where he/she should be located …" It is not clear whether "where" means which part of the prison or which particular cell. The strategy also states that decisions about whether an at-risk prisoner should share a cell must be recorded in the ACCT plan. It further says that "two prisoners known to be at risk of self harm must not be located together in a double cell, unless a case review team having considered the care of both prisoners decides they will both benefit from sharing with each other. The decision to locate two at risk prisoners together must be recorded in the CAREMAP".

Finding 11: The spirit of the Suicide and Self-Harm Management Strategy in place at the time was not adhered to in the way the decisions about AB's cell allocation were made on F Wing. On successive days, 20th and 21st June, prisoners told staff that they were unable to share a cell with AB and that AB was actively suicidal. There is, however, no record of the reasons for prisoners feeling that they were unable to share with AB being properly fed into the ACCT review process.

Recommendation H: We recommend that a more detailed policy is developed about the allocation of cells. For prisoners subject to ACCT monitoring, any cell moves should be agreed as part of the reviewing process, other than in an emergency when they should be reported to the Case Review.

Recommendation I: Cell moves in F Wing should be better documented and countersigned by management. If prisoners are moved for their safety and wellbeing, this should be noted in their prison files and ACCT document.

Recommendation J: Managers must ensure that any downgrading in Cell Sharing Risk Assessment is documented correctly, giving valid reasons for any decision.

Chapter Fifteen

How was the ACCT (Assessment, Care in Custody and Teamwork) process managed?

ACCT is a process intended to be a means whereby staff can work together to provide individual care to at-risk prisoners to help defuse a potentially suicidal crisis *or* to help individuals with long-term needs (such as those with repetitive self-injury); and to better manage and reduce their distress.

AB was subject to the ACCT monitoring system for almost his entire period at HMP Bedford. Indeed, it is arguable that given his suicidal behaviour in the police station he might have been placed on an ACCT immediately on his arrival. In fact, it was not until after AB's first act of serious self-harm that an ACCT was opened. Initially, AB was made subject to intermittent observations, but this was quickly changed to constant watch.

Bedford's ACCT procedures at the time are set out in the Suicide and Self-Harm Management Strategy". The On-Going Record of significant events, conversations and observations, which forms part of the ACCT process, shows that for the most part staff monitored AB at the required frequency. Dr Cumming considers that "the standard of entries in the daily observations was good"; but that not everyone who saw AB made an entry; and in this regard Dr Cumming notes that the mental health team did not complete a separate entry that mirrored their entry in the clinical IT records. But others such as Chaplaincy usually made an entry, as far as is known. Dr Cumming does not feel that the omission of entry by the mental health team had any bearing or impact upon the later incident.

However, many of the interactions with AB appear to have been of a rather cursory nature. At the first ACCT Case Review it is recorded that AB was informed "he needs to discuss issues he has so help can be given". At the twelfth review, on 24th June, a few hours before the incident of life-threatening self-harm, AB said he found it difficult speaking to staff.

The officers we spoke to said that they had had superficial conversations with AB, but with very little discussion about the offence or AB's feelings about it. The Head of Healthcare told us that "it was mentioned, the alleged offence, but if I remember rightly I don't think AB was … he didn't really say too much. I don't think he wanted to talk about it all. I think it was a quite a high profile case at the time, you know, so we don't pressurise, you know. If he doesn't want to talk about it then fine." She also said that "I think they sort of go into shock that it's actually happened. And maybe that was the same for him, I don't know. But we don't press. If he doesn't want to talk about it then we don't."

Dr Cumming comments that "Prisoners, often at the instructions of their legal representatives, frequently avoid discussing the offence for fear of the potential prejudice of their trial. Those who work with prisoners (whether it be a mental health team, prison officer or others) are aware of this and the consequences of probing

into this area such as having to complete SIR forms and that they might become a witness in the trial itself; they tend to exert caution. I sensed that this was the area that needed addressing but that the above factors did not facilitate this."

How staff conducted the ACCT Review meetings and case management role

The ACCT Review meetings were held on the days that they were scheduled and there are examples of good practice: the meeting that was deferred from 19th to 20th June so that a Community Psychiatric Nurse (CPN) could be present; and the decision to get a second opinion from Governor M on 24th June when AB was causing concern. Dr Cumming considers that "at all times the proposed ACCT review took place and in all instances there was a good level of attendance and on every occasion AB was included. The forms were correctly filled out, and there were recommendations made around level of observations, [and] risk level and issues identified were addressed and worked on following the review. It seemed a good standard, was detailed and appropriately completed."

The internal Prison Service investigation was critical of the number of different Case Managers who chaired ACCT reviews; it was seven in all. The Suicide and Self Harm Management Strategy document says that "wherever possible the Case Manager should arrange subsequent reviews at a time that he or she can be present in order to provide some continuity of care for the prisoner. Where the named case manager cannot attend, they must explain to the prisoner who is to take their place at the review and record that they have done this".

We have not found examples of such information being recorded and the impression is rather that reviews were chaired and attended by whoever was on duty and available at the time. Only one of the 12 reviews carried out between 6th and 24th June was fixed for a particular time of day.

Governor M told us that having the same Case Manager "is not easy, certainly at a local prison like this. Wherever possible, the Case Manager will be one of the Senior Officers from the area where that prisoner is located. ..... However, because they work - staff work shifts, sometimes a review might fall where a Senior Officer has said, has carried out the first assessment, set up a review in 48 hours, 72 hours, and not necessarily be in the prison when that review is due to take … and then it's picked up by another Senior Officer. I did have an issue with this. I did bring this up, about SOs arranging reviews when …, trying to arrange reviews when they were in, so that they had this continuity of care with the particular prisoner. However, all the best will in the world, that's not always going to work because staff go on leave, things happen, which means they might have set the … all best interests to set up a review, but unable to actually make sure they're there for that review to take place."

While these points have force, it is odd that the minutes of the Safer Custody Management Team Meeting on 10th April 2008 say that "in line with PSO 2700 it has been decided that the same case manager will deal with an open ACCT document from start to finish. Reviews will only be scheduled when that Case Manager is on duty. If the Prisoner does move wings, then the Case Manager will be changed in

that instance". When AB was on F Wing, his reviews were chaired by three different Senior Officers.

