



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Bullington in January 2014**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Bullingdon in January 2014. He was 39 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care at Bullingdon. The prison cooperated fully with the investigation.

The man was charged with sexual offences and remanded to Bullingdon in August 2011. He was convicted in March 2012 and received an indeterminate sentence. He disclosed that he had been diagnosed with post traumatic stress disorder relating to past events as a soldier but was not identified as at risk of suicide or self-harm. His symptoms of flashbacks and nightmares continued throughout his time in prison and he received extensive psychological and psychiatric support. The clinical reviewer concludes that the standard of mental healthcare the man received exceeded that which he could have expected in the community.

The man began to cut and burn himself in 2012, which he said was a way of relieving his nightmares and to punish himself. After acts of self-harm, prison staff managed him under suicide and self-harm prevention procedures. The man consistently said he had no thoughts of killing himself and talked about plans for the future. He said he wanted to complete the sex offender treatment programme in order to understand his offending and explain it to his family. He had also applied to move to a therapeutic community at HMP Grendon. However, on the morning of 13 January, prisoners' cells were unlocked at about 8.00am and at 9.00am an officer found the man with a ligature around his neck in his cell. It was apparent that he had been dead for some hours and the staff rightly decided not to attempt resuscitation.

The man had seemed withdrawn in the days before his death, but a doctor did not consider he was depressed. An officer said that he had been concerned about the man, but was used to his changing moods and did not believe he needed to be monitored under suicide and self-harm prevention procedures. While some of the suicide and self-harm procedures could have been implemented more effectively, I am satisfied that the man was generally well supported at Bullingdon and it would have been very difficult to predict his actions or prevent his death. Although it did not affect the outcome for the man, I am concerned that officers do not check prisoners' wellbeing when unlocking their cells in the morning and that the control room did not request an ambulance immediately an emergency code was called.

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

October 2014

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SUMMARY

1. The man was charged with sexual offences and remanded to HMP Bullingdon on 29 August 2011. It was his first time in prison. He disclosed that he had been diagnosed with post-traumatic stress disorder (PTSD). He said that he had no thoughts of suicide or self-harm.
2. On 3 November, the man reported symptoms of PTSD and thoughts of self-harm. A nurse assessed that he was depressed and referred him to the mental health team and a GP. The GP considered that he was at significant risk of self-harm but did not start the suicide and self-harm prevention procedures. The man had weekly psychology sessions with the principal clinical psychologist to help manage his PTSD symptoms, as well as frequent reviews with the prison's consultant psychiatrist and community psychiatric nurses. After initially declining medication, he agreed to sedative drugs but did not always take them as prescribed.
3. In 2012, the man began to self-harm by cutting his eye and burning himself. He said this was a form of release from the flashbacks of events in the army associated with his PTSD, as well as a way of punishing himself. He said he did not intend to kill himself and he was taking part in the sex offender treatment programme to try to understand his offending and explain it to his family. He felt that suicide would cause too much upset, but occasionally spoke about eventually ending his life after he was released from prison. In June and October 2012, staff managed him under suicide and self-harm prevention procedures (known as ACCT) for short periods. After further acts of self-harm in April 2013, a psychologist initiated ACCT procedures and he was monitored for two weeks.
4. The man continued to attend regular sessions with the prison psychologist and completed the sex offender treatment programme in June 2013. A few weeks later, he was discharged from structured therapy and psychiatric reviews, but initially remained under the care of the mental health team. He applied for a transfer to HMP Grendon to continue treatment in a therapeutic community and a review panel concluded that this would be appropriate after he had been assessed for the healthy sex programme. Throughout the year, the man reported cycles of feeling well, then regressing to paranoia and anxiety. The prison psychiatrist prescribed quetiapine, an antipsychotic and sedative medication, but the man did not collect or take it regularly, partly because he found it difficult to be around people in the medication queue.
5. At approximately 9.00am on 13 January 2014, an officer found the man hanging from the window of his cell by a shoelace. Signs of rigor mortis, suggested that he had been dead for several hours. The officer radioed a code blue emergency. During a telephone call giving further details of the incident, the ambulance service overheard that rigor mortis was present and decided to recall the ambulance and air ambulance. Officers and nurses arrived promptly. Nurses assessed the man and were satisfied that he had been dead for some time and that resuscitation would not be possible.

6. The investigation found that the man received a high standard of mental health support over an extended period, with extensive psychological therapy, as well as supervision by a consultant psychiatrist and community psychiatric nurses. However, prison staff did not fully recognise his risk when he first arrived at Bullingdon and, later in his sentence, when he reported acts of self-harm, staff did not always the implement suicide and self-harm prevention procedures promptly. ACCT case reviews held in 2012 did not include mental health staff involved in the man's care and did not properly reflect his level of risk. Nevertheless, we consider that that the time of his death it would have been very difficult to have predicted or prevented the man's actions.
7. We are also concerned that it appears that the man had been dead for several hours before he was found and that officers do not check the wellbeing of prisoners when they unlock cells in the morning. While it would not have affected the outcome for the man, an ambulance was not called immediately an emergency code call was received and there appears to be some confusion about the process. This needs to be clarified to be compliant with national instructions.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Bullingdon, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
9. The investigator went to Bullingdon on 16 January 2014 and obtained copies of the man's prison and medical records. She interviewed 14 members of staff and two prisoners at Bullingdon in February and March. She informed, the deputy governor of the preliminary findings of the investigation.
10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer joined the investigator for some of the interviews.
11. We informed HM Coroner for Oxfordshire of the investigation and we have sent the Coroner a copy of this investigation report.
12. One of the Ombudsman's family liaison officers spoke to the man's wife to explain the investigation process. She had no specific issues for the investigation to consider.
13. The man's wife received a copy of the draft report. She did not identify any factual inaccuracies or issues.

