Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Lee Jackson, a prisoner at HMP Bristol, on 1 September 2023

## A report by the Prisons and Probation Ombudsman

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## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO


## WHAT WE VALUE


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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Lee Jackson was found hanged in his cell on 1 September 2023 at HMP Bristol. He was 50 years old. I offer my condolences to Mr Jackson's family and friends.

Mr Jackson had been at Bristol for less than 24 hours when he died. His alleged offence was against his partner, he was withdrawing from alcohol, and while in police custody, he had said that he would not live. These factors increased his risk of suicide. Mr Jackson was not managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) and we consider that more should have been done to support him and manage his risks.

The clinical reviewer concluded that the care Mr Jackson received at Bristol was not equivalent to what he could have expected to receive in the community.

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

**Adrian Usher**
**Prisons and Probation Ombudsman** **November 2024**

# Contents

# Summary

## Events

1. On 31 August 2023, Mr Lee Jackson was remanded to HMP Bristol, charged with actual bodily harm against his partner. This was not his first time in prison. Mr Jackson was alcohol dependant and had a history of poor mental health.

2. Mr Jackson arrived at Bristol with a Person Escort Record (PER, a document that accompanies prisoners between police custody, court and prisons, which sets out the risks they pose). He had a suicide and self-harm (SASH) warning recorded in the PER (although the SASH risk marker was ticked as 'no' and the risk information was recorded in the wrong section). It said that while in police custody, Mr Jackson said that he was 'a psycho', had depression and was not going to live anymore.

3. A prison officer conducted Mr Jackson's reception and first night induction but did not review all of the information contained in the PER so missed the comments Mr Jackson had made in police custody. Mr Jackson told the officer that he had no thoughts of suicide or self-harm. The officer did not consider starting suicide and self-harm monitoring procedures (ACCT).

4. A reception nurse completed Mr Jackson's reception health screen and reviewed the paper copy of the PER. The nurse saw that Mr Jackson had a suicide and self-harm (SASH) warning and asked him about the comments he had made. Mr Jackson told the nurse that he did not have any thoughts of suicide or self-harm. The nurse recorded that there was no visible evidence of self-harm, he was emotional and feeling down, which is how he had presented on a previous sentence at Bristol, and considered he did not need to be monitored ACCT.

5. A GP at the prison saw Mr Jackson and noted that he had severe symptoms of alcohol withdrawal. The GP prescribed appropriate medications and referred him the substance misuse team.

6. At around 8.45am on 1 September, a substance misuse worker saw Mr Jackson. He said that he had anxiety and depression but did not have any active thoughts of suicide or self-harm. The substance misuse worker told Mr Jackson how to contact the Integrated Mental Health Team.

7. At around 10.00am, Mr Jackson collected his medication from the medications hatch and saw the nurse who had completed his reception screen. He said that he was hearing things and had not slept much. The nurse attributed this to Mr Jackson's severe withdrawal symptoms.

8. At around 11.30am, a prison officer unlocked Mr Jackson's cell for lunch. They saw Mr Jackson suspended from his toilet window by a ligature made of bedsheets. Prison and healthcare staff and paramedics delivered CPR. Mr Jackson regained a pulse and was taken to hospital.

9. In hospital. Mr Jackson suffered a cardiac arrest and at 7.54pm, it was confirmed that he had died.

## Findings

10. Mr Jackson had been at Bristol for less than 24 hours when he was found hanged in his cell. He had several risk factors for suicide and self-harm. We found that staff did not read all of the information in the PER that detailed his risk, were too quick to conclude that he was not at risk, essentially based on how he had presented on previous occasions at Bristol and so did not initiate ACCT procedures.

11. Staff did not follow the correct reception and first night induction process.

12. We have raised concerns about ACCT management at Bristol before. In August 2023, we sought assurance from the Prison Group Director (PGD) for Avon and South Dorset that the issues identified were being addressed. We are satisfied that the PGD has taken necessary steps to improve the management of ACCT procedures.

13. The clinical reviewer concluded that Mr Jackson's clinical care at Bristol was not equivalent to what he could have expected to receive in the community. She found that healthcare staff did not fully consider Mr Jackson's risk factors when assessing him in reception.

