



**Investigation into the death of a man  
at Bristol Royal Infirmary in November 2011,  
while in the custody of HMP/YOI Bristol**

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

**May 2012**

This is the report of an investigation into the death of a man at HMP Bristol in November 2011. The man had been remanded in custody for serious violent offences and had been at Bristol for eight weeks, before his death. I offer condolences to his family and everyone touched by his death.

My investigator conducted the investigation. Bristol Primary Care Trust (PCT) commissioned a review of the man's medical care, which was completed by the clinical reviewer. I am grateful to him for his contribution and report. The Governor of Bristol and his staff co-operated fully with the investigation.

The man had been recalled to prison following revocation of his licence after he had committed further offences. Staff at Bristol referred him to the prison's mental health team as he reported feeling low. A subsequent assessment concluded that he had no significant mental health issues, but he was offered counselling and one to one therapy. The clinical reviewer considers that the man's clinical care compares favourably with that which would be expected in the community.

On 25 October, prison managers moved the man to the segregation unit, while allegations that he had attempted to intimidate witnesses were investigated. On the morning of 2 November, he was unlocked from his cell in the segregation unit so that he could use the shower. A member of staff escorted him to the shower area and locked him in alone in accordance with normal procedures. Some 36 minutes later, the same member of staff returned to collect the man and discovered him hanging by a ligature attached to the light fitting.

Both discipline and medical staff attempted to resuscitate the man until the arrival of paramedics, who managed to stabilise him. They then took him to Bristol Royal Infirmary. The man did not regain consciousness and was placed onto a ventilator. He remained sedated and supported by the ventilator until the day he died when medical staff confirmed that he was clinically dead and withdrew treatment. The man was pronounced dead at 11.00am that day.

It is not possible to say why the man took his own life, although it seems, from the notes he left, that his actions were planned and that he felt he had let his family down. In all the circumstances, the investigation concludes that staff could not reasonably have foreseen his intentions and responded appropriately when they found him. However, procedures for monitoring prisoners using showers in a unit housing many vulnerable prisoners were haphazard and 36 minutes was too long a period to leave the man unsupervised in a locked shower. The prison has taken steps to rectify this, but the report recommends that the new practices are formalised and the prison's policies updated. The prison partially accepted this recommendation.

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.

**Nigel Newcomen CBE  
Prisons and Probation Ombudsman**

**May 2012**

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## SUMMARY

1. The man was remanded into custody at HMP Cardiff on 1 September 2011. He had been on conditional licence in the community, following a previous prison sentence and had breached these conditions by committing further offences.
2. On his arrival at Cardiff, it was quickly identified that during the man's previous sentence he had assaulted a member of staff at the prison and attempted to escape from custody. As a result, he was moved to HMP Bristol on 8 September.
3. At Bristol, a nurse assessed the man on his reception and went through his medical history with him. He told the nurse that he was receiving medication and this was confirmed with his community doctor. Apart from the medication, he mentioned no other health concerns. He declined to participate in the second stage of the health screen and gave no reason for doing so.
4. On 16 September, the man told a healthcare assistant that he was feeling low and angry about being back in custody and asked if he could speak to a member of the mental health team. The healthcare assistant made a referral to the team and a mental health social worker assessed the man on 20 September.
5. During the assessment, the man spoke about his previous offending, how he felt he had let his family down and said that problems in his personal life had also caused him to feel down. It was felt that he had no significant mental health problems, but he was referred to another member of the mental health team. Further assessment recorded that he was experiencing Post Traumatic Stress Disorder (PTSD) and he was offered a short course of one to one therapy as well as also counselling, which he agreed to do.
6. Staff considered the man's general behaviour to be good and said he was polite and respectful. However, the prison received information that he was continuing to try to intimidate witnesses in his case and this led to him being relocated to the segregation unit for 24 hours after which he returned to the residential unit.
7. Further information, received from other prisoners on the same residential unit, suggested that the man was planning to assault staff and cause unrest within the prison and this led to him being moved to the segregation unit again on 25 October. He denied the allegations, but staff told the man that he would remain in the unit until transferred to another prison.
8. On 2 November, the man was allowed out of his cell in the segregation unit to take a shower. He was given clean clothing and locked in the shower area at 1.30pm. The staff on the unit did not check on him while he was in the shower.
9. At 2.06pm two members of staff returned to the shower room to collect the man, and when they looked through the small window in the door, their view was obscured by a towel placed over it. When they opened the door the

officers discovered him hanging from the light fitting, with a ligature made from a torn bed sheet around his neck.

