

**Investigation into the circumstances surrounding the
death of a man at
HMP & YOI Gloucester in August 2011**

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

May 2012

This is the report of the investigation into the apparently self-inflicted death of a man at HMP & YOI Gloucester in August 2011. He was found by his cellmate hanging from the cell window bars with a ligature around his neck. Despite the best efforts of prison staff and paramedics, he could not be resuscitated. He was 25 years old when he died. I offer my condolences to his family and friends.

The investigation was conducted by one of my senior investigators. In addition, a clinical reviewer carried out a review of the clinical care the man received. HMP & YOI Gloucester co-operated fully with the investigation. I apologise that the report has been delayed.

The man had never been in prison before and was only two days into his sentence when he died. On his arrival, he told staff that he suffered with epilepsy and had been treated for mental health problems in the past. He said that he had deliberately harmed himself before, sometimes seriously, and had contemplated suicide. He was dependent on alcohol and also used illegal drugs. He was prescribed appropriate medication to treat his epilepsy, depression and alcohol dependency.

The man's history clearly indicated a number of risk factors known to increase the likelihood of suicide and self harm in prisons, but on several occasions in his short time in Gloucester, he denied he had any thoughts of harming himself and told staff that he was alright. Staff described him as seeming calm and giving them no cause to worry. His cellmate, who had apparently begun to get to know him quite well, also had no concerns that he might harm himself. He was very shocked by his actions. He was not being monitored under suicide prevention measures when he died.

Assessing the risk a prisoner poses to himself is not an exact science and involves balancing the prisoner's demeanour and behaviour against known risk factors. However, it is a concern that staff did not assess the man as at risk of self-harm. On the evidence available, greater weight should have been given to the static risk factors exhibited by him, including his history of self-harm, alcohol withdrawal and family history of suicide and the fact that this was his first experience of prison. While the clinical reviewer concludes that his healthcare was equivalent to that which he might have expected in the community, scope for improvement was identified with regard to cell location for those with epilepsy, and alcohol detoxification, recording practice and access to defibrillators in emergencies. Recommendations are made to address these issues.

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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SUMMARY

1. On 18 August 2011, the man was sentenced to eight months in prison having breached the conditions of a community sentence. He arrived at HMP & YOI Gloucester later that evening. He had never been in prison before.
2. He was dependent on alcohol and also used illegal drugs. He suffered from epilepsy and had a history of mental health problems. He had also deliberately harmed himself in the past and had contemplated suicide. However, those who had contact with him at court and on the journey to the prison did not have any immediate concerns about his vulnerability.
3. On his arrival at Gloucester, he was assessed by a nurse. The nurse decided that he needed to undergo an alcohol detoxification programme (where the prisoner is treated with medication to reduce the unpleasant and dangerous effects of reduced alcohol consumption). He began taking detoxification medication that night.
4. During the assessment, the man denied any thoughts of self harm or suicide and so the nurse did not place him on suicide and self harm prevention measures. However, the nurse did refer him to the prison mental health team and the substance misuse team for further assessment.
5. A prison officer working in reception carried out a first night assessment. He also recorded details of the man's previous history of self harm. He told the officer that he felt fine now he was in prison. The officer did not think that he posed a risk to himself.
6. The man was placed in a double cell with another prisoner who had also just arrived. The cellmate said that he had no concerns about him during their two days together.
7. A prison doctor assessed the man on 19 August. She ensured that he was prescribed the correct medication to treat his physical and mental health problems. The doctor was aware of his past but did not see any signs that caused her to worry about him.
8. A few days later the man and his cellmate collected their lunch and sat together to eat it in their cell. Between 12.30 and 1.30pm, all prisoners at Gloucester are locked in their cells and so he decided to watch television while his cellmate went to sleep. When his cellmate woke up, he discovered him hanging from the cell window bars with a ligature made from a bedsheet around his neck. He called for help and staff arrived quickly. Despite the best efforts of the officers and prison nurses, and the paramedics who arrived shortly after, he could not be resuscitated. His death was pronounced at 2.45pm.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 20 August and the case was allocated to a senior investigator. She visited Gloucester on 25 August to open the investigation. During her visit, she met the prison Governor and the governor on duty at the time of his death. She also met a member of the Independent Monitoring Board (IMB, described in paragraph 21) and the prison's family liaison officer. She was given copies of all of the paperwork, including the medical record, relating to his time at Gloucester.
10. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and invited them to contact her with relevant information. No-one came forward in response to the notices.
11. The local PCT appointed a clinical reviewer to undertake a review of the clinical care the man received at Gloucester. She had access to his full medical record.
12. In November, the investigator and clinical reviewer carried out six interviews with prison and healthcare staff. Following the interviews, the investigator provided written feedback to the Governor. The delay in the issuing of the report was caused by workload pressures within the Ombudsman's office.
13. The Coroner for Gloucestershire was informed of the nature and scope of the Ombudsman's investigation. He provided a copy of the post mortem report. The Coroner will be sent a copy of this report to assist with his enquiries.
14. The investigator had contact with Gloucestershire Police who also carried out an investigation following the man's death. (The police conduct an investigation after every death in custody to check whether there are any suspicious circumstances.) The police interviewed a number of staff and prisoners as a result of his death and shared copies of the subsequent statements with the investigator. They were content that there were no suspicious circumstances surrounding his death.
15. One of the Ombudsman's family liaison officers contacted the man's father to invite him to be involved in the investigation process. He did not raise any particular concerns or questions about the care his son received at Gloucester. He was also offered the opportunity to receive and comment on the draft version of the report, however, to date, has chosen not to do so. I hope that the findings of my investigation answer any questions he may have, should he wish to receive the report in the future.

