Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Hart, a prisoner at HMP Bedford, on 29 March 2023

A report by the Prisons and Probation Ombudsman

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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

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 His Majesty's 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 Hart died on 29 March, having been found hanging in his cell at HMP Bedford four days earlier. He was 37 years old. I offer my condolences to Mr Hart's family and friends.

Mr Hart had a history of anxiety and paranoia and had been supported several times through prison suicide and self-harm monitoring procedures while at Bedford, including when he died. An officer found Mr Hart tying a telephone cord around his neck a few hours before Mr Hart hanged himself. The officer took the cord away, but staff did not re-assess Mr Hart's risk to himself or consider increasing the frequency of their checks on him. There was also a five-minute delay in staff going into the cell when they could not get a response from Mr Hart. This may have been critical.

The clinical reviewer concluded that staff did not update Mr Hart's mental health assessment or create a care plan in response to his increased risk of suicide and self-harm.

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 **July 2024**

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Summary

Events

1. On 30 November 2022, Mr Steven Hart was remanded to HMP Bedford charged with breach of a non-molestation order.

2. Mr Hart was briefly supported through prison suicide and self-harm monitoring procedures (known as ACCT) on three occasions between December and mid-March 2023. On each occasion, Mr Hart either self-harmed or said he would self-harm due to anxiety and hearing voices.

3. On 18 March, Mr Hart's wing was locked down as there was intelligence that there might be a firearm in the prison. Mr Hart grew anxious that he was going to be attacked and at around midnight on 19 March he made cuts to his arm and neck. At an ACCT review the following morning, he also said that he had taken an overdose. He was sent to hospital for assessment and on his return to Bedford, was moved to the healthcare unit and placed under constant supervision.

4. Mr Hart remained under constant supervision until 23 March, when staff reduced his observations to four an hour.

5. At 5.02pm on 25 March, an officer saw Mr Hart placing a telephone cord around his neck. The officer took the cord away and made an entry in Mr Hart's ACCT. The officer did not report the incident to the officer in charge and no further actions were taken.

6. At 8.59pm, another officer found that Mr Hart's observation panel was locked or jammed. He thought Mr Hart might be using the toilet, so he first checked all the other prisoners on the unit and he also collected a key to unlock the panel. The officer returned to Mr Hart's cell at 9.04pm, and noticed a shoelace attached to the panel. When the officer forced the panel open, he saw Mr Hart in a seated position below the door with the shoelace around his neck. The officer radioed a medical emergency code, went into the cell, and cut the ligature. A nurse started cardiopulmonary resuscitation (CPR).

7. Paramedics arrived at 9.19pm and established a pulse. They took Mr Hart to hospital where he died on 29 March.

Findings

8. The decision, on 23 March, to reduce Mr Hart's ACCT observations to four an hour was reasonable: he said at the review that he was feeling well, was noted to have cleaned his room, had been for exercise that morning and interacted with other prisoners.

9. However, when staff removed a ligature from Mr Hart on the evening of 25 March, they should have recognised that his risk to himself had increased and held an immediate ACCT review. The officer should have also ensured that he informed the officer in charge of the prison.

10. When an officer could not open Mr Hart's observation panel or get a response from him, there was a five-minute delay before they went into the cell.

11. Mr Hart received good support from a number of the staff at Bedford, in particular from a supervising officer who chaired the majority of his ACCT reviews and from the bicycle workshop manager.

12. We did not receive all the information we requested for this investigation and there were delays to receiving some information.

13. Healthcare staff did not update Mr Hart's mental health assessment in response to his apparent increased risk of suicide and self-harm or create a care plan.

Recommendations

- The Governor should ensure that ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk and improve the quality assurance process that confirms this learning has been embedded.
- The Governor should ensure that all information requested by the PPO following a death in custody is provided promptly.
- The Head of Healthcare should ensure that mental health assessments are updated when there are changes in a prisoner's clinical presentation and circumstances.
- The Head of Healthcare should ensure that a care plan is created for prisoners who are at increased risk of suicide or self-harm.

The Investigation Process

14. HMPPS notified us of Mr Hart's death on 30 March 2023. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

16. The investigator interviewed nine members of staff and one prisoner at HMP Bedford on 30 and 31 May. He interviewed nine further members of staff between May and August through video-link.

17. NHS England commissioned a clinical reviewer to review Mr Hart's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with clinical staff.

18. We informed HM Coroner for Bedfordshire and Luton of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.

19. We contacted Mr Hart's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Hart's mother did not respond. Mr Hart's father contacted us and asked:

    - Why was Mr Hart not under constant supervision?
    - Was Mr Hart being bullied?
    - Where was Mr Hart located when he harmed himself?
    - Did Mr Hart leave a suicide letter?
    - How long was Mr Hart on life-support?

