

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Beddall, a prisoner at HMP Dovegate, on 26 February 2023

A report by the Prisons and Probation Ombudsman

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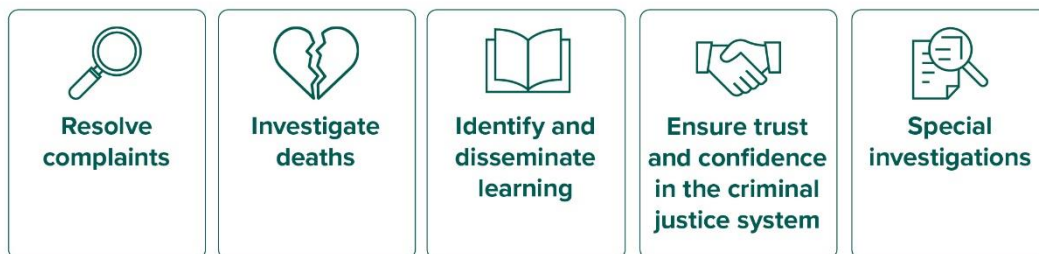
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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Christopher Beddall was found hanged in his cell at HMP Dovegate on 26 February 2023. He was 40 years old. I offer my condolences to Mr Beddall's family and friends.

Mr Beddall died just three days after he arrived at Dovegate. During this time, two important interviews – that should be used to identify any emerging issues for new prisoners, including about the risk of suicide and self-harm – were not completed.

On the night of his death, Mr Beddall's statements and actions indicated that his risk had significantly increased. He threatened to seriously harm himself, made bizarre statements and blocked the view into his cell. Despite this, wing staff left him unmonitored for over 20 minutes while they waited for the night manager to attend the cell, during which time Mr Beddall hanged himself.

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

Adrian Usher
Prisons and Probation Ombudsman

October 2023

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Summary

Events

1. On 23 February 2023, Mr Christopher Beddall was sentenced to 36 weeks in prison. It was his first time in custody. Reception staff interviewed and assessed him on arrival and decided not to start Prison Service suicide and self-harm prevention procedures (known as ACCT).
2. On 24 February, induction unit officers did not complete a required '24-hour' interview, which includes questions about settling, mood and vulnerabilities. On the same day, Mr Beddall refused to share a cell with another prisoner and was charged with a prison disciplinary offence as a result.
3. On 26 February, induction unit officers did not complete the required '72-hour needs analysis' interview, which includes questions relating to mental health and support services.
4. At 7.04pm, Mr Beddall pressed the intercom in his cell (which connects with the staff office) and told an officer that "the Devil was in the cell ... you might find a body". Another officer went to the cell to speak to Mr Beddall and found that he had used his shower curtain to block most of the view into the cell. Mr Beddall threatened to stab himself with a pen and refused to speak further. The officer left the cell to inform the night manager and start ACCT procedures.
5. At 7.33pm, the night manager arrived at and went into Mr Beddall's cell. He found Mr Beddall behind the shower curtain hanged from a ligature. Staff called for immediate emergency assistance and began cardiopulmonary resuscitation but, at 8.16pm, paramedics confirmed that Mr Beddall had died.

Findings

6. While Mr Beddall had some risk factors for suicide and self-harm when he arrived at Dovegate, he also had no recorded history of harming himself, was serving a short sentence, and was not currently receiving treatment for mental ill-health. In the circumstances, it was not unreasonable that Reception staff chose not to start ACCT procedures.
7. However, important risk interviews were not completed on Mr Beddall's first and third full days in prison. Staff at Dovegate have subsequently reviewed and identified changes to strengthen and monitor the induction process.
8. On the night of his death, prison staff left Mr Beddall unmonitored for over 20 minutes when circumstances indicated that his risk of suicide and self-harm had significantly increased.

