

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Spriggs a prisoner at HMP Bristol on 28 November 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

On 21 November, staff found Mr Graham Spriggs hanged in his cell. He died in hospital on 28 November. He was 47 years old. I offer my condolences to Mr Spriggs' family and friends.

Mr Spriggs was a challenging prisoner and he was clearly frustrated by his lack of progress through the system. His behaviour led to him being transferred from the segregation unit at HMP Channings Wood to the segregation unit at HMP Bristol, but his behaviour continued to deteriorate.

Only once following his conviction had Mr Spriggs ever been identified as at risk of suicide and self-harm during his sixteen years in prison, and there was no indication that he was at high risk of suicide in the days before he took his life. However, prison staff did not review Mr Spriggs when he was segregated at Bristol, as was required. While it was reasonable for safety reasons that staff denied Mr Spriggs access to a Listener when he asked to see one, they should have allowed him access to the Samaritans' telephone. There was a delay in calling an ambulance after Mr Spriggs was found hanged, an issue I have raised in two previous investigations into deaths at the prison.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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Summary

Events

1. Mr Graham Spriggs was convicted of murder in 2000. He was monitored under ACCT suicide and self harm prevention procedures for 24 hours following his conviction. He did not have a history of self-harm and never expressed any thoughts of suicide or self-harm. On 13 November 2017, Mr Spriggs was moved from the segregation unit at HMP Channings Wood to the segregation unit at HMP Bristol due to his disruptive behaviour.
2. At Bristol, Mr Spriggs initially interacted with staff and behaved appropriately. His behaviour deteriorated significantly after a disciplinary hearing on 19 November. He threatened staff with violence, was restrained and placed under a three officer unlock protocol.
3. Over the next couple of days, Mr Spriggs' behaviour remained poor, but deteriorated no further. At 6.48pm on 21 November, an officer found Mr Spriggs hanged in his cell. Staff and paramedics resuscitated him. He was taken to hospital, where he died on 28 November.

Findings

4. We are satisfied that it was reasonable for staff at Bristol to conclude that Mr Spriggs was not at risk of suicide or self-harm.
5. When Mr Spriggs was transferred to Bristol's segregation unit, no one reviewed whether he should continue to be segregated, as was required. This was a missed opportunity to review Mr Spriggs' needs and risks and to plan for the future.
6. Given his behaviour, it was reasonable that staff denied Mr Spriggs access to a Listener in the segregation unit. They should however have offered him an alternative source of support such as use of the Samaritans' telephone.
7. Mr Spriggs was subject to a three officer unlock protocol at the time he hanged himself and had previously threatened staff with violence. While we would generally expect staff to go into a cell as soon as possible, it was reasonable in these circumstances that the officer who found Mr Spriggs hanged waited for the required number of staff to arrive before going into his cell.
8. There was a delay in officers calling an ambulance after Mr Spriggs was found hanged. We have twice made recommendations to Bristol about this and repeat our concerns.

Recommendations

- The Governor and Head of Healthcare should ensure that prisoners held in segregated conditions are managed in line with PSO 1700, that reasons for segregation are appropriate to prisoners' circumstances, and are reviewed within 24 hours of arriving from another prison's segregation unit.

- The Governor should ensure that if a prisoner wants to see a Listener but there are concerns that safety cannot be guaranteed, staff promptly provide alternative sources of support such as access to the Samaritans' telephone.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that control room staff call an ambulance as soon as an emergency code is called.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Spriggs' prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Spriggs' clinical care at the prison.
12. The investigator interviewed seventeen members of staff, some jointly with the clinical reviewer.
13. We informed HM Coroner for Avon of the investigation and have sent her a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Spriggs' mother to explain the investigation. Mr Spriggs' mother asked what support her son received from mental health services, whether he was being monitored under suicide and self-harm prevention procedures and why he was transferred to Bristol.
15. Mr Spriggs' parents received a copy of the initial report. They did not highlight any factual inaccuracies, ahead of the report being finalised.

Background Information

HMP Bristol

16. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health provides primary healthcare and Hanham Health Services provides GP services. Avon and Wiltshire Partnership provides mental health and psychosocial substance misuse services and Bristol Community Health provides clinical substance misuse services. Bristol does not have a separate healthcare unit, but does have a reintegration unit, known as the Brunel Unit, for prisoners with complex mental health and physical needs.

