

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Bullingdon in September 2006**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**June 2011**

This is the report of an investigation into the circumstances of the death of a man at HMP Bullingdon. He was a remand prisoner who was found hanging in his cell on 26 September 2006. I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by an investigator from my office. A clinical review was carried out by Oxfordshire Primary Care Trust. I would like to thank the Governor of Bullingdon and his staff for their help and assistance during the course of this investigation.

The man had been at Bullingdon for just two weeks at the time of his death. Nothing arose to indicate to staff that he was having problems until the evening of 26 September. At roll-check that evening he was seen with a ligature and staff went into the cell to speak with him. An 'Assessment Care in Custody and Teamwork (ACCT) form was opened and the man was moved to a safer-cell. He was checked shortly after he was moved to the safer-cell, but around 30 minutes later he was found hanging. He had used a curtain rail as a ligature point. It seems the rail had been installed by a wing officer acting on his own initiative. It was not an authorised part of the cell design.

Soon after my investigation commenced, the circumstances surrounding the man's death were referred to the Crown Prosecution Service (CPS) for consideration of a possible prosecution of staff at Bullingdon. In the meantime my investigation was suspended. On 27 November 2007, the CPS wrote to the man's wife informing her that they would not be pursuing any criminal proceedings. I regret the delay to this investigation arising from the CPS's deliberations.

The first draft of this report was issued in May 2008. In response to comments received from the solicitors representing the man's family, I agreed to reconsider my conclusions. This report reflects my reconsideration of the issues and includes a new recommendation.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**June 2011**

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## SUMMARY

The man arrived at HMP Bullingdon on 11 September 2006. He was a remand prisoner charged with the offence of burglary. This was not the man's first time in prison custody. Just over a fortnight after his arrival in Bullingdon, he was found hanged in his cell.

As might be expected in the case of a person who had been in prison for such a brief period, the man's records contain little information or evidence about how he was generally getting on. He mentioned upon his first arrival that he was being treated for anxiety and depression, and he was prescribed medication for those two conditions. The man also said that he had never harmed himself in the past and that he had no present thoughts of doing so. On 13 September, a prison doctor noted that the man was having trouble sleeping and was slightly depressed. The doctor referred him to see the prison psychiatrist (although the man died before his appointment date).

The only notable entry in the man's discipline records was made on 22 September after he refused to leave a cell that he had moved into without permission. He pleaded guilty at a subsequent adjudication hearing<sup>1</sup> prior to which he had been found physically and psychologically fit for segregation (in the case of such a punishment being imposed).

During evening roll check on 26 September, the man, who was in a single cell, was seen holding a ligature. Staff went into the cell and one officer in particular tried for 20 minutes to engage him in conversation. The man was largely unresponsive. He declined offers to speak with a Listener<sup>2</sup> or to move into a shared cell with another prisoner. He also declined to see a chaplain the following morning.

Staff moved the man to a safer-cell (a cell adapted to minimise ligature points and other potential options for self-harm). Staff also opened an ACCT<sup>3</sup> form. In his role as unit manager, the senior officer decided that the man should be observed once per hour at irregular intervals. Staff observed him at least twice in the first few minutes after he had moved into the safer-cell.

At around 8.40pm, and probably no more than about 30 minutes since he was last observed, the man was found hanging from a ligature tied to a curtain rail for privacy screening of the cell toilet. (The curtain rail was not part of the original safer-cell design but was a later, unauthorised, addition.) Staff went into the cell to try to resuscitate the man. They also called ambulance paramedics who gave their assistance. Unfortunately, all efforts to resuscitate the man proved unsuccessful.

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<sup>1</sup> Adjudication hearings consider allegations that prisoners have contravened prison rules and regulations. When prisoners are found guilty, a punishment such as loss of association can be imposed.

<sup>2</sup> Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community.

<sup>3</sup> ACCT (Assessment, Care in Custody and Teamwork) is the process for managing and supporting prisoners who are judged at risk of self-harm or suicide.

