

**Investigation into the circumstances surrounding the  
death of a man  
at HMP & YOI Bristol in March 2010**

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

**July 2011**

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Bristol. He died in March 2010. He was 41 years old. He was found hanging in the cell which he shared with his son, his co-defendant, who was at work at the time. I would like to offer my sympathy and condolences to his son and the rest of his family for their loss.

The investigation was carried out on behalf of the Ombudsman by my colleague assisted by his colleague. I would like to thank the Governor of Bristol and his staff for their co-operation during the course of our enquiries.

The local Primary Care Trust (PCT) was commissioned to conduct a clinical review into the standard of healthcare the man received whilst in custody at HMP Bristol. The PCT appointed a clinical reviewer. I would like to thank him for the review. Unfortunately, I did not receive the clinical review until December 2010, which contributed to the delay of my own report (partly also due to the difficulty in speaking to certain members of staff).

This was the man's first time in prison and he spent much of the time feeling anxious. He had a history of depression, but did not always take his medication. He was monitored by suicide prevention measures on two occasions during his time in custody. The first time staff had noticed that he was worried by prison life. The measures were stopped once he had settled in but were put in place a second time after his apparent attempt to take his life on 25 February. After a few weeks, his mood appeared to lift and the measures were again removed. Unfortunately, just over two weeks later, he took his life.

His demeanour was affected by his imprisonment. I have found that prison staff tried to help him cope with his change in circumstances. I examine the use of suicide prevention measures. Although I believe that staff acted in good faith, my report identifies a number of areas where the suicide prevention processes could have been improved. In particular I am disappointed to repeat a previous recommendation about reviews after the suicide prevention measures come to an end. I also look at the concerns raised by his family. My recommendations concern suicide prevention procedures, and mental health assessments. I also highlight an area of good practice.

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

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**Acting Deputy Prisons and Probation Ombudsman**

**July 2011**

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## SUMMARY

1. The man was remanded into HMP Dorchester on 8 December 2009 charged with serious offences. It was his first time in custody and he struggled with his change in circumstance. His son had been remanded with him as his co-defendant, and this support did help him to a certain extent. However, suicide prevention measures were used, but were closed once he began to adapt to life in prison.
2. He and his son were transferred to HMP Bristol on 15 January. During his initial healthscreen interview at Bristol, he explained that he was anxious, had a history of depression and had taken an overdose ten years previously. His main concern was being able to share a cell with his son, which was authorised on 23 January.
3. On 3 February, Dorchester healthcare department emailed Bristol regarding a mental health referral that had been made for him, but had not taken place before he transferred. He was assessed two weeks later, on 16 February, by a mental health nurse who did not think that he showed clear signs of depression, but was somewhat anxious. As a result of the mental health assessment, he was referred to a counselling service.
4. He was a quiet prisoner who did not often come out of his cell. He and his son did not associate with many of the other prisoners. They were employed in the prison's workshop. He hung himself in his cell on 25 February but his son raised the alarm before he was injured. He was taken to the healthcare centre where he was assessed by a member of staff. Suicide prevention procedures were begun and he attended a number of reviews to monitor his well-being and state of mind. At a review on 7 March, he said that he regretted the alarm caused by his actions and would not attempt to harm himself again. The suicide prevention measures were stopped.
5. At the end of March his son returned to their cell after his morning work shift to find his father hanging. Officers and healthcare staff attempted to resuscitate him but the prison doctor certified his death a short while later.
6. This report contains eight recommendations. I also highlight an act of good practice regarding communication between Dorchester and Bristol.

## THE INVESTIGATION PROCESS

7. One of my investigators opened the investigation at HMP Bristol on 6 April 2010. He met senior prison managers and took copies of the documentation relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No-one came forward with regard to the notices. My investigator and his colleague visited the prison on 5 and 10 May, and 5 August, to interview staff and prisoners. Another investigator visited HMP Portland to interview an officer on the investigator's behalf on 24 May 2010. The officer had been on detached duty at Bristol at the time of the man's death, and has since returned to Portland. The investigator subsequently returned to Bristol on 2 December to interview a further member of staff.
8. My investigator wrote to the Chief Executive of the local Primary Care Trust (PCT) to commission a clinical review. Bristol PCT asked a clinical reviewer to review the care received by the man whilst at HMP Bristol. He received a copy of the relevant medical documents upon which he based his findings.
9. One of the Ombudsman's Family Liaison Officers (FLOs) contacted the man's family at the beginning of the investigation. He explained the investigation process and offered the opportunity to raise any questions or concerns they would like addressed. My Senior Family Liaison Officer then took over as the family liaison officer. She visited the family with my investigator on 17 May. At this meeting, the family raised the following issues:
  - They were concerned about the man's son, who was sharing a cell with his father. They wanted to ensure that he was being looked after properly.
  - They were worried that the man had not taken his anti-depressant medication whilst he was in prison.
  - They asked about the process of checking prisoners' outgoing mail. The family felt that if his mail had been monitored, prison staff may have noticed his intentions and watched him more closely.
  - The man's father wrote to the Governor of Bristol to express his concern for his son and grandson after his son's first suicide attempt. He was unsatisfied with the letter he received back.
  - The family were surprised that the man's son was double-handcuffed to a prison officer at his father's funeral and asked whether this is compulsory.
  - They wished to have all of his property returned to them.

## HMP BRISTOL

10. HMP Bristol is a Category B prison for the West of England. Prison Service Order (PSO) 0900 (Categorisation and Allocation) explains the reason for categorising prisoners:

*“Prisoners must be categorised objectively according to the likelihood that they will seek to escape and the risk that they would pose should they do so.”*

11. Category B prisoners are defined in the PSO as:

“Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult.”

