Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Coughlan, a prisoner at HMP Bristol, on 16 May 2023

A report by the Prisons and Probation Ombudsman

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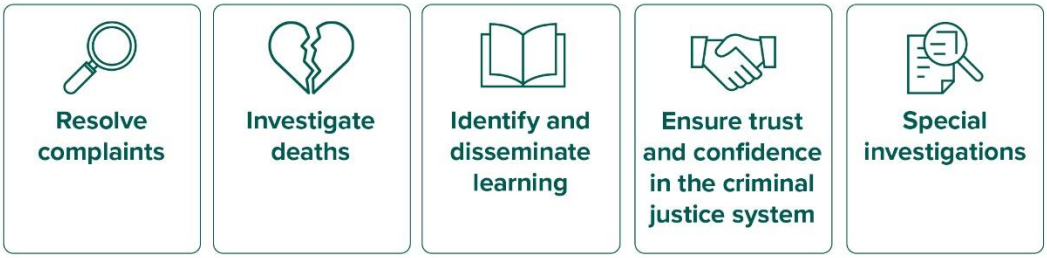
OUR VISION

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

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 Paul Coughlan was found hanged in his cell on 16 May 2023 at HMP Bristol. He was 49 years old. I offer my condolences to Mr Coughlan's family and friends.

Mr Coughlan was the fifth prisoner to take his own life at Bristol in three years. Up to the end of January 2024, there had been four self-inflicted deaths at Bristol since Mr Coughlan's death.

Mr Coughlan had been at Bristol for eight days when he died. It was his first time in prison and his alleged offence was against his former partner. These factors increased his risk of suicide. My investigation found that staff stopped suicide and self-harm monitoring prematurely. Staff placed too much emphasis on what Mr Coughlan told them and did not fully assess his risk factors.

The clinical reviewer concluded that the care Mr Coughlan received at Bristol was equivalent to what he could have expected to receive in the community.

My office has previously raised concerns about the standard of ACCT management at Bristol. In August 2023, I escalated concerns to the Prison Group Director. This is an issue that must be addressed urgently to avoid future self-inflicted deaths at Bristol.

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 **May 2024**

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Summary

Events

1. On 8 May 2023, Mr Paul Coughlan was remanded to HMP Bristol, charged with grievous bodily harm (GBH) against his ex-partner. This was Mr Coughlan's first time in prison. Mr Coughlan had suffered a traumatic brain injury in the community which caused memory loss and slurred speech.

2. Prison staff managed Mr Coughlan under Prison Service suicide and self-harm prevention measures (known as ACCT) when he arrived at Bristol after he told a reception nurse that he intended to self-harm in prison.

3. At the first case review the next day, staff stopped ACCT monitoring because Mr Coughlan said he had no thoughts of suicide or self-harm, and staff assessed his risk of suicide and self-harm as low.

4. On 11 May, the mental health team met and decided that Mr Coughlan did not need any further support or intervention and discharged him from their care.

5. At 5.12am on 16 May, an operational support grade (OSG) completed the morning routine check. He used his torch to look into Mr Coughlan's cell but could not remember what he saw. The OSG said he obtained a verbal response from Mr Coughlan before he moved to the next cell.

6. At 7.25am on 16 May, a prison officer went to Mr Coughlan's cell to complete the second morning routine check. He saw that Mr Coughlan had ligatured from his cell window. The officer immediately radioed a medical emergency code, went into the cell and cut the ligature. Staff decided not to start cardiopulmonary resuscitation (CPR) because it was clear that Mr Coughlan had died. Healthcare staff arrived shortly after and agreed that CPR was not appropriate. Ambulance staff arrived at 7.32am and confirmed that Mr Coughlan had died.

Findings

7. Mr Coughlan had several risk factors for suicide and self-harm. We found that staff were too quick to conclude that he was not at risk and ended support procedures prematurely. They appeared to base their decision on what Mr Coughlan told them rather than considering his risk factors. Mr Coughlan's care plan only recorded one of the issues discussed at the case review and staff decided to close the ACCT before he had received his antidepressant medication.

8. 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.

9. The clinical reviewer concluded that Mr Coughlan's clinical care was equivalent to what he could have expected to receive in the community. She found the healthcare

staff did not fully consider Mr Coughlan's risk factors when supporting the decision to stop ACCT monitoring.

Recommendation

- The Head of Healthcare should consider ways of encouraging staff to have greater professional curiosity about a prisoner's risk factors before supporting the decision to stop ACCT monitoring.

The Investigation Process

10. HMPPS notified us of Mr Coughlan's death on 16 May 2023.

11. 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.

12. The investigator obtained copies of relevant extracts from Mr Coughlan's prison and medical records, viewed CCTV and body worn video camera (BWVC) footage, and listened to recordings of radio transmissions and Mr Coughlan's prison telephone calls. She also obtained the HMPPS Early Learning Review and the police sudden death investigation report.

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

14. The investigator interviewed four members of staff at Bristol between July and September 2023. She and the clinical reviewer jointly interviewed healthcare staff.

15. 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.

16. The investigator spoke to Mr Coughlan's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Coughlan's mother said she was concerned that Mr Coughlan would have convinced prison staff that he was able to cope. She also asked questions that we have answered in separate correspondence.