20. We shared the initial report with Mr Hart's parents and with HM Prison and Probation Service (HMPPS). Mr Hart's mother identified an incorrect date in paragraph nine of the report, which we have corrected. Bedford notified us of an error with the identity of the officer who witnessed the telephone cord being taken from Mr Hart. We have corrected reference to this officer in paragraph 75.

Background Information

HMP Bedford

21. HMP Bedford is a local inner-city Victorian prison. Northants Healthcare NHS Foundation Trust provides all healthcare services. There is an inpatient unit with nine single cells and a four-bed dormitory. There is 24-hour healthcare provision.

HM Inspectorate of Prisons

22. Following an unannounced inspection of HMP Bedford in January and February 2022, the Chief Inspector wrote that real progress had been made at the prison since the last inspection in 2018.

23. However, following a further unannounced inspection in October and November 2023, the Chief Inspector found that standards had fallen badly. He noted that many officers at Bedford were inexperienced and did not have a clear idea of their role and this was impacting on the delivery of core services. The inspection found that prisoners spent too long locked in their cell with not enough to do.

24. Inspectors found that the rate of self-harm had increased by 84% since the last inspection and was among the highest in the male estate. Inspectors were also troubled to find that the prison had failed to identify learning opportunities from incidents of suicide and self-harm occurring both within the prison and at other institutions.

25. Inspectors noted that only 41% of prisoners who had been supported through ACCTs said that they felt cared for and many perceived ACCT reviews to be unproductive. Inspectors also found that too many ACCTs lacked a multi-disciplinary approach and care plans were frequently left incomplete.

26. Inspectors found that mental health services were not meeting the needs of patients with little evidence of delivery of meaningful evidence-based interventions. One-to-one interventions lacked structure and did not reflect patient need. In addition, care plans lacked sufficient detail to inform interventions and were not person centred.

27. Inspectors were also damning of some of the accommodation at Bedford, which the Chief Inspector noted was the worst he had seen.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2022, the Board identified some areas for improvement in ACCT management. However, their overall view was that genuine progress had been made in remedying previous deficiencies in implementation of the process. The IMB found that staff/prisoner relationships were of a mixed quality.

29. The Board found some good interactions on the wings and during formal settings, such as at ACCT reviews, but most of the feedback in the prisoner survey was

negative. The IMB reported that the mental health team lacked the capacity to meet the needs of prisoners with an overreliance on one-to-one interventions. The IMB noted that without significant investment, the provision of effective mental health services was likely to remain a challenge.

Previous deaths at HMP Bedford

30. Mr Hart was the eighth prisoner to die at Bedford since April 2020. Of the previous deaths, three were self-inflicted and four were from natural causes. In our investigation into a self-inflicted death in July 2020, we found that nurses failed to make ACCT observations appropriately on the night before the prisoner's death. There have been three deaths since that of Mr Hart, up to 16 February 2024. Of these deaths one was self-inflicted and two due to unknown causes.

Assessment, Care in Custody and Teamwork

31. 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.

32. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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

33. On 30 November 2022, Mr Steven Hart was remanded to HMP Bedford charged with breach of a non-molestation order by communicating with his ex-partner and going within 50 metres of her home.

34. A nurse assessed Mr Hart. She noted that he had deliberately banged his head while in police custody the previous day. The nurse also noted that he was now bright in mood with no current thoughts of suicide or self-harm. She did not start suicide and self-harm support procedures, known as ACCT.

35. Following the health screen assessment, a prison GP prescribed Mr Hart 30mg of mirtazapine (an antidepressant). Mr Hart said that he had been prescribed antidepressants in the community but had not taken his medication for the previous month or two as his depression had been stable.

36. On 2 December, Mr Hart moved to a cell on A Wing.

37. On 5 December, a nurse saw Mr Hart for mental health screening. She noted that he had a history of deliberate self-harm through cutting and making ligatures. She also noted that, in the previous month, he had attempted to set fire to himself and had gone to a multi-storey car park with thoughts of jumping until he was escorted down by security staff. She noted that Mr Hart said he had no current thoughts of suicide or self-harm. She noted that Mr Hart had no indications of acute mental illness, although he presented as a little anxious. He said he believed he might have attention deficit hyperactivity disorder (ADHD): people with ADHD can seem restless, may have trouble concentrating and may act on impulse. Mr Hart said that he had been waiting for a diagnosis for two years. (His medical record confirmed that this was the case.) The nurse noted that Mr Hart would not be taken onto the mental health caseload but would be managed with medication. She also sent a referral to the chaplaincy team for emotional support.