The PSO also explains the situation for un-sentenced prisoners:

“All prisoners on remand awaiting trial, or convicted and awaiting sentence, other than those provisionally categorised A, are to be placed in Category U (Unclassified). Category U prisoners will normally require Category B accommodation ... “

12. The prison receives male prisoners and a limited number of young offenders, both convicted and remand, from all the local courts. This results in a high turnover of prisoners. The prison can accommodate up to 606 adult male prisoners across seven wings. The first night centre is located on A wing along with the induction wing and detoxification unit. It also has a separate healthcare unit.
13. The local Primary Care Trust (PCT) provides the prison’s healthcare services. The healthcare centre has 20 in-patient beds. Mental health services are provided by Avon and Wiltshire Partnership Trust and six registered mental health nurses provide support to prisoners on a full-time basis.

### **Assessment, Care in Custody and Treatment**

14. Assessment, Care in Custody and Treatment (ACCT) is a care planning tool used by prisons to help support and monitor those prisoners identified as being at risk of suicide or self harm. The ACCT is a multidisciplinary process that encourages staff to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur. Prisoners are checked at specified but irregular intervals. Multidisciplinary case reviews are central to the ACCT process. The prisoner is invited, along with staff involved in his care, to discuss his level of risk and identify any additional actions that might help reduce that risk. A post closure review should be held after the procedures have been closed.

## **Personal officer scheme**

15. Each prisoner at Bristol is assigned a personal officer who acts as a point of contact should they need help. This officer is required to have regular conversations with the prisoner and record these interactions. In the latest inspection report of Bristol of January 2009, HM Chief Inspector of Prisons said that: "personal officer entries in history files were made regularly and all but one of the files we reviewed were up to date".

## **Her Majesty's Chief Inspector of Prisons**

16. With regard to self-harm and suicide, the Chief Inspector recommended in her previous inspection of HMP Bristol in January 2005 that there should be a safer custody strategy to help reduce the risk of self-harm. She also asked that the role and responsibilities of Listeners should be clarified. (Listeners are trained by the Samaritans to provide emotional support to fellow prisoners in distress.) During the more recent inspection in January 2009, the Chief Inspector found that:

"Self-harm and suicide were covered by an up-to-date policy and managed by two visible and proactive safer custody managers. Assessment, care in custody and teamwork (ACCT) documentation was mostly good and prisoners at risk were managed with care. Incidents of self-harm had decreased. There was a well-supported group of Listeners but access for young adults was unnecessarily restricted. There was good contact with prisoners' families."

## **Independent Monitoring Board**

17. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. In its most recent report from August 2009 to July 2010, Bristol IMB noted that the number of Listeners has increased to nine, and there are plan to increase them further to 12. The report also noted an increase in ACCT monitoring procedures being used, but said that this was due to a better system of recognising need.

## **Previous deaths at Bristol**

18. Since the Ombudsman was given responsibility for investigating all deaths in prison custody for England and Wales in April 2004, there have been seven self inflicted deaths at HMP Bristol. The last death was only a few days earlier than the man's on 26 March 2010. In one of the cases, a recommendation was made regarding ACCT post-closure interviews. Disappointingly, I have repeated this recommendation here. Although it is impossible to know what difference it might have made in the case of the man, I believe the Governor should seek to address it as soon as possible.

## KEY FINDINGS

19. The man was remanded into the custody of HMP Dorchester on 8 December 2009 charged with a number of serious offences. His son was remanded with him as his co-defendant. He had previously come into contact with the legal system but this was his first time in prison. A suicide/self-harm warning form was opened by escort staff as he had seemed very depressed while at court. Once at Dorchester, he told staff that he was very anxious because he had been told he could not share a cell with his son as they were potentially category A prisoners. (Category A prisoners are those whose escape would be highly dangerous to the public or national security.) He was identified as at risk of harming himself and the Assessment, Care in Custody and Treatment (ACCT) monitoring procedures were put in place.
20. At the beginning of the ACCT monitoring procedures, he was observed hourly. There were no Listeners in the prison at the time, but he was told that he could access the Samaritans' telephone line at any time by asking staff. He was too upset to answer whether he had any suicidal thoughts or intentions but said that he "felt the lowest that he could". He told staff that he had taken an overdose ten years ago that had required medical attention. At the case review following the assessment interview, he was judged to be at a raised risk of harming himself.
21. At the ACCT case review three days later on 11 December, he said that he was still a little anxious and would like the ACCT to stay open, but was happy to reduce the amount of observations. The help and support offered to him was fully explained and he was rated as being at low risk of harming himself. (His risk had been assessed as still raised on 9 December.) While the ACCT document remained open, he did not go out of his cell very much for exercise or association. It appears from his prison records that he and his son were quiet prisoners who kept their own company.
22. During the evening of 16 December, he said that some prisoners on the wing landing were making inappropriate comments about himself and his son. He did not mention any names and he was encouraged by Officer A to talk about the incident to staff in the morning. His concerns were noted in the wing book, and mention was made of opening an anti-bullying file. (This would instigate formal procedures to try to stop the bullying.) My investigator saw no evidence that an anti-bullying file was actually opened.
23. He had another ACCT review on 18 December. He said that he felt more settled and agreed that there was nothing to be gained by having the ACCT procedures in place any longer. He was reassured about the support available to him. He told staff that he was aware that if he began to feel low again, the ACCT could be re-opened. The ACCT was then closed.
24. It was recorded in his medical file on 31 December that he had not been taking Citalopram (an antidepressant drug he was prescribed) as he was too scared to come out of his cell to collect it. It was also recorded that he had a score of

moderate depression from the depression screening questions. There is no record that this information was discussed with officers on the wing.