HMP BULLINGDON

14. HMP Bullingdon opened in 1992. It is a training and local prison which holds up to 1,114 men and serves the courts of Oxfordshire and Berkshire. Healthcare services are provided by Virgin Healthcare and there are a minimum of two nurses on duty at all times, day and night.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons conducted an unannounced inspection of Bullingdon in July 2012. Inspectors reported that levels of self-harm were relatively low and staff made efforts to learn from serious incidents. Measures to support prisoners at risk of suicide and self-harm were good but there was a need for more consistency in case management and better attendance by staff from other disciplines. The inspectorate found that health services needed improvement and modernisation but mental health services were good. Many prisoners shared cells designed for one and there was insufficient purposeful activity.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the community who help ensure that prisoners are treated fairly and decently. In its most recent report, for 2012-2013, the Board commented that Bullingdon had a Good Samaritan support scheme with a rolling training programme for Listeners (prisoners who support other prisoners in distress). A prisoner safer custody assistant had also been appointed. Training for staff to act as assessors in suicide and self-harm prevention procedures was ongoing.

Previous deaths at Bullingdon

17. The man was the fourth of five prisoners at Bullingdon to die since January 2013 and the third self-inflicted death. There are no significant similarities between the circumstances of his death and those already investigated.

Assessment, Care in Custody and Teamwork (ACCT)

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

19. On 29 August 2011, the man was charged with sexual offences and remanded to HMP Bullingdon. It was his first time in prison. (The man was convicted on 1 March 2012.)
20. At his initial health screen at Bullingdon, the man told a nurse that he had been diagnosed with deep vein thrombosis and tinnitus. He said that he had no thoughts of suicide or self-harm, no mental health problems and had never received any psychiatric treatment. The nurse carried out a more detailed health assessment the next day and the man disclosed that he had previously received treatment for post-traumatic stress disorder (PTSD). He said he did not wish to be referred to the mental health team or need any additional support at that stage. He repeated that he had no thoughts of suicide or self-harm and had never tried to harm himself.
21. On 3 November, the man reported to the nurse that he was suffering from insomnia, flashbacks and low mood. The nurse assessed him using the patient health questionnaire. (PHQ is a diagnostic tool that measures the severity of symptoms of depression). The man told the nurse he thought he would be better off dead and said that he had thoughts of harming himself nearly every day. The man scored 24 on the PHQ scale, which indicated severe depression. The nurse therefore referred him to the mental health team and the GP. He did not begin ACCT procedures, despite what the man had told him.
22. One of Bullingdon's GPs, reviewed the man on 10 November. The man told the GP that he felt low and that he was coming to terms with losing his job as a soldier. He was also finding it hard to adjust to prison. He felt that he had two options – "leaving everyone", which he said he could not do, or getting help. The man refused to consider antidepressants at that point as he viewed taking medication as a sign of weakness, so the GP prescribed a five-day course of promethazine, a strong sedative used as a sleeping tablet. As the man had frequent thoughts that life was not worth living, the GP concluded that he was at significant risk of suicide and made a "semi-urgent" referral to the mental health team. She did not open an ACCT.
23. A community psychiatric nurse and nurse manager in the mental health team, assessed the man on 14 November. He told her that he had suffered flashbacks for about 18 months as well as panic attacks which usually occurred when he had nothing to occupy his time. He disclosed that, when he had been in the army, he had thought about putting himself in dangerous situations in which he might get killed, but he would not kill himself. The man said he was able to talk to his cell mate, who he got on well with and also had a military background. The community psychiatric nurse gave him information sheets about his conditions and referred him for psychological support.
24. After the community psychiatric nurse's referral, Bullingdon's principal clinical psychologist, had an initial consultation with the man on 24 November. The man said he did not have any suicidal thoughts and said he was keen to start

the sex offender treatment programme (SOTP). The clinical psychologist and the man discussed his background and agreed to meet for further therapeutic sessions to address his PTSD symptoms. After this meeting, they had weekly, hour long sessions.

2012

25. The clinical psychologist told the investigator that they did not speak very much about the man's offending as their focus was on strategies for managing his PTSD symptoms, which were mainly flashbacks and nightmares about his time as a soldier. He always told her that he would not kill himself as he wanted to make sense of his offending and be able to explain it to his family one day. He also spoke about his short and long term plans. However, at interview, the clinical psychologist said she felt that there had been significant things that the man would not disclose and he had great feelings of guilt but would not say what he felt guilty about. She thought this was partly because she was a civilian and he felt unable to tell her about events in the army that were confidential. She did not think the guilt was related to his offences. After one of their sessions, the clinical psychologist referred the man to a psychiatrist to review his medication.
26. A consultant psychiatrist at Bullingdon, assessed the man on 22 March 2012, as a result of the clinical psychologist's referral. (The man had not attended two earlier appointments in January.) The consultant psychiatrist found that he had significant symptoms of PTSD, with daily nightmares, flashbacks of disturbing images and chronically poor sleep. The man reluctantly accepted a prescription for paroxetine (used to treat depression and anxiety disorders).
27. The consultant psychiatrist told the investigator that he saw the man around a dozen times over an 18-month period. They did not discuss his offending but focussed mainly on his army life and post-traumatic stress. The man was sometimes vague about his war experiences but the consultant psychiatrist believed that they might have been linked to his offending. He always insisted that he might end up killing himself in the future but would not do so in prison as it would be upsetting for too many people and he eventually wanted to explain his offending to his family. The consultant psychiatrist said that some of the wing officers had previously been in the armed forces and were quite protective of the man.
28. On 16 April, the man told the clinical psychologist that he did not want to attend any further psychology sessions as he did not find them useful. The clinical psychologist offered to review him in a few weeks but he declined. She therefore discharged him from psychology support. She informed the consultant psychiatrist, who was due to see the man in May, that she was concerned about his mental health.
29. Many prisons operate a personal officer scheme to enable an appointed officer to develop more effective relationships with individual prisoners to help address their needs and act as a point of contact for advice and assistance. Throughout the man's time in prison, successive personal officers and other

staff frequently noted in his records that he had settled well, was a very good worker and mixed well with other prisoners. He had achieved enhanced status, the highest level in the prison's incentives and earned privileges scheme.

