Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Melvin Grant, a prisoner at HMP Bedford, on 21 November 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 Melvin Grant died in hospital from hypoxic brain injury (lack of oxygen to the brain) on 21 November 2023, one week after he was found unresponsive with a ligature around his neck in his cell at HMP Bedford. Mr Grant was 42 years old. I offer my condolences to his family and friends.

Mr Grant was being monitored using suicide and self-harm prevention procedures when he was found unresponsive in his cell. Staff had stopped constant supervision around seven hours before. The investigation concluded that the decision to stop constant supervision was a reasonable one in the circumstances.

When staff found Mr Grant unresponsive, there was a delay in entering the cell and starting CPR. We cannot say whether the delay made a difference to the outcome for Mr Grant, but we know that in a medical emergency, any delay could be critical.

The clinical reviewer found that the standard of care provided by the nurses during the emergency response was poor. The Head of Healthcare commissioned an investigation which is ongoing.

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** **November 2024**

# Contents

# Summary

## Events

1. On 29 August 2023, Mr Melvin Grant was remanded to HMP Thameside charged with robbery. On 27 September, he was moved to HMP Bedford.

2. On 10 October, Mr Grant told an officer that he was frustrated that he was at Bedford and wanted to be moved back to a London prison.

3. On 5 November, Mr Grant refused to leave his cell to collect his medication and meals. He told an officer that he did not feel well.

4. On 9 November, Mr Grant pressed his emergency cell bell and asked staff when he would get his canteen (items purchased from the prison shop). When an officer told him that it would not be until the next day, Mr Grant became angry and swallowed two razor blades. The officer started suicide and self-harm monitoring (known as ACCT). Mr Grant was later taken to hospital but was discharged in the early hours of 10 November.

5. When Mr Grant returned to Bedford, he refused to go into his cell and said that if he was made to go into the cell, he would assault his cellmate. Staff took Mr Grant to the segregation unit. They continued ACCT monitoring.

6. At around 12.30am on 13 November, Mr Grant started a fire in his cell. The fire service was called to assist officers in putting out the fire and Mr Grant was taken to hospital for smoke inhalation.

7. Later that day, Mr Grant returned from hospital. Staff placed him under constant supervision. Mr Grant told a nurse that he heard voices telling him not to eat or drink and to be violent. He said that the only way he could stop the voices would be to end his life.

8. On 14 November, a psychiatrist saw Mr Grant. He prescribed antipsychotic medication and noted that he should continue to be supported using ACCT.

9. At an ACCT review that afternoon, staff assessed that Mr Grant's risk of self-harm had reduced and they stopped constant supervision. They set observations at four an hour and agreed that Mr Grant should be moved to the prison's healthcare inpatient unit so that the mental health team could observe him more closely and ensure that he took his medication. Staff moved Mr Grant to the inpatient unit that afternoon and he was checked four times an hour in line with his ACCT plan.

10. During an ACCT check at 9.38pm, an officer saw Mr Grant lying face down on the floor with a ligature tied around his neck. She called a medical emergency code blue on her radio.

11. Two nurses and an officer responded and arrived at Mr Grant's cell. However, the first officer said that she needed to wait for a third officer to arrive before opening the cell. Nearly two minutes after calling the code blue, a third officer arrived and then staff entered the cell and cut the ligature from Mr Grant's neck.

12. Staff in the control room called for an ambulance at 9.44pm. At 9.46pm, an officer started CPR. At 9.51pm, paramedics arrived and took over the management of Mr Grant's resuscitation. The paramedics managed to regain a pulse and took Mr Grant to hospital where he was put on a life support machine.

13. On 18 November, a decision was made to end life support. Mr Grant died on 21 November.

14. The post-mortem report concluded that Mr Grant died from hypoxic brain injury (lack of oxygen to the brain) and pulmonary oedema (fluid in the lungs) caused by ligature strangulation injury.

## Findings

15. Due to its intrusive nature, constant supervision should be used only when a prisoner is at imminent risk of self-harm and should be used for the minimum time possible. We consider that the decision to end constant supervision on 14 November was a reasonable one. Staff assessed that Mr Grant was no longer in crisis and tried to mitigate the risk of harm by maintaining a high level of observations and moving Mr Grant to the inpatient unit.

16. We consider that there was an unnecessary delay in entering Mr Grant's cell. There was no need to wait for a third officer to arrive when there were already two officers and two nurses present. This resulted in a delay in starting CPR. We cannot say whether the delay affected the outcome, but we know that in a medical emergency any delay could be critical. We are aware that HMPPS is updating national guidance to staff on entering cells in medical emergencies.