HMP & YOI GLOUCESTER

16. HMP & YOI Gloucester is a local category B prison (meaning it holds prisoners considered to pose a standard risk to the public if they were to escape). The prison can hold up to 321 male prisoners (including a small number of individuals aged 18 to 21) on remand or convicted from courts in the local area.

Assessment, Care in Custody and Teamwork (ACCT)

17. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. 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 himself. 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 observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

Counselling, Assessment, Referral, Advice and Throughcare service (CARATs)

18. CARATs teams operate in every prison in England and Wales. They provide low intensity, non-clinical interventions to prisoners with substance misuse problems. They work primarily with those who use drugs, but can also work with prisoners who use both drugs and alcohol. (The service is not available to prisoners who only misuse alcohol.)
19. Prisoners may refer themselves to the service or be referred by staff. A CARATs worker will assess the prisoner's history of substance misuse and establish their support needs. Interventions on offer might include one to one counselling sessions, group work or specially designed programmes.

HM Chief Inspector of Prisons (HMCIP)

20. The prison was last inspected by HMCIP during a short follow up inspection in August 2010 (the last full inspection took place in 2007). In the published inspection report, HMCIP noted that performance had "deteriorated sharply" since the last inspection. To a large extent, this deterioration was the result of the physical decay of the mainly Victorian prison buildings.
21. Relationships between staff and prisoners were generally good and the prison had a "comprehensive and cohesive" suicide prevention strategy. Relatively low numbers of prisoners were supported under suicide prevention procedures but the documentation for those that were, was generally well completed.

22. Gloucester has two mental health teams, the mental health inreach team (MHIT), provided by the 2gether (NHS Foundation Trust dealing with mental health issues, substance misuse and learning disability issues in Gloucestershire and Herefordshire) mental health trust, and the primary care mental health team provided by the primary care trust. The MHIT works with prisoners with severe mental illnesses or those who are receiving specific mental health care in the community. The primary care mental health team works with prisoners with less serious mental illnesses such as depression and anxiety. HMCIP described health services at Gloucester as “well staffed” although the physical environment was again found to be “poor”. Mental health services were well integrated in the prison and had good links with external agencies.

Independent Monitoring Board (IMB)

23. Each prison in England and Wales is monitored by a board of unpaid members of the local community, appointed by the Secretary of State for Justice, known as the IMB. The role of board members is to monitor the conditions prisoners are held in and submit an annual report to the Secretary of State. The most recent IMB report for Gloucester covers 1 December 2009 to 30 November 2010.

24. The IMB noted their “dismay” that problems with the physical environment at Gloucester had not been dealt with, despite repeated criticisms by HMCIP and the IMB. The Board noted that some areas of the prison had been deemed “not fit for purpose”.

25. However, the IMB also noted much good work at the prison, including aspects of general and mental healthcare. The Board also praised the “thoughtful, innovative leadership” that meant that Gloucester was a “basically well-run prison”.

Previous deaths at Gloucester

26. The man is the seventh prisoner to apparently take his life at Gloucester since the Ombudsman began investigating all deaths in prisons in 2004. There are no particular similarities between the circumstances of the deaths or the recommendations made in the investigation reports.