The Investigation Process

9. The PPO was notified of Mr Beddall's death on 26 February 2023. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact him. No one responded. He obtained copies of relevant extracts from Mr Beddall's prison and medical records.
10. The investigator interviewed ten members of staff at Dovegate in April 2023.
11. NHS England commissioned a clinical reviewer to review Mr Beddall's clinical care at the prison. She jointly interviewed healthcare staff with the investigator.
12. We informed HM Coroner for Staffordshire South of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Beddall's partner and mother to explain the investigation and to ask if they had any matters they wanted us to consider.
14. Mr Beddall's partner asked us why he was in a cell by himself, whether his mental ill-health was properly treated in prison, and whether he should have been monitored under ACCT procedures in the time immediately before his death.
15. Mr Beddall's mother also asked whether his mental ill-health was properly assessed and treated. She asked whether prison staff promptly answered Mr Beddall's emergency cell bell on the night of his death.
16. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.
17. We also shared the initial report with Mr Beddall's partner and mother. Mr Beddall's mother identified two factual inaccuracies, which we have amended in this report.

Background Information

HMP Dovegate

18. HMP Dovegate is a Category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult prisoners. There is also a therapeutic community, separate to the main prison, which holds up to 220 prisoners. Practice Plus Group provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Dovegate was in October 2019. Inspectors reported that reception processes for new arrivals were efficient and that prisoners received good support during their early days at the prison. They found that initial interviews were sufficiently focused on safety and that the induction programme was comprehensive.
20. Inspectors reported that the number of self-harm incidents had fallen in the six months before their inspection and was relatively low.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to September 2022, the IMB reported that the number of incidents of self-harm had increased by 11 per cent in the reporting year, although this was still below pre-pandemic levels. They identified a slight reduction in the number of times ACCT procedures were started and reported that this reflected robust ACCT management.

Previous deaths at HMP Dovegate

22. Mr Beddall was the tenth prisoner to die at Dovegate since February 2020, and the second prisoner to take his own life in that time. There have since been two further deaths at Dovegate, one of which was self-inflicted. There were no significant similarities between Mr Beddall's death and those of the other prisoners.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

24. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. In March 2019, Mr Christopher Beddall reported suicidal thoughts and symptoms of depression and anxiety. A community GP prescribed antidepressants. In January 2020, following an episode of drug-induced psychosis, he was detained in a psychiatric hospital for two weeks under the Mental Health Act, during which time he was diagnosed with mania with psychotic symptoms. Mr Beddall was prescribed antipsychotics on his release.
26. In 2021, Mr Beddall did not attend several appointments with his community mental health team and was subsequently discharged from their service. He was no longer prescribed antipsychotics, and his antidepressant prescription was stopped at around the same time.

23 February 2023

27. On 23 February 2023, Mr Beddall was sentenced to 36 weeks in prison for possessing a bladed article in a public place. This was his first time in prison.
28. Court staff completed a Person Escort Record (PER, a form that accompanies prisoners on all journeys to communicate information, including about risk factors) and recorded that Mr Beddall had no risk of suicide and self-harm, no current drug or alcohol issues and no health issues.
29. In the afternoon, Mr Beddall arrived at HMP Dovegate. A Prison Custody Officer (PCO) completed a reception interview. He noted that Mr Beddall did not arrive with a suicide and self-harm warning form. He recorded that Mr Beddall said that he had never previously harmed himself and had no current thoughts to do so.
30. The PCO also completed a cell sharing risk assessment (CSRA, a form designed to assess the risk of violence a prisoner poses to a potential cellmate). He concluded that Mr Beddall's risk of severe cell violence was standard (on a scale of standard and high).
31. A nurse conducted an initial health assessment. She recorded that Mr Beddall described his previous psychiatric admission but said that he did not have any acute mental health issues. Mr Beddall said that his previous admission was due to a "drug induced psychosis". He denied any current drug issues but said that he drank rum most days. (She completed a check of alcohol withdrawal symptoms and recorded that Mr Beddall did not have any signs of withdrawal.)
32. The nurse recorded that Mr Beddall said that he had no thoughts of suicide and self-harm and no history of harming himself. She noted that it was Mr Beddall's first time in prison and that he said that his relationship with his partner had recently broken down. The nurse recorded that Mr Beddall was not currently prescribed any medication, but that he complained of pain in his ribs following an incident three weeks earlier. She referred him to the mental health team, to the alcohol brief intervention service, and asked for a doctor to prescribe pain relief.
33. When he arrived on M Wing, the induction unit, Mr Beddall refused to share a cell with another prisoner. He was allocated the single occupancy of a double cell.