17. We found some issues with the management of the ACCT process. We are concerned that there were missing supervisor checks, suggesting a lack of management commitment to the ACCT process.

18. The clinical reviewer found that the nurses who attended the emergency response displayed a clear lack of awareness of basic resuscitation practice. They also failed to lead the resuscitation process as they should have done. He escalated his concerns to the Head of Healthcare who has commissioned an investigation into the actions of the nurses involved.

19. The clinical reviewer found that the care Mr Grant received for his mental health was only partially equivalent to that which he could have expected to receive in the community. When the mental health team assessed Mr Grant, they did not use standardised assessment tools as recommended by NICE guidelines.

## Recommendations

- The Head of Healthcare should review:
  - the training arrangements in place to support effective delivery of resuscitation; and
  - the capability of the healthcare workforce as this relates to emergency response.
- The Head of Healthcare should review the arrangements in place for carrying out assessments of mental health needs to ensure that these are consistent with NICE guidelines.
- The Governor should carry out an audit to identify whether ACCT supervisor checks are being completed and address any failings.

# The Investigation Process

20. HMPPS notified us of Mr Grant's death on 21 November 2023.

21. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

22. The investigator visited HMP Bedford on 30 November. She obtained copies of relevant extracts from Mr Grant's prison and medical records.

23. NHS England commissioned a clinical reviewer to review Mr Grant's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with seven members of staff. In addition, the investigator interviewed one member of staff by telephone.

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

25. The Ombudsman's office contacted Mr Grant's family to explain the investigation and to ask if they had any matters they wanted us to consider. The family asked (via their legal representative):

    - how the prison managed Mr Grant's risk of self-harm.
    - whether staff were appropriately trained.
    - why there was a delay in staff adding Mr Grant's requested phone numbers to his account.
    - why they were unable to get through to the visits booking line to book a visit.
    - whether adequate physical and mental health care was provided to Mr Grant.

26. These issues have been addressed in the report and in the clinical review.

27. The legal representative also asked various other questions about prison procedures, and whether racism played any part in the treatment and care that Mr Grant received. We have addressed some of the issues raised in the report, and issues that are not covered in the report have been addressed in separate correspondence.

28. We shared our initial report with HMPPS. They found no factual inaccuracies.

29. Mr Grant's family received a copy of the initial report. The solicitor representing Mr Grant's family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

# Background Information

## HMP Bedford

30. HMP Bedford is a category B male adult prison. There is a healthcare unit with ten single cells.

## HM Inspectorate of Prisons

31. The most recent full inspection of HMP Bedford was in October to November 2023. Inspectors reported that standards had fallen badly since the last full inspection in 2022. HM Chief Inspector of Prisons issued an Urgent Notification to the Secretary of State for Justice because Bedford was failing to provide good outcomes for prisoners.

32. Three of the four areas inspected were rated as poor. Inspectors noted standards of cleanliness on wings and in cells had worsened considerably since the last inspection. They considered that it was some of the worst accommodation that the inspectorate had ever seen, and they deemed the segregation unit was a disgrace and not fit for purpose.

33. Rates of self-harm had increased by 84% since the last inspection and were among the highest in the prison estate. During the previous 12 months, 52 prisoners had been under constant supervision.

34. Inspectors reported that ACCT reviews lacked a multi-disciplinary approach, care plans were frequently incomplete, and issues raised by prisoners were not properly addressed and actioned. These issues were compounded by a poor mental health service which was not meeting the needs of prisoners.

## Independent Monitoring Board

35. 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 30 June 2023, the IMB reported that the prison remained overcrowded, the infrastructure was ancient, and the segregation unit was in a dire underground location. The Board was concerned that prisoners spent too long in their cells and that self-harm and violence levels were too high.

36. The Board reported that the mental health team struggled with limited resources to provide an effective service. Attendance at ACCT reviews was patchy. While there was a reasonably good attendance at the initial reviews, mental health staff were not routinely present at subsequent reviews.

## Previous deaths at HMP Bedford

37. Mr Grant was the sixth prisoner at Bedford to die since November 2020. Of the previous deaths, three were from natural causes and two were self-inflicted. There

are no similarities between the findings from our investigation into Mr Grant's death and the findings from our investigations into the previous deaths.

## Assessment, Care in Custody and Teamwork (ACCT)

38. 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.

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

40. 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

41. On 29 August 2023, Mr Melvin Grant was remanded in prison charged with robbery. He was sent to HMP Thameside. Mr Grant had a long history of substance misuse and was prescribed methadone (medicine used to treat heroin dependency). He was also prescribed medication for anxiety and depression. He had no recent history of attempted suicide or self-harm (the last suicide attempt being in 2014).