This report makes five recommendations. Two of these are about work on the fabric of the building, one is about completion of ACCT forms and another is a reminder to staff about safer-cells. I also endorse the two recommendations made in the clinical review.

## THE INVESTIGATION PROCESS

1. My investigator originally visited Bullingdon on 29 September 2006 when he met the Deputy Governor, one of the prison chaplains and a representative from the Prison Officers' Association. The investigator also met a member of the Independent Monitoring Board (IMB). Notices were displayed informing staff and prisoners about my investigation.
2. In all cases of a death in prison custody the police always visit to conduct an immediate investigation. The investigator met the police investigators who informed him that the circumstances surrounding the man's death were to be submitted to the Crown Prosecution Service (CPS) for consideration of possible criminal charges. The police advised that my investigation be suspended pending the considerations of the CPS.
3. I was subsequently informed that the CPS had decided that there would be no criminal prosecution. My investigation officially began on 27 November 2007. The police provided transcripts of their interviews with prison staff. The investigator interviewed five staff members, four of whom had been interviewed during the police investigation. No prisoners came forward in response to the posting of notices about the man's death. Oxfordshire Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Bullingdon.
4. One of my Family Liaison Officers contacted the man's wife to inform her of my investigation and to offer her the opportunity to ask questions and to raise any concerns she would like considered as part of this. The man's wife asked the family liaison officer to speak with her sister on her behalf. The man's sister-in-law responded for the family saying they were very concerned that the man had not been checked every 15 minutes after being moved to the safer-cell. The family also wanted to know why he had not been automatically moved to the prison healthcare unit when he was first found with a ligature.
5. The man's sister-in-law also said that when the family visited the prison they saw several complaint forms in one of the man's cells. The forms were collected by an officer who said that they would be put with the rest of the man's belongings and returned to the family. When the belongings were later returned, no complaint forms were included. When the family asked about this they were sent three blank forms and were told that these were the ones found in the cell. My investigator asked Bullingdon for its comments. My investigator was told that the man's cell contained a lot of clutter, but everything was put into sealed bags for return to the family. There were no other complaint forms so far as the prison knew.
6. Following the Coroner's inquest into the man's death the investigator obtained and listened to a recording of the proceedings including the evidence given under oath by relevant witnesses.

## HMP BULLINGDON

7. Bullingdon is a category C training prison in Oxfordshire that was opened in 1992. It holds convicted and unconvicted adult males. Bullingdon is also a local prison for category B prisoners.
8. The most recent inspection of Bullingdon by HM Chief Inspector of Prisons was an unannounced follow-up inspection in June 2004. The findings included:

“Bullingdon was safer than when we last inspected (in September 2002). Reception and induction procedures had improved and there was a greater overall focus on safer custody, with a relatively low level of incidents of self-harm ...

“... Although the prison’s action plan (in response to the inspection in September 2002) stated that ‘All shared cells have screened sanitation facilities’, toilets in many single cells were unscreened or only partially screened ... **[I recommend that] ... toilets in all cells should be effectively screened.**” (Emphasis in original.)

9. Bullingdon recorded 70 incidents of prisoners harming themselves in 2006 and two prisoners, the man and one other, apparently took their own lives. In the same calendar year, 367 ACCT forms were opened.
10. The Independent Monitoring Board’s annual report about Bullingdon for 2006/2007 included:

“In Bullingdon staff and prisoners work together to support those individuals in crisis. The aim being to prevent serious acts of self-harm and possible suicide. However, in September 2006, there were two self-inflicted deaths reported in the prison. As a result of the second death all safer-cells were taken out of commission and renamed reduced risk (pending re-commissioning) ...

“The number of ACCTs opened: (395) was consistent with the number opened the previous year including a percentage already opened by transfers in.

“Self harm also remains consistent at 51 incidents (about 11 to 12 per month) which is relatively small to the population of the establishment. The number of Listeners (23) is consistently above the recommended average and remain a huge asset to safer custody with training given three times a year by the Samaritans.”

11. None of the previous deaths that I have investigated at Bullingdon contains any recommendations relevant to the circumstances of the man’s case.