38. On 8 December, Mr Hart started work in the prison's bicycle repair workshop. That afternoon, Mr Hart told a prison GP that that he wanted an increase in his mirtazapine dose as he had been feeling "down" for the past four days. The GP increased the dose to 45mg, and he emailed the mental health team manager to ask for the mental health team to see him again.

39. On 9 December, the mental health team manager replied to the GP to say that when Mr Hart was reviewed on 5 December, he had been signposted appropriately and the mental health team would not be reassessing him at that time.

40. On 15 December, an officer started ACCT procedures after Mr Hart scratched the word "wanker" on his hand. Mr Hart said that he felt under threat from other prisoners due to his offence.

41. On 16 December, a Supervising Officer (SO, SO A), from the safer custody team chaired an ACCT review with Mr Hart. Another SO, who carried out the ACCT assessment interview, and a mental health nurse, also attended. Mr Hart said that he had spoken to a friend on the wing and now felt safe. He said that he used cutting as a coping mechanism and he did not want to die as he had four children. The SO A noted that everyone at the review agreed that an ACCT was

unnecessary and that Mr Hart would be better supported through a Prison Service Challenge, Support and Intervention Plan (CSIP): a process to support and manage prisoners who pose a risk of being violent or are at risk of violence. Staff closed the ACCT.

42. The SO A told the investigator that there were three SOs in the safer custody team and they chaired almost all of the ACCT reviews with the aim that case managers were consistent. The exception to this practice was that custodial managers (CMs) chaired reviews for prisoners under constant supervision.

43. On 17 December, SO A referred Mr Hart for a CSIP, noting that he was very vulnerable, could be the victim of bullying and required extra support through the CSIP process. Over the following weeks, staff recorded daily CSIP entries of conversations they had with Mr Hart, listening to his concerns and reassuring him.

44. On 28 December, the bicycle workshop instructor made an entry in Mr Hart's records about his positive attitude, good behaviour, good work ethic and attention to detail. She told the investigator that Mr Hart attended the workshop each morning from Monday to Friday and he worked hard but was slow to complete jobs as he was meticulous with his work. She also said that he was a person who needed routine, so he found weekends difficult when the workshop was closed.

45. At around 10.00pm on 26 January 2023, Mr Hart rang his cell bell. An officer responded and found Mr Hart bleeding from his thumb. He called a nurse and the Orderly Officer (officer in charge of the prison at night). Mr Hart said that he had harmed himself as he believed he was under threat from other prisoners who thought he was a sex offender. He also said that he was hearing voices outside his cell. The Orderly Officer opened an ACCT and directed that Mr Hart be observed three times an hour through the night. A nurse treated the cut to Mr Hart's thumb that she noted was not too deep.

46. On the morning of 27 January, SO A went to Mr Hart's cell to collect him for an ACCT review. Mr Hart had barricaded his door, but he removed the barricade when he saw her. She saw that he had scratched the word "nonce" onto his hand. Mr Hart named another prisoner who he said had been shouting on the wing the previous evening about him being a sex offender. She told Mr Hart that the other prisoner had had a cell search in the evening and that was why his cell had been unlocked during the night-time patrol period. She noted that the other prisoner came to Mr Hart's cell at that point to reassure him that no-one had been talking about him. She noted that Mr Hart calmed down slightly and agreed to come out of his cell for an ACCT review with her and a nurse.

47. At the ACCT review, Mr Hart said that being in prison was taking a toll on his mental health. He said again that he believed prisoners were spreading rumours about him. However, when SO A reminded Mr Hart what the other prisoner had said, he acknowledged that he could become paranoid at times, that he struggled with anxiety and then self-harmed as a release. Staff set Mr Hart's observations at one an hour and arranged his next ACCT review for 31 January.

48. SO A told Mr Hart that he could move to C Wing if he wanted. He agreed to move, and in the interim he moved that day to a cell with his friend. By the time she started

arrangements to move Mr Hart to C Wing, he said that after speaking to his friend, he wanted to remain on A Wing in a cell with him.

49. The friend told the investigator that he and Mr Hart got on well. He said that Mr Hart was well liked by other prisoners, and interacted with others when he was on the landing. However, he said that when Mr Hart was locked in his cell, he believed that the other prisoners were talking about him. He also had other strange thoughts such as believing people were tampering with his vape. He said that he would distract Mr Hart by playing cards with him and turning up the volume of the radio. He said that Mr Hart struggled with any disruption to his routine. He said weekends were especially difficult for Mr Hart as the bicycle workshop was closed and gym sessions and other time out of cell would be disrupted if there were staff shortages.