30. In April, owing to his PTSD, the man moved from working in the wing servery to a job as a wing cleaner. An entry in his records emphasised that the move was not a result of poor behaviour. During the evening of 2 May, officers recorded that the man had made an explosive device. (He later told a psychiatrist that he had inflated and burst a rubber glove.) The next day, he was moved to the segregation unit. The man went back to his wing during the afternoon of 4 May, but was taken back to the segregation unit a short time later as he had objected to a proposed move to a different spur. He had threatened to kill someone or set fire to his cell. He was charged with an offence under Prison Rules of using threatening, abusive or insulting words or behaviour.
31. During the disciplinary hearing on 5 May, the man apologised. He said that he was not trying to excuse his behaviour, but his medication was affecting him and causing problems. The charge was proven and his punishment was three days cellular confinement and loss of privileges. On the same day, while in the segregation unit, the man asked to see someone from the mental health team as he said he had not felt right since a change of medication. Later that day, he moved to the healthcare unit. He remained there until 16 May as there were no cells available on E wing after his period of cellular confinement ended.
32. At a review on 17 May, the man told the consultant psychiatrist that his anxiety had worsened and that the medication had not helped. He said that he had shut himself off socially, restricted his diet and inflicted pain as self-punishment. He regretted discharging himself from his psychology sessions. The consultant psychiatrist prescribed olanzapine (an antipsychotic) and referred the man to the clinical psychologist again, with a view to her resuming the psychology sessions.
33. The clinical psychologist began to see the man again on 28 May. Although the man reported that he felt a little more settled and, due to his medication, had fewer dreams, he said his main issue was self-harm. He said that he had started using incense sticks to burn his arm and around his eye. The clinical psychologist noticed that he had a scab next to his left eye. They discussed whether he would benefit from a single cell to reduce noise and the clinical psychologist completed an application form for this.
34. While an officer was supervising lunch on 7 June 2012, he noticed that the man had burned a number of patterns into both his arms and there were some fresh scabs. The officer opened an ACCT document and referred the man to the GP, who noted that the wounds were infected. During an ACCT assessment that afternoon, the man said that he had used a lighter to burn the designs on his arms as a form of release and self-punishment. He said that he had ongoing post-traumatic stress disorder, the noise on the wing had

made his tinnitus worse and he did not have any trainers to go running as a distraction and as a release. He added that he had no current thoughts of self-harm. At an ACCT review immediately after the assessment interview, staff assessed the man as low risk (despite the recent self-harm) and agreed that he should be observed at least once an hour. The caremap had a single action for the man to talk to staff and relieve stress. Management under this ACCT ended at a review on 14 June, attended by the man, the unit manager and a landing officer but no member of healthcare staff. It was recorded that he was settled.

35. The medical records show that the man continued to experience flashbacks and sleeplessness, as well as harming himself. The clinical psychologist held weekly psychology sessions with the man. The man said he found them useful but difficult because of the high emotional content. A community psychiatric nurse, also reviewed him frequently and he remained under the care of the consultant psychiatrist. In early August, the man moved to a single cell.
36. On 22 August, the clinical psychologist went to see the man in his cell after the sudden death (probable suicide) in the prison of a former cell mate. Although he was affected and distressed by this, he said he was coping by writing things down and talking to other prisoners. Later that month, the consultant psychiatrist stopped the man's olanzapine and replaced it with another antipsychotic, risperidone.
37. On 1 October, the man told the clinical psychologist that he had thoughts of harming himself by taking out his eyes because of increasing flashbacks about his experiences in the army. She noticed that one of the man's eyes was red and he explained that he had tried to detach his retina with a razor blade to take away the images, as a release and to punish himself for his offences. He said that he wanted to give up his job on the wing and isolate himself socially. The clinical psychologist discussed alternative coping strategies and initiated ACCT procedures. He was initially monitored hourly and staff were required to record three conversations a day. The next day, two Senior Officers and an Officer held a case review. There was no member of healthcare staff present. They noted that the man had no thoughts of suicide. He said he would try not to self-harm in the future, but agreed to use less severe methods if he felt the need to do so. At the end of the case review, the panel ended the ACCT monitoring.
38. On 4 October, the consultant psychiatrist concluded that the man's PTSD had worsened due to external stressors such as his psychological work and impending sentencing which was due in a few days. The man's personal officer noted on 9 October that he had been quiet for the last couple of weeks, possibly due to his forthcoming court hearing. He said that speaking to the man was hard, but he remained polite and although he worked well, he had given up his job in the lead up to his court hearing.
39. On 15 October, the man received an indeterminate sentence for public protection, with a minimum period to serve of 11½ years (which was

subsequently reduced to nine and a half years after an appeal). When he returned from court, a nurse assessed him. He told the nurse that he had expected a long sentence and was not worried. He said that he was relieved his trial was over. He had no concerns or thoughts of self-harm and was happy to go back to the wing. The man had given up his job just before his court hearing. After he was sentenced he wanted to work, so he again applied for a job serving meals on the wing and was subsequently made head server. Staff regarded him as an asset to the wing. They noted that he used his military training to organise and motivate his colleagues, who responded well to him. On 14 December, the man's PTSD symptoms deteriorated and he asked to be removed from duties in the servery.