## KEY FINDINGS

12. The man attended Oxford Crown Court in September 2006, charged with an offence of burglary. The court decided that the man should be remanded into prison custody and he was taken to HMP Bullingdon.
13. Upon arrival in Bullingdon, the man was seen by a nurse for a standard first reception health screen assessment. In answer to a question about recent medical consultations, the man reported seeing a doctor about anxiety and depression for which he had been prescribed fluoxetine (an antidepressant) and temazepam (a sleeping tablet). He also reported being treated by a psychiatrist two to three years before for the same conditions (anxiety and depression). The man said that he had never attempted to harm himself and had no present thoughts of doing so. In answer to a question about alcohol use, the man reported drinking 20 pints of lager per week. The man was not prescribed any medication that evening, but he was located into healthcare for probable alcohol detoxification to start the next day.
14. The man was seen the following day by one of the prison doctors, who noted that the man was showing symptoms of alcohol withdrawal. The doctor wrote prescriptions for several medicines, including diazepam for alcohol detoxification and fluoxetine for depression. The man remained in healthcare for a second night.
15. The same doctor saw the man again on 13 September. The doctor noted that he was slightly depressed, for which he referred him to the prison psychiatrist with an appointment made for 27 September. The doctor also noted that the man was fit to move to ordinary location (that is, to a standard prison wing) and he was moved to a cell on B wing.
16. On 22 September, an officer made a note that the man was proving to be demanding of staff time, was disrespectful of the prison regime and was not following prison rules. At interview, the officer said that she had very little recollection of the man. All that she could recall was that he had moved into another cell without authorisation and refused to leave the cell when asked.
17. The allegation that the man had 'disobeyed a lawful order' was considered at an adjudication hearing on 23 September. Before the hearing, he was seen by a nurse who found no clinical reason to advise against him being placed in segregation (in the case of such punishment being imposed). The man pleaded guilty to the charge laid against him. His punishment was loss of certain privileges.
18. A prisoner in Bullingdon at the time who was both an Insider<sup>4</sup> and a Listener said that he had spoken regularly with the man. He understood that the man had been in prison before, but he seemed to be finding this time quite hard. The man said that he was expecting a long sentence and was worried that his

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<sup>4</sup> Insiders are prisoners who speak to new prisoners in reception and induction to provide information for first time prisoners about life in prison.

children might be taken into care. On the evening before his death, the man spoke to his wife by telephone. The prisoner thought he appeared upset. The prisoner spoke with the man at tea time on 26 September when he said that he was unsure his wife would be able to cope with the children. The man seemed 'down', but not to the extent of being suicidal.

19. At about 7.45pm on 26 September, the first officer was conducting a routine evening roll-check of cells on the 3rd landing. When she looked into the man's cell she saw him standing on a chair trying to attach a ligature to the light fitting. The man noticed the officer at the door and immediately jumped down from the chair and threw the ligature away. The first officer asked the prisoner Insider who had previously spoken with the man to come to the cell door while she went to get assistance. The first officer said that at that time in the evening the prison was in 'patrol state'. This means that most of the prisoners had been locked into their cells and a cell is opened only if there are three officers present. Because of his role, the prisoner Insider, had still not been locked in his cell at that point.
20. The prisoner Insider said that when he was summoned by the first officer, he stood at the cell door. The man was sitting on his bed and began to pull the noose over his head. The prisoner Insider told him to take it off, which he did. The man began to cry and said that he had had enough. The prisoner Insider reminded the man that he had a family. The prisoner Insider estimated that within two minutes several officers arrived at the cell. The prisoner Insider went back to his own cell and stood at his open door. He said that the officers went in to the man's cell and he could hear them reassuring him.
21. The second officer was dealing with paperwork in the centre office when the first officer ran along the landing calling for assistance. The first and second officers went to the man's cell with a third officer and a senior officer. The man's door was unlocked and staff went into the cell. The second officer said he spent around 20 minutes trying to speak with the man. The man confirmed that he had a wife and children but also said that he had nothing to live for. The second officer asked the man why he was doing what he was doing and what he thought would be the impact on his family. The man did not respond to these questions. The second officer asked the man if he wanted to speak to a Listener, but he said no. The second officer asked the man if he wanted to telephone the Samaritans, or see a chaplain the next day, which he also declined. The senior officer said that an ACCT form should be opened on the man and that he should be moved to a safer-cell.
22. The senior officer confirmed that when staff went to the man's cell, it was mainly the second officer who tried to speak with the man. The senior officer heard the second officer ask the man why he had made a ligature and asking him also about his family. The man was not forthcoming with information but he did say at one point that there was nothing for him to carry on for. The senior officer told my investigator that he checked the man's records and saw that he had no history of self-harm. The man was asked a number of times whether he wanted to see a Listener or if he would like to share a cell with another prisoner. The man declined all these offers.