KEY EVENTS

27. The man was convicted of fraud, possession of an offensive weapon and racially aggravated assault in June 2011. He received a community order with three requirements – that he attend supervision with his offender manager (formally known as probation officers), obey a curfew and address his alcohol misuse.
28. In August, it became clear that the man had missed 190 hours of his curfew and failed to attend sessions focusing on his alcohol use. He was deemed to have breached the community order. (When an individual breaches a community order, they must return to court and may be re-sentenced. If the court decides that they are unlikely to abide by the conditions of a community order, they may be sentenced to a period of custody instead.) A pre-sentence report written explained that he had breached his curfew, in part, because he had lost his accommodation. At the time of his re-sentencing, he was living at the YMCA in Cardiff.
29. On 18 August 2011, the man was sentenced to eight months imprisonment at Magistrates' Court. He had never been in prison before. HMP Cardiff, the closest prison to the court, was full that day so he and several other prisoners were taken to HMP Gloucester instead.
30. He arrived at Gloucester at 6.38pm. He was one of ten prisoners to arrive that evening. Escort staff who supervised him at court and on the journey from the court to prison completed a Person Escort Record (PER). The PER notes any risks the individual may pose to himself or to others. It also provides a log of events and details of the handover between escort and prison staff. Staff completing the PER noted that he had a history of self harm: "Self harm – banging his head in cell July 2011. Suicidal marker April 2011." In the health risk section, the following was written: "Fingers missing of hand due to setting fire to himself 2005."
31. Staff wrote in the PER that the man said he was epileptic (although there is no record that he had any medication with him). Finally, they noted that he could be violent. There is no evidence to suggest that he harmed himself or raised concerns in any way while at court that day. Nor is there evidence to suggest that anyone who had contact with him while at court or on the journey to Gloucester thought that he contemplated self harm or suicide.
32. At about 8.15pm, Nurse A, a Registered Mental Health Nurse, completed the first reception healthscreen. (The purpose of the healthscreen is to identify any immediate physical or mental health needs.) The nurse recorded that the man was epileptic and had last suffered a fit two days previously. The nurse wrote that he was a drug user with a history of daily cannabis use. He was unable to provide a urine sample so he could not undergo a drug test. He described a history of heavy alcohol use. He said that he was regularly unable to remember the events of the previous night because he had drunk too much and that his alcohol consumption affected his life on a daily basis. He said that he drank about 360 units of alcohol each week. (Current government advice suggests that men drink no more than 28 units a week.)

33. Some questions in the first reception healthscreen relate to thoughts of self harm or suicide. The nurse recorded that the man said he had no thoughts of deliberately harming himself. He wrote that he appeared to be “coherent” and “calm” and that he was “engaging well in conversation”. The nurse mentioned that he had appropriate body language, did not appear to be distracted or preoccupied and made good eye contact. These are all signs that trained practitioners can use to help identify prisoners who might pose a risk to themselves. However, the nurse recorded that eight or nine years ago, he had lost some of the fingers on his left hand after “plunging his fingers into a chip pan”. The nurse also wrote that his mother had taken her own life about nine years previously.
34. The man said that his last contact with mental health services was “several months ago” but that he had been sectioned under the Mental Health Act in the past. (A patient can be sectioned if they are deemed to pose a risk to themselves or others because of a mental health condition. It normally means that the individual refuses to accept treatment. When someone is sectioned, they are forcibly detained in a mental health facility, such as a hospital, and can be treated against their will. Generally, the power to section someone is used in an emergency.) The nurse noted that he would refer him to the doctor, the mental health team and the prison drugs service.
35. The nurse was interviewed by the police after the man’s death. In his police statement, he said that he told him that he was not currently prescribed any medication for mental health problems. The nurse told the police that he did not think that he presented “in any way” as someone who posed an immediate risk to himself or others. As a result, he said he did not consider opening an ACCT plan.
36. The man was assessed by a support worker with the drugs service about ten minutes later. He examined him for signs of alcohol and drug withdrawal symptoms. (When someone who is dependent on alcohol or certain types of drugs suddenly stops using them, they may experience withdrawal symptoms which can make them unwell. Alcohol withdrawal is very dangerous and can be fatal if not properly treated.) He recorded that he showed no signs of alcohol or drug withdrawal.
37. According to the man’s prescription charts, he was prescribed an alcohol detoxification programme that night. (During the detoxification programme, the patient is prescribed a decreasing dose of medication, chlordiazepoxide, to help relieve the dangerous symptoms of alcohol withdrawal. The detoxification programme can last up to ten days, by which time the individual’s body has adjusted to the changed levels of alcohol.) At 9.00pm, he was given 40 milligrams (mg) of chlordiazepoxide.
38. During the investigation Nurse B was interviewed. She said that she worked predominantly with prisoners needing drug or alcohol treatment. She explained that, sometimes, prisoners are assessed in reception after the doctor has left for the day. If healthcare staff think that the prisoner needs to be prescribed

detoxification medication they will telephone the doctor and discuss the individual's needs. If the doctor agrees, the prisoner will be prescribed medication by the nurses and be examined by the doctor the following day. There is nothing in the man's medical record to confirm who prescribed his initial doses of chlordiazepoxide. However, in his police statement, Nurse A confirmed that he prescribed chlordiazepoxide for the first night, until he had been examined by the doctor.