25. He and his son were transferred to HMP Bristol on 15 January 2010. During his first reception interview, he stated that he was depressed and wanted to be in the same cell as his son. Nurse A wrote that he said that he did not feel like harming himself or committing suicide. Although she could not specifically remember her conversation with him, during an interview for this investigation, she agreed that she described his emotional state as good and his behaviour and mental state as "stable". It does not appear that he told her that he had previously been prescribed antidepressants. She would not, at that time, have seen his medical record at Dorchester which would have shown that he had been prescribed Citalopram.
26. It is the responsibility of the sending prison, (that is Dorchester), to ensure that all of the prison records go with the prisoner on transfer. Unfortunately, it appears that his prescription charts did not go with him, although his medical record did.
27. He was authorised to share a cell with his son on 23 January. During an interview with the investigator, Officer B (his personal officer), said that both father and son were appreciative of this and seemed happier. A prisoner in the servery came forward to tell staff that he and his son were not regularly collecting their food at mealtimes. When the officer spoke to them, they said that they did not have any problems and did not have large appetites.
28. The officer made a note in the man's records on 2 February. The officer explained to the investigator that the son had knocked into another prisoner who had "got verbally aggressive". The man told the officer that he was concerned for his son. The officer spoke to the other prisoner who confirmed that he "thought nothing else of it", which he reported back to him.
29. His wing sheet revealed that, although staff considered it to be helpful to him to be able to share a cell with his son, he was very quiet and did not come out of his cell very much. The investigator has heard conflicting explanations for his reluctance to leave his cell. Prison staff made reference to him being afraid to leave his cell. However, his son told my investigator that they simply preferred keeping themselves to themselves. Officer C told the investigator that, during February, he tried to get him a job as a wing cleaner. During interview, the officer said "... my impression was that they were both quiet and timid prisoners really, quite reclusive".
30. On 3 February, Bristol received an email from Dorchester about a mental health referral that had been arranged for him, but had not taken place before his transfer. The referral had been made because he had not taken Citalopram for approximately four weeks.
31. The assessment was undertaken nearly two weeks later on 16 February by a Registered Mental Health Nurse. He noted that he had not suffered any side effects from the medication and did not display signs of being depressed.

However, he said that he was of “low mood”. They discussed the fact that he had been too scared to leave his cell at Dorchester to collect his medication. He said that he had been quite intimidated in the medication queue. Nurse B explained that staff had various options when prisoners appear frightened to leave their cells and they can deliver the medication to the prisoner.

32. During the mental health assessment, the nurse wrote on the form that he had been sexually abused and so he would refer him to a counselling service. “Restart Citalopram 10 mgs” is written on the form. During interview, the nurse said that this was a note to himself to speak to the doctor about it. He said that he specifically asked him about any thoughts of suicide and he denied them. The nurse found no evidence of serious mental illness.
33. The nurse told my investigator that he spoke to the doctor after this assessment and explained that he had discharged him from the mental health team caseload. When asked if he spoke to the doctor about the possibility of resuming the prescription for Citalopram, the nurse said: “I presume I would have. I can’t honestly say because I can’t remember that far back to be honest with you”. No conversation with the doctor is recorded on the electronic record but the nurse said that this was because he was still familiarising himself with the electronic system. The nurse said that he would have spoken to the doctor and agreed that there was no need for him to be re-prescribed Citalopram. He was not able to recall the name of the doctor.

## **25 February – the man’s first attempt to harm himself**

34. At 9.04pm on 25 February, the man attempted to hang himself in his cell. He used a ligature made from his shoelaces tied to the bed frame. His son was asleep but woke to find him and raised the alarm. He had left a note on the back of a photograph saying “Love you all, no one believed me, sorry.” Staff intervened and he had not lost consciousness at the time that the alarm was raised.
35. He was taken to the healthcare centre and, following authorisation from the duty governor, placed on constant supervision under ACCT monitoring procedures until the first assessment interview was conducted. (Constant supervision is when a member of staff sits outside the cell and watches the prisoner at all times to prevent any attempt to harm himself. The member of staff should also interact with the prisoner to provide further support.) A Listener went to the cell and spent some time talking to him. The ACCT immediate action plan also required the Samaritans’ telephone system to be explained, and for healthcare staff to have regular conversations with him.
36. The ACCT assessment interview was undertaken at 9.00am the following morning by a Senior Officer (SO) A (the Safer Custody Manager). (Unfortunately there are a number of incorrect references in the ACCT document which name the man incorrectly. The SO told the investigator that this was a clerical error.)

37. The senior officer recorded in the ACCT assessment that the man said that he had recently had “issues with a co-defendant which has added to pressures already gained since being in prison”. (This reference is to another co-defendant and not to his son.) With regard to his attempt to hang himself, he said that he had “a second of madness” and, as the ligature became tighter around his neck, he panicked and released the pressure. He told the SO that he did not have any previous history of self-harm or suicide attempts. He stated that he was fine and that he felt “guilty and selfish”. He said that he had scared himself and had no further thoughts of self harm. It was discussed during the interview that he had three children, a wife and a business which were all reasons for him to carry on living. The SO recommended that he should be relocated from the constant supervision cell to the healthcare centre.
38. The SO stated in interview that during the ACCT assessment the man:
- “ ... talked about what he'd done the night before, very openly. He felt very guilty about doing it, he felt quite ashamed because he was in with his son and I just led on with questions like you do through an assessment. But he seemed quite relieved in a way that you know he hadn't gone through with it, you know that it was stopped and that he didn't actually kill himself.”
39. The ACCT caremap was completed by the SO and outlined the man's concerns and how staff could try to reduce his risk of harming himself again. Contacting his family was a key priority and this was arranged to be done from the healthcare office. On a separate form kept in the ACCT, information about the telephone call to his wife was recorded by the SO. He had told the SO that he did not want his wife to be told about his suicide attempt and so he said to his wife that he was fine. The SO noted that the conversation was positive and his mood improved substantially following the telephone conversation.
40. He also wished to leave healthcare and return to the wing to be with his son. The SO wrote that he was to be monitored for another 24 hours before arranging the move. His son needed to be told about his father's well-being and the SO agreed to contact the wing. He also told staff that he was bored so wing staff were asked to find employment for him as part of his care plan.
41. At 10.00am the same day, the first ACCT case review was held in healthcare. The review was attended by the man, a nurse, SO A and a governor. The note of the meeting recorded that he said that he felt more positive in the morning and had no thoughts of suicide or self-harm. It was noted that a telephone conversation with his wife had been arranged and his son had been informed that his father was coping. It also said that he was content to move out of the constant supervision cell to a normal cell in the healthcare centre, and was aware of the support available to him. His level of risk was identified as low. There was no mention of his history of depression or outstanding mental health assessment. It was agreed that hourly observations should be made during the night and a conversation should take place each morning, afternoon and evening.