In terms of participation of staff in the reviews, it was often down to availability. The review on 24th June was attended by a Senior Officer who had not previously acted as a Case Manager for AB, AB and an officer who told us that "If I was the nearest one to the office, then the SO would have asked me to sit in on the review". He agreed that he was really sitting in on the meeting rather than contributing. To her credit, the Senior Officer asked a Governor who did know AB better to come and see him afterwards, which the Governor did.

It would have been preferable if there had been a functioning Personal Officer scheme through which a particular member of staff was given some particular responsibilities for forming a constructive relationship with AB. The Suicide and Self-Harm Strategy dated April 2008 says that "Bedford runs a Personal Officer scheme" and that, despite the difficulties of running a scheme because of the transient nature of the population in local prisons, Personal Officers still have a vital role to play in the care of at-risk prisoners". We were told by some of the staff we interviewed that such a scheme was running, but there is little evidence that it played a role in AB's case.

HM Inspectorate of Prisons found in March 2009 that "The personal officer scheme was limited in scope. All wing file entries seen were minimal and did not demonstrate the level of knowledge that staff clearly had about individuals. Personal officers were allocated by cell number and therefore changed regularly. Management checks did not offer quality assurance. Prisoners were generally not aware who their personal officers were but this was mitigated by their confidence in approaching any member of staff for support or help. There was minimal personal officer engagement in issues key to prisoners' progress through their sentence."

Besides any designated Personal Officer, there were other people working in the prison who might have contributed more to AB's care, for example the mental health team and the Chaplains.

Dr Cumming has considered the adequacy and approach of the mental health team during AB's time in custody at HMP Bedford. Dr Cumming considers that the clinical information in the aftermath of the offence suggests that AB was experiencing a marked "adjustment reaction", but Dr Cumming did not find any evidence within the information that would suggest that AB had a psychotic illness. The early part of AB's remand was characterised by marked distress, with loss of appetite, withdrawal, tearfulness, low mood - the typical features that might be seen in those who have had a sudden loss and experience grief. During his time in custody, AB was seen on two occasions by mental health workers within the first week of his arrival; his case was closed to mental health on 10th June though there was further involvement and attendance at ACCT reviews. There was some imbalance in that the early involvement occurred during the initial period of distress but, as he began to deteriorate in the period before the incident, mental health services did not get involved or assess him again. Dr Cumming thinks that, of all resources within the prison, mental health (and potentially the Chaplaincy) had probably the strongest

remit and ability to explore the issues relating to AB's distress. Ideally a psychological approach would have been of greatest benefit, though it is speculative as to how much AB would have revealed or been prepared to discuss. It is thus possible that AB might have wanted to hide his intentions around self-harm.

As for the Chaplaincy, we spoke to one Chaplain who worked on Tuesdays. She happened to be a trained Samaritan. She said that she and all of the staff on F Wing were aware that AB was highly suicidal and that there was nothing that they could have done. AB felt that there was no point in living. As well as feeling the guilt and trauma involved with his crime, AB felt deeply bereaved. He was always tearful when she saw him. She was not surprised when she found out about the incident. This Chaplain did not share these insights with the formal ACCT review process. Ironically, she did see AB shortly after the ACCT review on 24th June, so could presumably have participated in that review if she had been invited. There was a strong case for involving her. The SO who chaired the review on 24th said she did not know if AB was religious because he had never said anything. Yet, on the initial CAREMAP it states that AB is religious and a practising Christian.

One of the regular F Wing officers told us that he thought that AB was religious and was at risk of taking his life in order to secure his future with the person, i.e. the victim of his crime. He told us, "I think that his intention was to take his own life at the first or any opportunity." This officer was involved in only one of the five ACCT reviews on F Wing, on 16th June.

The failure to involve the Chaplains in the ACCT Case Reviews is also an example of a weakness in meeting the Suicide and Self-Harm Management Strategy requirement that "the Case Review Team must consider Progress against the initial CAREMAP." So, too, is the failure to make progress in obtaining AB's glasses which he first requested on 7th June, as noted at point 5 on the CAREMAP of that day.

The actions entered on the CAREMAP also more often than not lack timescales. The column "by whom and when" contains a date on only five out of 18 occasions, with a further one saying "ASAP".

Finding 12: Despite some examples of good practice, the ACCT process was not managed as well as it could have been, with too many Case Managers and a failure to involve the most relevant personnel, consider all relevant information and follow up the CAREMAP in the Case Reviews.

Recommendation K: Either higher priority should be given to case management or more realistic Guidance about ACCT Case management needs to be produced. There should be continuity of Case Manager in ACCT reviews, with consideration given to whether a review deadline might be relaxed if that permits a Case Manager to attend, thus forming a more meaningful review.

Finding 13: Continuity of care more generally would have been improved by a functioning Personal Officer scheme and greater involvement from mental health services.

Recommendation L: Greater priority should be given to ensuring that prisoners with open ACCTs are allocated to a Personal Officer who attends or reports to all ACCT reviews.

Recommendation M: Greater efforts should be made to involve in ACCT reviews any of those who work in a prison who know a prisoner well, and to obtain their contributions if they cannot attend.

Recommendation N: All action points in ACCT documents should be time-bound and the use of "ASAP" discouraged.

Finally, there is a question about how well the ACCT process assessed the particular needs of AB that arose from the gravity and circumstances of his crime, his ethnic and cultural background and the level of interest in the case; and the efforts that were made to identify possible 'triggers' that might have increased risk.

The initial assessment undertaken on 6th June states, in the section headed "Triggers/warning signs to prompt immediate review", "No triggers identified" in Box 1 and the court date of 21st August is noted in Box 2.

AB's incident of life-threatening self-harm on 24th June 2008 took place on the day the victim of his crime was buried in Eritrea. Although there had been a funeral ceremony in London on Saturday 21st June, the victim's father had asked for S's body to be laid to rest in her home country. Whether this was a coincidence or AB planned to take his life on that specific date, we cannot know for certain. AB certainly followed newspaper coverage of his case, attempting to take a newspaper from the library on 12th June. A handwritten note made as part of the internal Prison Service investigation includes the phrase "was fully aware of media covering the funeral this week". Mr Y, who shared a cell with AB from 21st June, told us that AB had seen a newspaper article about it on 22nd June which other prisoners had seen and left out on a table in the Wing. If AB was in fact aware of the victim's funeral, the question arises as to whether the prison should also have been aware of it and seen it as a trigger.