39. Officer A and Nurse A completed the cell sharing risk assessment (CSRA) with the man that evening. (The CSRA assesses whether a prisoner is suitable for sharing a cell with another. It is based on known information, including the prisoner's offences and past behaviour, and also staff's judgement. Prisoners may be assessed as posing a standard risk or a high risk to others.) The officer recorded that he had been convicted of a racist offence, but that he denied being racist. The officer wrote that he was epileptic, smoked cigarettes and could not read or write. Nurse A recorded that he had not seen any medical records for him but, on the basis of available information, decided that he did not pose an increased risk to other prisoners. The officer agreed and recorded that he posed a standard risk to others and was, therefore, suitable for sharing a cell.
40. Nurse C was interviewed as part of this investigation. She said that, had she conducted the CSRA and given the man's history of epilepsy, she would have directed that he be given a cell on the ground floor and that he take the bottom bunk bed in a double cell. Nurse A did not give any instructions about what sort of cell he should be placed in or which bed he should use.
41. Officer A also completed the First Night Immediate Risk and Needs Assessment. The assessment is largely formed of "yes / no" questions, with some spaces for further information. The officer recorded that it was the man's first time in prison. He circled "yes" to the question asking whether the prisoner was dependent on drugs or alcohol.
42. One section of the assessment concerns self harm. The officer asked the man if he had any history of self harm or attempted suicide. He said that he did, having taken overdoses and tried to hang himself in 2009 and 2010. One of the questions on the assessment asks "How are you feeling at the moment?" and the officer recorded that he replied "alright / sound". He said that he had no immediate problems or concerns. The officer recorded that an ACCT plan did not need to be opened at that time and indicated that he had explained how the man could access support if he needed it. (There are three common forms of support on offer at most prisons: access to the Samaritans' telephone help line, the Listeners scheme and seeking staff support using the emergency cell bell. Most prisons are equipped with cordless telephones that can only be used to telephone the Samaritans. Listeners are prisoners who are trained and supported by the Samaritans to offer a confidential listening service to other prisoners. They are generally available 24 hours a day. All cells are fitted with emergency cell bells. Prisoners are told that they may use their cell bells if they need urgent staff attention.)

43. As part of the police investigation following the man's death, another prisoner was interviewed. He told the police that he also arrived at Gloucester on 18 August, having appeared at Magistrates' Court that day. He said that he travelled on the same escort vehicle as him but that they did not meet until they arrived at the prison. He said that the reception procedures took some time and he was not moved to a cell until some time after 11.30pm. He told the police that he and the man were placed in a first night cell together on A wing. (It is commonly accepted that the early days in custody are very stressful for prisoners and that their vulnerability is increased at this time. As a result, most prisons try to ensure that prisoners receive additional support from staff during their first days in prison.)
44. The prisoner said that he and the man began to get to know each other. He described him as "quite cheerful" and in a "happy mood". He told the prisoner that it was his first time in prison.
45. On 18 August, someone completed a CARATs referral form (the referral is not signed) which the service received the following day. The person who completed the form noted that the man needed to be referred because of his drug and alcohol misuse and that he needed to be seen by CARATs by 24 August.
46. Nurse C dispensed the man's dose of chlordiazepoxide first thing in the morning on 19 August. During interview, she explained that, when dispensing medication, nurses routinely look for signs of withdrawal and ask the prisoner how they are. She said that she saw nothing to worry her when he collected his medication that morning.
47. At 9.51am on 19 August, the manager of the MHIT made an entry in the man's medical record. She recorded that she had contacted his community doctor and the community mental health team in Cardiff. She wrote that she had spoken to his former mental health care co-ordinator, who had given some background information about him. The co-ordinator told her that the man had been discharged from the community mental health team "a while ago". He said that mental health practitioners did not consider him to be suffering with a serious mental illness. Instead, staff thought that his problems were the result of his misuse of drugs and possibly a personality disorder. (The term personality disorder is used when someone is considered to have particular difficulties with how they think, feel and behave. There are several different types of personality disorders which affect sufferers in different ways. While some personality disorder sufferers find antidepressants helpful, there is no recommended medical treatment for the condition. Treatment for personality disorders tends to focus on talking therapies and trying to change the individual's behaviour.)
48. The co-ordinator said that the man "sought out" medication and misused both illegal drugs and prescribed medication. According to him, the man found it difficult to take responsibility for his own actions. The manager wrote that he had never received a definitive diagnosis of his mental health problems and that no formal assessments had been carried out in the past which might help inform his treatment in prison.