24 February 2023

34. On 24 February, a doctor at the prison prescribed naproxen for Mr Beddall's rib pain.
35. As part of the induction process, an officer is required to complete a '24-hour' interview on a prisoner's first full day in custody. This includes questions about mood, behaviour, how they have settled and any vulnerabilities. No one completed Mr Beddall's interview. When Mr Beddall arrived at Dovegate, an officer on the induction unit was required to conduct this interview.
36. At around 9.45am, a nurse completed Mr Beddall's secondary health assessment. She recorded that there were no healthcare concerns, and that Mr Beddall had no thoughts of suicide or self-harm.
37. At around 10.40am, a Healthcare Assistant (HCA) and two colleagues completed an alcohol screening for Mr Beddall. She told us that Mr Beddall was socialising with other prisoners and appeared to be in good spirits. She recorded that Mr Beddall did not have any withdrawal symptoms and did not require an alcohol detox. She noted that when one of her colleagues asked Mr Beddall about his sentence, he said that he intended to "buy a machine gun and explosives to target the police station and judge who put him here". The HCA told us that Mr Beddall did not appear angry or upset when he said this and that he did not appear to have any symptoms of mental ill-health. She said that it was "more of a passing comment than anything". She completed a security intelligence report.
38. A security officer assessed the intelligence report. They recorded that it was likely to have been said in frustration at being in prison and that it was not known whether Mr Beddall was capable of carrying out such an attack.
39. At around 3.00pm, a PCO told Mr Beddall that he was required to share a cell with a particular prisoner. Mr Beddall refused. He told us that Mr Beddall did not give a reason why he would not share, but that it was a relatively common occurrence for prisoners to refuse. He said that Mr Beddall became angry and threw an object at the cell door. He charged Mr Beddall with the disciplinary offence of disobeying a lawful order.
40. The PCO told another PCO about Mr Beddall's refusal to share. She spoke to Mr Beddall at his cell and told us that he said that he would "rip somebody's head off" if he had to share a cell. She said that she then left Mr Beddall to calm down, but that he apologised to her later that afternoon. Mr Beddall then said that he did not want to share a cell because he experienced "mental health and schizophrenia". She did not make a referral to the mental health team.
41. A PCO completed a conduct report for Mr Beddall's disciplinary hearing. She recorded that Mr Beddall conformed with the regime, interacted well with other prisoners and had not caused any concerns for staff.

25 February 2023

42. On 25 February, an operational manager chaired Mr Beddall's disciplinary hearing. She recorded that wing staff reported to the adjudication liaison officer that Mr

Beddall was “feeling unwell due to his mental health” and would not therefore attend the hearing. She adjourned the hearing for a review of Mr Beddall’s mental health. (A nurse had made a routine mental health referral from Reception, which meant that Mr Beddall should be assessed within five working days of his arrival, which was 2 March.)

43. In the afternoon, a HCA completed substance misuse observations and recorded that Mr Beddall reported no concerns other than “feeling a bit shaky”.
44. Mr Beddall made two telephone calls to his partner and one call to his son. (Prisoners at Dovegate have telephones in their cells. All calls are recorded, and staff listen to a random sample for security monitoring. No one listened to Mr Beddall’s calls until after his death.) In calls to his partner, Mr Beddall said that he expected to have a year or two added to his sentence. (In this and in later calls, Mr Beddall told his partner and family that he was due in court on 3 March 2023. Prison staff told us that they had no record of this or any other future court dates.) Mr Beddall asked his partner to speak to his solicitor about a psychiatric report as he said that his issues were mental health, drug and alcohol-related.

