



**Investigation into the circumstances surrounding the
death of a man
at HMP Hewell in October 2010**

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

June 2012

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Hewell. He died in October 2010, at 58 years old. I would like to offer my sincere sympathy and condolences to his family for their loss.

The investigation was carried out on my behalf by my colleague. I would like to thank the Governors of Hewell and Bristol and their staff for their co-operation with our enquiries. I apologise that the report has been delayed.

The man did not cope well with his recall to prison after many years in the community. His unpredictable acts of violence and self-harm were apparently rooted in feelings of despair and injustice. Despite attempts at support by staff, he was suspicious of them and frequently chose not to engage with their offers of help. He spoke several times of ending his life and was subject to suicide prevention measures when he did so.

Nevertheless, there is clear scope for learning for the service as well. Key information concerning the man's risk of self-harm was not well communicated between prisons on transfer and the clinical reviewer concludes that there should have been greater involvement of mental health staff at a particularly stressful time in his time in custody. Finally, although a hot debrief occurred, staff did not receive the support of a critical incident debrief at which lessons might have been learned. Recommendations are made to address these shortcomings.

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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Prisons and Probation Ombudsman

June 2012

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SUMMARY

1. The man was born in 1952. He was recalled into custody on 24 March 2010 following allegations of serious historical offences being made against him. He had previously served a lengthy sentence for another offence but had been back in the community for eighteen years.
2. He was sent to HMP Hewell. During his induction he was very emotional and denied the allegations. Staff on the wing he was to go to were made aware of his situation and told that he needed to be monitored closely. Suicide prevention procedures were used three times while at Hewell. He showed signs of paranoia and harmed himself. On 5 July, he seriously assaulted his cell mate.
3. On 27 July, the man was transferred to HMP Long Lartin before going to HMP Bristol on 9 August. He set fire to his cell on 26 August. He was monitored through suicide prevention procedures for five days and spent five weeks in the healthcare centre. He again set fire to his cell bin and barricaded himself in his cell on 6 October. As a result, he was relocated to the segregation unit.
4. Due to the number of people in the segregation unit, the man was due to go back to Hewell after his court appearance a week later.
5. He was admitted to healthcare on 17 October and suicide prevention measures were begun again as he had said that he wanted to "end it all". The next day the decision was made for staff to continually observe him as he was found with a ligature made of shoelaces attached to his cell door.
6. A few days later the man appeared at Crown Court. He was taken to HMP Hewell following the court appearance. Constant observation was reduced to intermittent suicide prevention observations and he was located on normal location.
7. At 9.20pm that evening he was found hanged in his cell. An emergency alarm was raised and staff commenced cardio-pulmonary resuscitation (CPR). He was taken to the local hospital but was pronounced dead at 9.22pm following the decision by his family to end life support.
8. Four recommendations are made concerning the communication between prisons about vulnerable and at-risk prisoners and healthcare being aware of their court dates, and of the importance of holding a de-brief after a death in custody.

THE INVESTIGATION PROCESS

9. One of the office's investigators opened the investigation at HMP Hewell on 26 October 2010 as he was already visiting the prison that day on another matter. He met with senior prison managers, a representative from the Independent Monitoring Board (IMB) and from the Prison Officers' Association. He also visited the man's cell and requested copies of all prison documentation relating to him.
10. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. No-one came forward with regard to the notices. The appointed investigator visited the prison on 9 February and 1 March 2011 to interview staff.
11. The investigator wrote to the Chief Executive of the local Primary Care Trust (PCT) to commission a clinical review. The PCT asked a clinical reviewer to carry out a review of the care received by the man whilst at HMP Hewell. She received a copy of the relevant medical documents upon which she based her findings. The review was received in this office on 17 September.
12. We would like to apologise for the length of time taken to complete this investigation, and am aware of how this may have caused additional distress to the man's family. This was due, initially, to the delay in receiving the clinical review and subsequently to the volume of work in this office. The outstanding clinical review was chased up by this office on a number of occasions by e-mail and telephone and in writing on 14 June and 19 August.
13. The investigator contacted HM Coroner for Worcester to inform him of the nature and scope of the investigation. Upon completion, a copy of the report will be sent to the Coroner to assist his enquiries into the man's death.
14. The investigator provided written feedback to the Governor during the investigation, highlighting preliminary findings and any issues that had become apparent. She also wrote again to the Governor to apologise for the delay to the report.
15. One of the Ombudsman's family liaison officers contacted the man's family at the beginning of the investigation. She informed them of the investigation and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. Another family liaison officer took over and visited the family with the investigator on 14 December 2010. The family raised the following issues:
 - Why was he recalled to prison?
 - Did he make any allegations about his treatment in prison?
 - Was he subject to suicide monitoring procedures?
 - Were concerns raised regarding his mental health?
 - How had he hung himself?

- Why was there a delay in notifying the family after he was found?
- The family wished to have his personal belongings from his time at Bristol returned to them.
- Why was his cell cleared prior to the family attending the prison to view it?

16. It is hoped that this report provides further answers to the family.

HMP HEWELL

17. HMP Hewell was created on 24 June 2008 by merging three separate prisons which were located on adjacent sites (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). Hewell primarily serves the courts in the West Midlands, Worcestershire, and Warwickshire areas.
18. The new prison accommodates Category B, C, and D prisoners. All adult male prisoners are classified on reception and put into one of four security categories based on likelihood of escape and the risk to the public if they did escape. The categories are:
 - Category A: prisoners who would be highly dangerous to the public, police or national security if there were to escape.
 - Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult.
 - Category C: prisoners who cannot be accommodated in open conditions but who are unlikely to make a determined escape attempt.
 - Category D: open conditions, prisoners who can be trusted not to try to escape.
19. The man was a Category B prisoner at the time of his death.
20. There are eight house blocks, each divided into wings. House blocks one to six form the Category B prison and hold prisoners remanded by the courts, those awaiting sentence and convicted prisoners (including those sentenced to life imprisonment). Wherever possible, prisoners are allocated to a house block according to their categorisation.
21. Healthcare is provided by Worcestershire Primary Care Trust. The healthcare unit has 24 hour nursing staff, with in-patient care situated on the lower floor of the unit. All in-patients are encouraged to associate out of their cells, including eating in a communal dining area. There is a varied timetable of activities with nursing staff supporting patients to actively socialise together. A weekly multi-disciplinary meeting (comprising both discipline and healthcare staff) is held to discuss individual cases (both those who are physically and mentally ill).

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the prison service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves or committing suicide. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a meaningful conversation with the prisoner) are flexible and can be set according to perceived risk of harm.

23. As part of the process, a caremap (plan of care, support and intervention) is put in place and should be reviewed at regular multi-disciplinary meetings. Wherever possible, the prisoner at risk is also included in these review meetings.

Person escort record (PER)

24. The police, courts, escort and prison services have an agreed document called the PER for sharing information about prisoners as they are moved between the various agencies. It is essential that, when a prisoner is moved from a police station, court or prison to court, prison, hospital or other destination, those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular, it is essential that known risks of escape, assault, suicide or self harm or harassment are communicated to others into whose custody the prisoner is passed; to protect prisoners, staff and the public. It is also essential that any new risks that develop during a movement are recorded and flagged up for others. The PER is the key vehicle for ensuring that information about the risks posed by prisoners on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody.

