Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Kettles, a prisoner at HMP Bristol, on 11 November 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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 HM 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 Ian Kettles died on 11 November 2022, after he was found hanging in his cell at HMP Bristol. This was the fourth self-inflicted death at Bristol in three years and there have been seven self-inflicted deaths since. Mr Kettles was 58 years old. I offer my condolences to Mr Kettles' family and friends.

Mr Kettles had only been in prison for a week when he died. Staff started suicide and self-harm monitoring procedures on 7 November, when Mr Kettles reported increasing thoughts of suicide, but stopped them the next day, reassured that he was not at risk.

My investigation found that the decision to end suicide monitoring was premature. Staff placed too much emphasis on what Mr Kettles told them, rather than his known risk factors and recent events. They also recorded inaccurate information about Mr Kettles, which was relevant to assessing his risk of suicide.

Both HM Inspectorate of Prisons and the Independent Monitoring Board previously identified weaknesses in suicide and self-harm monitoring processes at Bristol, although both reported improvements more recently.

My office has previously raised concerns about the standard of ACCT management at Bristol and last year, the Acting Ombudsman escalated concerns to the Prison Group Director. I understand that due to the number of self-inflicted deaths at Bristol in the last 12 months, the prison has been receiving additional support and training on managing suicide and self-harm monitoring procedures. The Prison Group Director needs to satisfy himself that these measures have addressed the ongoing issues.

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

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

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Summary

Events

1. Mr Ian Kettles was remanded to HMP Bristol on 4 November 2022, charged with assault. Mr Kettles had been in prison before, but not for over 20 years.

2. Mr Kettles told the reception nurse that he had depression and was prescribed venlafaxine (an antidepressant) in the community. He said he had taken an overdose of medication six or seven years before but had not self-harmed or attempted suicide since. The nurse identified that Mr Kettles was showing alcohol withdrawal symptoms. She referred him to the mental health team and to the GP. The GP prescribed medication for alcohol withdrawal and high blood pressure but did not prescribe antidepressants as he needed confirmation of Mr Kettles' prescription from his community GP before doing so.

3. On 7 November, Mr Kettles told a substance misuse worker that he had suicidal thoughts, which had become worse and more frequent. He said he had thought about the quickest and least painful way to end his life. The substance misuse worker started suicide and self-harm monitoring procedures (known as ACCT). At the first case review the next day, staff stopped ACCT monitoring because Mr Kettles said he had no thoughts of suicide or self-harm, and he talked about future plans.

4. On 9 November, a GP prescribed venlafaxine after Mr Kettles' GP records were uploaded to his electronic medical record. Mr Kettles received his first dose of venlafaxine on 10 November.

5. During a routine check on the morning of 11 November, staff found Mr Kettles with a ligature around his neck, attached to the window bars. Staff and paramedics tried to resuscitate him but were unsuccessful. At 5.50am, paramedics pronounced that Mr Kettles had died.

Findings

6. We found that the ACCT was closed prematurely. Staff appeared to base their decision on what Mr Kettles told them rather than objectively considering his risk factors and the events of the previous day. Despite the ACCT case coordinator noting that he had read Mr Kettles' ACCT document and prison record, the case review log contained inaccurate information about Mr Kettles' history of self-harm and the reasons for the ACCT being opened. There was also no consideration given to the fact that Mr Kettles had still not received his antidepressant medication.

7. We have raised concerns about ACCT management at Bristol before and previously sought assurance from the Prison Group Director that the issues were being addressed. Despite being told that measures had been taken at Bristol to improve ACCT management, such as training and quality assurance, we have again found that ACCT procedures were managed poorly. There have been three further self-inflicted deaths at Bristol since Mr Kettles' death which has resulted in the prison receiving further support and training on ACCT management from HMPPS headquarters. Senior managers will need to review and monitor the impact

of this additional support to satisfy themselves that the measures have addressed the ongoing issues with poor ACCT management.

8. There was a long delay in Mr Kettles receiving his antidepressant medication. The clinical reviewer was satisfied that the Head of Healthcare had introduced measures to address this issue. However, she noted that Mr Kettles was not monitored for withdrawal symptoms given the sudden cessation of his antidepressant medication when he arrived at Bristol and made a recommendation on this.