42. In the ACCT document there is a form entitled "Review prior to discharge from healthcare" but this was not completed. He returned to the wing at approximately 10.30am on Saturday 27 February.
43. An officer recorded in his ACCT on-going record that he had spent time out of his cell talking to other prisoners, and was glad to be back with his son. No issues or concerns were raised by him on his return to the wing. It was recorded in the ACCT document that he and his son had a visit on Sunday 28 February which raised their spirits.
44. His ACCT was reviewed on 1 March by SO A and an officer in the G wing office. During the review he said that, although he felt much better and regretted his attempt to harm himself, he was still in a "low mood". The goals in his caremap were mostly completed but he still had a problem with boredom and it was suggested that he submit an application for employment. His risk of harming himself was again assessed as low.
45. He was noted as attending education on 3 March and was described as "quite cheerful" by Officer B. Later in the day, he was described as "being in good spirits" by another officer.
46. A further ACCT review was held on 4 March on G wing with a SO and an officer. He said that he still did not know why he had tried to hang himself and could only put it down to the fact that he had "had a visit from his wife that day and was thinking about missing her". He said that he was not suicidal. He repeated that he wanted to work and the staff attempted to facilitate this. The SO and officer wrote that the ACCT was to remain open for another week to ensure that he was given a further chance to settle. His level of risk and the frequency of observations remained the same. The next review was scheduled to be held on 11 March.
47. His personal officer, Officer B, wrote in the wing sheet on 7 March that he seemed to have recovered from his low mood and deeply regretted harming himself, especially because of the effect that it had on his son. On the same day, he had another ACCT review with Officer B and a SO. The review noted that he called his wife each day when his cell was unlocked. He was expecting to be employed, along with his son, in the prison workshop which he was looking forward to. Again, his mental health was not discussed and there was no contribution from healthcare staff.
48. He told the officers that he would not attempt to harm himself again. SO A, Officer B and himself agreed to close his ACCT document. According to the record of this case review, a post-closure interview was scheduled to have been held at 4.30pm the same day. It is not clear if this was a clerical error as ACCT post-closure interviews at Bristol are usually scheduled between seven and 28 days after closure. The investigator was told that a post-closure ACCT interview did not take place.
49. He and his son continued to share a cell. They began work in the prison workshop. During an interview with the investigator, Officer B stated that:

“... he [the man] did seem to brighten up a lot when he'd gone to work and he was out more and more and he got more used to the other faces around the wing.”

50. He was sent an appointment slip on 11 March for the Kinergy counselling service. He returned the slip the same day saying that he did not want to remain on the waiting list for the counsellor. His decision was not recorded on the electronic medical record, and Nurse B was not informed that he had changed his mind. Over the next two weeks, he continued to work in the prison workshop with his son. The work shifts were from 8.30am to 11.45am and 1.30pm to 4.00pm. He did not have any further recorded contact with the healthcare department, and there are no more entries in his history sheets.

### **31 March**

51. On the morning of 31 March, his son went to work as usual. He stayed in their cell as he complained of feeling ill. His son returned at 11.50am and Officer D unlocked the door so that he could go back into their shared cell after the morning's work. The officer locked the door and then his son immediately called from the cell that his father had hung himself.
52. The officer unlocked the door again and went into the cell. She found the man hanging from the bunk bed. She told his son to leave the cell and called for her colleague on the wing, Officer E. A general alarm was raised with an urgent message for any healthcare staff to attend. Officer D could not remove her anti-ligature knife out of her sealed pouch, and so the other officer removed it for her. She lifted him under the arms and the other officer cut the ligature. She moved the cabinet in the cell and they laid him on his back on the floor.
53. He was cyanosed (meaning that the skin looks blue due to a lack of oxygen) and Officer D was unable to feel a pulse. Officer F arrived at the cell and commenced chest compressions, whilst Officer E administered air using a pocket face mask (a mask that allows rescue breaths to be given through a valve). Officer D then left the cell.
54. In the meantime, Nurse C who was in the wing treatment room had been informed by an officer of a 'code blue' (a code blue alarm signifies a medical emergency related to breathing). He ran to the cell carrying the emergency bag, then ran back and collected the oxygen emergency bag to take to the cell.
55. Nurse D arrived at the cell and took over administering air from Officer E, using an ambu-bag (an ambu-bag is a hand-held device used to provide ventilation to person who is not breathing). Two more nurses arrived and at 11.52am Nurse E shouted for an ambulance to be called, which an officer said that they would do. At 11.56am, Nurse E heard on the radio that a doctor had been asked to attend. He shouted for the defibrillator as there was not one in the emergency bag on the wing.