2013

40. An entry in the man's records on 14 January 2013, noted that the clinical psychologist and a trainee forensic psychologist, had a meeting with the man about his anxiety around the sex offender treatment programme (SOTP). He felt he was just about coping and managed this by isolating himself as he did not like being around people. He commented that, although he had no intention of doing so, he was worried about the possibility of losing control and killing either a member of staff or another prisoner.
41. On 17 January, the community psychiatric nurse told wing staff that the man had not been collecting his medication regularly and it was important for him to take it. A Principal Officer agreed to tell officers to ensure that the man went to the healthcare centre each day to get his medication and that he had the medication he needed to take at night.
42. The man started the sex offender treatment programme on 11 February. His records show that initially he had been withdrawn on the course and only associated with a few other prisoners. He had used various coping strategies and settled down, but as the course progressed he found his strategies were less effective.
43. On 4 April, at an SOTP session, the trainee forensic psychologist noticed that the man had a bloodshot and swollen left eye. When she asked if he had self-harmed, he said that he tended to poke his eye with a pen or pencil to relieve his flashbacks. The trainee forensic psychologist began ACCT procedures, told wing staff and telephoned the mental health team to arrange for someone to see him that afternoon. (The man was taken to the accident and emergency department of a local hospital.) The man's ACCT observations were initially hourly. At his assessment interview, he said he had cut his eye with a razor blade and that his flashbacks were about seeing the death of other soldiers. He said that he had isolated himself as being around people was difficult and triggered his flashbacks.
44. A nurse, held the first ACCT case review on 5 April, in the inpatient unit of the healthcare centre. A wing officer, the community psychiatric nurse and two other healthcare staff attended. The man identified his problems as anxiety and sleeplessness and said that he was at his most vulnerable between

6.00pm and 9.00pm. The review assessed him as low risk. His caremap objectives were for the community psychiatric nurse to discuss the man's request for a change of medication with the GP and to arrange respite from the wing to give him some breathing space and reduce his anxiety level. It was agreed that he would remain as an inpatient for the weekend and the community psychiatric nurse would review him on Monday.

45. A custodial manager chaired the next case review on 11 April, which was attended by a prison psychologist and an SOTP facilitator. The man had stopped attending SOTP after his recent problems, but said he intended to rejoin the programme on 12 April. The review concluded that he was managing his PTSD well and using the available help. He said that he had no thoughts of suicide or self-harm and the review reduced his observations to three during the day, five at night and hourly between 6.00pm and 9.00pm, when his anxiety level was most high.
46. The same custodial manager held another ACCT review on 18 April, which two wing staff attended. The man said he was working hard to deal with his past. He had no thoughts of self-harm and agreed to ask staff for further support if he needed it. The ACCT was closed at this review. No healthcare staff were present. The man stopped taking his medication on 18 May and, in a review on 4 June, told the consultant psychiatrist that he felt better for it.
47. On 25 April, during a group SOTP session, the man told those present that he might seem agitated as he had stopped taking his antipsychotic medication without consulting the mental health team. His reason was that he wanted to go to HMP Grendon (a prison run as a therapeutic community) which would not accept him while he was taking antipsychotic medication. A group facilitator, advised him that he should stop his medication only under supervision and as part of a plan.
48. The man completed the SOTP core programme on 21 June. At a review with the community psychiatric nurse on 24 June, he said he felt more positive and looked forward to the next steps, including a transfer to HMP Grendon where he would be able to live in a therapeutic community to gain a better understanding of his offending behaviour. The man continued to have problems with his sleep as well as thoughts of self-harm but felt that to act on them would not change anything. The community psychiatric nurse agreed to continue fortnightly sessions with him.
49. The clinical psychologist discharged the man from structured psychological therapy on 8 July as he had completed a course of cognitive behaviour therapy, as well as SOTP. They agreed that another course of therapy would not be appropriate but more intensive therapy in a therapeutic community would be beneficial. In the meantime, the community psychiatric nurse would continue to support him.
50. A week later, on 15 July, the community psychiatric nurse noted that, although the man was still not sleeping, he appeared to be relaxed and said that he was managing his anxiety more positively. He asked to take a break from

therapy as he wanted to stop talking about everything and the community psychiatric nurse agreed to discuss this with the consultant psychiatrist. The next day, the man told the consultant psychiatrist that things were going quite well and he had found that doing the sex offender treatment programme had distracted him from his PTSD symptoms. He repeated his request to be discharged from the mental health team and said he did not wish to take any medication. The consultant psychiatrist noted that the man had no current thoughts of self-harm and he found no evidence of psychosis or major mood disorder. He agreed that it would be appropriate to discharge him. He later discussed this with the mental health team, who agreed and the man was discharged on 25 July.