23. The senior officer decided that the man should be moved to a safer-cell. He was taken to cell B213 which is on the 2nd landing close to the wing office. The senior officer said that he thought that the safer-cells had no ligature points. Despite this belief, the senior officer did what he could to eliminate potential ligatures. The man was wearing laced shoes, so he was asked to remove them and to leave them outside the cell. The senior officer also checked the cell to make sure there were no kettle or television leads. Cell B213 contained bedding material, but this is never removed in prisons even in the case of prisoners at potential risk of self-harm. Although the toilets had been made more private with the installation of privacy curtains, the senior officer understood the curtain rails were meant to collapse under any weight.
24. As the first officer was the person who found the man with the ligature, it was her responsibility to open an ACCT form. In answer to a question on the form asking her to describe why she was concerned the officer wrote:
- “[The man] had placed a ligature around his neck and attached this to a lighting fixture. [The man] stated he wanted to end it and has nothing to live for.”
25. Once she had completed the initial parts of the form, the first officer passed it on to the senior officer, the unit manager, for his consideration.
26. The role of the unit manager in the ACCT process includes deciding upon the ‘Immediate Action Plan’ (the plan for the prisoner’s support pending the first case review). Among other things, the senior officer had to decide on the appropriate frequency of staff support for the man. At Bullingdon, numerical codes are used to indicate the frequency of staff support under ACCT. The frequency of support ranges from level 1 (maximum risk requiring constant watch) to level 5 (minimum risk with one observation per shift). At interview, the senior officer said that he was aware that the man had no history of acts or thoughts of self-harm. Nor did he assess his demeanour as being much different from the majority of prisoners for whom ACCT forms are opened. The senior officer did not think that the man was at the higher end in terms of risk so he did not need to go to healthcare. He decided that the appropriate level for the man was level 4, which meant that he would be observed once an hour at irregular intervals.
27. The senior officer said that he checked on the man about five minutes after he had been put in the safer-cell and he was looking out of the cell window. The time by then would have been around 8.15pm. The senior officer asked the man if he was alright, but the man did not reply. The senior officer added that another officer (the third officer) told him that he had also checked the man.
28. The third officer said that he had been conducting a roll-check on the 2nd landing when he saw officers running up the stairs to the man’s cell. After the man was taken to the safer-cell on the 2nd landing, the third officer resumed his roll-check. A few minutes later, the officer reached the man’s cell. He looked into the safer-cell and saw the man sitting on his bed.

29. At about 8.40pm, the first officer went to check the man. When she looked into the cell she saw the man hanging from a ligature tied to the privacy curtain rail. The officer shouted for help and several officers, who were all nearby, came to the cell. The cell was unlocked and staff went inside. Two officers lifted the man's body and the first officer cut the ligature with her anti-ligature knife. Another officer came into the cell as the man's body was being lowered to the floor.
30. Once the man was on the floor, the first officer checked him for a pulse but could find none. She then attempted to give emergency breaths using a plastic mouth-piece, however there seemed to be a blockage and she could not get any air into the man's lungs. The first officer then gave two chest compressions. Another officer came into the cell at this point and he took over giving chest compressions while the first officer went back to trying to give emergency breaths. This time she was able to blow air into the man's lungs. The officers continued with their efforts to try to resuscitate the man until they were relieved by healthcare staff a few minutes later.
31. Two healthcare nurses arrived together. They carried out further checks on the man and took over the attempts at CPR (cardio pulmonary resuscitation). The man was also checked with a defibrillator<sup>5</sup> which advised that no shock be given. All examinations indicated that the man was dead. Even so, staff continued CPR until the arrival of ambulance paramedics at just after 9.00pm. The paramedics ran their own tests also attempted CPR. The man was pronounced dead at 9.16pm.