56. Two officers were running onto the wing when they heard the call for the defibrillator and went to collect it from the healthcare centre. (A defibrillator is a device that can restart the heart by giving it an electric shock. It cannot always be used and can only provide a shock if there is sufficient electrical activity in the heart.) Nurse F took over from Nurse D and administered air whilst Officer F continued to administer chest compressions.
57. The doctor arrived and took over the ambu-bag from Nurse F. He inserted an airway (a tube used to maintain a patient's airway) and continued to administer air. Nurse E cut the man's shirt and an officer applied the defibrillator pads. Nurse E then took over the chest compressions from Officer F. The defibrillator advised the staff not to shock him and cardio pulmonary resuscitation (CPR) was to be continued. At this point the officer took over the chest compressions. (The defibrillator has an audio device which instructs staff on the procedures to be followed.) The defibrillator again advised that no shock should be given and to continue CPR. At 12.00pm, the doctor certified that he had died. The paramedics arrived at 12.11pm.

### **Support for the man's son and other prisoners**

58. The man's son was initially placed with other prisoners that he knew. Once his father was pronounced dead, he was moved to the healthcare centre. He was informed of his father's death by the doctor and the ACCT monitoring procedures were begun to provide him with further support. He continued to work during the day and was also able to go back to the wing for association.

### **Support for staff**

59. Officer E described the support offered by the prison to himself and his colleagues as "brilliant". He said that the care team offered support before a debrief meeting with the Governor. Staff wrote out statements before being taken home. The officer also stated that he knew that if he wanted to speak to someone about the incident he could and was aware of the support available to him.
60. However, Officer D was less happy with the support offered to her. During interview she agreed the Care Team were very supportive, but she felt pressured to return to work and did not feel that she was taken seriously.

### **Liaison with the man's family**

61. The man's family arrived at the prison shortly after he died. They were taken aside and told of his death. His property was returned to his family although they were concerned that not all of his letters were included. A prison chaplain took the funeral, and the prison contributed to the costs of it. His son attended the funeral, although the family were unhappy that he was double-handcuffed to an officer. The family told the investigator that they were grateful for the support they had received from the prison following the death.

## ISSUES

### Clinical care

62. The clinical reviewer makes a series of observations and recommendations in the clinical review that I encourage the Head of Healthcare to review carefully. In respect of the overall level of clinical care given to the man, he concludes: “I do not feel there were significant differences in the care that was provided in prison compared with the community”. However, he does acknowledge that a prison environment provides further opportunities for supervision than that in the community.

### *Mental health support*

63. At Dorchester, the man refused to go to the treatment hatch to collect his anti-depressant medication. Staff at Dorchester believed that this because he was afraid to leave his cell. In the community, it is an individual’s choice to stop taking anti-depressant medication. This is true of an individual in prison as well, but the prison should ensure that it discharges its duty of care by following up any prisoners who do not cooperate. The clinical reviewer notes in his review that a physical assessment of the man would have been appropriate:

“In view of these symptoms I believe that a face to face review should have been made prior to stopping the prescribing antidepressant medication to assess if there was a mental health condition leading to the non-compliance.”

64. Given the mood-altering nature of the medication, it is reasonable to expect the healthcare services to follow up those who abruptly stop taking such medication. He writes that it may have been appropriate to stop prescribing the medication, but a face to face assessment would have enabled staff to check on his mental state. I agree with him and make the following recommendation:

**The Head of Healthcare at HMP Dorchester should ensure that where compliance with mood-altering medication is poor and behaviour is unusual a clinical face to face review should be carried out with the patient.**

65. It was reassuring to see that Dorchester contacted Bristol to inform them of the mental health assessment that they had not had time to undertake. While it is unfortunate that the man was transferred while awaiting an assessment, the clinical reviewer notes that the communication between the prisons in this specific instance was evidence of good practice. He says that:

“Dorchester healthcare subsequently contacted HMP Bristol to advise that a mental health review had not been completed. This is evidence of good communication between the clinical teams.”

**The communication between Dorchester and Bristol healthcare departments regarding the mental health referral is an example of good practice.**

*Anti-depressant medication*

66. Following the email from Dorchester, Nurse B undertook a mental health assessment on 16 February. During the review, he wrote on the paper document that he should speak to the doctor regarding the restarting of the Citalopram prescription. However, when he put this information on the electronic system, he neglected to include a record of the conversation he said he had with the doctor. The clinical reviewer writes of this:

“The clinical opinion was that in this situation restarting Citalopram was not appropriate ... Documentation is not clear about who or when assessments were completed and in this aspect record keeping should be improved.”

*The attempt to resuscitate the man*

67. Following the discovery of the man, staff attempted to resuscitate him. The clinical reviewer concludes:

“There is no evidence to suggest that the resuscitation was not handled well. The man was declared dead in HMP Bristol by the doctor and so resuscitation was stopped. This decision appears to have been appropriately taken.”

68. Staff responded quickly when he was found hanging and the investigation has not discovered anything of concern in the actions of the people involved in the day. However, I agree with the finding of the clinical reviewer about the following:

“The defibrillator was missing from the wing. Although this was checked daily its absence had not been notified by the nurses to the managers to organise its replacement. “

69. The lack of a defibrillator in the emergency bag on the wing was an oversight that could have had serious consequences. It is well known that the quick application of a defibrillator increases the chances of survival. It has not been suggested to my investigator that the missing defibrillator made a difference to the chances of survival for the man, but that would clearly not be so in every case.

**The Head of Healthcare should ensure that all defibrillators are in place and working correctly.**

### *Record keeping*

70. The prescription charts did not travel from Dorchester with the man which meant that the receiving prison, HMP Bristol, did not have all of the relevant information at the time of his arrival. The clinical reviewer writes: "Drug charts were not transferred from HMP Dorchester to HMP Bristol. This could have led to delay in understanding the clinical picture". The reviewer is also concerned about the quality of some of the documentation in the healthcare records. He comments that: "... in one area there was an almost incoherent mental health note with no use of punctuation". He makes a recommendation regarding record keeping that I have rephrased in order to be consistent with previous recommendations from my office:

**The Head of Healthcare should ensure that the entries made in medical documents are in accordance with the standards set out in the NMC Guide to Record Keeping.**

### **Assessment, Care in Custody and Treatment (ACCT) at HMP Bristol**

71. The man was subject to ACCT procedures at Dorchester at the start of his time in custody. Another ACCT was opened after his first attempt to hang himself at Bristol. He was quickly identified as at risk of harming himself on both occasions and I am satisfied that appropriate action was taken. The details of his next of kin were clearly identified and included at the start of the ACCT document which is a helpful way of ensuring that all relevant staff have access to the information. However, there are several aspects to the ACCT procedures at Bristol that raised concern.