Recommendations

- The Governor should ensure that staff manage ACCT procedures in line with prison policy, in particular staff should:
  - invite all relevant staff that are involved in supporting the prisoner to case reviews;
  - fully acquaint themselves with the prisoner's ACCT document and prison record, particularly if it is the first time they have met the prisoner;
  - assess risk based on the prisoner's behaviour and known risk factors and not on what the prisoner tells them.
- The Prison Group Director for Avon and South Dorset should commence a disciplinary investigation into the actions of CM A and his decision to close the ACCT on 8 November.
- The Prison Group Director for Avon and South Dorset should satisfy himself that meaningful improvements have been made to the management of ACCT procedures at Bristol.
- The Head of Healthcare should ensure there is a clinical process for monitoring prisoners who may be withdrawing from psychotropic medication associated with a risk of dependency and withdrawal.

The Investigation Process

9. HMPPS notified us of the death of Mr Kettles on 11 November 2022. 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.

10. The investigator obtained copies of relevant extracts from Mr Kettles' prison and medical records.

11. NHS England commissioned an independent clinical reviewer to review Mr Kettles' clinical care at the prison. The investigator and clinical reviewer jointly interviewed 12 members of staff.

12. We informed HM Coroner for Avon of the investigation. She gave us the results of Mr Kettles' post-mortem examination. We have sent the coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Kettles' son to explain the investigation and to ask if he had any matters he wanted us to consider. He asked why the prison appeared not to have access to Mr Kettles' medical records and how they ensured Mr Kettles' medical care if that was the case. He also asked whether there had been an incident between his father and another prisoner. We have addressed these issues in the report.

14. We shared extracts of this report with the prison in line with our advanced notification process. The prison identified no factual inaccuracies in the extracts shared.

15. We shared our initial report with HMPPS. They found no factual inaccuracies.

16. We sent a copy of our initial report to Mr Kettles' son. He did not notify us of any factual inaccuracies.

Background Information

HMP Bristol

17. HMP Bristol serves the local courts and holds up to 614 adult men. Oxleas NHS Foundation Trust provides healthcare services at Bristol and Doctor PA provides GP services. Change, Grow, Live (CGL) provides non-clinical substance misuse services.

HM Inspectorate of Prisons

18. The most recent full inspection of HMP Bristol was in June 2019. Inspectors reported that levels of self-harm had increased and were far higher than at most other local prisons. Incidents of self-harm were not routinely investigated to understand the underlying causes and there was not an effective strategy to reduce levels of self-harm. Important recommendations from PPO reports into recent self-inflicted deaths had not been implemented effectively. Inspectors found that the number of prisoners being supported using suicide and self-harm procedures (ACCT) was extraordinarily high, which compromised the quality of care given.

19. HMIP carried out a Scrutiny Visit at Bristol in September 2020. Inspectors reported that the ACCT management had been transformed since their last inspection. ACCTs were now used more appropriately, and few prisoners were left on open ACCTs for long periods. Prisoners they spoke to who were on ACCT felt well supported. The quality of ACCT documentation had improved but some were still below standard. They found poor care plans, reviews that were not sufficiently multidisciplinary and entries that were predictable and repetitive. The prison was aware of this and implementing measures to improve the quality of entries.

Independent Monitoring Board

20. 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 2022, the IMB reported that incidents of self-harm had reduced, and the number of prisoners supported by ACCT had fallen. Prisoners at risk of suicide and self-harm were monitored weekly.

21. The IMB reported that the prison's health provision was good and appeared commensurate with that available in the community.

Previous deaths at HMP Bristol

22. Mr Kettles was the sixth prisoner to die at Bristol since November 2018. Of the previous deaths, four were self-inflicted, one was drug related and one was from natural causes. There have been seven self-inflicted deaths since Mr Kettles' death. As there have been four self-inflicted deaths at Bristol in just over six months, the prison is receiving additional support and monitoring from HMPPS headquarters.

23. 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

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

26. On 4 November 2022, Mr Ian Kettles was remanded to prison, charged with actual bodily harm. He was sent to HMP Bristol. Mr Kettles had been in prison before, but not for over 20 years.