49. The manager asked the man's community doctor to share information with the prison. However, she concluded that, given the information she had received from the co-ordinator, he did not need to undergo an assessment by the MHIT. She was interviewed by the police following his death. She said that, although he did not warrant referral to the MHIT, she had referred him to the prison primary care mental health team and added his name to their waiting list. She wrote in the medical record that she would invite him to the prison safer custody group.
50. During the investigation, the manager was interviewed. She explained that the safer custody group was run by staff from the mental health team for prisoners with a history of self harm or who were considered to pose a risk to themselves. She described it as a "tight, supportive group". The man was placed on the group list.
51. At 10.23am, one of the prison doctors assessed the man. The doctor wrote details of the assessment in his medical record. She recorded that he had drunk ten litres of cider every day since his mother had taken her life eight years previously. She also noted that he smoked cannabis and sometimes injected amphetamines (although he said he had not done so for about three months). She continued the alcohol detoxification programme begun by Nurse A. She also prescribed thiamine, pabrinex, acamprosate, zopiclone and diazepam as part of the detoxification programme. (Thiamine is one of the vitamin B group. Pabrinex is an injectable solution of vitamins B and C, both of which are necessary for normal organ function and are normally deficient in those with a history of alcohol use. Acamprosate helps to combat the desire to drink alcohol. Zopiclone, a sleeping tablet, is normally only prescribed for up to seven days and diazepam is a sedative medication to prevent symptoms of anxiety.) The prescription chart indicates that he received 30mg of his alcohol detoxification medication at 8.00am and midday and 40mg at 10.30pm that day. He also received his correct doses at 8.00am and midday the following day, 20 August.
52. The doctor recorded that the man suffered an epileptic fit "the other day" and woke up to find himself on the floor. She prescribed 700 milligrams (mg) of Epilim and 200 mg of Tegretol Retard (both used to treat epilepsy) which he was to take twice a day. She also prescribed mirtazepine (an antidepressant) because he had a history of depression.
53. The doctor recorded some information about the man's previous history of "multiple" acts of self harm, including trying to hang himself, but wrote that he presented in a "normal mood and mental state" and had no thoughts of self harm. He told the doctor that he had lost the fingers on his hand when he "blacked out" as a result of his medication and his hand fell into a chip pan.
54. After his appointment with the doctor, the man was seen by a nurse who carried out the secondary healthscreen. This healthscreen logs information about vaccinations and tests that may be required. The nurse wrote that he volunteered to be vaccinated against Hepatitis B. (Hepatitis B is an infection of the liver. It can be caused by sharing injecting equipment or through intimate

contact with a carrier of the infection.) Other than receiving his prescribed medication, this was his last appointment with a member of healthcare staff.

55. The prisoner told the police that he and the man moved to a cell on the second floor of A wing. He chose to sleep in the top bunk bed and the other prisoner on the bottom bunk. He asked the prisoner questions about life in prison, such as how telephone calls were made. The prisoner said that he seemed “happy enough” and told him more about his life before coming to prison. That afternoon, the two men played pool together. The prisoner said that he and the man forgot to collect their medication that afternoon and that he was “agitated” by this and was knocking on his cell door. The prisoner said that the man then pressed the cell bell and told the officer who responded what had happened. At about 10.30pm, a nurse came to their cell and gave the man his medication.
56. The following morning the prisoner and the man collected their medication and their breakfast before returning to their cell. The prisoner described him as seeming “okay” and giving no signs that anything was wrong.
57. At 10.17am, an officer made an entry in the man’s electronic prison file. He wrote that he had completed the wing induction and that there were “no concerns”.
58. At about 11.30am, the prisoner and the man went to collect their medication again. After that, they took their lunch back to the cell. An officer worked on A wing that day. He was interviewed as part of the investigation and said that he escorted the man and another prisoner to collect their lunch at about midday. The two men were late getting their food because they had been waiting for their medication. The officer described “laughing and joking” with the prisoners. This was the first time the officer had met the man.
59. Between 12.30pm and 1.30pm on Saturdays staff take a lunch break and the wing is patrolled by fewer members of staff. The prisoner said that he and the man sat at the table in the cell to eat. Once they had finished, the man began to watch television and he fell asleep.
60. The prisoner was not sure what time he woke up, but when he did, he assumed that the man was asleep on the top bunk. He said that he got out of bed and walked towards the cell door, as he turned around he saw him hanging from the cell window bars with a ligature made from a bed sheet around his neck. He said that he immediately pressed the cell bell and then ran to him. He grabbed hold of his legs to support his weight and take pressure off the ligature. He described his feet as about two and a half feet off the floor. He remembered that he shouted out but although he could not recall exactly what he shouted, he thought it might have been “Officers! Officers!”
61. In his interview with the police, the prisoner said that the man gave no indication that he was going to take his life. He said that he was “exactly the same” from the first moment they met until lunchtime.