#### *The decision to place the man on constant supervision*

72. Following his attempt to hang himself on 25 February, the man was accommodated in the healthcare centre under constant supervision. Constantly supervising a prisoner is the highest level of observation and should only be used with prisoners who are deemed to be at very high risk of harming themselves. I believe that this was an appropriate response by the prison given the seriousness of his attempt to harm himself.
73. When a prisoner is deemed to require constant supervision, authorisation must be sought. In this case the Duty Governor agreed to the decision over the telephone. PSO 2700 (Suicide prevention and self-harm management) requires the first case review to be held immediately prior to unlock the following morning in cases where the prisoner is placed under constant supervision during the night. The man's review was held at 9.00am. This is actually after prisoners were unlocked, but I am not minded to criticise the prison as it is clear that he was reviewed early the next morning as required and as practicable.
74. HMP Bristol's Suicide / Self-harm Prevention Strategy document says:

“Being placed on constant supervision must trigger a referral for an urgent mental health assessment”

75. The first case review held on 26 February does not mention a mental health referral and there is nothing in the man’s medical record to show that this assessment happened. When the investigator spoke to the Safer Custody Manager he said with regard to mental health referrals for prisoners on constant supervision:

“It’s not a standard practice but being on constant supervision the healthcare have a massive input into that person and I can’t say for sure if the mental health team get involved with every single case. ... Not an automatic referral no ... “

76. The investigator was told by the Head of Healthcare that if a prisoner was subject to constant supervision then they would, in effect, be assessed continually. While this may be true, the policy clearly requires a formal assessment to be undertaken to check on the mental health of the person concerned. The ACCT process is there to support someone at risk of harming themselves, while a mental health assessment provides an opportunity for staff to assess the condition of a prisoner’s mental health at a particular point in time.

77. Annexe 8Y to PSO 2700 makes it clear that:

“Where the prisoner is not already under the care of secondary care mental health services, being placed on Constant Supervision must trigger an urgent referral for mental health assessment and, if appropriate, provision of care. PCTs/establishments should agree with their mental health service provider protocols for urgent referrals based upon clinical need.”

78. This lapse is particularly disappointing given that Nurse B had undertaken a mental health assessment of the man on 16 February. The nurse was not told that he had harmed himself and did not know that he had been placed on constant supervision. The nurse had recent relevant knowledge of him and it could only have assisted in his care and support if he had been involved. During interview, the nurse reflected on the role which he might have fulfilled:

“I would have done another assessment and this would have given me the evidence to say you’ve told me that you’re not feeling suicidal but clearly you are, can we talk about this and can we discuss why, what was going through, and then I would have identified trigger factors with him. I would have identified why he felt like this and also is he going to do it again, is he going to harm himself again, which is most important.”

79. He went on to explain how he may have got involved:

“But in this case what would happen would be the nurse; obviously I can only say what in an ideal world, the mental health nurse down in

healthcare looks into the notes. They'll see that he was seen by me, I have previous knowledge, previous knowledge is always a good thing to take into account, and I also have a relationship because I've seen the person before. So they would then phone upstairs and say we have somebody on constant watch, are you available to come down and do an assessment on this person or is there anything you can give me and use for them."

**The Governor and the Head of Healthcare should enforce their local policy to ensure that a prisoner placed on constant supervision is always referred for an urgent mental health assessment.**

*The decision to end the constant supervision of the man*

80. PSO 2700 explains:

"Acute suicidal crisis may be temporary and one aim of the case reviews should be to reduce the level of supervision progressively, substituting alternative supports, as the prisoner's condition improves. This will involve some degree of risk-taking as it involves the prisoner being allowed to gradually take more responsibility for him/herself. Constant supervision must only be for the shortest time possible and how the prisoner will be returned to normal location and/or a lesser level of conversations and observations must be reflected in the CAREMAP."

81. The PSO also recommends (in Annexe 8Q) a progressive scale of reductions in observation. SO A told the investigator that the prison would aim to reduce the level of monitoring steadily:

"But we couldn't move someone straight from a constant supervision straight back to the wing. You know we'd never do that, we always do it in steps constant supervision then goes to maybe a safer cell in the healthcare. We then review it again so we review every day."

82. The man was assessed as being at low risk of taking his life throughout the time ACCT processes were used. However, he went from being observed continuously to hourly observations at night, and one conversation each morning, afternoon and evening. His observations were reduced abruptly but I accept that he died some time (approximately three weeks) after the ACCT was closed, and it might not have changed the outcome in this case.

83. However, this might not be so in every case so I make the following recommendation:

**The Governor should remind staff of the guidance in the PSO to progressively reduce the level of a prisoner's observation when they are taken off constant supervision.**

*The lack of involvement of other staff in ACCT reviews*

84. Although staff from other departments were involved in his ACCT case reviews, I believe that the involvement of Nurse B, as the most recent mental health nurse to have spoken at length to him, would have been most useful. The nurse explained to my investigator how he would have acted, had he been invited to participate:

“What I tend to do if somebody’s on a constant watch is I like to do the assessment separately from the ACCT assessor or from the case manager just because it’s very overwhelming. And then I’ll try and sit in on the case review just because I think it may be somebody friendly for, and then you can prompt as well.”