HM Inspectorate of Prisons

17. At the most recent inspection of Bristol in October 2014, inspectors found that mental health provision was very good, delivering high-quality mental health care and that the Brunel Unit offered a therapeutic environment for prisoners with enduring mental health problems. Inspectors reported that relationships between staff and prisoners in the segregation unit were good, but record keeping had deteriorated since the last inspection and entries in prisoner files did not reflect much of the good work of staff. Inspectors reported that overall monitoring of the segregation unit had slipped since their last inspection.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to July 2016, the IMB said that the physical environment of the segregation unit was not fit for purpose due to vandalism.

Previous deaths at HMP Bristol

19. Mr Spriggs was the seventh prisoner to die at Bristol since January 2015, and the fifth to take his life. In two investigations, Bristol accepted our recommendations to address the delay in calling an ambulance.

Assessment, Care in Custody and Teamwork (ACCT)

20. PSI 64/2011 sets out how staff should manage prisoners whose behaviour is so challenging and disruptive that they need additional case management to manage their risk of harm to themselves, to and/or from others. A manager oversees the enhanced ACCT case management process and ensures a higher level of co-ordination between the different teams involved in the prisoner's care.

Key Events

Background

21. In September 2000, Mr Spriggs was convicted of murder and remanded to HMP Manchester. Staff very briefly monitored him under suicide and self-harm prevention procedures, known as ACCT. In July 2001, Mr Spriggs received a life sentence, with a requirement to serve a minimum period of 12 years before the Parole Board could consider whether to release him on licence. He had been in prison several times before.
22. Over the following years, Mr Spriggs progressed through the prison system, completing necessary rehabilitation courses and, in June 2013, he was transferred to HMP Sudbury, an open prison, as a category D prisoner. In November 2013, he absconded from prison, was re-categorised as a category C prisoner and returned to closed conditions at HMP Nottingham. At a routine health screen, a nurse noted that he had no recent history of substance misuse and that he denied any thoughts of suicide or self-harm. A GP later prescribed tramadol, an opiate based pain killer, for hip pain.
23. During the spring and summer of 2014, Mr Spriggs received regular support from the mental health team after he told them he had mild depression. He received support from the substance misuse team after he said he was taking illicit substances. Mr Spriggs tested positive for subutex, an opiate substitute used to manage those withdrawing from heroin, and staff concluded he had developed an opiate dependence. Mr Spriggs started a methadone stabilisation programme. On 6 October, healthcare staff diagnosed him with mild depression and gave him antidepressants.
24. On 14 August, staff told Mr Spriggs that the Parole Board had rejected his application to return to open conditions and had asked for him to have a full psychological risk assessment.
25. On 31 October, Mr Spriggs was transferred to HMP Channings Wood. At a routine health screen, a nurse noted Mr Spriggs denied thoughts of suicide and self-harm. Two weeks later, he told a nurse that it had been a blow to lose his category D status and he was finding it difficult to accept that his application for release had been rejected. A psychiatrist found no evidence of psychosis.
26. The psychological assessment was completed for the Parole Board in June 2015. It concluded that Mr Spriggs was not ready for release on licence and suggested he move to HMP Warren Hill to take part in the Psychologically-Informed, Planned Environment (PIPE) programme, which aimed to improve prisoners' psychological, social and physical well being. Mr Spriggs was aggrieved by the findings as he considered he had achieved what was required of him.
27. A prison psychiatrist assessed Mr Spriggs twice in September. He concluded that Mr Spriggs displayed no psychotic symptoms, but had a dissociative personality disorder and social phobia. The psychiatrist changed Mr Spriggs' antidepressants and noted that he denied thoughts of suicide and self-harm.