62. Officer B worked on A wing that day. She was interviewed as part of the investigation. She said that she had not met the man since he had arrived at Gloucester because she had been on leave. She told the investigator that she and Officer C were collecting dirty lunch trays from prisoners' cells on the first floor landing. (According to other staff, this would have been at around 2.00pm.) She then heard a cell bell ringing on the second floor. At the same time, another prisoner asked her for some cleaning products so she went to answer the cell bell and the other officer went to collect the cleaning items from the landing cupboard.
63. When she reached cell A3-8 (the prisoner and the man's cell) she looked through the window in the cell door and saw him hanging from the cell window with the prisoner supporting the weight of his body. She was not carrying a radio so she shouted to Officer C. (She did not enter the cell immediately as the man shared a cell with another prisoner and she required assistance before unlocking the door.) She could not remember what words she used to alert her colleagues to the emergency, however, staff said that there is a code system in place at Gloucester. (Code systems are used in many prisons. At Gloucester, staff either use code blue or code red. Code blue is used when a prisoner is not breathing, code red indicates that a prisoner is bleeding. The use of a code system helps healthcare staff responding to the emergency call to bring the right equipment to the scene.)
64. Officer D was on the ground floor when he heard shouting from the second floor. He told the investigator that he heard someone shouting a "code something" on that landing. He was carrying a radio and used it to alert the prison to a code red emergency. He said that he thought it was better that some kind of code call was made quickly. According to the incident log, the code call was made at 2.20pm. He then went to the staff office (located between A and B wings) and collected the emergency medical bag. Staff interviewed as part of the investigation explained that discipline staff are not trained to use the equipment in the bag. However, because the bag is heavy, they sometimes carry it to the scene of an emergency on behalf of nursing staff.
65. Officer C reached the cell door as Officer B unlocked it and they both went into the cell. Officer B said that she climbed on to the cupboard in the far corner of the cell and, using her anti-ligature knife, cut the ligature from the window bars. (All front line staff in prison must carry an anti-ligature knife. The knife is specially designed to safely cut ligatures from around a person's neck.)
66. Officer C, the prisoner and Officer A lowered the man to the ground and, initially, Officer C placed him in the recovery position. (When someone is unconscious but still breathing, they can be placed in the recovery position, lying on the floor. The position helps to keep the individual's airways clear and helps them to breathe more easily.) Officer B said that Officer C looked for signs of life. Officer D arrived at the cell very quickly with the medical bag. He went in and, realising that the man was seriously unwell, turned him onto his back. Officer D told the investigator that he had some emergency response training, although he thought it was out of date at that time. He told the investigator that he realised that the staff needed to begin cardiopulmonary resuscitation (CPR – normally the

combination of chest compressions and rescue breaths). As he and his colleagues prepared to do so, healthcare staff arrived at the cell.

67. Nurse B told the investigator that she was in the nurses' room with colleagues when the code red call came over the radio. A Healthcare Assistant went to collect the code red emergency equipment and Nurse B and Nurse D made their way to A wing. Nursing staff told the investigator that there are two emergency medical bags; one contains equipment that might be used if someone is not breathing (for code blue calls) and the other contains equipment that might be used in a code red call. As they reached the wing, officers advised them that it was, in fact, a code blue emergency. However, officers told them that the code blue emergency medical equipment had already been taken to the cell. Nurse B and Nurse C told the investigator that healthcare staff do not automatically take a defibrillator to a code blue emergency, preferring to assess the situation first. (A defibrillator is a machine which can deliver electric shocks to re-establish a normal heart rhythm in some circumstances.)
68. When Nurses B and D arrived at the man's cell, Nurse C, who had been working in reception, had already arrived. Nurse C told the investigator that, as she ran onto A wing, staff told her that the emergency medical bag had already been taken to the cell. When she went into the cell, she checked his for signs of life and, finding none, began chest compressions. Nurse B initially gave him mouth to mouth resuscitation, then she gave him oxygen via a face mask. Nurse C and Nurse D took turns to deliver chest compressions. Having begun CPR, Nurse C asked wing staff to call 999 for an ambulance. A Senior Officer (SO), who had arrived at the scene, used her radio to request an ambulance. According to the prison incident log, made at the time of the emergency, an ambulance was requested at 2.25pm.
69. Nurse C decided that there were enough nurses on the scene for her to leave to collect the defibrillator from the central office. By the time she returned to the cell, the paramedics had arrived. One of the prison doctors also arrived at the cell. The log records the first ambulance arriving at the prison at 2.30pm and the paramedics reaching the man's cell two minutes later. At this point, Nurse C returned to continue her work in reception. (A second ambulance arrived at Gloucester at 2.33pm.) The records do not make clear who pronounced the man's death but, at 2.45pm, all attempts to resuscitate him were ended.

Results of the post mortem report

70. The post mortem examination indicated that the man died as a result of hanging. The report concluded that there were no signs of any third party involvement.

Contact with the man's family

71. Following the man's death, a prison's family liaison officer was appointed. At 6.15pm, he and a chaplain went to the man's father's home address and broke the news of his son's death. In line with Prison Service Order (PSO) 2710 (Follow up to a death in custody) the prison offered to assist the family with the cost of the funeral. The family was also offered the opportunity to visit the prison.

Support for prisoners

72. The prisoner was moved to a nearby cell while staff treated the man. Shortly after his death, the doctor spoke to the prisoner about whether he needed to be prescribed any medication to help with feelings of anxiety or upset. He said that he did not need any medication but was told to alert staff if he changed his mind. Later that day, he was placed on an ACCT plan to provide him with support. All other open ACCT plans were reviewed on 20 August, in line with PSO 2710.
73. Prisoners at Gloucester were informed of the man's death by way of a note from the Governor. Prisoners on A wing contributed to a collection, which Officer D thought went towards a floral tribute at the funeral.