27. The reception nurse noted that Mr Kettles was very emotional when he arrived. He told her that he had depression, was under the care of community mental health services and was prescribed antidepressants. He said he had taken an overdose of medication six or seven years earlier but had not harmed himself since and had no thoughts of suicide or self-harm. The nurse referred Mr Kettles to the mental health team at Bristol. She also identified that Mr Kettles was showing alcohol withdrawal symptoms and had high blood pressure so referred him to the GP.

28. The GP at Bristol prescribed Mr Kettles with amlodipine for high blood pressure and thiamine for alcohol withdrawal. The GP did not prescribe antidepressants as they needed confirmation of his prescription from his community GP records before doing so.

29. Mr Kettles was given a shared cell on C Wing, a detoxification wing, under the care of the Substance Misuse Psychosocial Team (SMPT). Staff monitored him daily for alcohol withdrawal symptoms.

30. On 5 November. Mr Kettles' urine tested positive for cocaine. There is no prescribed treatment for cocaine withdrawal, but Mr Kettles continued to be monitored for alcohol withdrawal symptoms.

31. On 6 November, a nurse carried out a mental health assessment with Mr Kettles. He noted that this was brief as Mr Kettles had to attend a court hearing. Mr Kettles said he had been struggling with low mood for years, was prescribed venlafaxine (an antidepressant) and was on a waiting list for psychotherapy in the community, which he hoped to continue if he was not remanded again at his court hearing on 21 November. The nurse noted that Mr Kettles' venlafaxine prescription was confirmed by his GP records. (We were unable to establish during our investigation what GP records he was referring to here.) He did not arrange for venlafaxine to be prescribed to Mr Kettles at Bristol.

32. The nurse assessed Mr Kettles with likely moderate to severe depression and antisocial personality disorder. Mr Kettles said he had no thoughts of suicide or self-harm. He said he had self-harmed previously when he was under the influence of alcohol. The nurse noted Mr Kettles' risk of self-harm was likely to increase if he was remanded to prison again. He noted that he had not observed any symptoms to suggest Mr Kettles had a serious and enduring mental illness, so he did not recommend that he should be added to the mental health team's caseload. He thought that Mr Kettles would be better supported by the Substance Misuse Service (SMS).

33. The same day, the nurse contacted Mr Kettles' mental health team care co-ordinator in the community. (She responded on 9 November to say that Mr Kettles had been on their caseload but had only attended one appointment and was due to be discharged from their service.)

ACCT – 7 to 8 November

34. On 7 November, a SMS recovery coordinator met Mr Kettles to carry out a substance misuse assessment. She noted that Mr Kettles was tearful and emotional throughout. He spoke about past trauma, fear of losing his council flat, lack of contact with his children and worries that he would no longer get the mental health therapy that he was due to start in the community. He said that he had thoughts of suicide and self-harm but had denied it multiple times since arriving at Bristol. He said that his thoughts of suicide had become worse and more frequent over the past couple of days and that he was thinking about how he would do it in the quickest/least painful way possible.

35. At around 11.30am, the recovery co-ordinator started ACCT suicide and self-harm procedures and set observations at one an hour.

36. That evening, Mr Kettles went to the medication hatch and told the nurse that he was prescribed venlafaxine in the community. She sent a task to another nurse, who in turn sent a task to a non-medical prescriber asking them to follow this up. The next day, a pharmacist checked Mr Kettles' community prescription and confirmed he was prescribed venlafaxine, which had last been issued on 14 October.

37. At 11.15am on 8 November, a supervising officer (SO) completed the ACCT Assessment Interview. Mr Kettles said he felt good but was worried about housing on his release from prison and was thinking of changing his plea at court. Mr Kettles said he had previously self-harmed by cutting. He said there were no particular triggers for his self-harming, and he did not want to die. He said he had no support from family or friends. The SO and Mr Kettles agreed that he would attend the first ACCT case review later that day, that he should complete his stabilisation for drugs and alcohol withdrawal on C Wing, and he would apply to see the prison's bail officer about accommodation.