10. The officers immediately supported the man and cut the ligature, before laying him on the floor outside the shower room. Other staff on the unit, alerted to the situation, called for further assistance from medical staff via the radio network. The man was unconscious and no breathing or pulse could be detected. Staff carried out cardio pulmonary resuscitation (CPR).
11. The healthcare wing is attached to the segregation unit. Therefore nursing staff quickly arrived, bringing with them emergency equipment and took over from officers in treating the man. Efforts to revive him continued until the arrival of emergency paramedics, who continued to treat him and were able to deliver drugs to help restart his heart. Eventually, the paramedics detected a faint pulse and after transferring him to the ambulance took him to Bristol Royal Infirmary (BRI).
12. As is normal practice, two officers escorted the man to hospital, but no restraints were used due to his condition. On arrival at BRI, medical staff carried out further tests on the man, who remained unconscious, before moving him to the intensive treatment unit (ITU).
13. The man's condition did not improve and the escort staff were told that doctors were considering withdrawing treatment as tests had indicated the man was 'brain dead'. Just after 10.30am on the day the man died, all medical equipment supporting the man was switched off and other treatment withdrawn. A hospital doctor pronounced him dead at 11.00am.
14. After his death, there was some delay in notifying his relatives. However, this was largely due to circumstances beyond the control of prison staff. Debriefs were held and staff subsequently attended his funeral, to which the prison contributed financially. Staff spoke to all prisoners who were subject to suicide and self-harm monitoring at the time of the man's discovery in the segregation unit.
15. The investigation and review of the man's medical care has concluded that he was managed appropriately during his time at Bristol. However, it is considered that prisoners in the segregation unit should be monitored more closely while they are locked in the shower and a recommendation is made to ensure improved monitoring of such prisoners.

## **THE INVESTIGATION PROCESS**

16. Another of my investigator opened the investigation on behalf of the investigator who was investigating the case on 7 November, when he visited HMP Bristol. Notices were issued informing staff and prisoners of the investigation. They asked anyone who had information, pertinent to the investigation, to contact the investigator but no responses were received.
17. Bristol PCT conducted a review of the medical care provided to the man, while in custody. The clinical reviewer completed the review on their behalf and the subsequent report is attached in full at annex 1.
18. My investigator wrote to the Coroner to inform him of the investigation and to request a copy of the post mortem report.
19. One of my family liaison officers (FLO) wrote to the man's family, to explain the purpose of the investigation. The draft report will be made available to the family should they wish to see it. Following the issue of the draft report, the family chose not to receive a copy and have made no comments on the content of the report.
20. My investigator visited Bristol on 7 and 8 December and conducted interviews with nine staff. Transcripts of all the interviews are attached to the report. On conclusion of the investigation, he reported his initial findings to the Governor and followed this up in writing.

## **HMP BRISTOL**

21. Bristol prison receives adult males and some young adults (those under 21) from local courts, as well as sentenced category B prisoners from the West of England. The prison comprises seven residential wings, of which E wing is the segregation unit. It can accommodate ten prisoners, with an additional two cells that are classified as unfurnished.
22. The prison also has its own healthcare centre with an 18-bed inpatient facility. The responsibility for the delivery of healthcare at the prison rests with Bristol Primary Care Trust (PCT) who commissions the services. Avon and Wiltshire Mental Health Partnership Trust (AWP) provide mental health services.
23. The Oak Centre is a new area at Bristol, set up for prisoners to take part in an induction process. Various agencies are available to provide advice and support to prisoners with matters such as housing, benefits and legal matters. In addition to this, healthcare assistants are also present to see prisoners and record a medical history.
24. Since this office began investigating deaths in custody in 2004, there have been 24 deaths at the prison, including that of the man.

### **Her Majesty's Chief Inspector of Prisons (HMCIP)**

25. The most recent announced inspection by HMCIP took place in January 2010. The resulting report noted that Bristol was:

‘... a reasonably safe prison. However, support for prisoners in the crucial early days of custody was ineffective. Not all prisoners were able to benefit from dedicated first night services, and the induction process was ineffective. Conversely, suicide prevention measures were strong, with some innovative aspects, such as the involvement of prisoners' families. Though violence reduction procedures were also sound, foreign national prisoners and those with disabilities felt less safe than others, and there were some concerns about the governance of the use of force. There has been good work to reduce the supply of drugs and support substance using prisoners ...’

### **Independent Monitoring Board (IMB)**

26. 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 most recent annual report 2009-2010, published by the IMB at Bristol, raises no issues that are repeated, but the board did comment on the management of the segregation unit saying:

‘... It is the opinion of the board that the segregation unit is extremely well run, in a professional manner and with a great duty of care. Many prisoners have learning disabilities, and mental health issues, and

some prisoners are, on occasion, very violent. Staff deal with these prisoners in the proper manor, often having to deal with the most difficult prisoners ...'

### **Critical incident and hot debriefs**

27. A critical debrief normally takes place two weeks after a serious incident. It gives the staff the opportunity to understand the incident in detail, identify any learning points, review their feelings, and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment. A 'hot debrief' takes place immediately after a serious incident, allowing staff to receive immediate support.

### **Cut-down tools**

28. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must be provided with and carry, when on duty, their own personal issue tool

### **Emergency response codes**

29. Staff use emergency codes to summon assistance to deal with a particular situation. In most prisons, the common coding system is 'blue' to indicate a prisoner with respiratory problems, or who is unconscious, and 'red' to indicate a prisoner who is bleeding. The benefit of such codes is to allow medical staff to attend the emergency with the correct equipment and to minimise delays to treatment.

### **Listeners**

30. Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.