50. On 28 January, an officer noted a conversation with Mr Hart when he said he had cut himself as he thought people were "out to get him" and he thought things were being said about him on television. He said that he was feeling better following reassurance from staff and prisoners, and he asked to attend Sunday chapel the following day.

51. On 31 January, SO A chaired Mr Hart's next ACCT review. A nurse also attended. Mr Hart said that sharing a cell with his friend was helping him a lot. He also said that his friend kept the television quite loud and that helped drown out general shouting from other prisoners which stopped him thinking they were talking about him. Mr Hart said that he was going to the gym, was enjoying work, felt safe on A Wing and had no thoughts of suicide or self-harm. SO A noted that all at the review agreed to close the ACCT.

52. On 2 February, the bicycle workshop instructor noted that Mr Hart was visibly upset while at the bicycle workshop. He said he was struggling with not knowing what was happening with his court case. He also said that the gym was the only place he found "release", but his gym sessions had been cancelled that week. She contacted SO A to see Mr Hart.

53. SO A told the investigator that the bicycle workshop instructor contacted her many times to go to speak to Mr Hart in the workshop. She said that Mr Hart coped poorly if there was a break in his routine, such as closure of the gym or closure of the workshop. When she spoke to Mr Hart that day, she noted that he said he was just having a bad day and that he said he had no thoughts of suicide or self-harm.

54. On 21 February, the bicycle workshop instructor again called SO A to speak to Mr Hart at the workshop. SO A noted that Mr Hart was upset because his prison phone credit had not been topped up as it should have been, and he was still waiting for some prison trainers. Mr Hart said that staff were laughing about him, but he again accepted that he might be paranoid. She noted that Mr Hart struggled daily with issues that others found easy, but he immediately felt better once he had the opportunity to speak about his concerns. She also noted that Mr Hart said he had no thoughts of suicide or self-harm.

55. On 28 February, Mr Hart told a prison GP that he was not happy with his medication as he was continuing to hear voices. He said that speaking regularly with SO A was helping him. The GP sent a referral to the mental health team asking that they see Mr Hart urgently.

56. On 12 March, staff re-opened Mr Hart's ACCT after he made a comment about slitting his throat. A Custodial Manager (CM) held an immediate ACCT review with Mr Hart and a mental health nurse. Mr Hart said that he was struggling to sleep at night as the younger prisoners on A Wing were too loud and he again had thoughts that people wanted to harm him. The CM noted that Mr Hart said he was happy to continue sharing a cell with his friend. He set Mr Hart's observations at three an hour and arranged a further ACCT review for the following day.

57. The mental health nurse noted that Mr Hart appeared flat in mood, and he reported being anxious. She noted that Mr Hart had no signs of acute mental illness or major affective disorders, and she gave him an anxiety self-help guide.

58. On 13 March, an SO chaired an ACCT review with Mr Hart. Another SO and two mental health nurses all attended. Mr Hart said that he had been having a bad day the day before but was now feeling well. He said that while he sometimes found A Wing "a bit much", he did not want to move wings as he realised he had good support from prisoners and staff on the wing. He said that he had not harmed himself for a while and had no present thoughts of self-harm. The SO noted that everyone agreed that the ACCT should be closed.

59. Mr Hart remained on a CSIP. Staff continued to have daily conversations with him about how he was feeling.

60. On 16 March, an assistant psychologist saw Mr Hart in response to referrals to mental health from both a prison GP and SO A who were concerned about Mr Hart's anxiety and vulnerabilities with ADHD and potential autism spectrum disorder. (ASD – this is a developmental disability. People with autism often have problems with social communication and interaction and often have restricted or repetitive behaviours and interests.)

61. The assistant psychologist told the investigator that he spoke with Mr Hart for around 30 to 45 minutes. He said that while Mr Hart was low in mood, he was easy to talk to and was very forthcoming. They spoke about the traits associated with ADHD and he gave Mr Hart a screening tool to assess his own traits. He said that he also planned to give Mr Hart a screening tool for ASD. They spoke about support from the psychology team and Mr Hart agreed to attend an initial programme of between two and four sessions to identify his triggers for anxiety, regulation of emotions and development of coping strategies. He added Mr Hart to the waiting list.