What is also true, however, is the contrast between the picture obtained about AB from the observations recorded by the prison officers on F Wing and that which has been given by the prisoners with whom AB shared a cell. Mr Y, who shared with AB from 21st June until the incident, wrote to the Governor of HMP Bedford on 22nd July 2008, almost a month after the incident on 24th June. He writes how he witnessed first-hand "just how terribly distraught he was over the crime he committed". He told us that Mr AB rarely left his cell, spent a lot of time under his sheet crying and praying for forgiveness - so much that the sheet became wet with tears. Mr Y told us that he did keep staff informed about how AB was. Mr Y took the view that AB was "deep in his culture" and could not live with the guilt of having killed the girl he loved. He remembers discussing with one of the staff the cultural aspects of the case.

The first of the prisoners with whom AB shared on F Wing, Mr X, was interviewed as part of the internal Prison Service investigation in 2008. Mr X told him that "AB

would sleep during the day and cry at night sobbing and distressed." Mr Z, the second prisoner with whom AB shared a cell, told us that he found a noose that AB had made under his pillow which was braided and had obviously taken some time to make. AB had also said to Mr Z that if he was his friend, he would let him kill himself.

While these observations by prisoners were all made after the event, if they are taken at face value, they suggest that AB's level of risk in the days leading up to the incident on 24th June was more consistent with the "high" than the "raised" category. Mr Y told us that he did share his concerns with staff at the time. The other two prisoners must have done so to an extent when telling staff that they could not cope any longer with sharing a cell with AB. But the input of these prisoners was not fully taken into account in the ACCT reviews. Had it been, AB's risk might have been assessed differently.

The guidance in the ACCT document says that risk is "high" when, inter alia, "frequent suicidal ideas not easily dismissed; specific plan with likely access to lethal methods; situation experienced as causing unbearable pain." With hindsight at least, AB fell into this category.

Even without input from prisoners, a fuller appreciation of risk might have been obtained by ensuring the staff who had most contact with AB contributed to his care planning. One of the regular F Wing officers, who was the first on the scene at the incident on 24th June, told us, "I believe there was always a risk of him doing that. I think that his intention was to take his own life at the first or any opportunity." While the officer could have made an entry in the ACCT document, AB's history sheet and in the wing observation book, it is likely that he did not have the opportunity to feed this perception directly into the ACCT case review process, as he attended only one of the ACCT reviews, on 16th June, shortly after AB had arrived on F Wing.

Finding 14: A more thorough assessment of possible trigger points relating to AB's alleged offence should have been undertaken.

Finding 15: The views of AB's cellmates about his risk should have been fed into the risk management process.

Recommendation O: Further investigation of trigger points should be made where possible, such as the funeral of a victim, or events which carry particular significance in different cultures.

Recommendation P: Training should be given to ACCT Case Managers to develop skills for use whenever prisoners are unwilling to discuss the trigger points or circumstances surrounding their self-harming.

Recommendation Q: Mechanisms should be developed so that in appropriate cases the views of cellmates can contribute to the assessment of risk.

Chapter Sixteen

How well were AB's broader needs assessed (e.g. educational needs) and was he given access to appropriate regime activities?

AB was in Bedford for 19 days before the incident of life-threatening self-harm. The observations in the ACCT On-Going Record show that AB spent a very great deal of time in his cell. There are records of visits to the library and the gym and of playing pool. The prisoner who shared with AB from 21st to 24th June told us that AB rarely left the cell despite encouragement to do so from staff and from him.

While a limited regime is understandable in the Health Care Centre, once AB was on F Wing he might have expected to undertake work or other purposeful activity. Bedford's Suicide and Self-Harm Management Strategy says that "Attending gym, workshops, education and visits may form part of the care planned for the prisoner and should be actively encouraged".. When AB arrived on the wing, the first ACCT review held there, on 16th June, amended the CAREMAP to address the issue of boredom through getting work. The action required, namely to apply for work and the IT course, was completed on the same day. AB did have an assessment for education and was due to start the IT course on 25th June, but nothing more seems to have been done about work.

The internal Prison Service investigation found that prisoners that were interviewed on F Wing complained about a lack of activity. "They said that you had to be a staff favourite to get a job and some prisoners said they had two jobs while others had none." The prisoner interviewed by that investigation who did not have a job was a black and minority ethnic prisoner (as was AB). It was recommended that whether or not this was a coincidence should be checked using SMART monitoring - (the Systematic Monitoring and Analysing of Race Equality Template). The Action Plan drawn up to respond to the internal Prison Service investigation's recommendations says that such monitoring was due to commence in April 2009 but we have not seen any documentation to show whether it has been done.

The internal Prison Service investigation also recommended that prisoners on F Wing should be part of the normal labour allocation process to prevent allegations of favouritism in the distribution of jobs. The Action Plan reports this as having been completed in February 2009. The report of HM Chief Inspector of Prison's inspection of HMP Bedford carried out a month later, in March 2009, found that access to work "for vulnerable prisoners was particularly poor. The main workshop for them relied on work over spilling from another workshop, and at the time of the inspection there had been none for a month. Small numbers had access to the low-skill breakfast pack assembling." The IMB report for 2007-8 says that work takes place in the Association area.

The Inspection also found that perceptions of black and minority ethnic prisoners were significantly less favourable than those of white prisoners across many areas - for example, safety on the first night, victimisation, reception, living conditions,

personal support, staff interaction, and access to healthcare and work.

Finding 16: Although AB may not have been in the right frame of mind to work in F Wing, we think opportunities to occupy him out of his cell should have been more vigorously pursued so that he spent less time in his cell, and was able to experience a more positive environment during the day.

Chapter Seventeen

How was AB assisted in making contact with his legal representatives, social workers, family and friends? Was AB's desire to contact, from prison, the family of the victim of his crime dealt with appropriately by the prison?

We have discussed in Chapter Thirteen the weak efforts to locate a next of kin for AB. AB was assisted to make telephone calls with emergency credit given on 16th June. The SO who authorised this thought that this was for AB to make a call to his lawyer, but it is possible that the call was to AB's social worker, to whom he made a call on 17th.