85. During interview, the nurse said that recent staff changes have resulted in his team being invited more frequently to participate in ACCT processes. I have found that knowledgeable staff who know the prisoner are vitally important for the ACCT process to work effectively and I would encourage the prison to continue to develop this improved team-working.

*The 'Review Prior to Discharge from Healthcare' form*

86. PSO 2700 says:

“A pre-discharge Case Review must take place before a prisoner is returned to ordinary location from being resident in the Healthcare Centre. The Unit Manager (or Case Manager if different) from the receiving residential unit must be invited to this review. If it is not possible for them or a representative to attend, the reason why must be noted in the ACCT Plan. What healthcare will be doing to continue support of the prisoner must be clearly documented in the ACCT Plan.

The pre-discharge Case Review Team must:

- (a) Undertake the actions as listed in the section (above) regarding 'subsequent case reviews', taking into consideration any additional risk that may pertain to the move. (That is, this review should consider, along with staff from the receiving location, how best to reduce risk during and immediately following the move).
- (b) Arrange a follow-up healthcare appointment.

The Case Manager must complete the 'Review Prior to Discharge from Healthcare' form (page 18) and update the CAREMAP, frequency of conversations and observations and trigger factors on the front cover as required.”

87. The 'Review Prior to Discharge from Healthcare' form was not completed in the man's case. The Head of Healthcare told the investigator that it was her understanding that it is the case manager's responsibility to complete this form. However, SO A said that this would be healthcare's responsibility. There appears to be some confusion amongst staff as to who should take responsibility for the procedure. However, the PSO makes clear that it is the responsibility of the case manager to complete the form. (If a prisoner is in healthcare, the case manager should be a member of the healthcare team.) A follow-up healthcare appointment should also have been made, but there was no further involvement from the healthcare department in the ACCT process. This review is a valuable tool for staff to discuss the care required when a prisoner leaves healthcare and moves back to a location within the prison.

**The Governor must ensure that that the 'Review Prior to Discharge from Healthcare' procedures take place in accordance with requirements.**

88. The man left the healthcare department in the morning of 27 February, approximately 24 hours after his last case review. Therefore, a review was undertaken, even if not in line with the requirements of the PSO.

*The decision to close the ACCT*

89. At the case review on 4 March, he told staff that he was not suicidal, but it was agreed that the ACCT procedures should remain open for another week. The

next review was scheduled for 11 March. However, a further review was held four days earlier than scheduled, on 7 March, when it was decided to end ACCT procedures. PSO 2700 says:

“The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so ... The Case Manager must enter in the record of the final Case Review why the Case Review Team feel it is safe to close the ACCT Plan, and enter the date closed and date for a post closure interview..”

90. It is important to note that the prison was not obliged to wait until 11 March to have another ACCT review. Having an earlier review can be a good decision so that staff can react to any changes in the mood of the prisoner. The staff involved were also free to close the ACCT procedures if they were content that it was safe to do so.
91. Given that it was nearly three weeks after the ACCT was closed before he took his life, I do not suggest that a different decision would have changed the outcome. However, the PSO states that, as with all case reviews, the membership of the team should have been:

“One of the attendees must be the named Case Manager (and failing that, the Manager responsible for the prisoner’s location), one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff.”

92. No non-discipline staff, such as healthcare, went to his case review. Given his mental health issues, and due to his stay in healthcare, it would have been beneficial for a member of healthcare to have been involved in the decision to close the ACCT. The clinical reviewer stated that:

“The man had a history of depression and a recent serious attempt to hang himself. I would recommend that in this situation there should be clinical input, ideally from a mental health trained nurse, when the ACCT was reviewed.”

**The Governor and Head of Healthcare should satisfy themselves that healthcare staff are involved ACCT case reviews in accordance with the requirements of the PSO.**

*The lack of a post-closure interview*

93. PSO 2700 says:

“The Case Manager must enter in the record of the final Case Review why the Case Review Team feel it is safe to close the ACCT Plan, and enter the date closed and date for a post closure interview. The date of the first post closure interview is a matter for the case review team to decide but must be within 7 days of closure.”

94. My investigator was told that a post-closure interview did not take place. The interview is a vital part of the ACCT process as it enables the prison to assess whether the closure of the ACCT was appropriate, and ensure that the prisoner is sufficiently supported. It is impossible to know whether one or two post-closure interviews would have had any effect on the eventual outcome in the case of the man. However, I am disappointed that this extra safeguard was not in place for him. I repeat a recommendation that I made in a report following the death of a prisoner at Bristol in October 2007, and encourage the Governor to ensure that it is resolved quickly.

**The Governor and the Safer Custody Manager should ensure that ACCT case managers are aware of their responsibilities regarding post closure interviews.**

### **Contact with the man's family**

#### *The letter received by the man's father*

95. The man's father wrote to the prison to outline his concern about his son. The prison replied by way of a short, unsigned letter that his father did not feel adequately addressed the points which he had raised. My investigator has seen no reference to the letter in the prison records, including his ACCT document. Given that the letter expressed concerns about his state of mind, I think that it is unfortunate that more attention was not given to his father's worries. I believe that it would have been useful for those with a responsibility for caring for him to have been aware of his father's concerns.
96. His father was also unhappy with the tone of the reply he received, and fact that the letter was unsigned. Having seen the reply received by his father, I encourage the Governor to remind staff of the need for correspondence to be appropriate in tone and content.

#### *Checking mail*

97. The man wrote many letters to his family whilst he was in prison. These letters expressed his deep unhappiness with being in prison and, over time, seem to reflect a decline in his emotional stability. The family said that they expected the prison to have checked the letters, and therefore to have been aware of his declining stability. My investigator put this issue to the prison and they confirmed that the prison only reads up to 5 per cent of the post which is sent out by prisoners. It is therefore unlikely that the prison would have read all, or any, of his letters or should have been expected to. I think it would be helpful if, in the context of his worries, information of this sort had been explained to his father.