Reception

25. When prisoners arrive at the prison all their paperwork is checked before they are taken off the escort vehicle. Staff check the warrant to ensure that the correct prisoner is in custody, and then prepare the necessary records. The prisoner is taken from the vehicle and booked in by the senior officer on the front reception desk. Personal and offence details are taken, along with any known concerns. All prisoners see the first night in prison officer, reception officers, and the nurse on duty for an initial health screen.

Cell sharing risk assessment (CSRA)

26. In order to make sure that unsuitable prisoners do not share cells, a cell sharing risk assessment is completed by reception staff when a prisoner first arrives at the prison. It seeks to assess the likelihood of a prisoner seriously assaulting a cellmate.

Segregation unit

27. A segregation unit provides temporary accommodation for prisoners that have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners. The purpose of segregation is to maintain safety, order and discipline and the respect for human dignity. Segregation is sometimes necessary to help prisoners address negative aspects of their behaviour and return to normal location as soon as possible.

Her Majesty's Chief Inspector of Prisons (HMCIP)

28. The first inspection of HMP Hewell by the HM Chief Inspector of Prisons was in November 2009. The then Chief Inspector of Prisons found that:

“The central reception was enormously busy, but professional and efficient. First night arrangements required development, specifically the new arrangements for house blocks 1-6. An innovative and effective approach was taken to violence reduction, use of force was relatively low, and the segregation unit was well managed. Suicide and self-harm prevention arrangements were generally sound, although access to Listeners was poor.”

“Many aspects of the management of self-harm and suicide were good, although we had several concerns. We were not assured that prisoners in house blocks 1-6 had 24-hour access to Listeners. Samaritans telephones had been withdrawn on house blocks 1 to 7. On our night visit to house blocks 1-6, not all the patrols were carrying anti-ligature knives. Gated cells in the segregation unit had been used inappropriately to prevent prisoners from self-harming. The quality of self-harm monitoring documents was mixed. Initial assessor reports were generally good, case reviews were well written and care maps updated, but there was little evidence of multidisciplinary attendance at case reviews, and monitoring entries were mainly observational.”

Independent Monitoring Board (IMB)

29. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The latest report published by the Hewell IMB is for the time period 2009 - 2010. The report included the following:

“The Board is satisfied that ACCT/2052SH procedures are maintained at HMP Hewell. The inspection of ACCT records during Rota visits and observation of Houseblock routines indicate that care plans are followed and Case Reviews are conducted in accordance with prison rules and protocols. All staff now undergo refresher training every 12 months in the maintenance of an ACCT. Through the reporting year, Board members have attended ACCT Reviews, as observers. The Safer Custody team meets each month, with Listeners and Insiders attending and having an input. Also attending are representatives from the Samaritans and Reliance Prisoner Transport Services. The prison is aware of the importance of safer cells and first night requirements.

“Board members have continued to be impressed by the quality of care, understanding and compassion provided by the staff in the Segregation Unit, in what can be a very demanding area of the prison, when dealing, at times, with extremely difficult individuals. Board members have been contacted on a number of occasions to observe prisoners being

transferred to the Segregation Unit and at all times these transfers have been conducted in a professional and controlled manner.”

Previous deaths at HMP Hewell

30. Since the Ombudsman became responsible for investigating all deaths in custody in England and Wales in April 2004, there have been 17 deaths at Hewell, five of which were self inflicted. There are no direct similarities in relation to this investigation and any of the previous deaths at Hewell.

KEY EVENTS

HMP Hewell

31. The man was remanded into HMP Hewell on 24 March 2010, having been recalled to prison after allegations were made against him of serious historical offences. He had served a lengthy sentence many years previously but had been back in the community for eighteen years. He felt emotional at being back in prison and denied the allegations made against him. Staff were told to monitor him closely and he was encouraged to talk to staff if he thought he needed extra support at any time. As he was illiterate, an officer on the wing offered to help him with any paperwork he had.
32. During his first reception health screening, the man was asked about his medical history. He said he had received no physical injuries over the last few days and for fit for normal location, fit to work and to be located in any cell. He said that he had tried to harm himself whilst in prison previously (and 30 years ago whilst in the community), but had no thoughts of harming himself at that time. He was observed by a nurse as being stable and chatty with good eye contact.
33. There were no major events recorded until the man told staff on 13 April that he wanted to “just lie down and die”. This prompted staff to begin Assessment, Care in Custody and Treatment (ACCT) monitoring procedures. A Senior Officer (SO) made an entry on the prison’s electronic system to say that he was very distressed, but had no plans to kill or harm himself. He told the officer that he had cut his wrists some thirty years previously, but had not recently attempted to harm himself. He said that he had no problems with any staff or prisoners. He spoke positively about his elder daughter as he had just found out that she was pregnant and he was looking forward to becoming a grandfather.
34. The SO noted that he preferred to stay in his cell than associate with others and made a note in the ACCT document to help support the man and to help him feel more settled. At this stage the agreed level of observation for him was one significant intervention per shift (morning, afternoon and evening) and hourly observations during patrol state (when the prison is locked down). Also it was decided that there would be three observations a night on him, which would be recorded in the ACCT document.
35. Another entry was made in the man’s prison file on 14 April. It recorded that he was not coping at being back in prison after such a long time and was having thoughts of harming himself. He had said that he would only eat at breakfast time (presumably because other meals needed to be collected) and wanted to be located in a cell on his own. A decision was made to keep him located with his cell mate who was able to offer him support and a referral was made for him to see a registered mental nurse (RMN).
36. On 15 April, the man was relocated to the healthcare centre for his safety, as prisoners on his wing had become aware of the reason for his recall. An

officer noted in his prison file that he had been tearful during his ACCT review and was finding things hard. He said that he was in regular contact with his children and that he wanted to continue with his education.

37. A nurse assessed him in his cell during the early hours of 17 April. He had been found by the night operational support grade (a member of the night staff) dismantling razor blades, threatening to cut himself and banging his head on the cell door. She recorded in his medical record that he had initially refused to communicate and said that he had nothing left to live for. She increased his monitoring levels to one observation every half an hour.
38. A doctor examined the man later that morning. He made an entry in his medical record that he was upset, agitated and tearful. He prescribed diazepam (a drug used to relieve the symptoms of anxiety) and said he would review him in five days time.
39. An entry was made in the man's ACCT document at 2.20pm that afternoon that he had been found hiding under his bed with rolled up paper and a lighter in his hand, as if he was going to start a fire. It was noted that he came out from under the bed approximately five minutes later. His smoking materials and bedding were taken out of his cell for his own safety.
40. A nurse made an entry in the man's medical record at 4.09pm that he appeared preoccupied, anxious and agitated. He had also expressed the idea that he believed people were out to get him. He had been observed breaking the table in his cell with the apparent intent to use it as a weapon and hiding under his bed. Wing officers then saw him with a ligature around his neck. They intervened and his observation level was then increased again to constant supervision (constant supervision means a prisoner is observed by a member of staff constantly). At 8.00pm he was given his smoking material and his bedding back, but the constant supervision officer kept possession of his lighter. (He contacted the member of staff when he wanted to use the lighter.)
41. During an ACCT case review on 19 April, a SO noted that the man was still very upset and confused. He said that he was hearing voices, but was unsure what they said as there were so many of them. He was anxious about not being able to talk to his probation officer as their number had not been added to his account and he was struggling to eat and drink. The SO wrote that all staff were to encourage him and that he would be reviewed again the next day. The review was also attended by a registered mental nurse, a safer custody officer and the officer who was, at that time, observing him on constant supervision. There is no record of the difficulties with the probation officer's telephone number being resolved at that stage.
42. An officer went to the healthcare centre on 20 April to talk to the man. He told him that his probation officer was going to visit him in the next few days and they would hopefully be able to clarify things regarding his recall for him. He was said to be happy that the probation officer was coming to see him.