### **Reception and induction**

31. A Cell Sharing Risk Assessment (CSRA) is completed for every prisoner on his or her reception into custody. The document has recently changed and now requires all decisions to be evidence-based. This requires staff to check prisoners' previous convictions to identify potential risks to them sharing a cell. The CSRA assesses a prisoner as either a standard or high level of risk. If high risk and considered unsuitable to share, a multi-disciplinary team must review the risk frequently.
32. Reception staff do not routinely have access to a prisoner's past records, so at this point the prisoner is the main source of information. All prisoners will also have a Person Escort Record (PER). This document is used when escorting a prisoner between prisons, courts and police stations. It includes pertinent

information, such as a prisoner's risk to others or themselves.

33. The initial healthcare screen concentrates on the prisoner's immediate well-being, mental health, risk of self-harm or suicide, and any drug or alcohol withdrawal or detoxification issues.
34. All new prisoners are housed on the induction wing. If staff consider a prisoner is vulnerable, they will be given a cell on another more appropriate wing where they will receive their induction. During induction, staff ask about any immediate concerns, such as disability, their offence and general well-being. In addition, there is a further assessment, medical screening, and input from the education, and offender management units. Staff ensure that prisoners have a new reception pack, pin numbers to access the prisoner telephone system and explain visiting arrangements.

### **Counselling Assessment Referral Advice and Throughcare service (CARATs)**

35. The Counselling Assessment Referral Advice and Throughcare service (CARATs) team provide a substance misuse service for prisoners with serious drug and alcohol problems. The team works in partnership with the healthcare service and officers, to provide a service within the prison and as a referral agency for ongoing support to prisoners on their release.

### **Suicide and self-harm monitoring**

36. Assessment, Care in Custody and Teamwork (ACCT) has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT monitoring, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

## KEY EVENTS

37. The man was recalled to prison after breaching licence conditions imposed on him at the end of an earlier sentence. He was charged with witness intimidation and assault and remanded to HMP Cardiff on 1 September 2011.
38. On his reception at Cardiff, it was recorded that during his previous sentence at Cardiff he had attacked a member of staff, taken their keys and attempted to escape from the prison. The man also asked to be placed under the provisions of Prison Rule 45 for his own protection. Any prisoner can make a request to be placed under Rule 45 for their own protection, if they feel that they may be at risk of harm from other prisoners. However, the Governor, despite having a duty of care, does not have to grant the request. They must exercise their judgement as to the nature and extent of the threat posed to the prisoner. If granted Rule 45, prisoners will be normally located on a separate wing, with others who have also been considered vulnerable. The man had previously been subject to Rule 45 at Cardiff, so his request was granted. Due to the previous assault on the member of staff, he only remained at Cardiff until 8 September, when he was transferred to HMP Bristol.
39. On his arrival at Bristol, the man was assessed by Nurse A who completed a healthscreen with him. He told Nurse A that he had been prescribed both gabapentin and fluoxetine, but there was no record of this in his medical notes. (Gabapentin is primarily used for the treatment of seizures, but is also used for pain relief and bipolar disorders. Fluoxetine is used for treating depression.) The nurse contacted HMP Cardiff and spoke with the pharmacist who confirmed that the man had been prescribed neither medication while he was there, but that he had only been with them for three days. The nurse then contacted the man's community general practitioner (GP) who was able to confirm that he had been prescribed them regularly in the community. The nurse referred the man to the prison doctor for the medication to be re-prescribed.
40. As a standard part of the health screen, the man was asked about any previous or current thoughts of self-harm and told Nurse A that he had no such thoughts. He also told her that he had no previous mental health problems, when she asked about his medical history, despite his use of the medications previously mentioned. The nurse recorded that during her assessment the man was calm and cooperated well. Prison doctor, Dr A prescribed all his medication later that day.
41. Despite his transfer to Bristol, the man still wished to be placed on the vulnerable prisoners' wing (D wing) at Bristol following the reception procedures. Nurse B, who was due to complete the secondary health screen with the man, saw him the following day. However, he declined to participate in this and the nurse was only able to record that he did not feel like harming himself and that his blood pressure was 77 bpm. No reason was given for his refusal. The health screen for prisoners is divided into two parts. The initial health screen aims to identify the immediate medical needs, such as current medications, and illnesses. The secondary screen is usually completed the

following day and involves a more comprehensive assessment to record past medical history and family history.