### **After the man's death**

32. One of Bullingdon's chaplains, was contacted at home and asked to come into the prison. The chaplain told my investigator that he is a member of the prison care team and in that role went to speak to the staff who had been involved with the man that evening. He also said a prayer over the man's body.
33. The chaplain was asked to visit the man's wife in person to break the news of her husband's death. He went to the family home in the company of two police officers and told her what had happened. Bullingdon offered a financial contribution towards the man's funeral expenses.

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<sup>5</sup> A defibrillator measures electrical activity in the heart and emits audible instructions on management of the patient such as whether or not an electrical shock should be given.

## ISSUES

### The safer-cell and the privacy curtain rail

34. Safer-cells were first introduced in the Prison Service in 1997 with the aim of reducing the occupant's opportunities of self-harm. Features of a safer-cell include specially designed furniture and fixtures that are manufactured and installed to make the attachment of ligatures very difficult. Additionally, access to window bars is prevented through use of non-opening windows with integral ventilation grilles. However, it is recognised that no cell can be considered totally safe.
  35. It is understood that cell B213 was converted into a safer-cell around late 2002 to early 2003. It was a double cell and its design met with the Prison Service's approved specifications for safer-cells as they existed at that time.
  36. A low level privacy screen partially obscured the cell toilet from the cell door observation hatch, but offered no privacy if there was a second prisoner in the cell. A curtain rail was later installed in the cell to provide total privacy whenever there were two prisoners in the cell. The curtain rail was lightweight aluminium with two wall brackets and one ceiling fixing. The man tied the ligature at the point where the rail met the wall – that is, directly at the wall bracket where the rail was at its strongest. The bracket had been fixed to the wall with two long screws.
  37. My investigator made enquiries of Bullingdon about how the curtain rail came to be approved and installed. He was told by Bullingdon's works department manager that his department did not fit the rail. The works manager thought that the rail had been fitted by a wing officer acting on his own initiative. My investigator made further enquiries to clarify if this was what happened, but was told that no records exist about the installation. This is a matter of great concern.
  38. How the curtain rail came to be installed was explored in detail during the Coroner's inquest. Evidence was taken from various witnesses including past and present Governors at Bullingdon, staff from Bullingdon's works department and staff from Prison Service headquarters. None of the witnesses were able to confirm when the rail was installed, who installed it and who authorised the installation.
- I recommend that the Governor satisfies himself that only properly sanctioned alterations to cells are undertaken and that all work is carried out or supervised by the works department. The Governor should also ensure that no work is carried out that jeopardises the designation of a safer-cell.**
39. Following the man's death, the Prison Service's Safer Custody Group visited Bullingdon and inspected the safer-cells. Various aspects of cell B213 were found no longer to meet the latest specifications for a safer-cell. As a result, it was decommissioned as such a cell.

40. The updated specifications for safer-cells should have been issued to all prisons in March 2005. It is not clear whether these instructions reached Bullingdon and if they did why they were not acted on.