43. The SO held another case review with the man at 1.30pm that afternoon. He was said to still be upset and could not understand why he was in prison. He said he hoped to clear up some of his questions when he saw his probation officer. He had started eating and drinking small amounts and had been referred to see a mental health nurse who planned to assess him the following day. It was decided to keep him on constant supervision as he was still tearful and hearing voices.
44. The man talked with a doctor that evening. The doctor was also his doctor in the community so he knew him well. He said that his solicitors were trying to find out why he was in prison and why he was not due in court until November. He said that he felt unable to cope on normal location due to his feelings of paranoia. The doctor said that, as he was in Hewell on a weekly basis, he would be happy to see him again the following week. (It does not appear from medical records that he did see the doctor again, but he did see another doctor.)
45. On 21 April, the man had another case review with the SO. It was recorded in his ACCT document that he appeared in a positive mood and his speech and eye contact was good. He had started to interact with staff and other prisoners and his eating and drinking had improved. He said that he had no thoughts of harming himself, but said he did get anxious and paranoid at times. The SO recorded that he was due to see a doctor the following day for a full review and could be located in a normal cell in the healthcare centre. He also judged that his observations could be decreased from constant supervision to hourly documented observations.
46. An officer took him his recall pack that same day (this contained documentation explaining the reason for his recall into prison). His solicitors requested a copy of the documentation from the prison, however it was his responsibility to send it to them. The officer wrote the envelope out for him and he handed it in to be posted. The officer recorded in his prison file that his probation officer had been to see him, so he should not have been under any misunderstanding as to the reasons for his recall, even if he did not necessarily agree with them.
47. A doctor held a full review with the man later that afternoon. He told the doctor that he felt upset and betrayed by his probation officer and felt that they should have been there to help him, not bring him back to prison. He said that he felt frustrated at not being able to do anything about it and became tearful. He told the doctor that he was still hearing voices in his head, which made it difficult for him to think. He said he also thought that officers were talking about him, although he admitted that part of him did not think that was actually true. He said that he was scared to go out on the wing as he thought people were "out to get him" and that he had nothing left to live for as he had lost his wife and son (however this is at odds with subsequent information he gave about his family).
48. The man had tried to harm himself a few days previously and had tried to kill himself by stabbing his throat with a plastic knife. The doctor diagnosed him

to be suffering from an adjustment disorder (an emotional and behavioural disorder) and continued his prescription of diazepam. The doctor discussed him with a nurse and they felt it would be beneficial to start gradually reintegrating him back onto a normal wing.

49. Another case review was held by an officer that evening. The officer recorded in the man's ACCT document that his mood and presentation continued to improve. However, he noted that his probation officer's visit had left him confused and he hoped his upcoming visit from his solicitors would clear things up. He also wrote that he spoke positively about his family visiting the following week.
50. A doctor recorded in the man's medical record on 26 April that he was still upset by what he described as his probation officer letting him down, but did not feel like harming himself. The 10mg dose of diazepam had made him feel sick so this was reduced to 5mg to be reviewed in a week's time. He was also suffering from a chest infection, so the doctor prescribed antibiotics and pain relief. He was ready to be discharged to a normal location but, as there were no spaces available on houseblock five, it was decided to keep him in healthcare for the time being. A further entry in his medical record stated that he decided with a nurse that he did not want to take the diazepam and so stopped taking this medication.
51. The man had a case review later that afternoon with a SO. He said that he felt "alright" and was eating and drinking, but was unable to sleep due to back pain from his arthritis. He said he was happy to locate to houseblock two or five, but said that he would need to have a lower bunk because of his back.
52. He was located back to houseblock five on 31 April. He had a case review that day with an officer and was said to have had a good visit from his family the day before. He was considered to be eating, drinking and sleeping well and no current mental health issues were noted.
53. An officer conducted a case review on 4 May. The man told him that he felt fine and wanted to start employment. The officer arranged that, from that afternoon, he would be employed in workshop three. He said he was settled on houseblock five and was happy with his cell mate. He went on to say that he had a supportive family who were standing by him and he had no thoughts of harming himself. He was aware of the support mechanisms available to him and the ACCT document was closed. A post closure review was scheduled to be held a week later (this review is conducted following the closure of the ACCT to ensure that progress is maintained).
54. An entry was made in the man's prison file by a SO on 7 May. She noted that she had been informed by other prisoners that he kept a boiled kettle of sugared water in his cell (sugared water will stick to a person and worsen the burns from the water) as he thought the officers were going to "beat him up". She noted that he had been on subject to constant supervision recently and displayed bizarre behaviour before saying he was under threat. She wrote that she did not think that this was the case as he had a good relationship with

the officers on the wing. She noted that she contacted a mental health nurse, as she felt that he needed further assistance. There is no record of this referral or the outcome.

55. Officers saw the man bang his head on his cell walls and clutch the cell window bars on 9 May. He threatened that if staff entered, he would continue to hurt himself. His cell mate had advised officers that the kettle was filled with sugared water with the intent to harm staff. A SO entered in his prison file that he was in a very agitated state and was rocking back and forth when she went to his cell. She said that he initially refused to communicate, despite her attempts to engage with him. She requested a mental health nurse to attend, and a nurse responded. He was removed to healthcare using minimal force as he was largely compliant. It turned out that there was no hot water in the kettle. He was placed on constant supervision and ACCT procedures were recommenced.
56. A doctor was asked to assess the man later that day, following the incident in his cell. The doctor recorded in his medical record that he had a cut to his forehead from banging it on the cell wall, but he would not let it be dressed and was not keen on engaging with staff. The doctor noted that he was currently settled in healthcare and was drinking tea and smoking a cigarette. He said he did not want to be prescribed diazepam.
57. At 4.30pm a nurse assessed the cut on his forehead. There was minimal bruising and swelling and he allowed her to clean it, but not to apply a dressing. She observed that his pupils were equal in size and he was not suffering from blurred vision or vomiting.
58. A doctor reviewed the man in his cell on 10 May. She recorded in his medical record that he appeared fearful and anxious. He said he could not trust medical staff, which she said was evident as he would not talk to her if other doctors or nurses were within earshot. He went on to say that he thought prisoners were talking outside his cell and planning to kill him and that he was unable to sleep. He said he regretted his act of self harm, but still expressed ideas about not wishing to be there. He was vague about whether he heard voices, but appeared jumpy and had poor eye contact. She diagnosed him with a paranoid disorder, with possible psychosis (long term distrust and suspicion of others) and referred him for an urgent mental health assessment. It was noted that he refused all medications, including sleeping tablets.
59. A nurse assessed him later that afternoon. She noted that he was unkempt. He told her that prisoners on his wing had been calling him names regarding his offence and he did not feel safe on houseblock five. She pointed out that the wing was for prisoners who had committed similar offences and so he should not feel worried. He told her that he had an older son and teenage daughters. He said that his son had recently split from his wife and had gone missing which worried him. He also spoke of other problems he had in his personal life.