42. Little information is recorded about the man during his first week at Bristol, but on 16 September, Healthcare Assistant A at Bristol, saw him as part of a triage (assessment and prioritisation) clinic. The man is recorded as telling the healthcare assistant that he was feeling low and angry about being back in custody and wanted to talk to someone. He asked if he could be referred to the prison mental health team. She spoke with him about why he felt the way he did and suggested that he could also speak with a Listener on D wing. However, the man said that he had no wish to discuss his problems with other prisoners, especially on D wing. She referred him to the prison mental health team. The referral was received the same day by Mental Health Nurse A, who recorded that the man would be booked for a triage appointment.
43. On 19 September, the man submitted an application to see a member of the healthcare team and was assessed by Nurse C. He reported a cough and chest infection. After examining him, the nurse diagnosed a respiratory tract infection, advised him to refrain from smoking and requested that the prison doctor prescribe a course of antibiotics.
44. The man was triaged by Mental Health Social Worker A, from the prison mental health team, on 20 September. During the assessment, he told her that he was feeling low in mood and angry most of the time. He said that these feelings had been going on for five years and he had been taking fluoxetine for the past four years. When discussing his past, he said that he had committed many serious crimes, including armed robbery and hostage taking. He had also taken a prison officer hostage in the past. The man said that he had turned his life around and while in the community, had gained employment and a flat, but the recession had caused him to lose this job.
45. Mental Health Social Worker A recorded that the man was well presented, with good eye contact and was eager to talk about his life. He told her that he believed many of his problems stemmed from his childhood. He had previously tried to contact the mental health charity, MIND, to help, but had not heard from them. He had also experienced problems in his personal life. She recorded that his sleep and appetite were good, and he had no thoughts of self-harm or suicide. The man told her that he would like some counselling. She advised him that in order to have this he would need to be placed on medical hold, but this was not a guarantee that he would remain at Bristol. (Healthcare staff use medical hold to ensure that a prisoner is not transferred without the knowledge of the healthcare department. This can be for various reasons, such as outstanding hospital treatment, drug detoxification, or specialist appointments, such as counselling. However, medical hold does not guarantee that a patient will remain at a prison, if the appointment or treatment can be provided elsewhere.)
46. When interviewed, the Mental Health Social Worker A explained that a screening clinic is held twice weekly and any prisoner who has been referred to the mental health team will be assessed. It is only a brief assessment and

during her contact with the man, she had no concerns that he was clinically depressed. She said that he was preoccupied with why he had been recalled to prison and thought that it had been unjust. She had attempted to keep him on track and discuss his mental health concerns. She said that the man was 'fed up', but not angry and she felt that his mood was relevant to his circumstances. In addition to discussing his current problems, she also asked him about his motivation, sleep patterns, appetite and thoughts of self-harm or suicide. She said that none of the answers he gave raised any concerns.

47. The assessment completed by the Mental Health Social Worker A was then discussed at the single point of entry meeting, held by the mental health team every Friday, where all new referrals are discussed. She said that the plan was for the man to be referred for counselling and to be placed on Mental Health Nurse B's caseload for a medication review. She also explained to the investigator that the counselling service is run by a provider from outside of the prison and the counsellors are not required to make entries on the prison medical system when they have seen someone. This means that the mental health team rarely gets any feedback on someone who is receiving counselling.
48. The following day, the Mental Health Social Worker A was the duty worker in mental health and received a telephone call from staff on D wing. They told her that the man was in tears and asked if she would go to the wing and speak to him. However, she replied that she had seen him the previous day and did not consider that his problems were to do with his mental health, but were related to being in custody. She explained that other support networks were in place and advised them to ask a Listener to speak with him, as it was not her role.
49. Nurse A followed up the man on 26 September, in relation to his chest infection. She recorded that he still had an 'audible wheeze and productive cough' and made a request for further antibiotics to be prescribed. Prison doctor, Dr B prescribed these later that day. On 30 September, prison doctor, Dr C also re-prescribed gabapentin and fluoxetine, but he forgot to sign the treatment card. As a result, the request was sent back to the wing by the pharmacy for a signature to be obtained. This was passed to prison doctor, Dr D, on 3 October, who recorded that wing staff had also requested further antibiotics for the man. Dr D said that there was no explanation for this request and that this would be deferred until the man had been assessed. There is nothing on the man's medical notes to indicate that this assessment took place.
50. The man made an application to see a member of the healthcare team again on 4 October and was assessed by Nurse D. He told the nurse that he had previously been admitted to hospital and been told that he had two infections in the blood, but that the doctor was unable to specify what one of them was. He said that, at the time, the medical staff had been in a hurry to get him out of hospital, but had told him to tell his community GP as soon as possible. The man said that he was now getting stomach pains and wondered whether this could be related. He was asked about his previous medical history on reception at both Cardiff and Bristol and there is no record of him disclosing any of the above information. A referral was made for the man to be assessed by one of the prison GPs.