## Recommendations

- The Governor and the Head of Healthcare should ensure that all healthcare staff (including GPs who work in the reception area) have regular ACCT training.

- The Head of Healthcare should ensure all GPs in reception have access to prisoners' Person Escort Records including SASH warnings forms.

# The Investigation Process

14. HMPPS notified us of Mr Jackson's death on 2 September 2023.

15. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Jackson's prison and medical records, viewed CCTV and body worn video camera (BWVC) footage. She also obtained the HMPPS Early Learning Review and HMPPS internal investigation report.

17. NHS England commissioned a clinical reviewer to review Mr Jackson's clinical care at the prison.

18. The investigator interviewed three members of staff at Bristol and spoke to Mr Jackson's cellmate in February 2024. She and the clinical reviewer jointly interviewed healthcare staff. The investigation was transferred to another investigator.

19. We informed HM Coroner for Avon of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's office spoke to Mr Jackson's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Jackson's family did not raise any specific concerns.

21. Mr Jackson's family received a copy of the draft report. They did not make any comments.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

# Background Information

## HMP Bristol

23. HMP Bristol is a category B reception and resettlement prison for adult men. Oxleas NHS Foundation Trust provides physical and mental health services.

## HM Inspectorate of Prisons

24. The most recent inspection of HMP Bristol was in July 2023. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification (UN) process because he was so concerned about conditions there. (The Urgent Notification process allows HM Chief Inspector of Prisons to directly alert the Lord Chancellor and Secretary of State for Justice if he has an urgent and significant concern about the performance of a prison.) He noted that the UN process had been invoked after the last inspection in 2019 and many of the failings highlighted then were also observed during the 2023 inspection. Despite this, there were many excellent, dedicated staff in the prison who were doing their best to support the prisoners in their care. The issues highlighted included:

- Staffing across the prison was insufficient to ensure the delivery of a safe and purposeful regime.
- The number of self-inflicted deaths and reported levels of self-harm were much too high.
- Most prisoners spent 22 hours a day locked in their cells, with half of them sharing cramped cells designed for one.
- Wing staff did not develop effective relationships with prisoners. The prison was not delivering key work, wing staff had little time to advocate for prisoners who needed their help, and they lacked the capability and confidence to manage behaviour more effectively.
- Work to help prisoners rebuild ties with their families and significant others was too limited and poorly resourced.

25. A high number of prisoners at risk of self-harm were supported by Assessment, Care in Custody and Teamwork (ACCT) case management, reflecting the high levels of self-harm and reported mental health issues in the population. Care plans for these prisoners were reasonably good and informed by sufficient exploration of the risks and triggers for each individual. Staff made efforts to engage them in purposeful activity, and some had involved their families where appropriate. They also sought input from the mental health team, substance misuse service or other relevant departments. Oversight of ACCT case management had improved since the last inspection, and robust quality assurance and a programme of staff training were driving improvement.

26. Inspectors reported that there were staff shortages on the mental health team, which was struggling to meet increased demand. Referrals to the team had doubled in the previous six months with patients in crisis prioritised.

## Independent Monitoring Board

27. 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 31 July 2023, the IMB reported that there had been an increase in deaths, self-harm and violence and more prisoners than the previous year were on ACCT monitoring and constant supervision. There had been high levels of overcrowding (over 50% all year) with two prisoners in cells built for one person, and staffing was below the required levels, which affected the consistent delivery of a full daily regime, resulting in more prisoners spending time in their cells. Activities were often cancelled on the day and key working had not yet been re-established. The Board reported that there were insufficient staff in the mental health team to support the mental health needs of all prisoners. Priority was given to the most unwell.

## Previous deaths at HMP Bristol

28. Mr Jackson was the 12th prisoner to die at Bristol since September 2020, and the eighth self-inflicted death. By the end of July 2024, there had been one self-inflicted death at Bristol since Mr Jackson's death.

29. As a result of these self-inflicted deaths and the Urgent Notification issued by HMIP Bristol is receiving additional support and monitoring from HMPPS regional and national safety teams.