60. He told the nurse that he did not want to die, but would kill himself if he was located back on houseblock five. He said he would not hurt himself if he stayed in healthcare or was transferred out. She recorded that there was no evidence of psychosis and that he agreed to take some anti-depressants. She diagnosed him with an adjustment disorder with depression and said that he was to remain in healthcare for a few more days before considering a discharge to the houseblock. A doctor prescribed Citalopram (an anti-depressant used for depression and anxiety) later that day.
61. A doctor and a nurse assessed the man on 13 May as he had requested to go back to houseblock five. He said that he felt more relaxed and normal and said that the reason he harmed himself was because he thought a prisoner on his wing had read out a letter from his solicitors saying that his wife and daughter had turned against him and given false statements to the Crown Prosecution Service (this was not the case). When the officer read the letter out it actually said that there was no new evidence and police were yet to talk to his family. He said he could not understand why the prisoner would have done that to him, but that he had no intention of harming the individual concerned. The nurse advised him that in future if he needed any letters reading for him he was to contact safer custody, the chaplaincy or education. It is not clear whether the other prisoner was spoken to or if any further action was taken.
62. At 7.20pm that evening, a doctor made an entry in the man's medical record following a psychiatric review. He said that he had presented with good eye contact and seemed to have a good rapport with him. His speech was normal in rate and tone, he was not suffering from any delusions or hallucinations and had no thoughts of harming himself. The doctor wrote that he had a borderline learning disability, but no major mental disorder was noted.
63. A nurse conducted a review on 19 May. He said that the man had good eye contact and concentration and was able to follow the course of the interview well. He was polite and showed no evidence of psychosis or thoughts of harming himself. He presented as suspicious of others, but out of defence rather than due to a mental illness.
64. An officer made an entry in the man's prison file on 23 May that he remained quiet and did not associate on the wing. She said that he had just started working again and said he felt better for keeping himself occupied. A further entry was made by an administration officer working for safer custody on 3 June. She noted that his ACCT document had been closed and there were no further concerns at present.
65. The man attended an appointment with a doctor on 4 June. He said that he was kept awake at night by arthritic pain in his hip. He asked for sleeping tablets. However, the doctor explained that sleeping tablets were not the solution and prescribed pain relief and an arthritis anti-inflammatory drug.
66. An officer made another entry in the man's prison record on 20 June. She said that he had had a good week and a big improvement had been noticed

since he had moved in with a new cell mate. He appeared more stable and happy. He attended work well and associated with other prisoners on the wing.

67. On 1 July, wing officers reported that he acted suspiciously and appeared paranoid. A nurse spent some time speaking with him and found that he had some suspicion concerning other prisoners and staff. She noted no obvious mental illness and judged that his suspicion was more linked to his personality.
68. Another nurse responded to a code blue emergency call at 5.26pm that evening. (This is an emergency call to denote that a prisoner is not breathing.) He had barricaded himself in his cell and covered the observation hatch. Other prisoners on the wing were concerned that he was going to hang himself. Officers managed to gain entry into his cell with difficulty and, once inside, he told them that he was cleaning his cell. There was no evidence of a ligature and he was referred for an assessment with a doctor.
69. Two doctors assessed him approximately an hour later. He told them that he had covered his observation hatch to have a strip wash. He showed good eye contact and had a good rapport with them. He said he wanted to stay with his cell mate as he was on the same darts team as him in the community and he liked him. He denied being bullied and said it was not a suicide attempt.
70. The chaplaincy telephoned houseblock five on 3 July. They said that the man had spoken to them and said that someone was going to kill him and make it look like suicide but did not say who it was. ACCT procedures were begun. His mental health was being monitored because he was acting bizarrely. Shortly after the telephone call was received he barricaded himself in his cell, because he believed somebody wanted to kill him. However, he subsequently said that he did not really think this would happen and did not know why he had said it.
71. A SO made an entry in the man's file on 4 July that he was seen the day before by a mental health nurse. He had told her that he was a little anxious and this was in part due to the side effects of the new medication he was on (diazepam). She noted that his wife had called the prison because he had telephoned her and told her he was going to be killed and it would be made to look like suicide. When staff had gone to see him he had barricaded his door and covered up the observation hatch. When they managed to enter there was no-one else in the cell and he was adamant that he had done this to have a strip wash and he did not want female staff to enter and see him. This was discussed with a doctor, who deemed that he was telling the truth and was ok. When asked about the calls to his wife he said that he was just feeling anxious, did not really believe it and did not know why he had told his wife this. The SO had also been approached by another prisoner who said they had known him for years in the community. The prisoner said that the man was fine and his behaviour was a "blag" to get out of a prison sentence and

into a hospital. She made an entry in his security file and noted that his phone calls were to be monitored.

72. At 6.30am on 5 July, staff had to enter the man's cell as he had badly assaulted his cell mate. He was located in the segregation unit and was on a two officer unlock until further assessments could be made (this meant that two officers had to be present whenever his cell was unlocked).
73. A doctor assessed him at 12.50pm. His cell mate was receiving treatment in hospital. He declined to speak about the incident, stating that he would like his solicitor involved first. He said he felt ok in himself and appeared calm and relaxed, although he was guarded in his approach to the interview. He said he was not hearing voices or paranoid. The doctor noted a history of learning difficulties and that, as he was anxious, he could misconstrue things and fear for his life, which had led to the assault. The doctor prescribed Onlanzapine (an antidepressant) to address his paranoia.
74. A programmes facilitator made an entry in the man's file that he had attended all sessions of an alcohol awareness course and, although he was fairly quiet, was able to share his experiences with the group. She said that he had a good relationship with his cell mate in the group, who had helped him with his written work for the sessions.
75. On 7 July, the man's observations were increased to every ten minutes as he had been found with a sharpened spoon in his waist band. (This was reviewed on 14 July, although he continued to be monitored.)
76. A psychiatric review with the man was held on 8 July. He said that he had attacked his cell mate as he had made an accusation that he had offended against his family. He said he had lost it after the argument, but should have known better. The psychiatrist noted that his actions did not appear to be psychologically driven or caused by any mental disorder. He acknowledged this and said he did not like being bullied and did not like being accused.
77. It was decided on 14 July that the man could return to a normal wing and could be located on houseblock two. A management plan was implemented to assess his behaviour. It was explained to him that, due to the assault, he was a high risk prisoner (unable to share a cell) until he could be properly assessed. After a settling down period he could be considered to share with a willing and suitable cell mate in the near future. He was told that under no circumstances was he to approach his former cell mate on houseblock five, to which he agreed.
78. An officer recorded in the man's file that he had settled on houseblock two and his cell was clean and tidy. The officer said that he needed to be monitored as he could "turn on you in an instant" and, although he associated well, staff needed to be aware.