The Suicide and Self Harm Management Strategy says that, on opening an ACCT, the Unit Manager or Night Orderly Officer should find out who they feel is "likely to be supportive (e.g. family, friend, counsellor, personal officer, Offender Supervisor/Manager) and if possible help facilitate their talking with the prisoner". This task does not appear to have been completed and few efforts to identify family or friends were made during the period of AB's stay until 24th June. It was as a result of a telephone call from Children's Services on 17th June that the prison learned that AB was in contact with them, although, as noted above, a housing needs assessment on 8th June had revealed that AB was renting accommodation from them. This information was not acted upon by the prison.

After AB's arrest, the Children's Services Department had been contacted by the Police who had obtained their number from AB's mobile phone. AB's social worker had conversations not only with the Police but also with a mental health social worker who was presumably involved in the Mental Health Act assessment undertaken in the police station. Children's Services was not informed about what had happened to AB following his arrest until AB himself rang them on 17th June and told the social work team that "he thought he was being held at Bedford". The Children's Services Department faxed "Prison Locations" (presumably the NOMS Prisoner Location service) on 17th June, eventually receiving a reply on 28th July saying that AB was not known to the Prison Service". In the meantime the department had contacted HMP Bedford by fax and by telephone, speaking with Governor M on 18th June. AB's social worker arranged to come to visit AB on 26th June.

There was also further contact in the form of a letter from the Head of Children's Services to the Deputy Governor on 19th June, following a telephone conversation. This seems to have covered, among other matters, the question of AB's reading glasses.

The fact that AB had a family of his own in the UK was not known to Children's Services and became known to the prison only after the incident of life-threatening self-harm on 24th June. AB's next of kin was contacted by the prison who had discovered her details via the pin phone system because AB had been making calls to her.

We know that AB made a number of efforts to contact the family of his victim. According to one of his cellmates, "AB seemed more concerned about the mother and not being able to speak to her than anything else." AB became frustrated and angry when this was not permitted, walking out of his ACCT reviews on 20th and 23rd June and mentioning it at the review which was held four hours before he tried to kill himself on 24th June. Senior Officer J confirmed that "Yeah, there was several – yeah, several times that he wanted to contact the victim's mum. He wanted to say sorry, I think." At the meeting on 23rd June AB brought a letter with him and "just briefly handed it to the CPN and she then glanced at the address and said, 'I'm not sure if you'll be able to send this. Due to the case we'll have to make some enquiries regarding this.' And that's what, the point when he sort of became a little bit agitated."

This was the day after AB saw the newspaper coverage of his victim's funeral, which described her mother's inconsolable grief. This may have further increased AB's resolve to get in touch.

Another of the Senior Officers thought that AB might be in contact with his victim's family, saying "I mean whether he was writing to them via somebody else; some prisoners have got possession of mobile phones or access to mobile phones, as much as we try to stop them; it could be a number of ways. He just … it was just the way he looked, you know, like when we said, you know, "You can't contact the family", it was just … he gave me the impression that he already was although he denied it. But that's just my … that's just purely my opinion".

In stopping AB from writing, the prison should have been acting in accordance with PSO 4411 which deals with Prisoner's Correspondence. As for telephone calls, the relevant PSO is 4400.

At HMP Bedford we were told that if prisoners are on F Wing, "then all mail automatically goes to the Public Protection Office". It is not clear why this should be. PSO 4411 says at 4.8,

> "Prisoners wishing to correspond with the victim of their offences, or the victim's family, should first apply to the Governor for permission, which may be withheld if it is considered that the approach would add unduly to the victim's or family's distress (further information can be found in the Public Protection Manual or the National Security Framework - or Local Security Strategy). This is covered under Prison Rule 34 (2) & (3) and is compliant with Articles 8 & 10 of the ECHR. This restriction does not apply where:
>
> (a) the victim is a close relative (defined in paragraph 4.5 above) and who wishes to receive correspondence;
> (b) the victim has already written to the prisoner since conviction;
> (c) the prisoner concerned is unconvicted, unless there is evidence to support that they may be harassing the victim, thereby breaking any conditions imposed by the Courts, or attempting to pervert the course of justice by doing so."

In AB's case the relevant paragraph is (c). We have not seen any record of evidence that AB was harassing the victim, breaking court conditions or attempting to pervert the course of justice but, given the circumstances and high media profile of the case, the staff were right to be cautious.

AB's strong desire to contact the victim's mother may reflect an important aspect of the culture of Eritrea. Following the committing of crimes, particularly grave crimes, a strong emphasis is placed on the offender and their family achieving reconciliation with the victim's family.

The father of the girl whom AB killed was quoted in a newspaper article about the case as saying, "In our way of life, we deal with these things differently. We cannot allow one person to cause loss and suffering, not only to a victim of violence but also to his or her family and friends. We believe in an eye for an eye. An equivalent member of the perpetrator's family must be killed, or the family must negotiate for that not to happen. They will agree to pay for the victim's funeral, for the goats and sheep to be slaughtered for the feast and for an amount of money to be paid in recompense for the lost life. If this is not done, a judge will try to resolve the matter. If he fails, then the family can expect retribution."

It is possible that AB's almost desperate efforts to contact S's family may have reflected a need he felt to open this kind of negotiation. Although Mr Y told us he remembered having a conversation with a staff member about this, AB's attempts to make contact were not seen in this way by the prison. Had they been recognised in this way, some efforts might have been made to enable AB to contact an intermediary – perhaps the priest at his church.

More generally, it seems that HMP Bedford may not have been as aware as it could have been about the needs of foreign national prisoners. The HM Inspectorate of Prisons report in 2009 found that "the most significant recent incidents had featured foreign nationals, and we were concerned about this very vulnerable group. There was no dedicated foreign nationals' coordinator.

Foreign national prisoners felt less safe than British nationals, as well as having more negative perceptions over a wide range of issues. There was no consultation with foreign national prisoners and no meetings for them. Other than induction material, there was no information available in languages other than English. Interpreting services were used regularly and appropriately. There was contact with the UK Border Agency on administrative processes, but there were no surgeries or proactive work". While AB had been in the UK for some years, he might have benefited from a more comprehensive approach to foreign national prisoners.

Finding 17: While staff were right to be cautious about AB's wish to contact the mother of his victim, his reasons for wanting to do should have been explored and, if appropriate, some contact facilitated with an intermediary.