51. On 21 August, the man asked to see the doctor as he wanted to be prescribed beta blockers (a medication used to treat anxiety as it counteracts the effects of adrenalin). The next day, wing staff were concerned about the man and asked the community psychiatric nurse to see him. He again asked for beta blockers and when the community psychiatric nurse explored the reasons, he said his anxiety levels were extremely high as he was uncertain about his future. In particular, he had been told different things about where he would move from Bullingdon. He understood there was a plan for Bullingdon to change its function to a category C prison. He said he worried about harming himself but said he would not do so and just needed to reduce his anxiety levels. The community psychiatric nurse offered the man an appointment with the consultant psychiatrist, which he declined. She agreed to speak to the consultant psychiatrist about the man's medication. After a discussion an hour later, the consultant psychiatrist prescribed propranolol (a beta blocker), to be collected daily.
52. On 17 October, as he had completed the SOTP, the man became eligible for transfer to another prison. On 1 November, the man's personal officer noted that he was waiting for the outcome of an application to Grendon.
53. The consultant psychiatrist reviewed the man's medications with him on 22 October. The man reported ongoing anxiety as well as difficulties with sleep and controlling his thoughts and emotions. The consultant psychiatrist prescribed a low dose of quetiapine (an antipsychotic). He explained to the investigator that the man did not have a psychotic illness but, in low doses, quetiapine is used as a sedative and anti-anxiety medication. He was able to keep it in his possession and use as and when he needed it.
54. On 18 November, the clinical psychologist noted in the man's medical record that a number of officers had reported concerns to her about the man's welfare. He had been forced to spend a lot of time in his cell because of the change of the prison's function. The prison was no longer going to hold convicted category B prisoners with medium to long sentences. As a result, category B prisoners, such as the man, were no longer allowed to have full-time jobs, which were reserved for category C prisoners. Officers had noted that he had become more quiet and withdrawn and was exercising more. In the past, these had been signs that his mental health was deteriorating and that he was at risk of self-harm. The officers did not request increased mental

health input but asked if there was anything the clinical psychologist could do to enable the man to be given work to keep him occupied and distract him.

55. The clinical psychologist raised the concerns with the man's offender supervisor (probation officer) at Bullingdon. She also discussed them with the mental health team and emailed the custodial manager and the offender categorisation and allocation (OCA) unit. The custodial manager responded that wing staff had managed to get the man on art classes to help occupy him and that they were waiting for two things – a manager to sign off a recommendation for his transfer to Grendon and his recategorisation form to be sent to the OCA. The custodial manager agreed to monitor the situation and asked to be reminded if nothing happened in the near future. A nurse recorded the clinical psychologist's request about finding the man a job in his medical records. The consultant psychiatrist told the investigator that he did not think the man himself was too concerned about not having a job as he preferred to be by himself in his cell, but this was probably bad for his mental health.
56. The next day, 19 November, the man told the consultant psychiatrist that he felt better and that the quetiapine had helped him feel calmer during the day and to sleep. He had been feeling increasing paranoia because of spending more time in his cell but this had improved since he had started art classes. The consultant psychiatrist noted that the man had no current intention of harming himself, but said he had visions of hanging himself at some time in the future, after he left prison.
57. The man's personal officer, noted on 20 November that he seemed to be in a better mood and hoped that his transfer to Grendon would address his issues. He added, "After recent entries will require close contact to ensure that he does nothing silly??" the officer told the investigator that he had been referring to rumours that the man had been getting into arguments with other prisoners. (There is no other record of any problems with other prisoners.)
58. During November a forensic psychologist, carried out a Structured Assessment of Risk and Need (SARN), a detailed risk assessment and needs analysis carried out after prisoners complete the sex offender treatment programme. One of the risk management recommendations was that the man should continue to comply with mental health services in addressing and managing his post-traumatic stress disorder. The report concluded that he should complete the healthy sex programme, another sex offender course and after that, transfer to Grendon. (The report was disclosed to the man on 14 December, who noted on it that he felt there was a lack of direction about addressing his future treatment needs for PTSD.)
59. The offender supervisor chaired a post-programme review on 17 December 2013, to assess the man's progress on the SOTP. The review panel concluded that he had successfully completed the course and should be assessed for the health sex programme. They noted that the offender supervisor had applied for him to transfer to HMP Grendon after the assessment to complete further work in a therapeutic community.

60. The consultant psychiatrist reviewed the man's medication again on 24 December. The man reported a consistent cycle of feeling all right for two weeks, then becoming paranoid and not sleeping for a few days. During the paranoid phase, he said he did not want to leave his cell or mix with others and did not pick up his medication as he could not bear to stand in the queue, (which had been the case in the previous week). He told the doctor he now felt better, was associating with others and had started to collect his medication again. He enjoyed his art classes and had increased his exercise to help him to sleep. He said his mood was not low and he had no thoughts of harming himself. He wanted to continue taking quetiapine. The consultant psychiatrist considered that he no longer needed to see the man routinely and discharged him to the care of the GP.
61. On Christmas Eve and Christmas Day, healthcare staff recorded that the man continued not picking up his medication and that this had been reported to the community psychiatric nurse. The nurse noted that, when he went to collect his medication on 26 December, she asked him about his prolonged absence. He would not tell her the reasons but said that the consultant psychiatrist was aware of them. The nurse advised the man that he should take his medication regularly and that if he could not face the queue in the morning, she could give it to him in the afternoon. She noted that he seemed happy with this.

2014

62. On 10 January 2014, the man's had an appointment with a doctor which he had requested because of discomfort from an injury from when he was in the army. The doctor prescribed naproxen and paracetamol (painkillers) and advised him to continue physiotherapy exercises. The doctor told the investigator that the man did not mention any concerns about self-harm. He had maintained good eye contact, was lucid and articulate and did not seem depressed. This was his last healthcare appointment.
63. On 11 January, the man's personal officer recorded that the man had recently been withdrawn. He noted that he was now able to transfer to another prison so might move to Grendon. The officer told the investigator that the man had seemed a little unusual and odd at the time and had stopped carrying out certain voluntary tasks. He had asked him why he had been so quiet and the man attributed this to tiredness. The officer said that, although he had been concerned about him, this did not warrant opening an ACCT. He said he was used to the man's moods changing.

Events on 13 January 2014

64. An operational support grade, was on duty on the night of 12/13 January. He told the investigator that he completed roll checks at 8.50pm and 5.00am and noticed nothing unusual. The OSG described the purpose of the roll checks as a head count of prisoners and said that he used a clicker to count each one.