28. On 20 November, a member of the prison's substance misuse team reviewed Mr Spriggs' methadone maintenance programme. They told him that they would reduce his methadone from January 2016. Mr Spriggs said he did not want to take part in any drug recovery work, and that he would use illicit drugs when his detoxification ended.
29. In January 2016, a psychiatrist reviewed Mr Spriggs. He noted that Mr Spriggs remained anxious, spent most of his time in his cell, avoided social situations and saw no prospect of release. The psychiatrist referred him for psychological support and noted that Mr Spriggs had no thoughts of suicide or self-harm.
30. On 4 March, a psychologist assessed Mr Spriggs, noted his resistance to cognitive behavioural work and said his low mood was because he was serving a life sentence. Over the following months, Mr Spriggs received regular support from the psychologist, and it was noted that Mr Spriggs sometimes appeared irritable and agitated during these meetings.
31. On 5 May, a psychiatrist reviewed Mr Spriggs, and noted his continuing social anxiety. Mr Spriggs said he was worried that his anxiety would turn to anger and that he would "blow up". He said he was unhappy that officers did not leave him alone and that as he became less bothered about his future, his risk of aggression increased. The psychiatrist noted that Mr Spriggs appeared disgruntled rather than depressed, found fault with aspects of his mental health care and was demanding of solutions, but dismissive of suggestions for progress.
32. On 9 June, Mr Spriggs told the psychologist that he no longer wanted to see him and was hoping for a move to Warren Hill to take part in the PIPE programme.
33. On 12 and 13 July, Mr Spriggs spent two days in the segregation unit. He told a mental health nurse that he was not happy with his methadone reduction programme and had "difficulties" with everyday life. The nurse referred him to the substance misuse team. A nurse from the substance misuse team saw him the next day and assessed that there was no evidence of substance withdrawal.
34. On 10 August, the Head of Residence chaired a multidisciplinary review to allow Mr Spriggs to talk about his perceived lack of progression, expectations of staff and to discuss how they could support him in future. Mr Spriggs' offender supervisor and representatives from the mental health and substance misuse teams attended. Mr Spriggs was told it might take three months to be transferred to Warren Hill. He expressed frustration at still being in prison and said the healthcare team did not listen to him. Mr Spriggs denied thoughts of suicide and self-harm.
35. Until April 2016, Mr Spriggs, for the most part, caused few concerns, worked and was compliant with the prison's regime but his behaviour slowly deteriorated between April and November 2016. He faced prison disciplinary proceedings nine times, mainly for threatening staff.
36. On 10 November, the substance misuse team reviewed Mr Spriggs' methadone detoxification regime. Mr Spriggs said he had no substance related concerns, but wanted to swap his methadone to subutex, another drug used for opiate withdrawal. An officer noted that Mr Spriggs was frustrated that he had not heard

about his transfer to Warren Hill, was not doing any psychological work and did not want to be supported by the mental health team.

37. On 11 November, Mr Spriggs' behaviour deteriorated. The Head of Residence noted he was disruptive, unpredictable and was doing all he could to be transferred from Channings Wood. It was noted that it was unlikely that his request for a transfer to Warren Hill would be accepted because of his behaviour. An officer spoke to Mr Spriggs about his behaviour. The officer noted he was threatening, and said that the next time his cell door was opened he would assault an officer with weapons and boiling water. He noted that no amount of reasoning could calm Mr Spriggs.
38. Later that afternoon, the offender supervisor discussed Mr Spriggs' behaviour with his offender manager. She agreed with him that Mr Spriggs' deteriorating behaviour and the risk he posed to staff was incompatible with him being in a category C prison.
39. Mr Spriggs refused an order to move to the prison's segregation unit. When he was later taken to the segregation unit, he used abusive language and threatened violence against an officer. He was charged for his behaviour under prison disciplinary procedures. (Although Channings Wood did not provide paperwork about Mr Spriggs' segregation, they confirmed that he was segregated under Rule 53, pending a prison disciplinary hearing.)
40. On the morning of 12 November, Mr Spriggs refused to attend for his prison disciplinary hearings and they were adjourned. At approximately 5.00pm, due to his improved behaviour, an officer gave Mr Spriggs a kettle. He later refused to engage with staff when he learnt that the kettle did not work and could not be replaced immediately.
41. On 13 November, Mr Spriggs' negative behaviour continued, he threatened to kill an officer and try to stab him in the eye. Despite staff efforts to de-escalate his behaviour, Mr Spriggs incited other prisoners to start a dirty protest. He told staff that if he was given his lunch, he would throw it at them and would take a member of staff hostage.
42. At 12.05pm, staff used control and restraint techniques to remove Mr Spriggs from his cell after he had damaged it. He was put in special accommodation (a cell with no furniture in it). That afternoon, he settled and started to interact with staff. A healthcare assistant noted that Mr Spriggs was given his medication and had sustained minor injuries to his knee and finger. Mr Spriggs told him his mental health was suffering, but he was able to control himself. He denied any thoughts of suicide and self-harm. The healthcare assistant noted that he was going to refer Mr Spriggs to the mental health team, but did not as Mr Spriggs was due to move to Bristol. At around 2.30pm, Mr Spriggs was given a meal, but declined to have a chair in his cell as he said he preferred to sit on the floor.
43. Because of his unacceptable behaviour (threats to staff and inciting other offenders), Mr Spriggs was re-categorised from a category C to a category B prisoner. At 3.20pm, four officers in protective personal equipment removed him from the special accommodation and he was transferred to Bristol.