51. The following day, Mental Health Nurse B, met the man to review his medication. This took place because he had said that he no longer felt his antidepressant medication was working for him, during the earlier review with the mental health social worker. The nurse recorded that it was feasible that his current medication might be having less of an effect as he had been taking it for such a long time. She also recorded that it was clear to her during the assessment that the man suffered from 'severe hypervigilance associated with symptoms of Post Traumatic Stress Disorder (PTSD).' Hypervigilance refers to someone who is constantly on edge and anxious and is commonly linked with PTSD.
52. The Mental Health Nurse B wrote that the man agreed to engage with a short course to treat his PTSD at a clinic organised within the prison. She planned for him to attend six sessions and his medication would be reviewed during the process. However, he would remain as part of the primary mental health team's caseload.
53. When interviewed, Mental Health Nurse B explained that her role with the mental health team is as an independent non-medical prescriber, who provides advice on types of medication. She said that she is also able to provide clinics for anxiety disorders, such as those related to PTSD. She said that all mental health staff would deal with both primary and secondary care patients.
54. Mental Health Nurse B said that she identified that the man had severe hypervigilance during her first assessment. She did some brief work with him and he responded well. She had planned six sessions for the man, but as they depend on space and time, the waiting time to start providing the sessions is variable. In her contact with the man, she said that she had never considered him to be significantly at risk and if she had done so, she would have recorded it.
55. Following the referral by Nurse E on 4 October, prison doctor, Dr E assessed the man on 7 October in relation to his stomach pains. The doctor recorded that he first had the symptoms two years previously and it was worse at night, waking him two to three times. The man told the doctor that he had no dysuria (pain when passing water) at that time, but there had been blood on the tissue two days previously, after a bowel movement. He had no pain. The doctor asked about family history, but he replied that he was not in contact with them, so was unable to provide any information. He said that his appetite was 'up and down', but had lost around two and a half stone in the last four years. The man said that he felt he had lost more in recent weeks and thought this was due to the stress and anxiety of being in custody. On examination, the doctor recorded that the man's stomach was tender, there were no signs of either anaemia (iron deficiency) or jaundice (poor liver function). As part of the plan to treat the man, she arranged for blood and stool samples to be taken, a urine test and a referral to the smoking cessation clinic.
56. The urine test was completed the same day and all results were negative. The man's stool sample was tested for 'helicobacter pylori' on the Monday and the

results were negative. *Helicobacter pylori* refers to a bacteria found in the stomach that can be responsible for gastric problems. The blood test was due to be carried out on 11 October, but it is recorded that the man refused to have the test. No reason was given.

57. On 11 October, the mental health social worker was on D wing and was approached by the man who enquired what was happening about his contact with the mental health team. She was unable to access the medical computer on D wing as it was already in use, so was unable to provide a definitive answer. However, he told her that he had seen someone who wanted to increase his medication to 60mg and he was not keen for this to happen. He also said that they had offered him six counselling sessions, but again he disagreed as he felt his problems required more. From his description, she told him that it sounded as though he had been seen by Mental Health Nurse B and that the short intervention programme that he had been offered might help him contain some of his difficult feelings. The mental health social worker told the man that she would leave a note for the Mental Health Nurse B, asking her to clarify the position for him.
58. The same day, on D wing, the man told Nurse C that he was keen to see the doctor about his stomach pains. She told the man that the doctor had requested further tests and it would be advisable to wait until the results had been obtained, as the doctor would wish to discuss them with him. The medical record shows that the nurse booked an appointment for the man for the following week.
59. The man had his first appointment with the counsellor on 12 October. He was also re-located to the segregation unit on the same day, after information was received by staff that he was attempting to intimidate witnesses. (He had been remanded into custody for this same offence.) 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. Segregation is sometimes necessary to help prisoners address negative aspects of their behaviour and return to normal location as soon as possible. No force was used to relocate the man. He remained in segregation for 24 hours before returning to D wing.
60. On 18 October, prison doctor, Dr F, assessed the man after he had kicked his cell door and hurt his foot. On examination, the doctor recorded that there was slight bruising and tenderness, but the man had a full range of movement. He was prescribed pain relief and his foot was dressed with a support bandage. Healthcare Assistant, B, also saw the man the same day and completed further tests in relation to his stomach complaint. This included a blood test which, on this occasion, the man agreed to have. The following day he had his second session with the counsellor.
61. Nurse C spoke with the man again on 23 October, after he had asked to see her. He told her that he was feeling very low and re-iterated what he had told the Mental Health Nurse B previously about his medication not working. Nurse C recorded that she explained to him she was not a mental health nurse

and therefore was unable to offer further treatment. She also told him that she could see from the medical records that the mental health team had assessed him and they were dealing with his case. The man asked Nurse C if she was able to speed the mental health team along, but she explained that they were busy with a heavy workload and reassured him that they would see him soon. The nurse asked the man whether he had any thoughts of self-harm or suicide and he replied no to both.

62. After seeing the man, rather than making a referral to the GP, as she thought this might be confusing, Nurse C sent a task to the mental health team (a 'task' refers to an action on the electronic medical record allowing a user to send a request for something to be done, or a reminder to another member of the healthcare team. This task appears on the recipient's screen the next time they connect to the system). She explained to them that she had spoken with the man and that he had expressed concerns again about his medication.
63. The mental health team received the task sent by Nurse C the following day. Mental Health Nurse, C, recorded on the man's medical record that he had forwarded the task to Mental Health Nurse B as she was aware of the man's concerns around his medication and was delivering a short psychological course to assist him.
64. During the investigation, Mental Health Nurse B was asked what plans there were to deal with the man's medication concerns. She said that she was not keen to make radical medication adjustments unless she was in a position to monitor the patient regularly and she would prefer to see how they responded to therapy before making any changes. In his case, she had no significant concerns about depression and the plan was to maintain the fluoxetine, until he had been observed. The mental health nurse said that she felt that this was the best course of action as there are dangers associated with increasing or decreasing doses without proper monitoring.
65. During the morning of 25 October, prison doctor, Dr F reviewed the man and told him that the results of his tests were negative, but the blood results were still to be provided. During the consultation, the man asked the doctor about his medication and was told that she would task the mental health team to look at this. During the investigation, Mental Health Nurse B said that it was possible that a GP might choose to deal with such a request, but where the mental health team are involved this would be unlikely.
66. Later that day, the man was again re-located to the segregation unit as information had been received about possible assaults and plans to escape. The man is said to have made no complaints when he was taken to the segregation unit. He was told that he would remain there until 28 October, when he would be reviewed. Staff in the segregation unit said that the man was angry about being removed from the wing, but he told them that he did not hold them responsible and would not take it out on them.
67. Mental Health Nurse B was planning to see the man on 26 October, to begin her one to one sessions, but due to him being located in the segregation unit,