Support for staff

74. Not long after the man's death, the deputy governor held a hot debrief in the chapel. (Holding a hot debrief is a requirement of PSO 2710. The hot debrief brings together those staff involved in the emergency response and gives them an opportunity to talk about what happened. The purpose of the meeting is to provide support and reassurance to staff but can also highlight any immediate lessons to be learnt.) She held an additional hot debrief for healthcare staff in the healthcare department that evening.
75. Officer B told the investigator that members of the staff care and welfare team spoke to her and offered support. Staff involved also said that they were given the opportunity to end their shift early.

Information received after the man's death

76. At some point on 20 August, another prisoner passed a note to staff suggesting that the man had taken his life because he was being intimidated by other prisoners and ignored by his cell mate. There is no other evidence to suggest this to be the case and the first prisoner's police statement suggests that the two men got on well. The police officer investigating the death spoke to the second prisoner as part of his investigation. He did not wish to make a statement about the note he wrote. He said that he had not seen or spoken to the man before his death. He told the police that he was not aware of him having been put under any pressure by other prisoners.

ISSUES

Assessment of risk

77. The clinical reviewer notes that the man was known to have a history of self harm, mental health issues and substance misuse. She concludes that Nurse A carried out a “thorough and well documented” reception assessment of the man’s mental and physical health, including his risk of suicide. Following that assessment, he was appropriately referred to the mental health team and substance misuse specialists.
78. The day after his arrival at Gloucester, the manager of MHIT began gathering information about the man’s mental health problems from a community mental health service that had worked with him in the past and his community doctor. That information revealed that he had never received a formal diagnosis of his mental health problems but was not considered to suffer with a serious mental health condition. On the basis of the information gathered, she concluded that he was not suitable for referral to the mental health inreach team. However, she referred him to the primary care mental health team. He was also considered suitable for the safer custody group and this was logged in his medical record.
79. The clinical reviewer writes that the man’s mental state and risk of self harm or suicide were assessed twice by healthcare staff during his two days at the prison – once by Nurse A and once by a prison doctor. Both were aware of his history but neither thought that he showed any signs of vulnerability.
80. Given the short time between the man’s arrival at Gloucester and his death, there are few entries in his prison file. However, as part of the reception process, Officer A carried out both the CSRA and first night assessment. Elements of the latter assessment focus on thoughts of self harm or suicide. Again, he discussed his previous acts of self harm but denied any current thoughts. Those who met him described him as seeming calm and he said that he felt “alright”.
81. The man’s cellmate spent the most time with him. He told the police that he saw no signs that he was struggling to cope and was shocked by his actions.
82. We considered whether staff should have opened an ACCT plan on his arrival. Previous reports have been critical when prison staff place too much reliance on what the prisoner tells them and ignore the weight of other risk related information. The PER that accompanied the man to prison made reference to his history of self harm behaviour, and he later told staff of an attempted hanging the previous year and that he had taken an overdose the year before that. His mother had taken her own life some years previously and there is evidence to suggest that a family history of suicide increases the risk. He also had a history of substance misuse and mental health problems, both of which increase the risk of suicide. In addition, he was withdrawing from alcohol and these were the early days of his first time in prison. All of these factors are significant indicators of risk of self harm and suicide. Set against these, as outlined in the report, he consistently denied any thoughts of self harm or suicide when asked directly about this. His behaviour and demeanour gave no indications otherwise.

83. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, it is concerning that staff relied so heavily on the man's presentation, given the number of risk factors he exhibited during his time at Gloucester. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk.
84. There is clear evidence of the number of interactions staff at Gloucester had with the man and each member of staff recorded different indicators of risk. Unfortunately, it appears that no central collation and consideration of these risks took place, and his level of risk was thereby assessed primarily on the basis of his presentation. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged and we consider that more weight should have been given to the known risk factors in comparison to his presentation.

The Governor should ensure staff fully take into account all indicators of risk when assessing the risk of self-harm in prisoners.

Clinical care

85. The clinical reviewer concludes that, overall, the man received a standard of healthcare equivalent to that he might have received had he been living in the community.
86. On his arrival at Gloucester, Nurse A recorded that the man suffered with epilepsy and was dependent on alcohol. He also noted that he used illicit drugs. The clinical reviewer concludes that he was prescribed appropriate medication for his epilepsy and was quickly placed on an alcohol detoxification programme.
87. During interviews, Nurse C told the clinical reviewer that she would normally instruct that a prisoner with epilepsy be given a cell on the ground floor and be advised to sleep on the bottom bunk. She explained that both measures helped to prevent injury if the prisoner were to suffer a fit. Nurse A carried out the first reception healthscreen and CSRA. Although his epilepsy was noted, the nurse did not record any advice about where he should be located or which bunk bed he should sleep in. As a result of the apparently different practices among healthcare staff at Gloucester, the clinical reviewer makes the following recommendation:

The Head of Healthcare should provide guidance for healthcare staff detailing the most appropriate cell location for prisoners with epilepsy, including how best share to share this information with prison staff responsible for allocating cells.