42. On 27 September, Mr Grant was moved to HMP Bedford. Staff recorded that he engaged well during his induction, and they had no concerns.

43. On 8 October, Mr Grant told an officer that he did not want to get his medication. He said that he was frustrated that he had been moved to Bedford and wanted to be moved back to a London prison. Mr Grant said that he did not want to stay on the wing and wanted to move to the segregation unit. The officer told Mr Grant that there were no spaces in the London prisons. The officer noted that Mr Grant seemed less frustrated after their conversation, and that he collected his meal and returned to his cell.

44. On 5 November, Mr Grant refused to leave his cell to collect his medication or to collect his lunch or dinner. He told an officer that he did not feel very well. The officer offered to bring his meals to him, but Mr Grant refused.

45. On 9 November, at around 5.00pm, Mr Grant pressed his emergency cell bell and asked when he would be getting his canteen (items from the prison shop). An officer answered the cell bell and told Mr Grant that he would receive his canteen the next day. Mr Grant was unhappy with this and became loud and aggressive, and demanded to see a senior officer. When the officer told Mr Grant that this would not be possible, Mr Grant picked up two razor blades and swallowed them. The officer started suicide and self-harm monitoring (known as ACCT). A Supervising Officer (SO) completed the Immediate Action Plan and set observations at two an hour.

46. Later that evening, Mr Grant pressed his emergency cell bell and asked to see a nurse because his throat was hurting from swallowing the razor blades. A nurse saw Mr Grant and assessed that he needed to go to hospital. He was taken to hospital by ambulance and was escorted by two prison officers.

47. Following an X-ray, hospital staff assessed that Mr Grant did not need to be admitted to hospital but would need to return on Monday for a repeat X-ray, or sooner if he had any further issues.

48. Mr Grant returned to Bedford at around 1.20am on 10 November. Officers took Mr Grant back to the wing, but he refused to go in his cell. He said that he did not want to share a cell with his cellmate and that if he was put in that cell, he would assault his cellmate. Staff took him to the segregation unit and continued ACCT monitoring.

49. Later that day, at around 11.15am, a SO held a multidisciplinary ACCT review. A nurse from the mental health team attended. The SO recorded that Mr Grant engaged well in conversation and appeared calm and polite. Mr Grant said that he did not know why he had self-harmed the previous day and that he did not

remember swallowing razor blades. It was also recorded in the ACCT review that Mr Grant was struggling to recall his date of birth, and that he said he was avoiding prison food because he thought that something was being put in it. The case review team decided that Mr Grant should remain on ACCT monitoring and set observations at one an hour.

50. At around 12.30am on 13 November, Mr Grant started a fire in his cell. The fire service was called to assist officers in putting out the fire. Paramedics also attended and said that because Mr Grant had inhaled a considerable amount of smoke he needed to go to hospital. While being seen by the paramedics Mr Grant became agitated and started to hit his head on the wall. Staff restrained him to prevent him injuring himself.

51. At 2.20am, Mr Grant was taken to hospital by ambulance. While at hospital, Mr Grant was given oxygen but, after around 30 minutes, he became agitated and started pulling off the oxygen mask. Staff restrained him. Mr Grant discharged himself from hospital. When he returned to Bedford, staff placed him under constant supervision.

52. Later that day, a nurse assessed Mr Grant. He said that he thought his food and medication were laced with substances that would harm him and that he was hearing voices that were telling him not to eat or drink and at times to be violent towards others. He said that the voices had become such a nuisance that the only way he could stop them was to end his life. He said he had no plans and would await instructions from the voices. The nurse noted that Mr Grant had been seen banging his head and punching the walls in an effort to deal with the voices. The nurse recommended that Mr Grant should be reviewed by a psychiatrist.

53. At around 5.30pm, a prison manager held a multidisciplinary ACCT review with Mr Grant. A nurse from the mental health team attended. The manager noted that Mr Grant seemed depressed and said that he had had enough. When she asked him about the cell fire, he said that he did not know why he had started it. She told Mr Grant that a psychiatrist would see him the next morning.

54. The prison manager assessed that the risk of Mr Grant harming himself had increased and that he should remain under constant supervision. She set a review for the next day.

## Events of 14 November

55. At around 10.30am on 14 November, a psychiatrist saw Mr Grant. He noted that Mr Grant had drug induced psychosis (due to his past drug use) and prescribed him with antipsychotic medication (olanzapine). He noted that Mr Grant should remain on ACCT monitoring and would be reviewed in two weeks.