this was not possible. However, he was seen that day for a third time by the counsellor. Staff said that he was polite and well behaved while on the unit and gave them no cause for concern. He was seen daily by healthcare staff and reported no problems. When he was reviewed on 28 October, he disputed the allegation that he was planning a roof top protest, but is said to have accepted that he would remain in segregation until he could be transferred to another prison. He said that he had no concerns when asked and engaged well with the prison staff.

68. Segregation unit staff said that on 2 November, the man was no different from any other day. Staff spoke to him in the morning. They asked whether he wanted to use the shower and have the opportunity to use the exercise yard, he answered 'yes' to both. The investigator was told that the normal routine in the segregation unit was that staff would go to each cell, at around 8.00am, serve breakfast and ask if a prisoner required a shower or exercise. On a normal day, there would be three officers and a senior officer on duty in the unit. The morning would involve two staff and the senior officer completing adjudications and one officer patrolling the unit, facilitating showers and exercise where possible. Adjudication is the term given to an internal hearing into the breach of prison rules by a prisoner. There will normally be several hearings for different prisoners during the morning and the duty manager chairs them. In the majority of prisons, adjudications take place in the segregation unit.
69. Due to the number of adjudications that took place on the morning of 2 November, the man did not have the opportunity to take his shower. However, at 1.30pm, Officer A, unlocked his cell and escorted him downstairs to the shower room. The segregation unit at Bristol is on two floors, with the office upstairs and the shower room on the ground floor. Staff patrol both floors, but there are also closed circuit television (CCTV) monitors on both levels, which relay a constant picture to monitors in the unit office.
70. Officer A said that when he collected the man, he appeared the same as usual and was 'chatty' as they made their way downstairs. He said that the man was sitting on his bed fully clothed when he collected him and came straight out of his cell without hesitating.
71. The investigator asked whether there was a requirement for prisoners to be searched before going to the shower, and Officer A that this was not usual practice. He explained that prisoners are searched before leaving or entering the segregation unit and before going into disciplinary hearings, but they are not searched when collecting meals, using the telephone or before using the shower. He gave the man some clean underwear and shampoo, before locking him in the shower room.
72. The CCTV does not cover the inside of the shower room and staff do not constantly monitor a prisoner while they are inside. The investigator was told that previously, the shower room did not have a door fitted and this meant that a member of staff would have to stand outside the room while the prisoner showered. However, the prisoner had no privacy and it was not considered to be a good use of officer's time, so a door was fitted. There is a small window in

the door, large enough for an officer to observe the prisoner, but not so large that anyone walking past would have a clear view, to maintain the prisoner's dignity. Female staff work on and visit the unit daily.

73. The investigator asked Officer A how a prisoner would alert staff if they had finished in the shower room. He replied that two prisoners work as cleaners on the unit and usually the prisoner will call to them, as they are normally downstairs. They will then go to the office and tell staff. He said that staff would also go down to see if they have finished, but there is no set time given for them to take a shower.
74. Officers A and B went to collect the man from the shower at around 2.06pm. He had been in the shower area for 36 minutes. Officer A told the investigator that Officer B was going to deliver some paperwork to C wing, so he had asked if he could assist him unlocking the man on his way out.
75. Officer A explained that when collecting a prisoner from the shower, he would normally tap on the door before opening it and ask if they are finished. On this occasion, he said that when he looked through the observation window it was partially covered by a towel that had been placed over it. The officers immediately opened the door and discovered the man, fully clothed, hanging from the light fitting with a ligature made from a piece of torn bed sheet around his neck. Officer A said that the man's feet were several inches off the floor. He took hold of the man's body and lifted him up to release the pressure on the ligature and Officer B then cut the ligature using his cut-down tool. All uniformed staff carry a cut-down tool attached to their uniform.
76. The ligature was identified as a torn piece of bed sheet. During the investigation, the investigator viewed the shower area and it was apparent that the man would not have access to these items inside the shower room. As previously mentioned, he was not subject to a search before entering the shower room, therefore, we can only assume that he had taken the strip of torn sheet with him to the shower room.
77. Due to the restricted space inside the shower room, the officers moved the man to the corridor and checked for a pulse or signs of breathing. Officer A said that a cleaner was close by and he shouted to him to go and get other staff. By the time the other staff arrived, Officer A had started to perform chest compressions on the man.
78. The Senior Officer (SO) was in the unit office, discussing prisoners on the unit who needed to be reviewed, when the cleaner came upstairs and told them that staff needed help. She said that as she made her way downstairs, she pressed her personal alarm, as she was not sure at that point, what had happened. The personal alarm used by staff will alert the control room that they require assistance. Medical staff had also been alerted via both the radio and telephone.
79. The SO said that as she came downstairs, Officer B was getting out a resuscitation mask to begin mouth to mouth resuscitation on the man. (A