88. The clinical reviewer also notes that, contrary to good record keeping practice, healthcare staff who responded to the emergency call did not update the man's medical record until the day after his death. Furthermore, the entry made was incomplete. Staff interviewed as part of the investigation explained that, at the time of his death, they were not sure whose responsibility it was to update the medical record. They thought that it was most appropriate for the duty emergency response nurse to undertake this role. She agrees that this would be appropriate and makes the following recommendation:

The Head of Healthcare should clarify which member of staff is responsible for updating the medical records following a medical emergency.

Alcohol detoxification

89. The man was prescribed an alcohol detoxification plan on his arrival at Gloucester. Alcohol withdrawal is a dangerous condition and detoxification should be monitored and controlled carefully. Prison Service Order 3500 (Promotion of Healthcare) states that a prisoner with alcohol misuse issues: "requires treatment managed and supervised, where possible in (the) health care centre by trained and experienced staff." There is no evidence that prison staff gave any consideration to the most appropriate location for him. He was put in a shared cell on A wing, and there is nothing in his medical record to suggest that staff considered whether he needed supervision in the healthcare unit. On 19 August he did not collect his medication at tea time. There is no evidence that this was followed up by staff which raises concerns about how well his alcohol detoxification was being managed and supervised. While we accept that from the accounts available he did not seem to exhibit severe withdrawal symptoms, his alcohol misuse was considered serious enough to prescribe him medication, and his location and supervision should have been given careful consideration.

The Governor and Head of Healthcare should ensure that prisoners on alcohol detoxification programmes are managed and supervised in accordance with best practice guidance.

The emergency response

90. The man's cellmate discovered him hanging from the window bars in their shared cell some time after 2.00pm. He raised the alarm by pressing the emergency cell bell and shouting for help. Having done so, he took the weight of his body to relieve pressure on the ligature. Officer B responded to the cell bell and, on realising the situation called for help from her colleague Officer C. The two staff went inside the cell quickly and, together with the prisoner, cut the ligature and laid him on the cell floor.
91. Neither officers were carrying radios at the time, but Officer D, who was on the ground floor of the wing, was. Not all staff routinely carry a radio on the wing. He used his radio to alert the rest of the prison. During his interview with the police, Officer D explained that he had not heard whether his colleagues called that it was a code red or blue situation. He thought it better to make the

emergency call quickly rather than spend time checking the nature of the emergency and so he mistakenly radioed a code red.

92. The code system was devised to help staff responding to an emergency bring the right equipment to the scene. The nurses who responded brought equipment to deal with a prisoner who was bleeding. However, Officer D had already collected the code blue bag from the wing office and so the correct equipment was at the cell when the nurses arrived. We consider that staff at Gloucester are aware of the difference between a code red and code blue. The misuse of the system on this occasion was not caused by a system failure, but simply because the member of staff misheard the instruction. On that basis, no recommendation is made.
93. However, nursing staff interviewed as part of the investigation said that they do not automatically take the defibrillator to a code blue call. Code blue calls indicate that someone is not breathing. In some situations, swift use of the defibrillator can help to restart the patient's heart. The nurses did not initially take the defibrillator to the man's cell and Nurse C left the scene to collect it once her colleagues had arrived. The following recommendation is made to limit any possible delay:

The Head of Healthcare should ensure that nursing staff take a defibrillator with them as standard when responding to a code blue emergency.

94. Despite the above recommendations, we consider, and the clinical reviewer agrees, that staff responded quickly to the emergency and efforts to resuscitate the man, although ultimately unsuccessful, were appropriate.

CONCLUSION

95. The man was sentenced to eight months in prison on 18 August 2011. He had a history of substance misuse, mental health problems and self harm and it was his first time in prison. Days later he was found hanging from the cell window bars by his cellmate. Attempts to resuscitate him were unsuccessful.
96. He apparently gave staff and fellow prisoners no reason to worry about him. However, he exhibited a number of risk factors which should have caused prison staff more concern. There was also no consideration of the best location for a man at risk of suicide undergoing alcohol detoxification.

RECOMMENDATIONS

1. The Governor should ensure staff fully take into account all indicators of risk when assessing the risk of self-harm in prisoners.
The prison accepted this recommendation.
2. The Head of Healthcare should provide guidance for healthcare staff detailing the most appropriate cell location for prisoners with epilepsy, including how best share to share this information with prison staff responsible for allocating cells.
The prison accepted this recommendation.
3. The Head of Healthcare should clarify which member of staff is responsible for updating the medical records following a medical emergency.
The prison accepted this recommendation.
4. The Governor and Head of Healthcare should ensure that prisoners on alcohol detoxification programmes are managed and supervised in accordance with best practice guidance.
The prison accepted this recommendation.
5. The Head of Healthcare should ensure that nursing staff take a defibrillator with them as standard when responding to a code blue emergency.
The prison accepted this recommendation.