Recommendation R: Given the growing number of foreign national prisoners, we recommend that the Prison Service initiates research into how murder /

killing is perceived and dealt with in other countries, particularly in relation to cultural expectations within communities.

Recommendation S: Establishments holding foreign national prisoners should be assisted in understanding cultural differences in respect to attitudes to death, murder and taking one's own life.

Chapter Eighteen

Broader Problems on F Wing

During the period that AB was on F Wing there were a number of problems. The issue of the alleged contamination of food came to a head on 24th June, when the staff sensibly organised a meeting to reassure the prisoners. This was the day of AB's act of life-threatening self-harm.

We know that AB was one of the few prisoners who did eat lunch on that day. It seems likely that widely-held concerns about the food, and incidents of abuse stemming from prisoners on another wing would have created a threatening atmosphere on the wing which would have done little to help AB's state of emotional distress. Senior Officer J said she thought the food issue had nothing to do with AB's suicide attempt, but she accepted that the wing was not that settled.

It also appears that the Samaritans phone was not available at this time. We do not know whether AB might have made use of the phone if it had been working, but the opportunity may not have been there had he wished to do so. The minutes of the Safer Custody Management Team meeting held on Thursday 19th June say, under the Chaplaincy Report, that "There appears to be problems with access to the Samaritans phone on F Wing. There have been complaints of prisoners being denied access to the phone and the lack of privacy.... [the Head of Safer Custody] will ensure that the Governors order is reissued to remind F Wing staff of this."

On 9th July, two weeks after the incident of life-threatening self-harm, the Governor re-issued a notice to staff reminding them that "should any prisoner request private use of the Samaritans phone, they must be taken to the Listeners suite to enable the call to take place. The use of the Samaritan's phone must be logged under the normal procedures."

The minutes of the July Safer Custody meeting, held the next day, 10th July, record that "the problems with the use of the Samaritans phone on F Wing have now been resolved and the Chaplaincy are very happy with the way things are running now".

The Chaplaincy representative who attended the Safer Custody Meetings in June and July could not recall the particular problem. Nor could any of the staff we spoke to, although one of the Chaplains said that the phone was always going wrong and that some Listeners refused to visit prisoners on F Wing, (presumably because of the nature of the alleged crimes committed by some of the prisoners there).

The internal Prison Service investigation concluded from interviews with staff and prisoners that "F Wing appeared to be a unit isolated from the rest of the prison and may well be easily overlooked, as there are few incidents or difficulties experienced on the unit operationally".

HM Inspectorate of Prisons reported in March 2009 that “Vulnerable prisoners had raised concerns about the contamination of their food, and this had been dealt with to the satisfaction of the prisoners we spoke to.” It made no other references to F Wing. The Independent Monitoring Board report dated July 2007 - June 2008 noted that F Wing was “run by experienced and committed officers. The Board receives many compliments from the prisoners about the care received”. The two former prisoners that we spoke to in the course of the investigation were very complimentary about the staff on F Wing. Both of them made the point that the incident with AB was in no way the fault of the staff.

AB himself wrote in the notes that he wrote in his cell “First of all, I really do appreciate to all of you nurses and officers, you are really nice guys. Thanks you a lot for all the help”.

Finding 18: We do not think that the broader problems on F Wing directly contributed to AB’s attempted suicide but they may reflect a lack of management attention being given to a small unit.

Chapter Nineteen

How well was the Incident managed on 24th June?

Two main issues arise in respect of the incident of life-threatening self-harm on the evening of 24th June 2008. The first is whether anything more could have been done to prevent or respond to the incident which would have reduced the likelihood of serious harm. The second is whether Bedford Prison's own procedures were followed during and after the incident.

In terms of prevention, Dr Cumming considers that "the day of the incident itself tends to give a mixed presentation - thus the observations in the morning and to a lesser degree later are in contrast to the observations of the chaplain. This perhaps reflects the ability of the chaplain to look past the questions around self harm and to build upon a rapport that chaplaincy is often very skilled at. There does not appear to be any indication of immediate risk and the request for a shower does not seem unusual. There were other signs which on their own were not major but together could be relevant. Thus on 20.6.2008 he began to stare out of the window (in a similar way to the initial part of the remand), he had also missed a couple of meals - however this should be counterbalanced with his positive thoughts about an IT course the next day and that he was in other ways functioning well, concentrating on television and attending education. It is difficult to be certain around the degree of planning or whether this was sudden and opportunistic; it is worth noting that risk is a dynamic concept subject to change and fully developed plans of suicide and self harm may not be formed until shortly before the event itself."

There is a question about whether AB might have been found more quickly than he was. The ACCT On-Going Record says AB was found at 18.50, which is the latest time at which his twice-hourly observation should have been made. The other records (the Wing Record and the Patient Record) suggest it was at 19.00 at least when AB was discovered. Officer T told us that he thought that he recalled his colleague Officer C, who was the first on the scene, "saying that as a result of one of these half-hourly obs, that's when he found him". The ten-minute delay in making the required observation might have been critical.

But Officer C told us that he had seen and talked to AB when he was replacing the card on AB's cell, which would have been sometime between 18.20, when Officer C recorded AB as being out on association queuing for a shower, and 18.50. One of the prisoners interviewed in the internal Prison Service investigation said that he had met AB coming back from the shower at about 18.30 so if he is right, Officer C's interaction with AB must have been after this. After his interaction with AB, Officer C told us that he then went down and did another two cell cards down on the 2s, had a quick look into the Association Room and then went back upstairs. On his way back to the office at just before 7 pm, Officer C told us that he went past AB's cell, noticed the door was closed, and in his words "I went into the office and looked on the ACCT document, 'cause what I'd actually done, although I'd spoken to him, I hadn't recorded that in the ACCT document. When I went in I'd pencilled in a half hour

when the half hour was up. I looked at that and went straight back out." It was then that he found AB hanging.

Officer C thinks that AB did not expect him to return so quickly. He told us that "he knew, obviously by talking to him, he'd obviously worked it out that the half hour was nearly up. And he would have expected me to fill in the ACCT document and then that's him for a good half hour after that. However, like I say, I don't know if he got access to the original document, but I pencilled in the actual time that he was due. And I didn't make an entry after I'd spoken to him. And I went back and looked at him when the half hour was nearly up. So, and that was about two, three minutes after the actual time we'd had a chat."