resuscitation mask is a piece of equipment that provides a barrier between the patient and the first aider, when performing mouth-to-mouth resuscitation.) She took the mask from Officer B and began to give breaths to the man while Officer B continued the chest compressions.

80. Staff Nurse F, the clinical manager for the Integrated Drug Treatment Services (IDTS) at Bristol was on C wing when she heard the general alarm for the segregation unit come over her radio. She said that this was followed by a code blue alarm. Most prisons use a coding system for medical emergencies, to indicate the type of problem and medical equipment that may be required. Code red indicates that a patient is bleeding and code blue that it is a respiratory problem or the patient is unconscious.
81. Nurse F said that she was concerned that the alarm was for the segregation unit and she decided to go there. Nurse G had already arrived by the time she got there and was continuing chest compressions while SO A was maintaining the man's airway. She added that a number of nursing staff were present by this time as the healthcare wing is attached to the segregation unit, separated only by a door. She took over the chest compressions and Nurse H took over maintaining the airway. She also asked whether an ambulance had been called and was told that it had been called following the first code blue call and was en route.
82. Nurse F said that chest compressions continued and were rotated amongst the nurses present and a prison doctor, Dr G. A defibrillator was placed on the man, but indicated no shock, so CPR continued. A defibrillator is a portable electronic device that delivers a controlled shock to a patient to enable the heart to regain a normal rhythm. The device will detect any heart activity and if none is present will indicate that no shock is possible.
83. Nursing staff continued the resuscitation attempts until the arrival of paramedics at 2.34pm, who took over the treatment with the aid of the prison nursing staff. Paramedics gave the man fluids and medication to try to restart his heart and eventually they detected a faint pulse. The paramedics transferred the man to the ambulance and took him to Bristol Royal Infirmary at 3.06pm, where treatment continued.
84. Immediately after the man had been taken to Bristol Royal Infirmary on 2 November, all staff who had been involved in treating him and who were present in the segregation unit, attended a 'hot debrief' chaired by Governor A. The purpose of the debrief was to allow staff to discuss the events and their concerns, if any. It also provided an opportunity to highlight immediate areas of concern in respect of procedures or handling of the incident.
85. Staff went to the man's cell and discovered a letter written to his children, in which he apologised for letting them down. There was also a bag of legal paperwork, with a note attached, asking staff to ensure that it was passed to his solicitor. During interviews, staff made no mention of the bedding being checked to confirm whether the sheets had been torn.

86. All prisoners in the segregation unit were spoken to and staff ensured that they were offered support if required. A review also took place of all prisoners subject to suicide and self-harm monitoring under the Assessment, Care in Custody, and Teamwork (ACCT) procedures. This is a requirement following a death in custody.
87. Once stabilised, the man was moved to the intensive treatment unit (ITU). He remained unconscious throughout. Prison staff had escorted him to hospital and two staff remained with him at all times. However, due to his condition, no restraints were used at any time. The hospital requested details of the man's next of kin, but were told by the prison that he had given no such details.
88. On 4 November, Officer C arrived at the hospital to take over escort duties from the staff who had been on duty overnight. Officer C said that he arrived at around 7.00am and after receiving a handover from the outgoing staff, he and his colleague took up positions beside the man's bed. He added that there was a nurse regularly checking on the man and checking the machinery to which he was attached. The man remained unconscious and unresponsive.
89. At around 10.00am, a nurse came into the room to speak to the officers. She told them that doctors had discussed the man and were considering withdrawing treatment. This was because they believed that the man was unlikely to recover as tests had indicated that he was brain dead. When a patient is considered 'brain dead' all treatment is usually withdrawn and cardiac death is allowed to occur.
90. Officer C spoke with the duty manager at the prison and told him about the decision to withdraw treatment. The officers then remained with the man until this had taken place and the hospital doctor pronounced him dead at 11.00am.

### **Actions following the man's death**

91. The man had provided no next of kin details when he went into custody. All prisoners are asked, on reception, to provide such details and/or a number and name of anyone they wished to be contacted in an emergency. However, they are not required to do so and might choose not to.
92. The man had not had contact with his family for a number of years and as a result, the prison's family liaison officer (FLO), Governor B spent around 24 hours contacting the police, solicitors and probation premises where the man had previously stayed, in an attempt to obtain an address.
93. Details were eventually obtained and Governor B made contact with the family and arranged to visit them on Monday 7 November. The family were shocked by his death, but said that they had not had any contact from him for many years. Governor B provided the family with information about the Coroner's inquest and this office's investigation. He also explained that financial assistance was available to the family to assist with funeral expenses.