79. The man's ACCT document was reviewed and closed on 22 July. He was due to have a post closure review a week later (however he transferred to another establishment before this could be done).
80. He was interviewed by staff from the public protection team and told he was not to have any contact with anyone under the age of eighteen. He was not permitted contact with his daughters until a full risk assessment could be completed. The public protection team started the procedure immediately and told him that he would be informed of the outcome at the completion of the process.
81. He asked to see a nurse on 23 July. He asked her about his application for a new mattress. She could see no entry by a doctor or psychiatrist regarding this in his medical record and made him a doctor's appointment so he could discuss it. She noted him to be bright and chatty in manner and looked physically well, although he complained of aches and pains. She asked him briefly about the assault and remarked that he looked much better than when she had seen him last. He said that he felt a lot better in himself but still had a low level of paranoia, which was more down to his environment than mental illness.

HMP Long Lartin

82. On 27 July, the man was transferred to HMP Long Lartin. On arrival he said he suffered from paranoia and had seen a psychiatrist in HMP Hewell. He presented as preoccupied, anxious and paranoid. It was noted that he had been subject to constant supervision at Hewell, had no major mental illness but had borderline learning difficulties with underlying personality difficulties.
83. He was examined by a doctor on 29 July for pain in his right shoulder that he had experienced for six months. He said he was classed as disabled in the community due to arthritis in his spine and hip. She referred him for physiotherapy. He said that he felt slightly down as he had been wrongly accused and it kept him up at night as he tried to think back to the past. He sometimes felt like people talked about him, but had no thoughts of harming himself. There were no other significant events noted during his time at Long Lartin.

HMP Bristol

84. On 9 August, the man was transferred to HMP Bristol. His person escort record (PER) stated that he had been on the vulnerable prisoner wing at Hewell (where prisoners who require protection or are viewed as poor copers are located). He was located on D wing, a normal residential wing.
85. A doctor examined him on 18 August for the pain in his shoulder. He explained that he was referred for physiotherapy at Long Lartin. The doctor said that there was a long waiting list for physiotherapy, but he could have remedial gym sessions instead as the waiting list was shorter. He agreed to this idea. He said that he felt sleepy in the day and awake at night. The

doctor agreed to change his diazepam dose to the evening instead of the morning.

86. The man set fire to his cell at Bristol on 26 August. He suffered from smoke inhalation and was given his inhalers for his asthma. Ibuprofen was prescribed for his wrist as it was sore and slightly swollen following the restraint procedures to remove him from the cell. The doctor spoke with the mental health team and it seems that there was no evidence of mental illness but he was showing clear signs of a personality disorder. (Personality disorders are mental health conditions that affect how people manage their feelings and how they relate to other people.) It is not clear what, if any, action was taken.
87. ACCT procedures were begun and he was put on hourly observations. He had a mental health assessment the next day, where he said he was paranoid about other prisoners and staff talking about him. He said he was very frightened in prison, but he set fire to his cell on the spur of the moment as he wanted to keep everyone away. He said that he did not think it through and regretted his actions and was re-located to a cell in healthcare.
88. An officer made an entry in the man's prison file that the ACCT monitoring procedures were stopped on 1 September. There is no evidence of a post closure review and no information about why this happened. He went to court on 21 September. It was recorded in his medical record that he returned just before tea time and appeared in good spirits. He spent the rest of the evening watching television in healthcare.
89. Staff began the process of moving the man back onto D wing on 2 October, but had to wait for a single cell to become available. He said he was happy to share, but this was not possible as he had been assessed as high risk (not suitable to share with other prisoners).
90. The man's prison file shows that he was moved onto a wing on 5 October (although it is unclear from prison documentation whether this was D wing). The next day an officer went with a nurse to give him his medication. He had barricaded his cell door shut by placing furniture behind it. He moved it when asked and said he had been cleaning his cell. The officer was concerned as he had been located on the wing following five weeks in healthcare after setting his cell alight.
91. At 6.12pm, the man was taken to the segregation unit after setting fire to his cell bin and barricading his door. He sustained an injury to his left shin during the incident. When staff opened the door to his cell, his leg had been caught between the door and the table. He was able to stand, but was limping. He was examined by a doctor the next morning, but was reluctant to talk about the incident.
92. Another doctor was called to the man's cell at 4.19pm on 7 October. He said that he had sustained a cut to his finger while being restrained by officers. The doctor considered it apparent that he had cut himself since being

assessed by the other doctor. However, the doctor could not tell if he had inflicted the injury in order to claim that officers had hurt him or to derive advantage from the injury for other reasons. Through the prison's internal disciplinary procedures (known as adjudications) he received 36 days concurrent to his sentence for his recent actions.

93. The Head of Residential spoke with the deputy governor on 12 October regarding the number of prisoners they had in the segregation unit and asked for support in reducing the numbers. He gave the deputy governor a list of prisoners in the unit and later that day he received a list of prisoners to be moved, which included the man. The deputy governor said that the man was due at court on 19 October and, following his court appearance, he was to return to HMP Hewell as that was his original prison. He said that he had informed the Deputy Governor at Hewell regarding this.
94. On 13 October, the man was approved to have level three contact with his daughters. This meant that his letters and calls would be monitored. There are no further details regarding this in the records.
95. At approximately 11.30am on 17 October, the man pressed his cell bell. An officer responded and he told him he wanted to see a nurse to acquire tablets to "end it all". The officer moved him to a cell with a closed circuit television (CCTV) camera in it and, having done this, noticed that he had tied a ligature to the cell window made from a bed sheet. ACCT procedures were recommenced.
96. A SO made an immediate action plan in the ACCT. This was to keep the man in a single cell and subject to hourly observations throughout the day and night until further assessment. He was also made aware of the Listener Scheme (where prisoners have been trained to talk and listen to other prisoners in need).
97. He was admitted to healthcare because of his low mood and it was noted he was due to have a mental health assessment. On arrival in healthcare, he seemed to be in a brighter mood and was issued with a safer custody blanket and a spoon. All other cutlery was taken away. This was to limit his ability to harm himself.
98. An officer conducted an ACCT assessment interview at 10.10am the next morning. He refused to sign any forms or to communicate very much. He said that he had had enough with everything including the trial and allegations against him. He said that everyone wanted him dead and he could "hear people creeping around". He said that he had harmed himself thirty years previously and had some thoughts of suicide. He said that he should not have called for help the other day before being moved to the camera cell as he had no reason to live and had not seen his children in a while. The officer did not fill out the section in the ACCT about agreeing with the interviewee what is to happen next.

99. Another officer completed a caremap with the man. He had small achievable goals set, such as putting a transfer in to move to an establishment closer to his home to enable his wife to visit him and to apply for a television to help combat his boredom. He said he wanted to settle back onto a normal location and an ACCT review was to be held to facilitate this. He was very uncommunicative for the rest of the morning. He was said to be low in mood and spent the rest of the day lying on his bed and sleeping.
100. At 9.45pm that evening, he was found with a ligature made of shoelaces tied to the cell door. A SO, nurse and duty governor agreed that he should be subject to constant supervision. He was moved cells to facilitate this.