HMP Bristol

44. There were no issues with Mr Spriggs during the transfer. When he arrived at Bristol at 6.20pm, he told a Supervising Officer (SO) in reception that he wanted to go to the segregation unit as he felt more comfortable there. Mr Spriggs said he hoped to move to another prison soon to get on with his sentence and sort himself out. Officers noted that Mr Spriggs was compliant, calm, polite and respectful.
45. Mr Spriggs was segregated under Prison Rule 53, pending a prison disciplinary hearing for a number of charges for his behaviour at Channings Wood. His segregation was authorised by the Head of Operations.
46. Mr Spriggs refused to be assessed by a nurse but said he had no concerns apart from an injury to his right hand, which he said happened when he was restrained earlier that day. She told Mr Spriggs she would book him in for a review of his hand the next day. Another nurse gave Mr Spriggs his medication and assessed that there was no medical reason why he could not be segregated. (While the prison was unable to find a copy of the assessment, he confirmed he had completed one.)
47. On 14 November, a GP reviewed Mr Spriggs. He raised no concerns, but wanted reassurance that he would get his medications. A member of the substance misuse team was unable to assess Mr Spriggs as an officer had told him that it was not an appropriate time. (It is not clear from the medical records why Mr Spriggs could not be assessed.)
48. The Head of Safer Custody and Equalities spoke to Mr Spriggs. He told her why he was transferred to Bristol and that things had been going “downhill” at Channings Wood for a while. They discussed how his transfer was an opportunity for a fresh start and Mr Spriggs said that he understood why he had been segregated. She asked Mr Spriggs if he wanted to see the mental health team. Mr Spriggs said he was not bothered either way, but was happy to have a chat. She referred him to the mental health team.
49. A mental health nurse noted that Mr Spriggs had been referred to the mental health team and that Mr Spriggs had a personality disorder. He was due to be discussed at the team’s next meeting. An officer noted that Mr Spriggs had raised no concerns with staff, was quiet and polite.
50. On 16 November, a GP noted that Mr Spriggs was vague and said he had been diagnosed with lots of ‘disorders’ and had bad thoughts. The GP noted that Mr Spriggs was smiling and pleasant throughout, displayed no evidence of acute mental health issues and had been referred to the prison’s mental health team. Later that afternoon, Mr Spriggs spoke to his parents by telephone.
51. On 17 November, a governor noted that Mr Spriggs was relaxed and friendly. That afternoon, he refused to return to one of the prison main wings and was charged under prison disciplinary proceedings. A mental health nurse assessed that there was no medical reason why he should not continue to be segregated.
52. In the afternoon, a worker from the prison’s substance misuse team assessed Mr Spriggs, who told him about his anti-social personality disorder and his

methadone reduction programme. Mr Spriggs said he was concerned that his methadone prescription had been reduced too quickly. He did not identify any withdrawal symptoms and Mr Spriggs denied thoughts of suicide or self-harm. During the assessment a mental health nurse told Mr Spriggs he would have a mental health assessment in the near future.