30. In previous investigations, we raised concerns about the quality of ACCT management at Bristol, in particular the premature closure of ACCTs and staff's reliance on what the prisoner told them rather than an objective assessment of the prisoner's risk of suicide and self-harm. Despite Bristol having introduced measures in 2020 to improve ACCT procedures, we continued to raise the same concerns and recommended that the Prison Group Director for Avon and South Dorset should write to the Ombudsman setting out what was being done to improve ACCT management at Bristol. He responded in January 2023 and set out a range of measures including training and quality assurance.

## Assessment, Care in Custody and Teamwork

31. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

# Key Events

32. On 31 August 2023, Mr Lee Jackson was remanded to HMP Bristol charged with actual bodily harm against his partner. It was not his first time in prison, and he was known by staff at Bristol.

33. Mr Jackson had a history of alcohol dependency and diabetes and was prescribed medication for this condition in the community. He also had a history of anxiety and depression and had attempted suicide in 2019. He had never been subject to ACCT monitoring before.

34. On arrival at Bristol, just after 7.00pm, escort staff took Mr Jackson to the reception area and handed Officer A a box containing four paper Prisoner Escort Records (PER), one of which belonged to Mr Jackson. On the second page of Mr Jackson's PER, under the heading 'self-harm', it said that Mr Jackson was not at risk of suicide or self-harm and did not need any additional observations. However, on the fourth page, under the heading 'medical care' it noted that Mr Jackson had previous brief contact with mental health services (prior to remand), his concerns were primarily related to alcohol dependence, and he said that he was 'a psycho', had depression and was not going to live anymore. The officer placed the box of PERs on the reception desk and carried on with processing other prisoners who had arrived at reception.

35. Mr Jackson made a phone call to someone but there is no record of who he called.

36. Mr Jackson was taken to see Officer B (a relative of Officer A) for his reception and first night induction. The officer noted that Mr Jackson engaged well, said that he did not have any thoughts of suicide or self-harm and had not self-harmed before. He accessed the electronic PER but did not have the paper copy. He did not read the all the information about Mr Jackson in the PER. At interview, he said that when he checked the digital PER, he looked at Mr Jackson's offence and his level of risk. He said he did not usually check the medical section of the PER because healthcare staff in reception would deal with the healthcare issues. He said that he saw that the self-harm risk marker was ticked as 'no' and therefore, did not read the document any further because it was related to healthcare concerns.

37. Mr Jackson told Officer B that he was aware of the support available from Listeners and knew he could speak to staff if needed. The officer completed Mr Jackson's cell sharing risk assessment and recorded that Mr Jackson had no markers for suicide and self-harm.

38. An OSG collected Mr Jackson's paper PER from the reception desk, placed it in a file and handed it to the reception nurse.

39. The reception nurse completed Mr Jackson's reception health screen. She completed a Clinical Institute Withdrawal Assessment for Alcohol and the results indicated severe withdrawal from alcohol. She referred Mr Jackson to the Psychosocial Substance Misuse Team (PSMT). She arranged for Mr Jackson to see a GP because she was concerned about his withdrawal symptoms.

40. Mr Jackson said that he did not have any thoughts of suicide or self-harm. The reception nurse noted there was no visible evidence of self-harm. She noted the

information in the medical section of the PER and asked Mr Jackson about his comments. Mr Jackson said that he made them out of anger and that he would not kill himself. She noted that Mr Jackson was emotional and feeling down. At interview, she said that Mr Jackson had presented as emotional and low in mood at Bristol in the past, so she did not think he needed to be monitored under ACCT.

41. A GP at the prison saw Mr Jackson in reception and noted that he was presenting with marked alcohol withdrawal symptoms and prescribed withdrawal medication. Mr Jackson told him that his mood was low, and he had fleeting suicidal thoughts, but did not intend to attempt suicide or self-harm. He said his community GP had prescribed thiamine (a vitamin B1 supplement), ramipril (blood pressure medication), citalopram and mirtazapine (antidepressants). The GP increased his mirtazapine dose and prescribed the usual dose of ramipril and citalopram. At interview, he said that he was not aware that Mr Jackson had a SASH warning, but did not consider ACCT procedures were necessary.

42. Mr Jackson was located in a shared cell on the first night wing. Mr Jackson's cellmate said that Mr Jackson was chatty and appeared happy that evening. Mr Jackson knew other prisoners on the wing and intended to talk to them over the next few days. He said that Mr Jackson did not express any thoughts of suicide or self-harm. They both went to bed at around 10.00pm and did not speak again as the cellmate went to court early the next day.