38. Custodial Manager (CM) A held the first ACCT case review at 4.00pm. A crisis support worker in the mental health team attended. A SO and a C Wing officer provided verbal input. CM A noted that he had contacted SMS and invited them to attend the case review, but they had declined due to staffing levels. (SMS staff disputed this and said they had not been asked to attend.) Despite CM A noting that he had looked through Mr Kettles' ACCT and prison notes before the review, he noted that Mr Kettles had not been in custody before, which was incorrect, and that he had not self-harmed before, which was also incorrect. He also noted that he had spoken to the mental health team who had said they were not aware of any reports that Mr Kettles had self-harmed or attempted suicide in the community.

39. CM A noted that when asked about thoughts of suicide and self-harm, Mr Kettles said he had none at all and that he would never self-harm. He noted that Mr Kettles said he had never self-harmed or attempted suicide, either in custody or in the community, and that while he had at times been 'rock bottom', he had never considered acts of self-harm.

40. CM A noted that Mr Kettles' biggest risk was his ongoing alcohol detoxification, but Mr Kettles thought he was over the worst of it. He said he was concerned about losing his home and his possessions which he had worked hard for, and lack of

contact with his children, whom he had not seen for over 20 years. Mr Kettles also spoke of his guilt about his offence against his partner and the subsequent breakdown of his relationship. He said he was drunk when he committed the offence and could not remember it.

41. CM A noted that Mr Kettles talked about the future. He was hopeful that he would get a suspended sentence when he appeared in court again at the end of the month, which would allow him to access community drug and alcohol services. He said that he was much happier with his new cellmate and that he wanted to get work off the wing to keep active and busy. (Mr Kettles said that he had not got along with his previous cellmate due to the age difference and lack of common interests but there is no record of any incident with his previous cellmate.) CM A recorded that Mr Kettles was presenting as more and more positive each day. He and the crisis support worker agreed to stop ACCT monitoring and scheduled a post-closure review for 15 November.

42. Mr Kettles successfully completed his alcohol detoxification, and on 8 November, he was moved to a single cell on B Wing. He repeatedly asked staff about his venlafaxine.

9 to 10 November

43. At 11.59am on 9 November, Mr Kettles' GP summary, which confirmed he had been prescribed venlafaxine in the community, was uploaded to his medical record. In response, a GP at Bristol prescribed venlafaxine to Mr Kettles, and he received his first dose. The same day, a healthcare assistant completed a secondary health screen for Mr Kettles. There were no concerns about his mental or physical health.

44. On 10 November, a nurse met Mr Kettles for his first substance misuse monitoring assessment. Mr Kettles said he was 'fine now' because he had started taking venlafaxine. Mr Kettles said he had no thoughts of suicide or self-harm, and he showed no signs of drug or alcohol withdrawal. That evening, the mental health team discussed Mr Kettles and concluded that he would not be added to their caseload.

45. The same day, Mr Kettles met a pre-release probation services officer. She noted that Mr Kettles seemed a little flustered and he told her it was because it was the first day he had taken his antidepressant medication. Mr Kettles spoke about his concern that he would not be able to return to his home, particularly as his alleged victim lived in the same block of flats. Mr Kettles said he had issues with drugs and alcohol prior to prison and had anxiety and depression. She noted Mr Kettles' resettlement plan was to get some clarity on his housing situation and be allocated a peer mentor on his release.

46. At approximately 9.00pm, an operational support grade (OSG) carried out a routine check on B Wing. There were no issues.

Events of 11 November

47. At 5.12am, during a routine check, the OSG noticed that Mr Kettles had covered his observation panel so he could not see into the cell. He looked through a gap and

could see Mr Kettles crouched down in the corner of the cell with a ligature around his neck, made from a bedsheet, and tied to the window bars.

48. The OSG radioed an emergency code blue (to indicate a prisoner is unresponsive or not breathing). He did not know whether it was safe to go into Mr Kettles' cell, so waited for other staff to arrive. An officer arrived at 5.14am and went into Mr Kettles' cell. She cut the ligature, laid Mr Kettles on the floor and checked for a pulse and breathing. When she found neither, she started chest compressions.