Return to HMP Hewell

101. The man attended Crown Court on the morning of 19 October in regarding the alleged assault of his cell mate at Hewell. Following his court appearance and, as arranged by the deputy governor, he was taken to HMP Hewell. A SO (a member of staff at Bristol) wrote that he had been informed that the man would not be returning to Bristol and so he had telephoned the safer custody team at Hewell. He gave them background information on his recall and alleged offences and that he had been subject to constant supervision when he left that morning. He asked them to convey the message to the Safer Custody Senior Officer. The member of staff who took the telephone call said that the SO had given the impression that the man no longer needed constant supervision and so they did not inform anyone that he was on a constant level of observation.
102. The duty governor (at Hewell) telephoned the governor who was Head of Residential at Bristol and said that the man could not return to Hewell as the prisoner he had assaulted was still there and that he (the man) was on an ACCT. The governor advised him that the deputy governor had spoken with his counterpart at Hewell who was therefore aware that the man was not to return to Bristol. He said there was nothing Bristol could offer him as a life sentence prisoner on recall. He had also been located in the segregation unit, which was not good for his mental health. He said that they thought keeping him at Bristol was not conducive to his wellbeing and would pose a risk to him and others. The duty governor reluctantly agreed for him to stay at Hewell, with the view to finding him an alternative suitable establishment such as HMP Dovegate or HMP Bullingdon.
103. The man's person escort record (PER) clearly indicated on the front that he was subject to ACCT procedures and was subject to a constant level of observation. It also documented that he was an arsonist who suffered from paranoia. His prison record was sent with him. He then went through the first reception screening process where he underwent a health assessment which was carried out by a nurse. He said that he suffered from asthma, had depression and arthritis, and had made several self-harm attempts in the past. His cell sharing risk assessment classed him as high risk as he had previously assaulted another prisoner and was of significant vulnerability.

104. The Safer Custody Manager and duty governor held an ACCT review following the man's health assessment. (The Safer Custody Manager had not been working in reception, but was called down by a member of staff (it is not known by whom) as they were concerned that he had been on a constant watch at Bristol and wanted advice from the Safer Custody Manager.)
105. The Safer Custody Manager had had previous interactions with the man at Hewell regarding his difficulty in coping and coming to terms with being back in prison. The duty governor felt that the ACCT was not clear as to what level of observations the man was on or the level of conversations he was subject to. They did not see the PER form, although this should have been available in reception, but the man informed them that he had been subject to constant supervision. He explained what had happened in the incidents that led to him being on an ACCT and on constant supervision. He called it a "silly act" and said he had just been worried about going to court. He said that he was happy to be back at Hewell and all he wanted was to be located in a normal cell with a television and a kettle. He went on to say that he was eating and drinking reasonably well.
106. Another review was scheduled for the next day and the man's level of risk was reduced to low. The duty governor was called away during the review, so the Safer Custody Manager finished it on his own. He felt that the goals in the care map had been met and therefore he no longer needed to be subject to constant supervision. He noted in the ACCT:
- "Case review held. He was very upbeat about being back at Hewell. His issues were discussed and resolved. He requested to be located in a normal cell with a TV and kettle. After assessing any risks and discussing with the res (residential) manager on HB2 C Spur, this was facilitated. No need for constant supervision."
107. The man's observations were reduced to every three hours during the day and every two hours during the night and this was recorded on the front of the ACCT document.
108. He was located in a normal cell on houseblock two. The Safer Custody Manager informed the duty governor of this later in the afternoon, who agreed with the decision. He told the investigator during interview that he spoke to the nurse who saw the man during his reception interview and they said they had no concerns about him. He therefore felt there was no need for a member of healthcare staff to be present at the review.

Events of 19 October

109. An officer wrote in the man's ACCT at 8.45pm that he had observed him sitting on the top bunk. He asked what he was doing up there and he replied that it was cooler up there.
110. At 9.20pm, an Operational Support Grade (OSG) checked on the man as part of his ACCT observations. He thought he could see him in a sitting position,

but felt that something was not right and turned on the cell light. He saw him hanging from the top bunk and called a code blue over the radio. As he had previously assaulted a cellmate, the OSG did not feel it was safe to enter on his own and waited for other officers to arrive. A Principal Officer (PO) Jervis and two officers arrived at the cell approximately five minutes later (this was not considered an unreasonable amount of time given their location at the time of the emergency call). They entered the cell and noted that he was grey in colour and cyanosed (had a blue colour tinge around his mouth).

111. The PO Jervis and Officer A supported the man's body and Officer B cut the ligature made from bed linen. They laid him on the floor. By this time Officer C, a nurse and a Healthcare Assistant (HCA) had arrived at the cell and an ambulance had been called. Officer C and the PO started cardio pulmonary resuscitation (CPR) while the nurse administered oxygen. A defibrillator (used to detect any heart activity and apply a shock when appropriate) was applied, but instructed staff that no shock should be applied throughout the entire CPR attempt.
112. The ambulance and first response paramedics arrived at 9.45pm. Officer C continued to assist with CPR while the paramedics administered adrenaline intravenously. They managed to detect a heart beat, although the man was unable to breathe on his own. At 10.14pm, he was taken to the ambulance and driven to the local hospital. Two officers accompanied him in the role of escort officers. They arrived at the hospital at 10.30pm, where doctors advised them that his prognosis was not good.
113. The deputy governor attended the hospital at 0.20am on 20 October. She informed the Governing Governor of Hewell of the situation. The man was transferred to the intensive care unit (ICU) and was only able to breathe very slightly on his own. The Governor then informed the next of kin (there is no documentation to explain why this was not done sooner) and a family liaison officer was appointed. The man's wife stated that she wished to visit her husband but had no means to get there, so the Governor and deputy governor went to collect her and took her to the hospital.
114. At 6.00am, one of the nurses in the intensive care unit said that the man had been sick and lost a lot of fluid. He remained in a critical condition.
115. The family liaison officer telephoned the man's wife and introduced herself as the family's liaison officer at 9.30am on the morning of the 20 October. She then attended the hospital with the Head of Security, at 11.45am where they met with the family. They offered assistance with anything the family needed. The family asked a few questions regarding the circumstances of the incident, which they answered to the best of their knowledge. The family acknowledged that staff had worked hard to resuscitate the man as he would not have made it into the intensive care unit otherwise. The family were not aware of the outcome of his court appearance and so the Head of Security agreed to try and find out on their behalf. He informed the family that the man had been remanded until another court date on 2 November.

116. The family liaison officer and the Head of Security returned to the hospital just after 3.00pm. The man was taken for a computerised tomography (CT) brain scan at that time. The scan showed that his brain was swelling and his prognosis was not good. Approximately an hour later medical staff asked to speak to his family. They said that he had swelling to the brain and there was little chance of recovery.
117. The family made the decision to turn off the life support machines at 8.00pm. Many family members were outside the ward and went to spend some time with him. The doctors switched off the life support machines at 9.10pm and he was pronounced dead at 9.22pm by a hospital doctor.
118. The family liaison officer rang the family the next day to enquire whether they needed anything. They asked for his property, and she agreed to visit them with it later that day.
119. She arrived at the family home at 2.50pm with a member of the prison chaplaincy team. They handed over the man's property and money that he had in his prison account. There appeared to be a watch missing, which the family liaison officer said she would look in to. (However, despite enquiries she was not able to find the watch). She explained what would happen next, gave them the opportunity to visit his cell, and offered assistance with funeral expenses. The chaplain said that other prisoners wanted to make a collection to send flowers to the funeral. The family said they appreciated the gesture. The chaplain also advised that a memorial service would be held at Hewell the same day as the funeral. Again, the family were appreciative of this.
120. The funeral was held on 2 November 2010. The family liaison officer and deputy governor attended on behalf of HMP Hewell. The man's family visited the prison and his cell on 7 November. They were unclear how he could have used a ligature to harm himself as they could not see an obvious ligature point. They also wondered why the cell had been cleaned. (The family liaison officer subsequently explained to the investigator that this is usual practice at Hewell. This office considered that, in future, it would be better for the family who are due to visit to be asked whether they would prefer to see the cell as it was, or after it had been cleaned). She gave the family some more property which had been left in his cell. They were also given a copy of the order of service from the memorial held at the prison.