62. On 17 March, Bedford received intelligence that there was a firearm in the prison. C Wing was locked down and at around midday on 18 March, A Wing was also locked down. A specialist Prison Service team (the National Tactical Response Group - NTRG) went to the prison to systematically search for the weapon and none of the prison's regular officers or nurses were allowed on the wings in the meantime. Prison staff prepared 24-hour meal packs which were delivered to cells by NTRG staff. Staff told the investigator that certain prisoner medication was contained in the meal packs. Mr Hart's mirtazapine was not included in his packs since mirtazapine has potential for abuse. Therefore, he did not receive his mirtazapine on 18, 19 and 20 March.

63. Mr Hart's friend told the investigator that the security lockdown was very difficult for Mr Hart. The NTRG had first searched the opposite side of their landing and Mr Hart believed from the voices that there was a conspiracy to attack him.

64. During the lockdown, prison staff phoned prisoners to check on their welfare. When an officer spoke to Mr Hart at just after midnight on 20 March, he said there were people outside his cell who were coming for him. He then said he wanted to take his life and he ended the call. The officer informed NTRG who checked Mr Hart and found that he had made cuts to his arm and neck. A nurse treated the cuts and staff restarted ACCT procedures.

65. SO A held an ACCT review with Mr Hart on the morning of 20 March. Mr Hart kept repeating that he could not handle the voices any longer, that he would prefer to be dead and would hang himself as soon as he could. He also said that he had taken an overdose. She placed Mr Hart under constant supervision and staff escorted him to hospital for checks.

66. Mr Hart returned from hospital at 4.43pm, but staff sent him back to hospital an hour later. It is not clear from the records why they did so. Mr Hart returned again to Bedford at around midnight and was moved to a constant supervision cell in the healthcare unit. A nurse noted that the hospital had made no adverse findings.

67. On 21 March, a CM held an ACCT review with Mr Hart. A SO and two mental health nurses also attended. The CM noted that when Mr Hart first came into the room he was talking very quickly. He said that he had not had his medication during the lockdown period and that had made him very anxious, and he had started hearing voices again. He also said that A Wing was too big and too loud, and he was already feeling more settled in the healthcare unit. The CM reassured Mr Hart that his medication would recommence now that he was in healthcare. Towards the end of the review, Mr Hart said that his mother was in the process of arranging a video call with his children. The CM kept Mr Hart under constant supervision and arranged a further ACCT review for the following day.

68. The CM held Mr Hart's next review on 22 March. A nurse, an SO and a member of the chaplaincy team also attended. The CM noted that Mr Hart was clearly agitated when he came to the review. He said that he had been unable to sleep the previous night as the two constant supervision officers observing him and the prisoner in the cell next door had talked all night. He said they were talking about him, and he feared they would switch off the cameras and let people into his cell to harm him. The CM explained to Mr Hart that she suspected his thoughts had been triggered by the lockdown period on A wing when NTRG staff had been going into cells. She noted that Mr Hart then calmed down and they were able to have a more relaxed conversation. She noted that the nurse told Mr Hart that it would take a few days for the reinstated mirtazapine to get into his system, but he would then see an improvement in his sleep and mental state. She noted that Mr Hart was in a much better frame of mind by the end of the review. He told staff that his mother and a cousin had arranged to visit him on 1 April. She again kept Mr Hart under constant supervision and arranged a further ACCT review for the following day.

69. One of Mr Hart's constant supervision officers noted that she had a "very productive" conversation with Mr Hart from 4.00am to 5.00am on 23 March. Mr Hart had spoken about how difficult he had found the lockdown period when he missed

medication and had been kept in his cell. He said that it was difficult for staff to understand his behaviour, as they did not understand his mental health. He also said that he was sorry about his behaviour towards staff while he had been in healthcare. An entry in his records the previous night noted that he had shouted various expletives at staff.

70. The CM held a further multi-disciplinary ACCT review with Mr Hart at 11.00am on 23 March. She noted that Mr Hart seemed calmer and more settled. He said that he was feeling great. He said that he had tidied his room, put clean bedding on his bed and had apologised to an officer, as well as opening up to her about his mental health. She noted that Mr Hart had followed her previous advice to start writing down his thoughts so he could discuss them with staff rather than allowing his thoughts to play on his mind. Mr Hart said that he had gone to the healthcare exercise yard that morning, he had used the exercise equipment and got other prisoners to join in. She noted that everyone agreed that Mr Hart was no longer in crisis and that his observations should be reduced to four an hour. She set his next review for Monday 27 March. Mr Hart was then moved from the constant supervision cell to a standard cell in the healthcare unit.

71. On the morning of 24 March, the assistant psychologist briefly met Mr Hart and spoke to him about starting psychology sessions. He noted that their first session would be on 27 March, and they would meet either in the healthcare unit, or in the bicycle workshop if Mr Hart had returned to work. He noted that Mr Hart was engaging with education at the time of their meeting, and he appeared well.