49. Other officers arrived at Mr Kettles' cell a minute or so later.

50. A nurse responded to the code blue call and arrived at Mr Kettles' cell at 5.17am, followed by a colleague. The nurse attached a defibrillator to Mr Kettles, which advised no shock. They took turns administering chest compressions.

51. Paramedics arrived at Mr Kettles' cell at 5.25am and took over CPR. However, resuscitation attempts were unsuccessful and at 5.50am, paramedics declared that Mr Kettles was dead.

52. Mr Kettles left a note in his cell which said that it 'was over', that it was his decision and his chance to 'take control'.

Contact with Mr Kettles' family

53. The prison appointed a family liaison officer (FLO). The Governor and the FLO visited Mr Kettles' son's address that morning, but he no longer lived there. Police located Mr Kettles' son and broke the news of his father's death. After that, the FLO liaised with him and other family members.

54. The prison contributed to the cost of Mr Kettles' funeral, in line with national instructions.

Support for prisoners and staff

55. After Mr Kettles' death, the Governor 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.

56. The prison posted notices informing other prisoners of Mr Kettles' 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 Kettles' death.

Post-mortem report

57. Mr Kettles' post-mortem report concluded that he died from hanging.

Findings

Assessment of risk of suicide or self-harm

58. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide or self-harm.

59. A substance misuse worker started ACCT procedures for Mr Kettles on 7 November, after he told her that he had thoughts of suicide, which had become worse and more frequent. He told her that he had started thinking about the quickest/least painful way to end his life. Staff stopped ACCT monitoring at the first case review the next day.

60. We found that staff stopped ACCT procedures prematurely, that this decision was based on inaccurate information and that too much emphasis was placed on what Mr Kettles said rather than his objective risk factors and recent events.

61. CM A noted in the case review log that he had read Mr Kettles' ACCT document and his prison notes before holding the case review. However, he recorded inaccurate information in the case review log, which did not align with the other documentary information on Mr Kettles. For example, he recorded that Mr Kettles' ACCT was opened because, 'he was low in mood and made vague comments regarding thoughts to harm himself'. This did not fully reflect what Mr Kettles had said to the substance misuse worker the day before, particularly that his thoughts of suicide had become more frequent, and he had thought about the quickest/least painful ways to end his life. Also, he recorded that Mr Kettles had not self-harmed before when it clearly said that he had in the record of his ACCT Assessment Interview.

62. The case review log focused on Mr Kettles' 'forward thinking', and it seemed to be this that persuaded the case review team to close the ACCT. There appeared to be no consideration given to the fact that the day before, Mr Kettles was very tearful and expressed strong thoughts of suicide with evidence of planning the best way to do it. This dramatic change should have raised concerns, particularly as Mr Kettles had told the substance misuse worker that he had previously denied thoughts of suicide when asked by staff.

63. Staff decided to close the ACCT when Mr Kettles had still not been prescribed his antidepressant medication, something which was clearly troubling him. Also, no one from SMS had any input as they were not at the case review. This input would have been important given Mr Kettles was undergoing alcohol detoxification. CM A recorded that he had spoken to SMS and invited them to attend. However, SMS staff disputed that they had been invited and the Head of Healthcare said that attendance at ACCT case reviews was prioritised if healthcare staff were invited. Whichever is correct, the fact remains that CM A made the decision to close the ACCT without SMS in attendance.

64. CM A's decision, as ACCT case coordinator, to close the ACCT on 8 November was plainly wrong based on the evidence available. Not only did he ignore the very

recent evidence that Mr Kettles' thoughts of suicide were getting stronger and that he was thinking about the best way to end his life, but he made inaccurate records about what had triggered the opening of the ACCT and Mr Kettles' history of self-harm. All the evidence pointed to the fact that Mr Kettles was at imminent risk of suicide and that he was probably not going to be honest about it. We find it inexplicable that he chose to believe Mr Kettles' statements that he had no thoughts of suicide or self-harm and that he recorded that he was 'presenting more and more positive with each day' when he had admitted only the previous day that he had repeatedly lied to staff about having no thoughts of suicide or self-harm when he had had them all along and they were getting worse. We recommend:

The Governor should ensure that staff manage ACCT procedures in line with prison policy, in particular staff should:

- **invite all relevant staff that are involved in supporting the prisoner to case reviews;**
- **fully acquaint themselves with the prisoner's ACCT document and prison record, particularly if it is the first time they have met the prisoner;**
- **assess risk based on the prisoner's behaviour and known risk factors and not on what the prisoner tells them.**

The Prison Group Director for Avon and South Dorset should commence a disciplinary investigation into the actions of CM A and his decision to close the ACCT on 8 November.