Support for staff

121. A hot de-brief was held at 1.30am in the communications room. This meeting was undertaken to provide staff with the opportunity to talk about their involvement in the incident and consider their issues or concerns. A few issues were raised including the potential lack of clarity surrounding the code blue emergency call. It was said that staff are used to code blues being called and so the level of urgency is not always clear. It was also felt that there were not enough staff on shift during the night to be able to respond to a serious incident. The new contingency plan (for staff working on night shift) was mentioned and it was thought that the previous version was much easier.

Staff had found it hard to find the new guidance and paperwork. Staff also raised concern regarding the number of prisoners on ACCT monitoring procedures. All staff were offered further support through the care team and staff welfare system, but all said they felt fine to carry on with their shift. (A further critical incident de-brief, where staff are offered the opportunity to review the event and talk about their feelings, was not held.)

Support for prisoners

122. All prisoners who were subject to ACCT procedures had an additional review to ensure that they were not adversely affected by the man's death. They were also reminded that they could speak to staff, Listeners or the Samaritans if they felt affected by his death.

ISSUES

Clinical care

Overall care

123. The clinical review draws a number of conclusions about the man's period in custody. The clinical reviewer concludes that his physical health did not contribute significantly to him taking his own life. She concludes in her report that:

“I do not believe he would have received a higher standard of care if he were in the community.”

124. However, there are a number of further issues regarding his clinical care that require analysis.

Mental health

125. Despite his frequent interactions from the mental health team the clinical reviewer explains that he was not suffering from an enduring mental illness during his time in custody:

“He was diagnosed with ‘Adjustment disorder’ on his arrival at HMP Hewell. He was seen on numerous occasions during his incarceration and at no point was he found to have any other treatable form of mental illness.”

126. She acknowledges that there was a period of some weeks when he did not have input from the mental health team. This occurred whilst he was at HMP Long Lartin and HMP Bristol. During this time his olanzapine medication was stopped as there was felt to be no clinical indication for it. It should be noted that she does not criticise the decision to stop the medication in her review.

127. The clinical reviewer also notes that: “The man was placed on constant watch on several occasions whilst in prison. Initially thoughts of mental health problems were a major feature. As time went on these occasions seem to have been viewed more as a behavioural issue and not to represent a real threat to his life.”

The lack of mental health input in the months before his death

128. As noted above, the man had little input from the mental health team, particularly in the months leading up to his death. Although he was not suffering from an enduring mental illness, the clinical reviewer writes: “Given his history and his circumstances it would have been appropriate for the mental health team to review him as his court date approached”. The lack of any recent mental health assessments meant his state of mind is unclear. She goes on to say that: “he should, without doubt, have undergone a mental

health review in the last 2 months of his life and the mental health team should have played some role in the days or weeks prior to his court case. “

The Head of Healthcare should ensure that a mechanism is in place to alert members of healthcare, in particular the mental health team, of impending court dates for at risk prisoners.

Conclusion

129. The clinical reviewer notes that “The man was not a danger to himself because of mental illness, he was a danger because he was a man who felt he had lost everything including his reputation”. He clearly felt he had nothing left to live for. Despite the seven months in custody and despite the comprehensive mental health assessments and the long periods on ACCT books his basic situation had not changed. She writes of his decision to take his life:

“Given the man’s lack of a treatable illness it is by no means certain that his suicide could have been prevented. He, it seems, killed himself because he was in a situation he could see no way out of.”

Transferring the man from Bristol to Hewell

130. It is important to consider the appropriateness of the man’s transfer back to Hewell from Bristol, given that he was subject to constant supervision at the time. Prisoners who are subject to ACCT monitoring procedures are vulnerable and at risk of harming themselves. Therefore, it is important that their vulnerabilities, and the impact change can have upon them, is considered before prisoners are transferred. Prison Service Order 2700 (Suicide Prevention and Self-Harm Management) states:

“The intention to transfer a prisoner on an open ACCT Plan (or in the post-closure phase of ACCT) must be discussed with the receiving establishment, a record must be retained in the sending establishment to show this has been done (as well a record made in the ACCT Plan), and relevant information must be conveyed either with or ahead of the prisoner. The proposed transfer, and issues arising from it, must be discussed at a case review with the prisoner ...

131. The investigator spoke to the deputy governor at HMP Bristol to find out why the man was transferred back to Hewell. The prison submitted a written response which explained that there were a high number of high maintenance prisoners in the segregation unit at that time (the man being one). He said he spoke with another governor at Bristol and told him that the man, who was due at Magistrates Court on 19 October, was officially a Hewell prisoner. He said that he should return there at the end of his court hearing and said he had also advised the Deputy Governor at Hewell of this decision.
132. When this was raised with staff at Hewell, they were reluctant to take the man as he had been in court for assaulting a prisoner who was still there.

However, the Head of Residential responded that the Deputy Governor had agreed his return to Hewell with the Deputy Governor at Hewell. Bristol also said that he had easier access to visits from his family at Hewell, and Bristol could not offer him a regime which could cater for his needs. In addition, due to two serious incidents at Bristol which he had been involved in he would have to be returned to the segregation unit there. These factors persuaded Hewell to accept him.

133. In a written response to this issue the Governing Governor of Hewell provided a different account to that of Bristol. He said that the prison had no prior knowledge of the man's admission to Hewell, or his appearance at court that day. He also said that the prison was not advised before the man arrived at Hewell that he was subject to constant supervision. He confirmed that the deputy governor contacted the Head of Residential at HMP Bristol, but that the Head was unwilling to accept him back. Given that the man had had a long day and was subject to ACCT procedures, he said Hewell took the approach of putting his needs first and accepted him there.
134. It is clear that both prisons wanted to transfer the man for legitimate reasons. He had been located in the segregation unit at Bristol due to two serious incidents and the prison felt he was unable to return to normal location. Also they felt they could not offer him the type of regime he needed and that he was further away from his family. Hewell had concerns about him returning there, not least because the prisoner he was alleged to have assaulted was still at the prison. Despite this, Bristol remained unwilling to take him back into their custody.
135. It is difficult to make a judgement about which prison the man should have moved to, as both prisons had reason not to accept him. However, what is beyond doubt was a breakdown in communication and the prisons do not agree on the sequence of events. There clearly should be recorded dialogue between prisons in such an instance to ensure that both prisons understand the reasons behind the transfer and appropriately manage any connected issues.
136. This leads on to the second issue which is whether Hewell were informed that the man was on a constant watch when he left Bristol. A SO's written evidence is that this was the case, although it is unclear whether this information was passed on in good time by the Safer Custody Department at Hewell. The SO said that he had rung Hewell and asked to speak to another SO, however as she was unavailable he spoke to a member of staff. The SO said he told her that the man would be returning to Hewell after his court appearance, informed her that he was a recalled life sentence prisoner who was facing further serious charges and that he had been placed on an ACCT after he was found to have made a ligature two weeks earlier. The SO said he also passed on information that he was on a constant watch and the member of staff agreed to pass this information on to the Safer Custody Senior Officer.