26 February 2023

45. An officer from the induction unit is required to complete a ‘72-hour needs analysis’ on a prisoner’s third full day in custody. The document includes questions about mental health issues, support provided during the induction process, conflicts with other prisoners and access to the Samaritans and Listeners. No one completed Mr Beddall’s 72-hour interview.
46. At 5.08pm, a PCO locked Mr Beddall’s cell door for the night. She said that they had a brief conversation about a chair outside Mr Beddall’s cell (which he had used earlier while watching other prisoners playing pool) and that Mr Beddall said that he was “fine”.
47. At 5.10pm, Mr Beddall telephoned his partner. He told her that he was due in court on 3 March and that he might get an additional two-year sentence. Mr Beddall said that he would “try to get in a mental hospital” if this were to happen. He said that he “shouldn’t be in here ... I’m fucked in the head ... I’m holding it together for you and the kids”. Mr Beddall said that he had “major psychiatric issues” but was “hiding them through humour”.
48. Mr Beddall told his partner that he would see a doctor the next day to obtain quetiapine (antipsychotic medication), which he intended to trade for a vape. He discussed future visits and said that he had applied for jobs in prison.
49. At 5.27pm, Mr Beddall telephoned his son and daughter. He told them that if he was given an additional sentence on 3 March he would “go mental and get put in a mental hospital and escape”. Mr Beddall said that he had “been hiding [my mental health issues] through humour”.
50. At 6.45pm, Mr Beddall made a 13-minute telephone call to his partner. He spoke about his arrest and said that he had been “sleep deprived and under the influence of alcohol”. Mr Beddall said that he “went out with a knife because I wanted someone to kill me ... I didn’t intend to harm anyone”. He said that he was “taken to

the nut house” when he was arrested and “bullshitted” them, so he was not admitted. (There is no reference in Mr Beddall’s prison or medical records of a potential psychiatric admission when he was arrested.) Mr Beddall said that he expected to get an additional two-year sentence and that he believed that his actions did not warrant this. He told his partner that he would call her again the next day.

51. At 7.04pm, Mr Beddall pressed the intercom in his cell. (Prisoners on M Wing can communicate with the staff office through an intercom system.) PCO A answered. He told us that Mr Beddall said, in a raised voice, that “the Devil was in the cell ... you might find a body”. PCO B, who was also in the staff office, said that she would go to the cell to speak to Mr Beddall.
52. At 7.10pm, PCO B arrived at Mr Beddall’s cell and spoke to him through the observation panel for just over a minute. She said that Mr Beddall had tied his shower curtain across the width of the cell to block off the sleeping area and that she could only see the bottom of his legs behind the curtain. When she opened the observation panel, Mr Beddall came to the door and said “I’ll stick a pen in my neck” before moving back behind the shower curtain. She said that she tried to get Mr Beddall to engage with her, but he said, “I don’t want to talk to anybody”. She decided to notify the night manager and to start ACCT procedures.
53. When PCO B returned to the office, PCO A agreed to contact the duty manager, a Custodial Operations Manager (COM), while she began to complete an ACCT document. The COM told us that he said that he advised PCO A that he would visit the unit to speak to Mr Beddall. He said that he did not give the staff any instructions on how to manage Mr Beddall’s risk before he arrived.
54. PCO B said that there were no blank ACCT documents in the office, so she had to go to another area of the prison to obtain one. (She said that she first went to Reception, where there were also no blank documents, and then to the Safer Custody office to obtain an ACCT document. She returned to the office after the COM had arrived on the wing.)
55. At 7.31pm, the COM and the deputy night manager arrived on M Wing. The COM went to the cell of an Insider (an experienced prisoner who lives on the induction wing to help and advise new arrivals into prison) to ask him how Mr Beddall had been during the day. He told us that the Insider said that there was nothing out of the ordinary.
56. At 7.33pm, the COM arrived at and went into Mr Beddall’s cell, followed by the deputy night manager and PCO C. They found Mr Beddall sitting on the floor behind the shower curtain, with a ligature around his neck made from a belt and tied to the bed frame. The PCO radioed a medical emergency code blue, indicating a life-threatening situation, while the COM and the deputy night manager cut the ligature and began cardiopulmonary resuscitation.
57. At 7.36pm, two nurses arrived and supervised the resuscitation. At 7.58pm, paramedics arrived at Mr Beddall’s cell and, at 8.16pm, they confirmed that he had died.

Contact with Mr Beddall's family

58. At 1.10am on 7 February, two prison family liaison officers visited Mr Beddall's partner and informed her of his death. Dovegate contributed to funeral costs in line with national policy.