65. A prisoner told the investigator that he was the man's closest friend at Bullingdon. He said that he had last seen him at around 12.00pm on Sunday, 12 January. He was aware that the man used to cut his eye because of nightmares and that he sometimes suffered from low mood, partly because of his lack of progression to Grendon and because he had not been re-categorised to category C. The prisoner said that he knew there was no roll check at 9.00pm on the evening before the man's death as he usually sat facing the door to wait for it. He did not recall a check at 5.00am, but accepted that he might have been asleep at the time. He noted that the man had not turned up to get his medication on the morning of 13 January, but had not been surprised about this as he knew that the man did not like taking it and would often do without it, if he could.
66. Another prisoner and friend of the man, recalled that he had last seen him just before they were locked up at around 4.00pm on Sunday afternoon. He said that he and the prisoner had had a cup of tea with the man. (Although the prisoner had said he had not seen him since 12.00pm.) Another prisoner had offered a pile of sci-fi magazines and the man took them. The other prisoner said that the man usually came to his cell each morning as soon as they were unlocked. When he did not appear on 13 January, he assumed that the man had felt low and had stayed in his cell.
67. The prisoner knew about the man's background and low moods. He said that the man had been concerned about his transfer to Grendon as he had received mixed messages. The prisoner understood that some of his paperwork had been lost and there appeared to be issues about the move. The prisoner also said that he was very sure that the 9.00pm roll check had not taken place. He thought that the 5.00am roll check might not have been done either as he was usually disturbed by staff turning on the cell light during the check. He said that when officers unlocked cells in the morning at 8.00am, some officers said good morning, but others, particular officers usually based on other wings, tended to just unlock the door without saying anything to them or getting a response.
68. An officer said he started unlocking prisoners at 8.00am to allow them to go to education or work. He said that he and another officer had unlocked the prisoners on E wing that morning. The officer had opened the man's cell and then went back to her own wing after she finished unlocking the cells. She told the investigator that she noticed nothing untoward when she opened the man's cell. The officer said that he would usually just unlock the cell door without speaking to the prisoner. After unlock that morning, he said that he spent the next hour helping prisoners with questions.
69. Another officer was also on duty. He was the veterans in custody officer and said that he had known the man in that capacity and had arranged for him to receive visits from an organisation that provided support to ex-forces staff and their families. The officer said that the man had been very helpful and had worked in trusted positions, but just before he died he had become reclusive.

The man had spoken to the officer about his experiences and shared with him a diary he had written about one of his tours of duty.

70. At 9.00am, another officer went to lock the cells of those who had no work or education to go to. He said that he would open the observation flap of each cell and push the door open to check whether the prisoners were inside before locking them in. When he reached the man's cell, (which was a single cell) the door was slightly ajar. He pushed it open and saw the man sitting on the radiator under the window next to the bed. He was facing the cell door, with a black cord (a shoelace) around his neck tied behind the curtain and he looked blue-grey.
71. The officer said he shouted to the other officer, who was at the other end of the wing. He then went into the cell, radioed a code blue emergency message (which indicates a prisoner is unconscious, not breathing or has breathing difficulties). He used his anti-ligature tool to cut the cord between the man and the window and lowered him to the floor. An officer said that the man's body was very stiff and cold. He cut the cord from around his neck and checked for signs of breathing, but there were none. He shouted again for the officer and then repeated his code blue message over the radio to be sure that it had been heard. When the officer arrived, he also checked the man, but found no signs of life. The officer said that his arm was stiff and locked at a 90 degree angle to his body. He made a third code blue call and a nurse arrived shortly afterwards.
72. The officer said that when he went into the cell, he intended to start cardiopulmonary resuscitation. However, as the man felt ice cold, stiff and rigor mortis appeared to have set in, he realised that it would be futile and left the cell when a nurse arrived. The officer thought that the man must have been dead for several hours. An SO, the custodial manager and the duty governor arrived shortly afterwards.
73. An officer was on duty in the communications room. He said that, at 9.01am, he received a code blue call. He did not immediately call an ambulance as he told the investigator that he could not hear the initial message very well because of poor transmission. Shortly afterwards he heard the code blue from the officer. He called an ambulance at 9.04am.
74. While an officer was seeking permission for an air ambulance to land, the ambulance despatch service overheard an SO mention over the radio that rigor mortis appeared to have set in. When they heard this, they said that they could not send an ambulance. The officer explained that the staff at the incident were not qualified to confirm or certify the death and no doctor was available, but the ambulance service advised him to telephone the police. A few minutes later, at 9.12am, staff called the police, who did not arrive until 10.56am. The custodial manager told the investigator the prison's protocol with the ambulance service is that an ambulance should attend if the prisoner has not been pronounced dead.

75. A nurse noted in the medical records that at around 9.03am, she had responded to a code blue call on E wing. She told the investigator that she had heard the call while she was on her way from the segregation unit to the outpatient unit. She ran into the unit and grabbed the red emergency bag, a defibrillator and a suction device. (A defibrillator is a life-saving device that analyses heart rhythm and automatically delivers electric shocks after a cardiac arrest when it determines there is a rhythm that is likely to respond.) When she arrived at the cell, the man was lying on his back on the floor with two officers kneeling beside him. The nurse said that she found no pulse or movement, his pupils were fixed and his tongue and lips were blue. She believed that the man was in a state of rigor mortis. Two more nurses arrived and the nurse cut the man's shirt to apply the defibrillator pads.
76. The nurse noted in the medical records that after the code blue message, she ran from the healthcare inpatient unit to the wing with her colleague, another nurse. When they got there, an officer told them that rigor mortis had set in. The nurse said that the man was cold and it was obvious that rigor mortis was present. They checked the man with the defibrillator which found no heart rhythm and established he had no blood pressure. The nurse opened the man's eyes and found that both pupils were fixed and dilated. The nurse found a clear bag in the man's pocket, containing a photo, a poppy and a suicide note.
77. At interview, the custodial manager said that she thought that nurses had attempted resuscitation, but she could not recall whether the nurse was performing chest compressions or using the defibrillator. None of the officers or nurses said they had attempted resuscitation and all were clear that it would have been futile as rigor mortis was present.
78. At 9.32am, a doctor arrived and certified the man dead. He told the investigator that doctors do not carry radios and an officer had asked him to attend the incident at around 9.20am. It took around two to three minutes for him to get to the cell. He said that he could tell instantly that the man had been dead for some time because of the pooling of blood around his body.