### *Knife to fashion the ligature*

98. The family was under the impression that he had used a knife to fashion the ligature he used to hang himself. My investigator spoke to the prison who confirmed that a knife was not used, and no knives were found in his cell.

### *The man's property*

99. The family were concerned that there were still some letters of his that had not been returned to them. My investigator spoke to the prison who confirmed that all the property had been returned.

### *The man's funeral*

100. The man's son went to his father's funeral. He was double-handcuffed (meaning that his hands were hand-cuffed together and he was also cuffed to a prison officer.) The family told the investigator that they considered this to have been unpleasant given that he was at his own father's funeral. The investigator spoke to the prison who confirmed that all Category B prisoners are required to be double-handcuffed when they are outside the prison.
101. Although the son had not been convicted or sentenced and so he should have been classified as Category U, he was in a Category B establishment and was therefore treated as a Category B prisoner. I understand how distressing this was for his family. However, the son had been charged with a number of serious offences and the prison has a responsibility to escort prisoners securely outside of the establishment and prevent their escape. They were following established protocols, and I do not make any criticism of the prison.

### **Support for staff**

102. One member of staff, Officer D, was unhappy about some aspects of the care provided to her by Bristol following the death of the man. She told another investigator from my office that she felt pressurised to return to work before she felt ready. She acknowledged that the care team were very supportive, but felt uncomfortable in her dealings with the senior staff about her return. This situation may have been exacerbated because she was away from her usual workplace and colleagues.
103. She was obviously affected by the death of the man. This may have been worsened by the fact that she usually worked at HMP Portland and had only been in Bristol a few days where she may well not have known many of her colleagues. Regardless of this, it is important for all prisons to be aware of the duty of care they have to their staff in the aftermath of such a traumatic event.
104. However, it should be noted that the other staff involved in the incident spoke favourably of the support offered to them by Bristol.

## CONCLUSION

105. The man found it hard to adjust to prison life, and struggled during his time at both Dorchester and Bristol. He was initially provided anti-depressants but then stopped taking them. In the community, people have the right to choose to stop taking their medication. However, in a prison setting with the duty of care that implies, I believe that greater attention should be paid when prisoners stop taking mood-altering medication. Dorchester alerted Bristol to the need for him to undertake a mental health assessment which was a positive action.
106. I believe that staff attempted to reassure him and put the ACCT procedures in place at appropriate times in order to further support him. However, my investigation has drawn attention to a number of issues with the ACCT process at Bristol. It was also disappointing to see that staff with recent knowledge of him were not involved during the ACCT process.
107. His mental health seems to have declined while he was in custody and he was assessed by a mental health nurse shortly before he first attempted to harm himself. This nurse was not informed of his subsequent actions which meant that he was unable to assist colleagues responsible for the ACCT. No mental health assessment was undertaken when he was placed on constant supervision which was another missed opportunity to ensure that knowledge of his mental health was shared at a vulnerable time for him. Although he died approximately three weeks after ACCT processes ended, it is important that Bristol focus on the improvements they can make in this area in order to guard against future deaths in custody.

## RECOMMENDATIONS

1. The Head of Healthcare at HMP Dorchester should ensure that where compliance with mood-altering medication is poor and behaviour is unusual a clinical face to face review should be carried out with the patient.

**The National Offender Management Service accepted this recommendation, writing:**

“Within the health care at HMP Bristol we will ensure that reports of non compliance with medication are reported and a face to face review carried out. Currently all clinicians and pharmacy pick up non compliance.”

2. The Head of Healthcare should ensure that all defibrillators are in place and working correctly.

**The National Offender Management Service accepted this recommendation, writing:**

“There are defibrillators on all wings these are checked daily and recorded as such.”

3. The Head of Healthcare should ensure that the entries made in medical documents are in accordance with the standards set out in the NMC Guide to Record Keeping.

**The National Offender Management Service accepted this recommendation, writing:**

“Documentation audits are carried out each year to ensure compliance with this.”

4. The Governor and the Head of Healthcare should enforce their local policy to ensure that a prisoner placed on constant supervision is always referred for an urgent mental health assessment.

**The National Offender Management Service accepted this recommendation, writing:**

“All Prisoners placed on constant supervision receive a referral to the MHT. Case managers will be made aware that an urgent MH referral not a routine referral is required for prisoners on constant supervision.”

5. The Governor should remind staff of the guidance in the PSO to progressively reduce the level of a prisoner’s observation when they are taken off constant supervision.

**The National Offender Management Service accepted this recommendation, writing:**

“Suicide Prevention Strategy will be reviewed and to state that all prisoners coming off constant supervision will be located in Healthcare for a minimum period of 24 hours on hourly observations. LNTS reminding all staff of policy to be released.”

6. The Governor must ensure that that the ‘Review Prior to Discharge from Healthcare’ procedures take place in accordance with requirements.

**The National Offender Management Service accepted this recommendation, writing:**

“LNTS to be released reminding all residential wing managers not to accept prisoners from Healthcare until a Review prior to discharge from Healthcare is completed.”

7. The Governor and Head of Healthcare should satisfy themselves that healthcare staff are involved ACCT case reviews in accordance with the requirements of the PSO.

**The National Offender Management Service accepted this recommendation, writing:**

“Case managers to be briefed that any ACCT CAREMAP issues regarding healthcare must involve a member of the nursing team attending the review.”

8. The Governor and the Safer Custody Manager should ensure that ACCT case managers are aware of their responsibilities regarding post closure interviews.

**The National Offender Management Service accepted this recommendation, writing:**

“LNTS to be released reminding ACCT Case managers of their responsibilities regarding post closure reviews.”

### **Good practice**

1. The communication between Dorchester and Bristol healthcare departments regarding the mental health referral is an example of good practice.