94. Governor B remained in contact with the family and assisted in arrangements for the funeral. This took place on 22 November and Governor B attended.

## ISSUES

### Segregation

95. The investigator reviewed the documentation relating to the man's removal from the residential wings and relocation to the segregation unit, as well as the reasons for the decision. The man had a proven history of violence towards prison staff. In addition, the prison had received credible information on both occasions that he was involved in or planning some form of indiscipline, that might threaten the security of the prison. Therefore, we are satisfied that the decision to relocate him to the segregation unit was reasonable.
96. There is evidence that all the paperwork required when a prisoner is located in segregation was completed appropriately and that reviews of the man's situation were made in accordance with the policy. The segregation unit policy at Bristol was being adhered to and national requirements for the staffing and operation of segregation units were in place.

### Access to showers in segregation

97. Staff working in the segregation unit mentioned that it was a fast-paced environment, with requirements for various tasks to be completed throughout the day. The staff said that this would often lead to them losing track of time, as they would just go from one task to another.
98. When asked, the staff said that there was no set time for a prisoner to be given to take a shower, but it was usually around 15 to 20 minutes. When it was pointed out that the man had been in the shower room for a total of 36 minutes, all staff said that they were surprised by this and they had only thought it was, at most, 20 minutes.
99. It is our view that 36 minutes is an inordinately long time for a prisoner to be in a locked shower, particularly in a unit where many of the prisoners will be vulnerable in some way. The SO told the investigator that since the man's death, staff working in the segregation unit were more conscious of time and are required to check on prisoners in the shower area at ten minute intervals. While it is accepted that staff at Bristol have adopted these new working practices we make the following recommendation:

**The Governor should ensure that staff monitor prisoners using the shower in the segregation unit, at intervals of no longer than ten minutes and that the segregation unit policy is revised to reflect this requirement.**

### Mental health provision

100. The clinical reviewer particularly comments on the man's mental healthcare in his report. He says that the man had a history of mental health problems and was assessed by a number of clinicians at regular intervals. The clinicians were clear that they found no evidence of serious mental illness; that the man was not planning to harm himself and he did not feel suicidal. The assessment

by an experienced mental health nurse confirmed two ongoing problems, psychological distress from being in prison and symptoms of a chronic and complex PTSD. Treatment for both had been offered and accepted.

101. In relation to the man's medication, the clinical reviewer says that there were plans to review his medication as part of the ongoing treatment for his PTSD. However, the PTSD was an ongoing chronic issue that did not require emergency input, and to change medication alone without more formalised treatment could have led to deterioration in symptoms.

### **Response to medical emergency**

102. During the investigation, there were no concerns identified in relation to the response of officers and healthcare staff on 2 November. As the healthcare wing was separated from the segregation unit by a door, nursing staff were able to get to the man in a very short space of time and all emergency equipment was available. Emergency medical codes were also used effectively.
103. The clinical reviewer also says that in his opinion, there were no significant issues with the resuscitation, and the situation was 'well handled'. We agree.

### **Quality of clinical care provided**

104. The clinical reviewer says that he feels the care provided to the man compared extremely well and may have been better than that expected within the community. He explains that treatment for PTSD is difficult to access in the community. The level of assessment for the possibility of the man's mental health problems happened quickly and effectively.
105. No recommendations have been made in relation to the man's medical care or on healthcare provision at Bristol.

## CONCLUSION

106. The man had spent a significant time in custody prior to his recall to prison and it is documented that this had not been without its problems. He had a history of assaulting both prison and non-prison staff and an unwillingness to abide by prison rules. Due to this previous behaviour, he was transferred from Cardiff to Bristol to await his court case.
107. During the investigation, staff reported no problems with the man's behaviour on a day-to-day basis. However, they said information had been received that suggested his actions might have an impact on the security of the prison and this resulted in him being relocated to the segregation unit on two occasions. Although he was unhappy with this, he is said to have displayed no animosity towards staff.
108. The man engaged with the prison mental health team at Bristol, from an early stage and following assessment and counselling was arranged to help him deal with previous traumatic events in his life. In all his dealings with both mental health staff and primary care nurses, he always denied any thoughts of self-harm or suicide when he was asked explicitly about this.
109. The investigation concludes that, in all the circumstances, the man's actions on 2 November could not have been reasonably foreseen and that when he was discovered, staff carried out the emergency procedures appropriately. However, the investigation calls for better supervision arrangements for prisoners in the segregation shower area.

## RECOMMENDATIONS

**The Governor should ensure that staff monitor prisoners using the shower in the segregation unit, at intervals of no longer than ten minutes and that the segregation unit policy is revised to reflect this requirement.**

*The Prison Service partially accepted this recommendation and said:*

*Staff in the segregation unit will be vigilant and random checks will take place whilst prisoners are using the showers to ensure their well-being. Whilst a 10-minute timeframe has been stipulated, there are occasion's usually operational emergencies when this would be difficult.*