It is likely that Officer C went back a little more than two or three minutes after talking to AB. He himself told us that he had gone downstairs and replaced two cell cards there and looked in the Association area before returning upstairs.

A medical assessment letter prepared on 10 November 2008 states that "According to his IMR the prison staff is of the view that he was hanging for a period of between 5 and 20 minutes before he was discovered", but we have been unable to find this in the IMR.

Finding 19: It seems possible that had AB been checked at 18.50 on 24th June 2008, his attempt at self-harm might have been prevented or frustrated. The interaction between an officer and AB which took place between 18.30 and 18.50 should have been recorded in the ACCT On-Going Record

As for whether procedures were followed during and after the event, we have considered the records of what happened and what we were told, in the context of a checklist covering what must be done when there is an incident of deliberate self-harm. We do not know if the checklist was completed at the time of the incident.

There are two actions about which there remains a question.

The first is that Oscar One (which is another name for the Orderly Officer) should have appointed a member of staff to maintain a log at the scene. We have not seen a log, so it is not clear whether one was produced and has been lost or one was not produced.

The second is that the Duty Governor should have ensured statements were obtained from all staff/prisoners involved. An incident report was produced with short statements from the second on scene (dated 26th June - two days after the incident) and the Orderly Officer (dated 24th June, the day of the incident). It did not include a statement from the officer who was the first on scene or the nurse who arrived. Again either no statements were made or, if they were, they were not retained. The officer who was first on the scene could not remember whether he wrote a statement but told us, "I believe I would have done. I don't see any reason why I shouldn't have done. And I'm sure that Security would have made sure that I had done". The Incident Report form does not however have space for individual accounts of incidents by different staff members.

The lack of these documents means that it is difficult to be certain about the precise timings involved. AB's next of kin has expressed particular concern about the length of time the ambulance took to arrive at Bedford. There is some discrepancy about this (noted in Chapter Nine above). The Incident Log says that the ambulance was requested at 19.05 and arrived at 19.06., which seems an improbably short time. The log also says "Paramedic Arrived" at 19.23. Officer T, the second on scene, told us that he thought the ambulance came within six or seven minutes of being called.

As for leaving, the Incident Log notes "Paramedic Leave" at 19.33 and the ambulance "en route to S/Wing" [South Wing Hospital] at 19.40. The Prisoner Escort Record form notes that AB was discharged from F Wing at 19.30 and that he arrived at S Wing at 19.40. Despite the discrepancies, it does not seem to be the case that the Ambulance took as long as 40 minutes to arrive.

The internal Prison Service investigation concluded that the "response to AB being found hanging was exemplary" and, despite some lack of clarity about the precise alarm calls made and the exact sequence of events, we agree that the response was prompt and effective.

Finding 20: Once AB was discovered on 24th June, staff responded as well as they could have.

Finding 21: A log should have been taken at the time of the incident and statements should have been taken from all of those involved shortly afterwards.

Finding 22: The Security Incident Report is not the most appropriate vehicle for reporting on serious incidents of self-harm.

Chapter Twenty

How well did HMP Bedford prevent Suicide and Self-Harm?

In June 2008 Bedford prison had a 4 star rating for overall performance. This is the highest rating achievable and is recognition of continuous improvements in Self Audit, performance against targets, HMCIP reports and Measuring the Quality of Prison Life (MQPL, a survey of prisoners).

The self-audit program, and each of its core modules, is at regular intervals externally examined for compliance against national standards by the Standards Audit Unit of the National Offender Management Service, Ministry of Justice.

In June 2007, one year prior to AB's incident of life-threatening self-harm, Bedford prison received a Standards Audit score of 94% for Suicide and Self Harm & Handling a Death in Custody. This is a commendable result. It is interesting to note that in September 2008, after the AB incident, the audit score had dropped to 81%. The Key Performance Target (KPT) was national and set at 80%. This was therefore a significant reduction in audit score.

Self-harm and suicide pose a significant risk in a local prison and the audit results show where Bedford prison needed to improve.

An extract of significant deficiencies in September 2008 audit includes:-

Baseline	Comments	Potential consequences
60.3	There were a number of managers not trained to ACCT Case Manager level.	Those trained could be overloaded with cases to manage. Insufficient management quality checks. Action points not being met through lack of authority.
60.5	Residential Senior Officers were not routinely completing daily checks of action plans.	Trigger points could be missed. Items not actioned in acceptable timeframe. Frustration of prisoners in distress and staff working in ignorance.

60.6	There was no evidence that a large number of staff had completed ACCT foundation training.	Overloading of those staff who were trained. Ignorance of CAREMAPS and trigger points amongst staff could lead to avoidable self-harm incidents.
60.8	Handover of prisoners on an open ACCT were not routinely recorded. Wing staff did not know the requirements of the ACCT CAREMAP of prisoners in their care.	Ignorance amongst staff of CAREMAPS and trigger points could lead to avoidable self-harm incidents. Prisoners could think that nobody cares about auctioning anything in their CAREMAPS.
60.9	Information received from families, agencies etc was not being passed on to relevant areas and actions recorded in prisoner files.	Opportunities to avoid crisis missed. Potential trigger events not known to staff. Chances to offer support to prisoners in crisis missed.

In June 2008 there were 35 open ACCT documents. This was higher than usual for Bedford and would put a strain on resources to both manage the case load and offer appropriate and adequate care to all prisoners in crisis. It is interesting to note that during 2009 and 2010 the number of open ACCTs reduced but the incidents of self-harm doubled in some months.

In F Wing (the vulnerable prisoners unit), where AB was being held at the time of the incident, he was the only prisoner on an open ACCT. During the year 2008, for eight of the months there were no open ACCTs in F Wing, for two months there was one ACCT open, for one month two ACCTs were open and, finally, in one month three ACCTs were open. In a small unit within a prison this is not unusual; the prisoners could generally expect to have more contact and support from staff; it should be easier to observe prisoners in distress.

A negative aspect of a small unit could be complacency about self-harm and the ACCT documents. With ACCT documents being a rarity on the unit, staff may not be as familiar with them as their main wing colleagues. They may not be used to delivering the CAREMAP and they may not see the significance of comments made by prisoners in distress. It appears from what some of the prisoners have said, both to us and to the internal Prison Service investigation, that staff were informed of AB's

distress but this was not put into his ACCT document to inform the many reviews he had.