43. During the night, a nurse checked on Mr Jackson three times to monitor his withdrawal symptoms. She did not note any concerns.

## Events of 1 September

44. At 5.25am on 1 September, an officer noted that Mr Jackson had settled and slept well. Mr Jackson said he was okay and needed his night medication.

45. At around 8.45am, a member of the substance misuse team visited Mr Jackson to complete a substance misuse assessment. Mr Jackson said that he had anxiety and depression but did not have any thoughts of suicide or self-harm. She did not note any concerns about Mr Jackson but told him how to contact the Integrated Mental Health Team if needed.

46. An officer saw Mr Jackson during the morning domestics period, where prisoners have time out of their cell to shower, make telephone calls and can have outside exercise. Mr Jackson had a shower; staff gave him clean bedding and clothing and he spoke with other prisoners on the wing. Mr Jackson did not present any concerns to staff.

47. At 10.00am, Mr Jackson collected his medication from the medications hatch and the reception nurse assessed him. His observations (blood pressure, oxygen levels, etc) were within the normal range. Mr Jackson told her that he was hearing things such as his girlfriend whispering to him and that he did not sleep well. She completed a Clinical Institute Withdrawal Assessment for Alcohol and again noted that Mr Jackson was presenting with severe withdrawal symptoms. She attributed his hearing of voices to withdrawal, rather than a mental health symptom.

48. At about 10.40am, the member of the substance misuse team dropped off some art materials to Mr Jackson to help occupy himself while in his cell. She put them under his door, and he thanked her.

49. At 11.31am, an officer went to unlock Mr Jackson for lunch. When he opened Mr Jackson's cell, he saw that Mr Jackson had hanged himself from the toilet window, using bedsheets. He called for help and a colleague responded. The colleague radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). Control room staff called an ambulance immediately. The officer used his anti-ligature knife to cut the ligature and they started CPR.

50. Healthcare staff arrived at Mr Jackson's cell at 11.33am and supported staff with CPR and used a defibrillator. At 11.45am, paramedics arrived and took over Mr Jackson's care.

51. At 12.04pm, Mr Jackson regained a pulse and was given oxygen. He was taken to Bristol Royal Infirmary and was taken into intensive care.

52. Mr Jackson had a cardiac arrest and, at 7.54pm, it was confirmed that he had died.

53. Mr Jackson did not leave a note.

## Contact with Mr Jackson's family

54. Once Mr Jackson had been taken to hospital, the Deputy Governor tried to phone Mr Jackson's mother several times but was not able to make contact. At 4.30pm, she spoke to Mr Jackson's mother and informed her that Mr Jackson had been taken to hospital.

55. Mr Jackson's family attended the hospital to be with him.

56. The prison appointed a family liaison officer, who provided support to Mr Jackson's mother and offered advice as to the next steps.

57. The prison contributed towards Mr Jackson's funeral costs in line with national policy.

## Support for prisoners and staff

58. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

59. After Mr Jackson's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

60. The prison posted notices informing other prisoners of Mr Jackson's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Jackson's death.

61. Safer custody staff gave prison listeners and the wing manager postvention leaflets to share with prisoners and staff.

## Post-mortem report

62. The post-mortem report gave Mr Jackson's cause of death as complications of prolonged cardiorespiratory arrest, caused by suspension by a ligature. The toxicology report showed therapeutic ranges of prescribed medication. It did not detect any illicit substances.

# Findings

## Assessment of Mr Jackson's risk of suicide and self-harm

63. Mr Jackson had been at Bristol for around 16 hours when he was found hanged in his cell. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Jackson had several of these risks including that he was on remand for a violent offence against his partner and had a history of relationship instability. Mr Jackson was also experiencing severe withdrawal from alcohol, was low in mood and was taking antidepressants and said that he was hearing voices. He had been identified as a heightened risk of suicide and self-harm while in police custody.