Contact with the man's family and next of kin

79. The man's wife was serving a prison sentence at the time of his death. At 12.00pm, one of the prison's family liaison officers, contacted his wife's prison to arrange for her to be told what had happened. At 12.30pm, another family liaison officer, went to break the news of the man's death to his nominated next of kin, an army captain and welfare officer in the man's former unit, but no one was at home. The family liaison officer therefore contacted the police, who agreed to visit him too. The army officer later telephoned the prison. The police offered to visit the man's mother, who lived in North Wales and, later that afternoon, confirmed that they had told her the news.
80. The man's wife decided to postpone the funeral until after she was released from prison in March and could arrange it herself. The prison offered to contribute to the funeral expenses in line with national guidance.

Support for staff and prisoners

81. The duty Governor held a debrief meeting for the staff involved in the emergency and the care team attended to offer support. No concerns were raised about the emergency response. He reminded staff of the support services available.
82. Wing officers reviewed all prisoners subject to suicide and self-harm prevention monitoring and implemented more frequent wellbeing checks in case they had been adversely affected by the news of the man's death. They reminded other prisoners of the availability of Listeners (prisoners trained by the Samaritans to help others suffering emotional distress) and they allowed the two prisoner friends of the man to sit in the single cell with the door unlocked.

Post-mortem report

83. The post-mortem report concluded that the cause of the man's death was hanging.

ISSUES

Clinical care

84. When the man arrived at Bullingdon, he disclosed that he had been diagnosed with PTSD, arising from events when he served in the army, but he declined a referral to the mental health team. At that stage, he also denied thoughts of suicide or self-harm. Just over two months later, he reported flashbacks, insomnia and low mood. A nurse diagnosed depression and referred him to the mental health team.
85. Throughout his time at Bullingdon, the man received extensive therapeutic support from the psychiatric and psychological teams, including frequent contact with a psychologist, consultant psychiatrist, community psychiatric nurse and the nurse manager. He also participated in the sex offender treatment programme. After initial reluctance, the man agreed to medication, but he did not always collect it or take it as prescribed.
86. The clinical reviewer concludes that the care that the man received at Bullingdon was equivalent to that he could have expected in the community and that the mental health resources were significantly above those available to similar patients in most GP practices. We are satisfied that the man clinical care, particularly his mental health care, was good.

Assessment and management of the man's risk of suicide and self-harm

87. PSI 64/2011, which covers safer custody and PSI 74/2011, Early Days in Custody both list a number of risk factors and triggers for suicide and self-harm. PSI 74/2011 notes that all staff should be alert to the increased risk of suicide/self-harm posed by prisoners in those categories and act appropriately to address any concerns. When he arrived at Bullingdon, the man had or was subject to a number of factors that were significant indicators of risk including, he was a remand prisoner; it was his first time in prison; early days in custody; he had been diagnosed with mental health problems; he had been accused of a violent offence against a family member and was subject to child protection measures. (He was subsequently diagnosed with severe depression, an additional indicator of risk.)
88. At both his initial health screens, the man told staff that he had no thoughts of suicide or self-harm. However, during the second screen, he disclosed that he had been diagnosed with PTSD but declined a referral to the mental health team or any other support.
89. The man had a range of risk factors which should have been considered carefully in the context of suicide and self-harm, but it is not apparent what weight, if any, was given to them. While it would have been very difficult to predict or prevent his actions and full consideration of all the risk factors in reception might still have concluded that he was not at serious risk, it is a concern that insufficient weight was given to his serious known risk factors.

There seems to have been a reliance on his personal presentation and his statements that he had no current thoughts of suicide and self-harm.

90. The man first reported thoughts of self-harm to a nurse in November 2011. The nurse assessed him, using a depression diagnostic tool which indicated severe depression but did not start ACCT monitoring. The man repeated those thoughts to a doctor a week later and she concluded that he was at significant risk of suicide, yet she did not start the suicide and self-harm prevention procedures either. On several occasions during his sentence, the man reported to staff that he had either harmed himself or had had thoughts of self-harm or suicide, but they did not open an ACCT document.
91. The man was managed under the ACCT suicide and self-harm prevention provisions on three occasions. He explained that he harmed himself to try and relieve his PTSD symptoms of nightmares and as a form of self-punishment. When asked about his intentions, he mostly said that he did not intend to commit suicide as he wished to learn about the reasons for his offending, to be able to explain it to his family and staff viewed this as a protective factor. Occasionally, he expressed thoughts of killing himself, but said he would not do it in prison. Mental health and wing staff helped him to develop coping and distraction strategies.
92. The man's most recent ACCT monitoring started on 4 April 2013. Two of the three case reviews were multidisciplinary, with representation from the mental health team and an SOTP facilitator. In view of the man's considerable mental health problems, it is a concern that those held for his previous periods of ACCT monitoring, in June and October 2012, had no consistent case manager and no input from the mental health team. Not all decisions about level of risk were soundly based and staff assessed him as low risk in spite of recent and continued self-harm. We recognise that a number of these issues were some time before the man's death and he had a lot of support outside the ACCT process, but the purpose of ACCT procedures is to include all those involved in the care of a person at risk and this did not always happen. We consider that at the time of his death there was little to indicate that the man was at increased risk. However, it is important that ACCT procedures operate effectively and in line with the national guidance. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Ensuring that reception staff consider all the known risk factors of a newly-arrived prisoner when determining his risk of suicide or self-harm;**
- **Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care, with a consistent case manager where possible;**
- **Opening an ACCT whenever there is evidence that a prisoner has self-harmed; and**
- **Considering all known risk factors when determining the level of risk of self-harm.**