From examination of AB's ACCT document, audit documents, minutes of Safer Custody meetings and action plans, it is evident that much work was done for audit compliance but possibly at the expense of quality interactions and reporting. The audit of September 2008 highlights lack of training for staff at all grades in ACCT and the lack of quality checks on ACCT documents by Senior Officers. It identifies poor handover of prisoners in crisis and many staff not knowing what was expected of them in the CAREMAPs.

In April 2010 the Standards Audit Unit reassessed the Suicide and Self Harm, Handling Death in Custody modules, using a new scoring method. Bedford achieved an overall Green marking which means that there is a sound system of risk management and control likely to achieve system objectives.

Finding 23: Several of the findings identified in this investigation may reflect wider weaknesses in Bedford's approach to suicide-prevention at the time.

Recommendation T: Performance on Suicide and Self-Harm Prevention should continue to be a high priority element in the audit of prisons.

Part Four Observations about Inquiry Procedure

Chapter Twenty-One

Inquiry Procedure

A number of different investigations and inquiries have been conducted into aspects of AB's management at Bedford.

a) Near Miss Investigation of Incident in Reception on 5th June 2008

After AB attempted suicide in Reception on 5th June 2008, the Head of Safer Custody at Bedford carried out an investigation, producing a short report which was sent to the Governor on 16th June. Four recommendations were made and included in the Safer Custody Continuous Improvement Plan, which is a consolidated document including action points following deaths in custody and near miss investigations. Two examples of good practice were noted. These included the introduction of CCTV in the small holding room in Reception and the application of anti-pick mastic around the edges of the cell window bars in both holding cells to prevent ligatures being tied. A review was carried out into the location and monitoring of vulnerable prisoners in Reception and a new system was introduced. Post-incident procedures in respect of staff were also reviewed in July 2008, but it is not recorded what, if any, changes were made to these.

Finding 24: We consider that the Near Miss Investigation of the Incident in Reception on 5th June 2008 was a speedy and appropriate investigation, identifying important changes which were implemented.

b) The Incident on 24th June 2008

i) A Staff Debrief was held immediately after the incident on 24th June. This was held by the Duty Governor and Orderly Officer and involved the staff who had been involved in responding to the incident, plus the Senior Officer responsible for F Wing that day. The Incident Report records that "no learning points came through and all staff were offered counselling." Officer C who took part described it as "a quick debrief". The Duty Governor told us that an immediate debrief was held with the staff who had responded to the incident in order to allow them to express their feelings. Responsibility for any further debriefs to consider lessons learned were a matter for the Safer Custody team at Bedford.

Finding 25: While an immediate debrief was important, we think that there might have been a more considered opportunity to learn lessons in the days after the incident on 24th June.

ii) Visit from Area Safer Custody Adviser (ASCA)

The Safer Custody Continuous Improvement Action Plan refers to recommendations made following a visit to HMP Bedford on 16th July 2008 by the Area Safer Custody Adviser "to review systems" following AB's incident of life-threatening self-harm. The visit was made by the Area Safer Custody Adviser and an official from the Safer Custody and Offender Policy Group which is part of the National Offender Management Service (NOMS) and is now called Offender Safety, Rights and Responsibilities Group (OSRR). We have not seen any other documentation relating to this review. The Continuous Improvement Action Plan records four recommendations.

The first recommendation relates to "lack of information forwarded to HMP Bedford prior to the arrival of AB". The Safer Custody Group and Offender Policy Group are to raise the issue with PECS (the Prisoner Escort and Custody Service). The Responsible Person is the Safer Custody Group. In the 2007-8 Action Plan there is no entry in the box headed "completion date". A later version of the Plan which we have seen, headed "Closed Actions" and dated 2009, says "completed", but without a date.

The second recommendation is that the relevant Social Services are contacted to contribute to Case Reviews for AB. This was taken forward and AB's social worker attended a review on 15th August 2008.

The third recommendation is "Review of Case Manager procedures". The Action noted is "Review to take place" but the Responsible Person box has no entry in the 2007-8 Plan. The Completion Date box has the entry "Case Managers reminded of need for consistency in approach to Case Management". The 2009 Closed Entries version has SPC [Safer Prisons Coordinator]/Head of Prisoner Care as responsible and the action as completed, but without a date.

The fourth recommendation is "Consideration of seeking alternative Safer Accommodation in establishment". The Action says that "Points 4-8 are subject to funding from area. ASCO to submit these recommendations to Area Manager for funding decision". (ASCO is likely to contain a typographical error and is in fact ASCA - Area Safer Custody Adviser.)

The recommendations that follow (which are in fact numbered 5 - 9) relate to a Safer Accommodation Review which seems to have been undertaken as a result of the ASCA visit and gave rise to a further five recommendations for conversions and improvements to safer and gated cells and to the Listener Suite. All but one of these recommendations were subsequently rejected. The accepted recommendation concerned the conversion of Cell A 2-15 to a Safer Cell.

We have not seen the remit and terms of reference either for the visit "to review systems" or the Safer Accommodation Review which seems to have resulted. The nature of the link between AB's case and the lack of Safer Cells is not clear.

There is no suggestion in any of the ACCT documentation that AB should have been placed in such a cell had it been available.

iii) The internal Prison Service investigation

On 8th August 2008, the Governor of another prison was directed by the Area Manager of the Eastern Region of the Prison Service to investigate the management of AB, with terms of reference specifying that he should consider in particular:

- the circumstances and appropriateness of his care at Bedford
- his management specifically with regard to the assessment and management of self-harm
- the circumstances of his transfer from court and any documentation that accompanied him to Bedford.
- whether he was identified as being at risk prior to his reception and later.

This Governor was required to provide a report by 8th September 2008. The Continuous Improvement Action Plan for 2007-8 records the Investigation as being completed in December 2008.

The Investigation concluded that, "while generally managed in a caring and supportive manner, the procedures around his care could have been more robust and tightly managed. F wing needs some management attention to ensure robustness of process on the unit."

The report made 13 recommendations which "focus on the means of ensuring a tight grip on both these areas".

We have considered the recommendations made by this internal Prison Service investigation report at relevant points during this report of our own investigation. For the most part they are consistent with our own.