64. Despite his risk factors and having a SASH warning, staff did not start ACCT monitoring procedures when Mr Jackson arrived at Bristol. The reception officers saw that the information recorded in the risk section reported that Mr Jackson did not present with any suicide or self-harm risks. They did not read the risk related information recorded (wrongly by the police) in the medical section of the form. Both Officers A and B had up-to-date ACCT training.

65. Although the reception nurse saw the SASH warning and noted Mr Jackson was emotional and feeling low, she considered that he had presented in this way when he was previously at Bristol and therefore did not consider that ACCT procedures were necessary. She had not had ACCT training at that time.

66. We found that the combination of incorrect completion of the PER, prison staff not reading the form in its entirety and the nurse considering that Mr Jackson's low mood was normal for him meant that staff did not properly assess his risk and missed an opportunity to monitor Mr Jackson under ACCT procedures for a period.

67. The Head of Operations at Bristol told the investigator that reception staff at Bristol were under additional pressures. He said that Bristol received 50-60 new receptions each week, which was high compared to similar prisons. He said that since January 2024, the prison had introduced a dedicated first night centre (at the time Mr Jackson was at Bristol, prisoners were put on a wing with prisoners from the main population). He had also implemented changes to take some pressure off reception staff. Officers on the first night centre now complete the initial assessments which allows for greater consistency. We consider this a positive step to easing the pressures in reception and ensuring better quality and continuity for prisoners in their first days in custody.

68. The Head also said that in light of Mr Jackson's death, additional quality assurance checks are completed to ensure that staff follow the correct procedures including reviewing all PERs and SASH information in detail so that staff identify those prisoners who are at increased risk. This includes a first night reception database and a SASH warning tracker. The prison's operations team and contracted escort services provider, Serco, hold a monthly meeting to discuss and share risk information and work together to improve outcomes.

69. The Head of Safety said that since Mr Jackson's death, 84% of prison staff have had ACCT training and the remaining 16% will complete the training by the end of September 2024. He said it is not mandatory for healthcare staff to complete annual ACCT training, however, Oxleas NHS Foundation Trust offer safeguarding training. He said 15 healthcare staff had attended ACCT training since Mr Jackson's death, including the reception nurse, and new healthcare staff are offered the training.

70. The Head of Healthcare told us that the need for regular and consistent ACCT training for healthcare staff had been identified and escalated to Oxleas NHS Foundation Trust. While annual ACCT training is not currently available to healthcare staff, they are expected to be compliant with prison service orders and frameworks, which include identifying patients at risk of suicide or self-harm. Therefore, there is a clear expectation that healthcare staff have adequate knowledge and understanding of the ACCT process.

71. At interview, the prison GP said that he was not aware of the information relating to Mr Jackson suicide and self-harm risk, and did not know what a PER was as it was not a document GPs used in their assessment. He had not had or been offered ACCT training. We question whether GPs covering reception duties are able to make good quality decisions on a prisoner's level of risk, and properly contribute to the safeguarding of all prisoners, if they have not had ACCT training and do not see relevant risk related information on newly arrived prisoners. We recommend:

    **The Governor and the Head of Healthcare should ensure that all healthcare staff (including GPs who work in the reception area) have regular ACCT training.**

    **The Head of Healthcare should ensure all GPs in reception have access to prisoners' Person Escort Records including SASH warnings forms.**

72. In our investigation into a self-inflicted death at Bristol in November 2022, we found that staff placed too much emphasis on what the prisoner said rather than their objective risk factors. In August 2023, we recommended that the Prison Group Director for Avon and South Dorset should satisfy himself that meaningful improvements had been made to the management of ACCT procedures at Bristol. The PGD has implemented assurance measures to provide additional support to case managers and to quality assure Bristol's ACCT procedures. In light of the changes Bristol has made to both reception procedures and ACCT management, we make no further recommendation.

## Mental and physical healthcare

73. The clinical reviewer concluded that Mr Jackson's clinical care at Bristol was not equivalent to what he could have expected to receive in the community because his risk of suicide and self-harm was not holistically assessed when he arrived. The care Mr Jackson received in relation to his substance misuse was equivalent.

74. The clinical reviewer made recommendations to the Governor and the Head of Healthcare which they will wish to consider.

## Inquest

75. At the inquest, held on 11 May 2026, the Coroner concluded that Mr Jackson died by suicide.

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