Roll checks and unlocking cells

93. At Bullingdon, roll checks are carried out at 9.00pm and 5.00am. An operational support grade signed to say that he had conducted both checks that night, but told the investigator he recalled nothing untoward. The two prisoners were adamant that the 9.00pm check did not take place. There is no way of resolving the conflicting accounts of whether the roll checks were completed. As they are primarily a head count of prisoners and not carried out to establish their welfare, it is conceivable that the OSG counted him without realising the situation, particularly as he had died in a sitting position. It is also possible that the man hanged himself sometime after the 5.00am check.
94. Of greater concern is that a number of the officers we interviewed during the investigation said that, when they unlock cells in the morning, they quickly glance through the observation flap, unlock the door and move on to the next cell. They do not necessarily speak to prisoners or check their welfare. The two prisoners also said that this was usually the case, although they acknowledged that some officers would speak to them at that time.
95. For their own safety, officers are expected to make contact with a prisoner through the observation hatch before opening a locked cell door. When unlocking a cell they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead." We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency response

96. When the man was found hanging in his cell, the officer acted quickly. He called a colleague nearby and followed the procedures for reporting an emergency. The communications room did not hear the first code blue call clearly, but another message was sent almost immediately afterwards and an officer in the communications room called an ambulance immediately. During transmission of the details, the ambulance service overheard that rigor mortis was present and stood down the ambulance and air ambulance. The clinical review considers this was not an unreasonable decision and we agree.
97. It was clear to both wing staff and the nurse who attended the incident that the man was already dead as rigor mortis was present, therefore they did not attempt cardiopulmonary resuscitation. European Resuscitation Guidelines

2010 state that, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it would be futile ...” Although the custodial manager thought the nurses had attempted resuscitation, they had used a defibrillator and blood pressure machine only to check the man and did not administer cardiopulmonary resuscitation. We consider that this was an appropriate decision.

Emergency protocol

98. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.
99. Bullingdon issued a local emergency protocol on 29 May 2013 and the guidance is in line with the PSI. However, during her interview with the investigator, the custodial manager, the custodial manager who responded to the incident, said the procedure at Bullingdon is that the communications room waits for two minutes before calling an ambulance to give the operational manager and healthcare staff time to respond. The officer who was on duty in the communications room, said he was aware of this but said that the change had yet to be implemented and ambulances were still called automatically. However, we note that the first code blue was made at 9.01 and an ambulance was not called until 9.04am. Although the officer said that the first code blue call was indistinct he was aware it was a code blue and should have called an ambulance immediately. Evidently, this made no difference in the man’s case as he was already dead, but in other emergencies any delay can be crucial.
100. The PSI says that staff should not delay calling an ambulance and it should not be a requirement for healthcare staff or the duty manager to attend before doing so. We are concerned about the uncertainty about the current process and at the suggestion that there should be a delay of two minutes before calling an ambulance. This is not in line with the national instruction. We make the following recommendation:

The Governor should ensure, in line with PSI 03/2013, that all staff fully understand and adhere to the protocol for the use of emergency codes and that an ambulance is called automatically, immediately an emergency code is called.

RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Ensuring that reception staff consider all the known risk factors of a newly-arrived prisoner when determining his risk of suicide or self-harm;
 - Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care, with a consistent case manager where possible;
 - Opening an ACCT whenever there is evidence that a prisoner has self-harmed; and
 - Considering all known risk factors when determining the level of risk of self-harm.
2. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.
3. The Governor should ensure, in line with PSI 03/2013, that all staff fully understand and adhere to the protocol for the use of emergency codes and that an ambulance is called automatically, immediately an emergency code is called.

Action Plan
Action Plan – Updated 31st July 2014.

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<p>harmed; and</p> <ul style="list-style-type: none"> • Considering all known risk factors when determining the level of risk of self-harm. 		<p>make contact with those involved in the care of an at-risk prisoner and request their input in multi-disciplinary case reviews, to contribute (in person or in writing) to the case reviews, and ensure there are consistent case managers, wherever feasible.</p> <p>Staff were reminded through a NTS in July 2014 to open an ACCT when a prisoner self-harms or is deemed to be at risk of self-harm or suicide. The Safer Custody Team also re-issued a NTS in July 2014 regarding learning points and triggers for those at risk of suicide or self harm</p>		

<p>2 . The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.</p>	<p>Accepted</p>	<p>A NTS was issued in July 2014, regarding the requirement to conduct safety checks on all prisoners who are unlocked. Residential</p>	<p>Complete.</p> <p>Head of Safer Custody</p>
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Action Plan
Action Plan – Updated 31st July 2014.

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
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Custodial Managers have reinforced and briefed all residential officers of the importance of receiving a response from prisoners when locking and unlocking

3	The Governor should ensure, in line with PSI 03/2013, that all staff fully understand and adhere to the protocol for the use of emergency codes and that an ambulance is called automatically, immediately an emergency code is called.	Accepted	A NTS was re-issued, July 2014, reminding staff of the protocol for the use of emergency codes, which requires staff in the communications room to call an ambulance immediately when an emergency code is used. A laminated copy of the medical emergency protocol is situated prominently in the prison for all control room operatives reminding them of the protocol.	Complete Head of Safer Custody	
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