53. Later that afternoon, Mr Spriggs was relocated to the prison's Brunel Unit, a wing adjacent to the segregation unit, used for prisoners with severe mental health or disability issues as his cell in the segregation unit was needed for another prisoner.
54. On 18 November, an officer noted that Mr Spriggs continued to be polite and adhered to the wing's regime. In the afternoon, Mr Spriggs spoke to his mother on the telephone. The investigator listened to these calls, which did not suggest he was at risk of self harm.
55. On the morning of 19 November, the Head of Safer Custody & Equalities chaired Mr Spriggs' prison disciplinary hearing. She adjourned one of the charges from Channings Wood so that more evidence could be gathered. She did not proceed with two of the other charges. Mr Spriggs pleaded guilty to a further charge for refusing to return to normal location a few days earlier at Bristol.
56. After the hearings, the Head explained to Mr Spriggs that his cell in the Brunel Unit was needed for another prisoner, and he was asked to move to a cell on a standard wing. Mr Spriggs refused to move. She said that he became agitated, raised his voice, became verbally threatening and said he would have to be segregated. As Mr Spriggs left the room, he picked up a chair and threatened an officer with it. She called for help and Mr Spriggs was escorted to a cell in the segregation unit to calm down. Soon afterwards, Mr Spriggs started to damage his cell by kicking at the sink and taps. Officers went into the cell and restrained him, preventing him from causing further damage. He was moved to an adjacent cell without furniture. Mr Spriggs co-operated, calmed down, and allowed officers to search him.
57. A nurse assessed Mr Spriggs, and concluded that there was no reason why he should not be segregated.
58. Because of his behaviour and physical threats to staff, Mr Spriggs was put on an unlock protocol (which meant that he could not be unlocked unless three officers were present). Mr Spriggs was charged with threatening behaviour. The Head and other members of staff tried to interact with Mr Spriggs that day but he continued to threaten them.
59. That evening, Mr Spriggs accused an officer of terrorising him and asked to speak to a Listener (a prisoner trained by Samaritans to support other prisoners in distress). A custodial manager who was present told Mr Spriggs that he could not see a Listener until he had calmed down. The manager said he made a risk assessment and did not consider that it was safe for Mr Spriggs to see a Listener, but that he would consider it further once his behaviour had improved. (Mr Spriggs never saw a Listener and was not offered the use of the Samaritans phone.)

60. On 20 November, segregation unit staff noted that Mr Spriggs was quiet and polite and co-operated with his unlock protocol. In the afternoon, he cleaned his cell, showered, took some exercise and telephoned his parents. An officer noted in Mr Spriggs' case history that there was "no... moving forward" and that Mr Spriggs had made further violent threats to damage his cell. The officer noted that he thought Mr Sprigg's intention was to play staff against each other.
61. Later in the afternoon, the Head of Safer Custody & Equalities spoke to Mr Spriggs, who was lying on his bed listening to his radio. Mr Spriggs told her he did not want to speak, but said he was fine and that she was not to worry about him. She noted that Mr Spriggs was calmer, had received some of his personal property and was engaging better with staff. She concluded that his unlock protocol could gradually be relaxed.

21 November

62. At 9.17am on 21 November, a prison GP spoke to Mr Spriggs through his cell door. Mr Spriggs told her he was anxious and not sleeping well. She again referred Mr Spriggs to be reviewed by the mental health team.
63. Officer A noted that Mr Spriggs had stayed in his cell all morning, lying on his bed, and that his behaviour had generally been poor. Mr Spriggs told Mr Spriggs took his lunch, but according to Officer B was reluctant to interact with staff.
64. At 3.43pm, a nurse from the mental health team noted in Mr Spriggs' medical record that she had been asked to assess him and planned to do so on 24 November.
65. At 5.23pm, Officer C noted that, although Mr Spriggs had had a quiet morning, the rest of his day had been poor. He noted that staff were not safe around Mr Spriggs because of the possibility he might assault one of them. He noted that Mr Spriggs did not receive his evening meal as he failed to comply with his unlock protocol and that he also refused to take his medication.
66. The duty governor noted that when he visited the segregation unit, Mr Spriggs refused to interact with him and was dismissive of Officer A.
67. At around 6.05pm, Officer A checked on Mr Spriggs as he was about to finish work. Mr Spriggs had blocked his cell observation panel and did not respond when spoken to. The officer told his colleagues and left the unit with Officer B to look through Mr Spriggs' cell from the outside. Shining a torch through the window, they saw Mr Spriggs lying on his bed, apparently asleep. The officers tapped on the window to wake Mr Spriggs, who was annoyed and jumped out of bed. The officers returned to the wing and, with other officers present, Officer A opened the cell door and removed the obstruction from the observation panel. Officer B said that Mr Spriggs was abusive and threatening and did not want to listen to the officers when they told him that removing the blockage was for his welfare.
68. At around 6.25pm, Officer B returned to Mr Spriggs' cell as he could hear banging. The officer spoke to Mr Spriggs through the door. Mr Spriggs was irate and shouting abuse at the officer, saying that "you are all fuck" and "I'm going to get you sacked". He said he left the cell and planned to return a little later.