72. At 11.15am, Mr Hart's education instructor noted that he believed everybody was "out to get him". However, all of the other entries in his records that day indicated he had had a good day. A late entry noted that Mr Hart was in a great mood, had chatted about a range of topics and had spent the evening doing learning packs and a jigsaw.

Events of 25 March

73. Mr Hart's final telephone call was a five-minute call to his mother made at 12.16pm on 25 March. Despite several requests, the investigator was not provided with a recording of the call. He was then told that the phone calls were no longer available as they are automatically overwritten after a period of time. Prison staff said that they had listened to a recording of the call shortly after Mr Hart's death and Mr Hart had told his mother that he believed that staff and prisoners were intending to harm him.

74. One of Bedford's chaplains spoke to Mr Hart in the early afternoon. She noted that he strongly believed that the food he was being given might not be fit to eat and he also believed that other prisoners were shouting accusations against him. She noted that Mr Hart appeared a lot calmer after she had spent time speaking with him.

75. During the afternoon and evening, Officer A (who had been a prison officer for four years) was responsible for Mr Hart's ACCT checks. CCTV shows that at 5.02pm, he pulled a telephone cord through Mr Hart's observation panel. He told the investigator that he saw Mr Hart beginning to put the cord around his neck, so he thrust his arm through the panel, grabbed the cord and pulled it out. He said he

asked Mr Hart for an explanation, but he gave none. He made an entry in the ACCT form and said that he told his colleagues and a nurse about the cord. Other officers confirmed they were aware of the incident, and Officer B actually observed Officer A removing the cord, as she was carrying out constant supervision on a prisoner in a nearby cell. However, there is no entry in the clinical record from the nurses on duty to confirm they were told. Officer A also said that he tried to contact the Orderly Officer by telephoning his office, but there was no answer. The investigator asked him why he did not radio the Orderly Officer, given that he could be anywhere in the prison and not necessarily in his office. He acknowledged that that was what he should have done.

76. The investigator also asked Officer A about his other checks on Mr Hart that afternoon. The investigator said that from his observation of the CCTV it was unclear whether he made all the checks that he had signed for on the ACCT. He said that he believed that he had made all of his checks.

77. A CM told the investigator that he was the Orderly Officer that afternoon. He said that he was always contactable by radio and if he had been told about the ligature, he would have spoken to Mr Hart and re-assessed his risk.

78. Officer A's last check on Mr Hart before his shift ended was at 8.44pm. He wrote a statement to say that Mr Hart was sitting on his bed, and they made eye contact. He asked Mr Hart if he was okay and hoped he had no hard feelings towards him, but Mr Hart did not respond. CCTV confirms that Officer A spent seven or eight seconds at Mr Hart's door before moving to the next cell. Other officers then started a shift in healthcare. Officer A briefed Officer C on the events during his shift, including that he had taken a ligature from Mr Hart.

79. One of the other officers then told Officer C of a potential problem with one of the prisoners under constant supervision, so he spoke to him for a few minutes.

80. After carrying out a few administrative tasks, Officer C began a routine roll check on all the prisoners on the unit. CCTV shows that he tried to open the observation panel in Mr Hart's cell door at 8.59pm, but it would not open. He tried to look through any gaps and he then walked away from the cell. He told the investigator that he wondered if Officer A had earlier locked the panel to stop Mr Hart throwing objects onto the landing. He also thought it possible that Mr Hart had jammed the observation panel as he needed to use the toilet. He said that he walked away to check other prisoners and to give Mr Hart a few minutes' privacy to finish using the toilet it that was what he was doing.

81. At 9.04pm, Officer C returned to Mr Hart's cell with a key to unlock the panel. He said that he called Mr Hart's name several times, without reply, and when he put his hand on the observation panel, he saw a shoelace attached to it. He forced open the panel and saw Mr Hart in a seated position at the bottom of the door with his legs facing into the cell. The shoelace was around his neck and was tied to the observation panel. He radioed a code blue emergency (to indicate a prisoner is unconscious or having breathing difficulties). He then ran to get an anti-barricade key so the door could be opened outwards as Mr Hart's body was blocking the door. He returned with the anti-barricade key, but he and another officer managed to push the door open. He cut the ligature, laid Mr Hart on the floor and within around 40 seconds a nurse got to the cell and started cardio pulmonary

resuscitation (CPR). Staff took turns giving CPR and they also attached a defibrillator.

82. At 9.09pm, staff in the control room requested an ambulance. (We asked Bedford why there was an apparent delay between Officer A's code blue call and the control room calling an ambulance but did not receive any response.) Paramedics arrived at 9.19pm. They then took charge of the efforts to resuscitate Mr Hart. At 9.29pm, the paramedics established a pulse and at 9.48pm they took Mr Hart to hospital without restraints.