65. In its last full inspection of Bristol in June 2019, HM Inspectorate of Prisons (HMIP) found that the very high number of ACCTs opened compromised the quality of care given. The situation appeared to have improved by September 2020, when HMIP carried out a Scrutiny Visit, though inspectors still found some examples of poor care plans and ACCT entries.

66. In our investigation into the last self-inflicted death at Bristol in December 2021, we found that on two occasions, staff had prematurely closed the prisoner's ACCT and placed too much emphasis on what the prisoner said rather than their objective risk factors.

67. Following that investigation, we recommended that the Prison Group Director write to the Ombudsman setting out what was being done to address weaknesses in ACCT management at Bristol. In January 2023, the Prison Group Director responded and said that various measures were being implemented to improve ACCT management, including training and quality assurance. The new Head of Safer Custody at Bristol in March 2023 told us at interview that his focus had been on training new ACCT case coordinators, as the lack of staff trained to perform this role meant that they had to deal with a high number of cases, which had impacted on the quality of ACCT reviews. He also said that they had increased quality assurance of ACCT documents and the themes identified were fed into an action plan.

68. Bristol has received additional support from HMPPS headquarters due to its recent high number of self-inflicted deaths, which has included training on identifying and assessing suicide and self-harm risk and on ACCT procedures. We recommend:

The Prison Group Director for Avon and South Dorset should satisfy himself that meaningful improvements have been made to the management of ACCT procedures at Bristol.

Clinical care

69. Mr Kettles was not prescribed venlafaxine until 9 November, and did not receive it until 10 November, six days after arriving at Bristol. Mr Kettles told the reception nurse when he arrived that he was prescribed venlafaxine and repeatedly asked for this medication over the following days.

70. A summary care record (SCR – electronic record of important information created from GP records) was available when Mr Kettles arrived at Bristol, which confirmed his community prescription for venlafaxine. However, it was not accessed and instead a request was made for his GP records to confirm his prescription. It is unclear why the GP who prescribed amlodipine and thiamine did not access the SCR to confirm the antidepressant prescription. As Mr Kettles arrived at Bristol late on a Friday afternoon, healthcare administration staff would not have requested the GP records until Monday 7 November at the earliest, which caused a further delay.

71. The Head of Healthcare identified this issue during the internal review following Mr Kettles' death. They created a 'continuity of medicines' briefing and shared this with healthcare staff. It reminded healthcare staff of the process to follow when a prisoner arrives in reception, including accessing the SCR. The Head of Healthcare told the clinical reviewer that a subsequent audit found that there was 100% compliance of use of the SCR and patients were prescribed their medication within 48 hours of arriving at Bristol. The clinical reviewer was satisfied that these actions had addressed the issues identified, so did not make a recommendation.

72. The clinical reviewer advised that sudden withdrawal from venlafaxine can cause irritability, instability and anxiety. The British National Formulary (BNF) prescribing guidelines suggest that any reduction of this medication be done slowly. There was no consideration that Mr Kettles may have been suffering withdrawal symptoms following the sudden cessation of venlafaxine.

73. If it had been recognised that Mr Kettles could have been experiencing withdrawal symptoms related to the sudden cessation of venlafaxine, more may have been done to prescribe him with the medication sooner. This may also have formed part of the risk assessment when considering his risk of suicide and self-harm. We recommend:

The Head of Healthcare should ensure there is a clinical process for monitoring prisoners who may be withdrawing from psychotropic medication associated with a risk of dependency and withdrawal.

Inquest

The inquest held from 13 to 24 January 2025 concluded that Mr Kettles died by suicide.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
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T l 020 7633 4100