69. Officer C returned at around 6.48pm. The officer shone his torch through the observation panel and saw Mr Spriggs hanging from the window by a bed sheet, with his feet touching the floor. The officer called a code blue and pressed the general alarm, but did not go into the cell.
70. A nurse arrived within 15 seconds of the alarm being raised and Officer B told her that Mr Spriggs was hanging. She told the officer that they needed to go into the cell, but the officer said they had to wait until other officers had arrived due to Mr Spriggs' unlock protocol. Another nurse also responded. Officer D arrived around 20 seconds after the second nurse, but the officers did not go into the cell. Officer D said he radioed for further assistance and for an ambulance to be called. (South Western Ambulance Service records show that the ambulance was called at 6.51pm.) At 6.49pm, Officer B unlocked the cell door when he heard further officers responding, including a further officer. This was approximately one minute and twenty seconds after he had first arrived at the cell. They went into the cell.
71. Officer B held Mr Spriggs while Officer D tried to cut the ligature but due to its thickness, the officers had to untie it. Mr Spriggs was taken onto the landing and a nurse started cardiopulmonary resuscitation, assisted by other healthcare staff.
72. At 7.03pm, paramedics arrived. They administered emergency treatment, re-established Mr Spriggs' pulse and took him to hospital at 7.50pm, where he died on 28 November.

Contact with Mr Spriggs' family

73. An officer was appointed as Bristol's family liaison officer. At 8.00pm, the Head of Corporate Services told Mr Spriggs' parents that their son had been found hanging in his cell and had been taken to hospital. Support was offered to Mr Spriggs' parents and, after his death, the prison offered to contribute to Mr Spriggs' funeral in line with national instructions. Mr Spriggs' family were positive about the support they received from the prison.

Support for prisoners and staff

74. A custodial manager in the Operations Department debriefed officers and healthcare staff. Staff notified prisoners of Mr Spriggs' death, and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Spriggs' death had affected them.

Post mortem examination

75. The results of the post-mortem examination said that Mr Spriggs' cause of death was hypoxic-ischaemic brain injury, pneumonia and cardio-respiratory arrest as a consequence of compression of the neck due to suspension by ligature. Toxicology tests detected levels of Mr Spriggs' prescription drugs which were consistent with therapeutic use.

Findings

Assessment of risk

76. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. The PSI lists a number of risk factors and potential triggers for suicide and self-harm. Staff should continually assess prisoners' risk of suicide and self-harm and be alert to increased risk and address any concerns, including starting ACCT monitoring, if necessary.
77. Mr Spriggs arrived with some risk factors, including hopelessness, substance misuse, mental illness, personality disorder and negative Parole Board findings. Despite this, he had never self-harmed during his sixteen years in prison and he denied thoughts of self-harm during his time at Bristol. No member of staff who came into contact with Mr Spriggs during his short time at Bristol had reason to consider that he was at risk. We are satisfied that it was reasonable for staff to conclude that Mr Spriggs did not pose a risk of suicide or self-harm, which warranted ACCT monitoring.