All of this Governor's recommendations were accepted by Bedford Prison and an Action Plan was drawn up covering the 12 recommendations relevant to Bedford. The Action Plan records each of the recommendations having been completed in January or February 2009, with the exception of the SMART monitoring for determining proportionality of BME labour allocation, which was due to commence in April 2009.

In fact, several of the completion dates refer, not to the substantive making of the change that had been recommended, but to the fact that some action has been taken to inform relevant staff of the change that is needed. While obviously an important starting point, that is all it is. In the case of three of the recommendations, the action consisted of sending an email to relevant staff, and in a fourth case a memo was sent.

For example, on 8th February 2009 an email was sent to all Governor Grades informing them of the requirement to be present at all ACCT Constant

Supervision Reviews. It is doubtful if, on its own, such an email would ensure that the recommendation would be acted upon. Further work would presumably be needed to influence the procedures of scheduling Case Reviews so that Governor Grades would be involved. Clarification should have been given about whether this should ideally be the Head of Safer Custody (if that is a Governor Grade post) or the Duty Governor or the Residential Governor.

A similar critique could be made of some of the other responses in the Action Plan. Without integrating recommendations into the systems and routines of work, they are unlikely to be implemented in a sustained way.

The specific recommendations from the internal Prison Service investigation do not seem to have been reported on in the two Continuous Improvement Action Plans that we have seen. For example, the 2007-8 Plan notes, "Investigation completed Dec08. Recommendations Accepted", without specifying the recommendations. The Closed Action Plan for 2009 does not specify the recommendations either and says that they were received in December 2009 (presumably a typo).

The HM Inspectorate of Prisons report carried out in March 2009 noted that the death in custody action plans had been completed but were not routinely monitored for continuing compliance. The Inspectorate recommended that "Death in custody action plans and the safer custody continuous improvement plan should be monitored for ongoing compliance."

Bedford Prison's response to this has been to use the monthly Safer Custody Meeting to monitor compliance. While this is welcome, it does not detract from the need for fuller action plans.

Finding 26: Action plans should contain more detailed methods of how recommendations might be put into practice and for proposing indicators for measuring progress in their implementation.

The Independent Article 2 Investigation

The present Investigation was commissioned in September 2010 by the Secretary of State for Justice under the State's obligation under Article 2 of the European Convention on Human Rights to investigate the circumstances surrounding the life-threatening act of self-harm. The general level of cooperation with staff at Bedford Prison has been good, and we have benefited from having a consistent liaison officer at the prison to deal with our requests.

We have found the system of disclosure somewhat cumbersome, with permission needing to be granted by the Offender Safety, Rights and Responsibilities Group of the National Offender Management Service, which is part of the Ministry of Justice. In addition, although many of the documents requested were supplied following a request from the investigation, there may have been other documents that were in the possession of the Prison Service which would have assisted us, but because they were not requested by us, they were not provided. Some

instances of requesting documents later in the investigation came about as a result of interviews with staff who suggested additional items that they felt may be of assistance to us.

We were disappointed that certain records were not available that might have assisted us. These include telephone and visits records.

Recommendation U: In cases of near death or serious injury, the Governor should initiate an investigation as a matter of urgency, securing all relevant documents and evidence.

Recommendation V: Where a case of near death occurs, the scene, documentation and any files should be secured in the same way as follows a death.

Recommendation W: A clearer policy should be developed about the nature and extent of investigations which should take place following incidents of self-harm, so that prisons know when a local investigation within the prison is likely to be adequate, when an internal Prison Service investigation by the Area Manager is needed and the circumstances in which an independent Article 2 investigation is likely to be commissioned.

Chapter Twenty-Two

The Appropriate Level of Public Scrutiny

The Commission to conduct the Article 2 Investigation requires the provision of a view by the independent investigator about the appropriate element of public scrutiny in all the circumstances of the case. Public scrutiny forms an important aspect of the investigative obligation under Article 2 of the European Convention on Human Rights. We have considered carefully whether the publication of the final version of this report will be sufficient to satisfy the requirement for public scrutiny or whether some further stage in the investigation is needed, such as a public hearing. I have reached the view that the publication will suffice and a public hearing is not needed in this case.

In reaching this view I have considered two questions. The first is whether there are serious conflicts in the evidence which require the questioning of witnesses in a public setting to test the credibility of what they say. There are some inconsistencies in the evidence given to us, for example about the exact timings and sequences of events both on 5th June when AB attempted suicide in Reception and on 24th June 2008, the date of AB's life-threatening attempted suicide. These inconsistencies are minor and to be expected when asking witnesses to recall events from more than two years past. The inconsistencies do not affect the main findings of the investigation.

AB's next of kin raised a particular concern about the length of time it took for the ambulance to arrive at Bedford on 24th June. While it is not exactly clear how long it took, there is no evidence that it took as long as 40 minutes.

The second question is whether the investigation has uncovered convincing evidence of widespread or serious systemic failures, such that a public hearing might be warranted to maintain public confidence.

The investigation has found some failures in the way AB was managed at Bedford; we have made a total of 26 findings and 23 recommendations. We have explored, for example, the way that AB's security classification was handled, the way in which decisions about his location were made and aspects of the ACCT process, in particular the case management function which was undertaken by seven different staff members in a three-week period. Some of these may have reflected some broader weaknesses at the time but, although Bedford's performance in respect of suicide-prevention declined between 2007 and 2008, it was still meeting the national target in 2008.

In addition, it does appear that some of the procedures which prisons are supposed to apply are not only a counsel of perfection, but simply not possible to implement in a busy local prison. The question of balancing the need to hold, on the one hand, regular reviews of at-risk prisoners at the scheduled frequency, with, on the other, the objective of maintaining a single Case Manager and involving in those reviews

staff members who genuinely contribute to the care planning process, is a difficult one. We think the Prison Service needs to consider this balance afresh. But it is a technical question to which a public hearing would not contribute a great deal.

Similarly, the investigation has identified a need for the Prison Service to develop a better understanding of some of the cultural dimensions of crime and punishment as they impact on prisoners who have been brought up in other countries. This is increasingly important given the large and growing numbers of foreign national prisoners in the prison system, but it is primarily a question to be addressed through research.

We very much hope that our findings and recommendations will make an important contribution to the improvement of the management of prisoners such as AB in the future. We do not, however, consider that any further element of public scrutiny is required in this particular case.