56. At around 2.00pm, a prison manager chaired a multidisciplinary ACCT review. She recorded that Mr Grant engaged well, maintained eye contact, and told her that he had no thoughts of suicide or self-harm. The case review team assessed that Mr Grant's risk of self-harm had reduced, that he was not in crisis and that he no longer needed to be under constant supervision. They agreed that Mr Grant needed support and high observations and that he should move to the prison's healthcare

inpatient unit so that the mental health team could observe him and ensure that he took his medication. They set observations at four an hour and scheduled the next review for 21 November.

57. Shortly after the ACCT review, staff moved Mr Grant to the healthcare inpatient unit.

58. At around 8.40pm, Officer A started her night shift in the healthcare unit. In her statement she said that she received a full handover at the beginning of her shift, which included information about Mr Grant. She said that during a routine check of prisoners, she saw Mr Grant sitting up in bed.

59. Officer A completed ACCT checks at 9.02pm, 9.16pm and 9.28pm. At the 9.28pm check, she recorded that Mr Grant was looking out of the observation panel of his cell door, and that when she asked him if he was okay, he nodded.

60. At 9.38pm, Officer A checked Mr Grant again. When she looked through the observation panel, she could see that he was lying face down on the floor and had a ligature tied round his neck. She called his name, but he did not respond. She immediately shouted for healthcare staff and radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately).

61. Two nurses and Officer B, who were all working in the healthcare unit, responded quickly and arrived at Mr Grant's cell. However, Officer A said that she needed to wait for another officer to arrive before opening the cell door. Another officer arrived after around two minutes. Officer A opened the cell door and used her anti-ligature knife to cut the ligature, made from bedsheets, from Mr Grant's neck.

62. At 9.44pm, an Operational Support Grade (OSG), who was working in the control room, called an ambulance. Body worn camera footage shows that at 9.46pm, Officer B started CPR, which was then continued by a Custodial Manager (CM). At 9.51pm, paramedics arrived and took over the management of Mr Grant's care.

63. The paramedics managed to regain a pulse and took Mr Grant to hospital where he remained in a coma in the critical care unit. Doctors said that no brain activity could be found, and on 18 November a decision was made to end life support. Mr Grant died on 21 November.

## Contact with Mr Grant's family

64. The duty governor at Bedford on the evening of 14 November told us that Mr Grant's prison record had no address or telephone number recorded for his next of kin (his grandmother). She was therefore unable to contact Mr Grant's grandmother as soon as Mr Grant was taken to hospital. The next morning, she went to the prison's business hub and obtained Mr Grant's grandmother's address. As HMP Belmarsh was much closer to the address than Bedford, she asked Belmarsh to send one of their family liaison officers to visit Mr Grant's grandmother to break the news.

65. At around 12.15pm on 15 November, a prison chaplain, a family liaison officer and an officer, both from Belmarsh, went to Mr Grant's grandmother's home to tell her that her grandson was in hospital.

66. On 17 November, a prison chaplain from Bedford took over the role of the family liaison officer and went to the hospital to support Mr Grant's family. Throughout the time that Mr Grant was in hospital, the family liaison officer maintained contact with Mr Grant's family and went to the hospital on several occasions.

67. The Prison Service contributed to the funeral expenses in line with national instructions.

## Support for prisoners and staff

68. After Mr Grant's death, a prison 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.

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

## Post-mortem report

70. The post-mortem report concluded that Mr Grant died from hypoxic brain injury (lack of oxygen to the brain) and pulmonary oedema (fluid in the lungs) caused by ligature strangulation injury.

# Findings

## Assessment and management of risk

71. Prison service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the processes (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm. The PSI provides a list of risk factors and triggers that may increase the risk of suicide and self-harm. These include violent offences against another person and a mental illness diagnosis, both of which applied to Mr Grant.

72. Staff correctly started ACCT procedures for Mr Grant on 9 November when he swallowed razor blades. On 13 November, after Mr Grant had started a cell fire, staff considered that his risk of self-harm had increased so decided that he should be under constant supervision.

73. Following a multidisciplinary ACCT review chaired by a prison manager on 14 November, staff stopped constant supervision and set observations at four an hour. They also agreed that Mr Grant would be moved to the healthcare inpatient unit where he could be closely monitored by the mental health team.

74. Constant supervision is intrusive and can have potentially negative impacts. It must therefore be used only where a prisoner is at imminent risk and used for the minimum amount of time necessary. We consider that the decision to stop constant supervision for Mr Grant on 14 November was a reasonable one in the circumstances. Staff took appropriate actions to minimise his risk by setting a high level of observations and placing Mr Grant in the inpatient unit so he could be monitored by mental health staff.