**I recommend that the Prison Service revises its arrangements for communicating updates to guidance on safer-cell specifications. The revised arrangements should include the need for prisons to confirm compliance with the updated guidance.**

#### **The assessment of the man's level of risk and the action taken in response to that assessment**

41. When the man was found attempting to tie a ligature, staff responded promptly and tried to explore the motives behind his actions. The man was not very forthcoming with information but said that he had no reason to carry on (with his life). Staff said that he was clearly upset. The man declined all offers of help: seeing a Listener, telephoning the Samaritans, being moved to a shared cell with another prisoner or seeing a chaplain. After staff had spent around 20 minutes trying to converse with him, he was moved to a safer-cell and an ACCT form opened for him.
42. Under the ACCT process, it was for the senior officer as unit manager to decide and write an 'Immediate Action Plan'. The ACCT form itself explains that the purpose of the immediate action plan is to find the most appropriate environment and location for the prisoner pending the first case review (which will be held within the following 24 hours). The senior officer wrote on the plan that he had located the man in 'a ligature free cell' supported by 'level 4' (hourly) observations. The senior officer also wrote on the plan that: 'Everything has been removed from his possession that [he] can harm himself with'.
43. As an easy reference guide about ACCT and about dealing with prisoners at risk the Prison Service has issued staff with a small booklet: the 'Pocket Guide for Staff'. The guide provides help in recognising some of the signals indicating that a prisoner might be at risk. The guide then goes on to explain the procedure for opening and operating the ACCT process. The guide explains that a key aim of the ACCT approach is to identify individual need and to offer individualised care and support. The guide gives no specific direction on what level of support, including frequency of observations, would be appropriate in any particular situation.
44. Prison Service Order (PSO) 2700 deals with suicide and self-harm prevention and it includes guidance on the ACCT process. However, as with the pocket guide, PSO 2700 gives no examples of situations where a particular level of observations might be applicable. Nor is any such guidance contained in Bullingdon's local suicide and self-harm prevention policy document. My investigator spoke to the Prison Service about the ACCT training provided to unit managers (such as the senior officer). My investigator was told that the training course does not include 'typical scenarios' of differing prisoner presentation that might point towards differing levels of observation. He was told that the reason

for this is that staff are expected to deal with prisoners as individuals. In deciding on a support plan, unit managers should tailor that to the individual and their individual set of circumstances.

45. The senior officer said during his police interview that he understood that the safer-cell was free of ligature points and that the shower curtain rail was designed to collapse under any weight – he added that rails were constantly being replaced because they tended to collapse too easily. The senior officer asked the man to remove his shoes (and therefore his shoe laces) and also checked that the cell contained no other potential ligatures such as electrical leads. He had therefore done everything that he thought was reasonable in terms of the environment into which he was locating the man. The senior officer did not remove the bedding from the cell however, as that is something that is never done.
46. In his interview with my investigator, the second officer said that although the man was totally uncommunicative, this did not necessarily indicate that he was obviously at great risk. He said prisoners are often uncommunicative. The second officer thought it was reasonable for the senior officer to have decided that the man be observed once per hour. If he had disagreed with that assessment he would have told the senior officer at the time.
47. The man's sister-in-law said the family thought that the man should either have been checked every 15 minutes if located in the safer-cell or should otherwise have been moved to the healthcare unit.
48. Deciding on the appropriate level of observation in the man's case was a matter for the senior officer's personal judgement. It is very easy in retrospect to say that the senior officer misjudged the situation and underestimated the man's level of risk. However, the senior officer had to make a decision based on the evidence in front of him at the time, including that the man seemed to have no history of self-harm before the attempt to tie a ligature. The senior officer thought that the man was no different to most prisoners for whom an ACCT form is opened. It is relevant that in the vast majority of cases ACCT forms are opened and subsequently closed without the prisoner having come to any significant harm. For instance, in 2006, 367 ACCT forms were opened in Bullingdon, 70 incidents of self-harm were recorded and two prisoners apparently died at their own hand.
49. Only those present at the time are in a position to say how the man compared to others who indicate by their deeds or words that they might be at risk. At interview, the senior officer and the second officer both said that the man did not seem at significant risk. Despite this, the senior officer considered the risk raised to a level where he considered it appropriate to move the man to a safer cell and to confiscate his shoe laces. The senior officer appears to have relied heavily on the fact that he had put the man into a cell that he believed was ligature free rather than putting in place or setting up a high frequency of observations to monitor and offer support to him. I do not doubt the senior officer's genuine belief that the cell was ligature free, but having reconsidered the matter at length I now feel that the level of observation should have been set

at a frequency greater than once per hour. Observation and interaction with prisoners at risk of suicide is always to be preferred over simply removing the means by which a prisoner can take his own life. That said, I note that the man was checked on two occasions just after he was moved to the safer-cell and nothing untoward was noticed. This means it is probable that less than 30 minutes had elapsed between the man last being checked and seeming to be well before he was found hanging at the next check. Unless it were judged that the man should have been subject to constant observations (and I do not make that judgement), it follows that the set level of observations may not in fact have been critical to the outcome.