Segregation

78. Mr Spriggs was first segregated at Channings Wood on 11 November. We are concerned that Mr Spriggs' segregation records from Channings Wood are not available to confirm the reason for his original segregation and to provide assurance that he was reviewed before he left the prison, as Prison Service Order (PSO) 1700 on Segregation requires.
79. Mr Spriggs was transferred to Bristol due to his deteriorating behaviour. PSO 1700 says that if a prisoner is moved from segregation to another prison, the aim should be for the prisoner to be managed on a standard wing in the receiving prison. It is only if managing a prisoner posed too high a risk to safety that he might be located in segregation at the receiving prison, with a case review taking place within 24 hours.
80. While we recognise that Mr Spriggs might have been determined not to return to a standard wing and had made such a move problematic when he arrived at Bristol, he was segregated under Rule 53 pending a prison disciplinary hearing and the prison did not carry out a 24-hour segregation review, a mandatory requirement. This review was a missed opportunity to have reviewed Mr Spriggs' reasons for transfer, to have understood and planned how to address his underlying issues, to have assessed his future needs (including input from mental health and the substance misuse teams), and to have identified plans to reintegrate him into a standard wing as soon as possible.
81. Segregation units hold some of the most challenging but also most vulnerable prisoners whose risk may increase if staff fail to provide the required regime and monitoring, designed to safeguard them. We are concerned about the process which saw Mr Spriggs enter, then leave then return to the segregation unit and the lack of planning, staff engagement and monitoring of Mr Spriggs in his last

days at Bristol, and we make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners held in segregated conditions are managed appropriately in line with PSO 1700, that reasons for segregation are appropriate to prisoners' circumstances, and are reviewed within 24 hours of arriving from another prison's segregation unit.

Access to Listeners

82. PSI 64/2011 on Safer Custody says that prisoners should be given timely access to a Listener, if they request one. Given the risk posed by Mr Spriggs' behaviour, it is reasonable that staff did not give him access to a Listener when he asked to speak to one on 19 November. However, staff should have considered and provided him with an alternative source of support, such as the use of a Samaritans' telephone. We make the following recommendation:

The Governor should ensure that if a prisoner wants to see a Listener but there are concerns that safety cannot be guaranteed, staff promptly provide alternative sources of support such as access to the Samaritans' telephone.

Entering cells in an emergency

83. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. However, staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid and dynamic risk assessment.
84. We recognise that it can be difficult for staff in such circumstances to make instant decisions, but when there is a potentially life-threatening situation, it is essential to act quickly and exercise operational judgement. In his clinical review, the clinical reviewer commented that any delay in opening the cell door would have reduced the likelihood of Mr Spriggs making a full recovery. While we would generally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life, we would not expect staff to put themselves in unnecessary potential danger.
85. When Officer B found Mr Spriggs hanging, he did not open the cell as he feared Mr Spriggs, due to his earlier behaviour, and believed that he posed a high risk because of his three officer unlock protocol. It is reasonable in these circumstances that concerned for his personal safety, he waited for the required number of officers to arrive before going into Mr Spriggs' cell.

Emergency response

86. PSI 03/2013 says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly says that control room staff should automatically call an ambulance whenever there is an emergency code and a member of the prison healthcare team or a duty manager need not attend the scene before emergency services are called. The PSI notes that it is better to act with caution and call an ambulance as it can be cancelled later, if not needed. The PSI is clear that control room staff should not check with managers, healthcare staff or others at the scene before calling an ambulance, but should be alert to updates and keep the ambulance service informed.
87. Bristol's protocol with South West Ambulance Services indicates that prison staff are required to gather and provide information to the ambulance service to ensure an appropriate priority of response. Officer B appropriately radioed a medical emergency code blue when he found Mr Spriggs hanging. Despite this, there was a delay of around two minutes before the control room called an ambulance.
88. As in our previous investigation reports into deaths at Bristol in January and March 2016, we continue to be concerned that the protocol with the ambulance service remains in conflict with the requirement in the PSI for an ambulance to be called immediately. In line with national instructions, we consider that in life-threatening situations, an ambulance should be called immediately and further information passed to the ambulance services once it is available.
89. In emergencies, delays can have a significant impact on a person's chance of survival. While staff and paramedics were able to establish Mr Spriggs' pulse, we cannot know whether earlier intervention might have affected the outcome for him. It is important that prison staff understand their roles in a medical emergency, and we make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that control room staff call an ambulance as soon as an emergency code is called.

Clinical care

90. While the clinical reviewer concluded that Mr Spriggs' clinical care was equivalent to the care he would have received in the community, he made a number of findings in his clinical review. Although these had no direct impact on Mr Spriggs' death, the Head of Healthcare at Bristol will need to address his findings.

**Prisons &
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