83. Mr Hart remained in intensive care in hospital until he died at 2.10pm on 29 March.

Contact with Mr Hart's family

84. Prison staff telephoned Mr Hart's mother when he was first sent to hospital, and she was able to spend time with him over the following days. A CM was appointed as the family liaison officer, and he met Mr Hart's family at the hospital. Mr Hart's mother and other family members were with him when the life support machine was switched off and he died.

85. Bedford contributed to the cost of Mr Hart's funeral in line with national instructions.

Support for prisoners and staff

86. After Mr Hart's death, a CM 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.

87. The prison posted notices informing other prisoners of Mr Hart's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hart's death.

Post-mortem report

88. The pathologist noted that there were no significant findings on toxicological analysis of Mr Hart's blood samples and gave his cause of death as asphyxiation due to hanging.

Findings

Assessment of Mr Hart's risk of suicide and self-harm

89. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

90. Mr Hart had several risk factors. In the month before he was remanded to custody, he had attempted to set fire to himself and had thoughts about jumping from a high building. When he got to prison, he told staff that he felt anxious, heard voices and was prescribed medication for depression and anxiety. During his time at Bedford, he was intermittently subject to ACCT support after he self-harmed or, on the last occasion, on 20 March, said he had taken an overdose. This ACCT remained open until he died.

91. There were good examples of staff engaging with Mr Hart, trying to understand his concerns and manage his risk. A particular SO A chaired the majority of Mr Hart's ACCT reviews and also provided him with support outside of this process.

92. Staff put Mr Hart under constant supervision on 20 March after a difficult three-day period for him when the prison was on lockdown following the report of a firearm in the prison. Mr Hart did not receive his mirtazapine in those days, which increased his anxieties and belief that he was at risk from other prisoners.

93. At ACCT reviews on 22 and 23 March, staff noted Mr Hart was becoming more settled and on 23 March his observations were reduced from constant, down to four an hour. We consider that the reduction in observations was a reasonable decision based upon the assessment of his apparent level of risk at that time.

94. However, we are concerned that when Mr Hart's risk subsequently escalated on 25 March, this was not appropriately communicated, assessed or managed.

Events on 25 March

The telephone cord

95. At 5.02pm on 25 March, Officer A saw Mr Hart placing a telephone cord around his neck. He took the cord from him and made an appropriate entry in his ACCT form. Other officers were aware of the incident, but it is unclear whether he told a nurse, as there is no entry about this in the medical record. He also said that he tried to contact the Orderly Officer by telephoning his office, but without success.

96. By the nature of the role, the Orderly Officer can, at any time, be anywhere in the prison. Even if Officer A did attempt to telephone the Orderly Officer's office, this was not an efficient way to try to contact him. He should have radioed the Orderly

Officer. The Orderly Officer said that if he had been told about the ligature, he would have gone to the healthcare unit to speak to Mr Hart to re-evaluate his risk. It was a clear failing on Officer A's part not to have contacted the Orderly Officer.

97. Following Mr Hart's death, the Governor arranged an investigation into this omission, and Officer A was temporarily suspended from work. We are satisfied that Bedford has taken appropriate action with regards to him. However, we remain concerned that several other officers knew about him taking the telephone cord, with one having witnessed the incident. No one ensured that an urgent ACCT case review took place to find out how Mr Hart was feeling, assess his risk and decide whether an increase in his observations was necessary. Officer A told more officers about the incident when there was a changeover for the evening shift and again no one took the initiative to ensure Mr Hart's risk was reviewed. We therefore regard the issue with risk assessment as more widespread than Officer A and make the following recommendation:

The Governor should ensure that ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk and improve the quality assurance process that confirms this learning has been embedded.

Possible missed ACCT checks

98. When the investigator reviewed the CCTV for the afternoon and evening of 25 March, he identified several occasions when ACCT checks were not apparently made despite these being recorded in the paperwork as having been done: the investigator separately contacted the Governor with the times of six potential omissions, the last of which was at 6.45pm. The officer responsible for the checks was again Officer A. The prison conducted a further disciplinary investigation. The outcome of that investigation was that it could not be ascertained for certain whether he failed to make any of the checks that he signed for. We therefore make no recommendation.