137. It is imperative that such crucial information is effectively passed from one prison to another and properly recorded, so that a full history of the prisoner can be established, appropriate actions taken and safeguards put in place. This is the responsibility of both the sending and receiving establishment.

The Governors of Hewell and Bristol should ensure that important safer custody information is properly recorded and passed to the relevant department as soon as possible

The ACCT review held on 19 October

138. The man met with one of the Safer Custody managers when he arrived at Hewell on 19 October, and an ACCT review was carried out immediately. The duty governor was present for part of the review, but got called away. Nobody from healthcare was present for the review, but the Safer Custody manager said they had seen him in reception and told him they had no concerns about him. He said that he considered that he had a good relationship with him (as he remembered him from his previous time in custody there) and felt they could identify any issues between them.
139. It was appropriate that an ACCT review was carried out in reception, and that an experienced officer was asked to carry it out given the requirement for it to have been completed within 24 hours. However, there were systemic failings in this ACCT process which give cause for concern. The Safer Custody manager did not have all the necessary paperwork available to him (in particular the PER form) and, although he had spoken to the nurse about the man, she did not take part in the review. Furthermore, the duty governor was called away during the review, which left him and the man to complete it alone.
140. Prison Service Order 2700 (Suicide prevention and self-harm management) explains that ACCT reviews should comprise a multi-disciplinary team of staff:
- “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.”
141. Given the man’s history of involvement with mental health teams the ACCT guidance suggests that it would have been preferable for a healthcare member of staff to be present: “Care for prisoners at risk must be multi-disciplinary, using the skills of all staff from different disciplines, depending on the needs and wishes of the person at risk”. This is particularly important given that the review would be considering the appropriate level of observation for him. Removing a prisoner from constant supervision is an important assessment that can only be enhanced by the presence of other professionals. Whilst appreciating how busy a prison’s reception is, it is important that these ACCT process is followed.

The Governor should ensure that ACCT reviews are carried out by multi-disciplinary staff in accordance with ACCT guidelines.

The decision to reduce the man's level of observation

142. During the ACCT review on 19 October, The Safer Custody manager decided that the man's observations could be reduced from constant supervision to three times an hour during the day and twice hourly throughout the night. The duty governor agreed with this decision, when subsequently told of it. The Safer Custody manager made his decision based on how the man was presenting to him at the time and from his previous knowledge of him. Although he did not have his complete prison record with him (that would have been en-route from Bristol) or the PER form in front of him, he was aware that he was subject to constant supervision as he had made a ligature whilst at Bristol the day before. The man played this down and said it had been a silly act and he did not intend to harm himself.
143. PSO 2700 says that constant supervision is only to be used sparingly and when there is clear suicidal intent. Annex 8Y of the order says it is a "temporary arrangement" and makes clear it is only for when staff think they might attempt suicide at any moment. It also stresses that any reduction in observations will mean that some "risk-taking" is required. However, it also says that such reductions from constant supervision should be done slowly.
144. PSO 2700 also 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." The PSO also recommends a progressive scale of reductions in observations.
145. The prison officer knew the man and believed him when he said he had no intention of harming himself. This was despite not having all the relevant documentation in front of him to make a considered decision. However, on balance, bearing in mind what is set out in the PSO, reassurance from nursing staff on reception and that the Safer Custody manager maintained observations (albeit reduced), his actions can be considered defensible in the circumstances.

The man's location on his return to Hewell

146. Once back at Hewell, the man was located in the same houseblock as the prisoner he had been accused of assaulting. However, the layout of the prison and the spurs that he and the other prisoner were on meant that they would not have come into contact with each other. Furthermore, the prisoner was told where he was located and he raised no concerns.

The actions of staff upon finding the man

147. The Operational Support Grade (OSG) who found the man seemed unsure when interviewed about when to enter a prisoner's cell. However, the Governor has published all night routines in the Night Procedures document, and each OSG had a copy of this. It makes it clear that a member of staff may enter a cell if it is safe to do so and the security of the prison is not compromised. It is for the staff member to make a judgement about their situation. In this case, the OSG made a decision not to enter the cell before he had support of other staff, given what he knew about him and the fact that he was alleged to have assaulted his cell mate. This was reasonable, given what was known about him.

Breaking the news to the man's family

148. The time taken to inform the man's family, once he had been transferred from the prison to hospital, does not seem excessive. Prison Service Order 2710 (Follow-up to a death in custody) says that the prison must arrange notification of the next of kin as soon as possible and in a suitable manner. His prison records needed to be accessed to identify his next of kin, which was done once he was en-route to hospital and the Governor had been briefed after arriving at the hospital.

A debrief not held

149. Although a hot de-brief was held after the man died, a critical incident de-brief was not arranged. The Governor accepted this was an error and has agreed to remedy this. Critical incident de-briefs have been held since.

The Governor should ensure that a critical incident de-brief is held after every death in custody.

Rumours of bullying

150. The investigator found no evidence of that rumours were circulated by prison staff about the man's alleged offences, or that he was being bullied or treated unfairly. There is evidence, however, that he suffered from periods of paranoia (which he acknowledged) and felt unsettled on occasions.

CONCLUSION

151. There is no doubt that the man's behaviour was unpredictable during his time in custody. He appeared to suffer from emotional stress and admitted he could be paranoid. However, the cause for this appears to have been environmental rather than psychological as he was unhappy at being in prison, and felt that he had little left to live for. Although he came into contact with different departments around the prisons, including the mental health team, it was hard for any staff to change his attitude. However, the report has highlighted that more could have been done leading up to his court appearance.
152. The other important area covered by the investigation was the transfer of the man from Bristol to Hewell shortly before his death. Prisoners subject to ACCT procedures are clearly vulnerable and any transfer should be considered carefully. It is unfortunate in this case that the prisons involved do not appear to have had a clear and properly recorded conversation regarding him. The more information a receiving prison has regarding the incoming prisoner, the better they can support them. The findings of this investigation suggest that more work needs to be done to strengthen and formalise such communication.

RECOMMENDATIONS

To the Governor:

1. The Governor's of Hewell and Bristol should ensure that important safer custody information is passed to the relevant department as soon as possible.
This recommendation was accepted by both prisons
2. The Governor should ensure that ACCT reviews are carried out by a team of multi-disciplinary staff in accordance with ACCT guidelines.
The prison accepted this recommendation
3. The Governor should ensure that a critical incident de-brief is held after every death in custody.
The prison accepted this recommendation

To the Head of Healthcare

1. The Head of Healthcare should ensure that a mechanism is in place to alert members of healthcare, in particular the mental health team, of impending court dates for at risk prisoners.
This recommendation was accepted by both prisons