Support for prisoners and staff

59. After Mr Beddall's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
60. The prison posted notices informing other prisoners of Mr Beddall's death and offering support. All prisoners being monitored under ACCT procedures were observed more frequently in the time after Mr Beddall's death, and a manager was assigned to offer additional support to them.

Post-mortem report

61. A post-mortem examination identified the cause of death as hanging.
62. Mr Beddall's mother asked us about a white powder that was found in his pocket after his death. Toxicology tests identified that this was coffee whitener.

Findings

Identifying the risk of suicide and self-harm

63. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Dovegate should have identified Mr Beddall as at risk and begun ACCT procedures to support him.

Reception

64. PSI 64/2011 recognises that prisoners are at increased risk of suicide and self-harm in their first days in custody. Mr Beddall had some other risk factors for suicide and self-harm when he arrived at Dovegate: it was his first time in prison, and he had previously been detained in a psychiatric hospital. However, Mr Beddall had no recorded history of self-harm and was subject to a short prison sentence (with a potential release date of a little over two months). He was not currently under the care of community mental health services or prescribed medication for mental ill-health. Reception staff noted this information and the reception nurse made appropriate referrals. In the circumstances, it was reasonable that reception staff chose not to start ACCT procedures when Mr Beddall first arrived at Dovegate.
65. The reception nurse made a routine referral to the mental health team, based on Mr Beddall's reported history of psychiatric admission. This meant that he should be assessed within five working days of arrival (which was 2 March 2023). The clinical reviewer concluded that this was the appropriate decision, based on Mr Beddall's presentation and the information available at the reception health screen.

Director to Note

Day one and day three assessments

66. Some aspects of early days risk assessment were not completed in line with local expectations. The required '24-hour' and '72-hour needs analysis' interviews were not completed. This meant that prison staff did not give themselves the best opportunity to assess how Mr Beddall had settled into prison or to identify whether he had any ongoing or emerging issues. Had these interviews been carried out, they might have helped staff to identify and address any uncertainty about future court attendance or consider further his reasons for not sharing a cell.
67. A COM started as Early Days in Custody Manager two days before Mr Beddall died. Before this, there was not an assigned manager for Early Days and the role was overseen by several managers who shared it with other duties. Following Mr Beddall's death, the COM reviewed 24-hour and 72-hour interviews for other prisoners and identified further occurrences when the interviews were not completed.

68. The COM has since changed the process so that a manager, rather than an officer, must complete the 24-hour interview. An induction unit officer will still complete the 72-hour interview, but if no permanent induction officer is available, a manager will complete the interview (rather than an officer from elsewhere in the prison). He also explained that he now reviews all induction paperwork on a weekly and monthly basis to identify whether any stages have been missed.
69. We are satisfied that the induction interview process has been appropriately reviewed and amended following Mr Beddall's death. The Director will want to ensure that managers continue to review and monitor the completion of these important interviews.

Evening of 26 February 2023

70. Mr Beddall's comments and actions from 7.00pm on 26 February indicated a potentially significant increase to his risk of suicide and self-harm. He spoke about seeing the "Devil" in his cell, threatened to stab himself with a pen and blocked the view into his cell.
71. PCO B appropriately went to the cell when Mr Beddall first made unusual comments on the intercom. At the cell, Mr Beddall said little, other than threatening to harm himself, and he had positioned the shower curtain seemingly to block the view into the cell.
72. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, states that when staff discover that a panel has been blocked, and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare. When a prisoner has been identified as at risk of suicide and self-harm, it is especially important that staff take immediate action. PSI 64/2011 states that when the risk of harm is imminent, action to keep the prisoner safe and under supervision will take priority over completing the initial sections of the ACCT document.
73. While PCO B could see Mr Beddall's feet, his actions and words indicated that he might be at high risk of suicide and self-harm. She appropriately concluded that she should start ACCT procedures and alert the night manager. While we are satisfied that she acted with Mr Beddall's best interests in mind and with the intention of taking immediate actions to manage his risk, hindsight also indicates that she could have remained at Mr Beddall's cell until the night manager attended.

Inquest

74. The inquest into Mr Beddall's death concluded on 26 March 2025, and concluded that Mr Beddall died from self-inflicted hanging without an attempt to end his life.

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