The jammed observation panel

99. Officer C came on duty at 8.45pm on 25 March and received a briefing from Officer A, which included that he had taken a ligature from Mr Hart. When he tried to check Mr Hart at 8.59pm during his routine roll check, Officer C found that his observation panel was either locked or jammed. He tried to look into the cell, but he thought that Mr Hart was possibly using the toilet, so he allowed him some privacy and first checked the other prisoners. When he returned to the cell at 9.04pm, he found that the reason the observation panel was jammed or stiff was because there was a shoelace looped over the panel which was attached to Mr Hart's neck and bearing his weight.

100. We recognise the conflict between keeping prisoners safe, and the need to maintain some degree of privacy and decency. However, Mr Hart was on a high level of ACCT observations and had been found with a ligature just four hours earlier. We cannot know if Mr Hart was already hanging when Officer C first got to the cell but in such a situation, even a slight delay can have a significant impact on the chances of a prisoner's survival.

101. Bedford's Governor's Order 671, Roll checks and accounting for prisoners, states that staff must ensure the correct prisoners are in each cell at roll check. If staff are unable to see a prisoner, they must instruct the prisoner to remove the obstruction. If they still cannot see the prisoner, staff must unlock the door. We consider that Officer C should have ensured he could see Mr Hart at 8.59pm before moving away to check other prisoners.

102. The Head of Suicide and Self-Harm Reduction told the investigator that Officer C, along with all other staff, had been reminded of the correct action to be taken if an observation panel is blocked or obscured. She said that they had emphasised the importance of swiftly getting a response, especially if a prisoner is on an ACCT. We therefore make no further recommendation, but the Governor will want to satisfy herself that the learning has been embedded.

Missed mirtazapine medication

103. Due to his wing being in lockdown, Mr Hart did not receive his mirtazapine medication on 18, 19 and 20 March. It could not be included in the meal packs delivered, due to its potential for abuse and healthcare staff were not allowed on the wing to administer it to Mr Hart. Both the lockdown and lack of medication impacted Mr Hart's mental health and he self-harmed late in the evening on 20 March.

104. The Head of NTRG told us that the scale of the lockdown at Bedford was unprecedented and truly exceptional. The need to ensure the safety of staff and prisoners by ensuring there was no firearm in the prison needed to be balanced against ensuring that prisoner's critical needs were met. He explained that had staff raised concerns Mr Hart's missed medication with NTRG as presenting a risk to his life, they would have assessed and responded to this. Indeed, this is what happened when prison staff told NTRG that Mr Hart had said he wanted to end his life.

105. We are satisfied that Mr Hart missing his medication was unavoidable in the context of the intelligence that NTRG was investigating.

Providing information to the PPO

106. The investigator had difficulty securing the information he needed for this investigation from the prison. He had to chase some information several times. In addition, the prison never provided him some information, such as a download of Mr Hart's telephone calls or the reasons for the five-minute delay in calling the ambulance. It is crucial to the integrity of our investigations that prisons provide information when asked and without delay. We make the following recommendation:

The Governor should ensure that all information requested by the PPO following a death in custody is provided promptly.

Clinical care

107. The clinical reviewer found that the care Mr Hart received for his physical health and substance misuse needs was of a reasonable standard, but she considered

that the care he received for his mental health needs was only partially equivalent to that which he could have expected to receive in the community. She noted that Mr Hart was prescribed medication for anxiety, had mental health involvement at ACCT reviews and was assessed by psychology. However, she noted that there was no updated mental health assessment despite Mr Hart's ongoing risk concerns, which included acts of self-harm, ongoing paranoia, and the fact that he had been placed under constant supervision. She noted that these risks should have led to the creation of a care plan. We make the following recommendations:

The Head of Healthcare should ensure that mental health assessments are updated when there are changes in a prisoner's clinical presentation and circumstances.

The Head of Healthcare should ensure that a care plan is created for prisoners who are at increased risk of suicide or self-harm.

108. The clinical reviewer has made several other recommendations which we do not repeat here, but which the Head of Healthcare will need to address.

Governor to note

109. We note that there was an apparent five-minute delay between the time that the code blue call was made at 9.00pm and contact with the ambulance service at 9.05pm. The investigator asked a senior prison manager the reason for the delay but did not receive any explanation. The Governor will wish to assure herself that staff immediately request an ambulance when there are emergency radio calls.

Good practice

110. We consider that Mr Hart received good support from various staff at Bedford. In particular, we note the support he received from SO A, the bicycle workshop instructor and a prison GP. In addition, prison staff recorded almost daily entries while Mr Hart was subject to a CSIP from 17 December onwards. Staff made considerable efforts to reassure Mr Hart and allay his fears.

Inquest

111. An inquest into Mr Hart's death held between 30 June and 9 July 2025 concluded that his cause of his death was asphyxiation due to hanging.

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