75. We found some issues with the management of the ACCT process. The care plan had minimal actions, the ongoing record lacked detail and there was no record of any meaningful conversations. In addition, there were missing supervisor checks which suggests a lack of commitment to quality assuring the ACCT process. While we do not consider that these issues impacted on the care provided to Mr Grant, we are concerned that there were no supervisor checks throughout the time that he was under ACCT monitoring and that should have highlighted the other issues we identified. We make the following recommendation:

    **The Governor should carry out an audit to identify whether ACCT supervisor checks are being completed and address any failings.**

## Emergency response

### Delay entering the cell

76. PSI 24/2011 on the management and security of nights says that under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two/three (subject to local risk assessment procedures) members of staff are present one of whom

should be the NOO. However, the PSI also says that staff have a duty of care to prisoners, themselves and other staff, and that the preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life, then cells may be unlocked without the authority of the NOO and an individual member of staff may enter the cell on their own, if safe to do so.

77. When Officer A saw Mr Grant lying on the floor with a ligature around his neck and he failed to respond to her, she immediately called a code blue. She did not enter the cell. We can understand why she did not feel safe to enter the cell alone. However, Officer B and two nurses arrived quickly. Officer A still did not open the cell door and can be heard saying on the body worn camera that she needed to wait for another officer to attend before opening the cell door.

78. In their statements, both Officers A and B said that Mr Grant had a history of assaulting staff and prisoners, so they were wary of opening the cell door. The investigator could not find a record of Mr Grant assaulting any prisoners or staff while at Bedford or at any prison since 2016.

79. The investigator interviewed the custodial manager in charge of the prison on the night of 14 November and asked him about the protocol on opening cell doors at night in a medical emergency. He said that it was a difficult choice and a judgement call. He said that the expectation was that if it was safe to do so, staff should enter the cell.

80. We consider that as there were two officers at the cell, along with two nurses, it was safe for them to enter the cell. There was an unnecessary delay in entering Mr Grant's cell and providing emergency care.

81. While we did not find any direct evidence of racial discrimination in the course of the investigation, it has been well documented that due to racial stereotyping, black prisoners are assumed to have a history of violence when it is not the case. We cannot say whether this was a factor in this case.

82. It is not possible to say whether the delay impacted on the outcome for Mr Grant, but we know that in a medical emergency, any delay could be critical. Staff uncertainty about entering cells in an emergency has been a recurring issue in PPO investigations. As a result of a recent national recommendation, HMPPS begun a programme to update national guidance for staff on entering cells in an emergency to preserve life. We therefore make no recommendation.

### Delay in calling the ambulance

83. The code blue was called at 9.38pm but an ambulance was not called until 9.44pm. When we asked the OSG in the control room about this delay, he said that he did not realise that there had been a delay, and his only possible explanation was that he was trying to obtain as much information as possible to relay to the 999 operator.

84. We are aware of ongoing work, commissioned by the Director General of HMPPS and in collaboration with health partners, to address this issue so we make no recommendation.

### Nurses' role in resuscitation

85. The clinical reviewer considered that the two nurses involved in the emergency response showed a clear lack of awareness of basic resuscitation practice. Both nurses also failed to display the leadership expected in an emergency.

86. We escalated these concerns to the Head of Healthcare at Bedford who has commenced an investigation into the nurses involved. We recommend:

**The Head of Healthcare should review:**

- **the training arrangements in place to support effective delivery of resuscitation; and**
- **the capability of the healthcare workforce as this relates to emergency response.**

## Clinical care

87. The clinical reviewer concluded that the care Mr Grant received for his mental health was partially equivalent to that which he could have expected to receive in the community. The clinical reviewer found that when the mental health team assessed Mr Grant, they did not use standardised assessment tools as recommended by NICE guidelines. We recommend:

**The Head of Healthcare should review the arrangements in place for carrying out assessments of mental health needs to ensure that these are consistent with NICE guidelines.**

## Informing next of kin

88. Mr Grant was taken to hospital at around 11.00pm on 14 November and placed in an induced coma. His family were not notified until 13 hours later, when staff in the business hub were able to search Mr Grant's prison file for next of kin details. Given the seriousness of Mr Grant's condition, we consider that this was too long.

89. While we do not make a recommendation, we bring this issue to the Governor's attention so that she can consider what measures could be put in place to avoid such delays in future.

## Inquest

90. At the inquest, held from 6 to 20 October 2025, the jury reached a narrative conclusion as follows: "We, the jury, agree that on a balance of probabilities in taking such action that night, Melvin Grant intended his life to end. We also believe that the decision to downgrade Melvin's observation, due to a serious failure in sharing relevant information regarding his mental health, probably made more than a minimal contribution to Melvin's death."

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