50. The senior officer believed that the safer-cell was totally free of ligature points. Safer-cells are designed with a view to minimising ligature points. The man used as a ligature point a privacy curtain rail that was not part of the room's original specification. Even so, the term 'safer-cell' rather than safe-cell was originally chosen precisely because it has so far proved impossible to make any cell totally safe.

**I recommend that the Governor remind his staff that no cell is entirely safe.**

51. Having decided that the man should be observed once per hour, the senior officer noted this by entering the locally understood term 'Level 4' on the ACCT form. The instructions in PSO 2700 indicate that the frequency of observations should be set out not in code or jargon but using clear and ordinary language. PSO 2700 goes on to say that the failure to use plain English has led to misunderstandings, both following internal prison moves and on transfer.

**I recommend that the Governor reminds staff to use plain language when completing ACCT forms.**

### **The ligature**

52. The man made the first ligature from bedding material. When he was moved to the safer-cell, he was asked to remove his shoes preventing him from using his laces as a ligature. Staff also checked the safer-cell to ensure there were no kettle or TV leads that could be used for this purpose. However, the safer-cell was supplied with bedding material. Once again the man tore a strip from this material to fashion another ligature. Staff did nothing wrong in leaving the man with bedding material. It is not uncommon in situations such as the man's for prisoners' shoes (and therefore laces) to be confiscated. But within the Prison Service's decency agenda, prisoners will ordinarily keep their own clothing and will normally be provided with standard bedding material. I would not wish to see any change to that principle.

## RECOMMENDATIONS

### I make the following three recommendations:

1. I recommend that the Governor satisfies himself that only properly sanctioned alterations to cells are undertaken and that all work is carried out or supervised by the works department. The Governor should also ensure that no work is carried out that jeopardises the designation of a safer-cell.

*Prison Service response: recommendation accepted. The Estates Department of the establishment have been advised of these requirements. Quarterly checks to be actioned by Estates Department. Target date for completion: 30 September 2008.*

2. I recommend that the Prison Service revises its arrangements for communicating updates to guidance on safer-cell specifications. The revised arrangements should include the need for prisons to confirm compliance with the updated guidance.

*Prison Service response: recommendation accepted and implemented. Area Managers have been reminded of the importance of clearly certifying the current status of their cells, based on the safer cell guidance contained in the revised PSO 2700. Annex 10D of this document specifically provides a protocol for checking and signing off that safer cells meet the requirements of the current safer cell guide.*

3. I recommend that the Governor remind his staff that no cell is entirely safe.

*Prison Service response: recommendation accepted and implemented.*

4. I recommend that the Governor reminds staff to use plain language when completing ACCT forms.

*Prison Service response: recommendation accepted. The form that was completed for the man has been revised however the point regarding plain language will be incorporated into the local Suicide Prevention Policy. Target date for completion: 30 November 2008.*

### I also endorse the following two recommendations which have been drawn from the clinical review:

5. When a prisoner reports depression a detailed record of suicide risk assessment should be made in their medical records.

*Prison Service response: recommendation accepted. Advice given to PCT to ensure that medical practitioners are aware of this recommendation. Head of Healthcare to liaise with the Primary Care Trust via clinical governance meeting. Target date for completion: 30 November 2008.*

6. A regular assessment of mood should be made and recorded in the medical records of prisoners going through a detoxification regime.

*Prison Service response: recommendation accepted. Update made at the individual case review as part of ongoing support. Head of Healthcare to implement. Target date for completion: 30 November 2008.*