17. Mr Coughlan's family received a copy of the initial report, but no comments or factual inaccuracies were raised.

18. HMPPS accepted all recommendations made and provided a copy of their action plan to address these.

Background Information

HMP Bristol

19. 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

20. The most recent inspection of HMP Bristol was in July 2023. Following the inspection, the Chief Inspector of Prisons invoked the Urgent Notification (UN) process because he was so concerned about conditions there. (The Urgent Notification process allows His Majesty's 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.

21. 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.

22. 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

23. 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

24. Mr Coughlan was the ninth prisoner to die at Bristol since the start of May 2020, and the sixth self-inflicted death. There had been another four self-inflicted deaths at Bristol by the end of January 2024.

25. 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.

26. 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

27. 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. 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.

28. 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

29. On 8 May 2023, Mr Paul Coughlan was remanded to HMP Bristol charged with GBH against his ex-partner. This was Mr Coughlan's first time in prison.

30. When he arrived at Bristol, a prison officer completed Mr Coughlan's first night induction interview. He noted that Mr Coughlan engaged well and was aware of the support available to him. The electronic escort risk assessment recorded that Mr Coughlan was at risk of suicide and self-harm and staff should monitor him once an hour. Prison staff completed a cell sharing risk assessment (CSRA, assesses a prisoner's suitability to share a cell). This recorded that Mr Coughlan was suitable for sharing a cell.

31. A reception nurse noted that Mr Coughlan had superficial cuts to his forearms and was prescribed 20mg of fluoxetine (antidepressant). Mr Coughlan had experienced a traumatic brain injury (TBI) approximately ten years previously which caused memory loss and slurred speech. He said that he had attempted suicide by ligature in the community but did not say when this had happened and said he intended to self-harm in prison. When the nurse asked Mr Coughlan if he had any current thoughts of suicide or self-harm he said, "if I was given a gun, I would have to think about it". As the nurse was concerned for his safety, she started suicide and self-harm monitoring procedures (known as ACCT) with initial observations set at one an hour. She also sent a referral to the mental health team. Healthcare staff requested a summary of Mr Coughlan's prescribed medication from his GP in the community.

32. Prison staff gave Mr Coughlan a single cell in the vulnerable prisoner's area of the induction wing due to the unknown challenges caused by his TBI. Prison staff observed Mr Coughlan once every hour during the night and did not note any concerns.

33. Also on 8 May, a mental health support worker and a nurse saw Mr Coughlan in his cell. Mr Coughlan said he was joking when he threatened to self-harm and asked for an increase in his antidepressant medication. The nurse sent a task to a GP at the prison to review Mr Coughlan's medication.

34. On 9 May, a Senior Officer (SO) completed an ACCT assessment. Mr Coughlan said that he had not received his antidepressant medication. He felt stressed about sorting the benefits he received in the community and was worried about losing his home. Mr Coughlan was due to attend court and was worried about his trial. She told the investigator she did not record this as a potential trigger on Mr Coughlan's ACCT plan because she was unaware of the court date.

35. Later that day, a SO held the first ACCT case review alongside a mental health nurse. Mr Coughlan spoke about his two children and said he wanted to regain contact with them but understood this would be difficult. He felt the charges against him were very harsh but was looking forward to the opportunity to put his side across in court. Mr Coughlan said that he was due to attend court on 5 June. He said that he had used cocaine in the past but did not achieve much of a buzz from it. The nurse told Mr Coughlan that he was displaying symptoms of attention deficit hyperactivity disorder (ADHD - a mental health condition that can cause unusual

levels of hyperactivity and impulsive behaviour) and she referred him for an assessment. The SO added one action to Mr Coughlan's care plan (designed to identify the main areas of concern and the actions required to reduce risk) in relation to an ADHD assessment. Mr Coughlan said he had attempted suicide with a ligature once in the community but had cut himself down straight away. He was still waiting for his antidepressant medication. He said he had no current thoughts of suicide and self-harm. Despite Mr Coughlan having several risk factors for suicide and self-harm, the SO assessed his risk as low and decided to stop ACCT monitoring. The post-closure phase would end on 16 May.

36. That day, prison staff contacted Mr Coughlan's solicitor on his behalf and asked them to manage his finances while he was in prison.

37. On 10 May, a GP at the prison prescribed Mr Coughlan 20mgs of fluoxetine. A risk assessment said that Mr Coughlan was not allowed to keep his medication in his cell.

38. On 10 May, prison staff completed Mr Coughlan's induction. Mr Coughlan engaged well, and staff explained where he could seek support. Mr Coughlan said he was concerned about associating with a prisoner on another wing and staff added a non-association detail to Mr Coughlan's NOMIS (electronic prison record). On 10 and 12 May, Mr Coughlan made two telephone calls to his solicitor to discuss his financial affairs. Mr Coughlan did not disclose any thoughts of suicide and self-harm.

39. An entry in Mr Coughlan's medical record noted that staff had held a mental health team crisis meeting on 11 May. While Mr Coughlan reported a history of suicide attempts, these appeared to be impulsive rather than planned attempts. The mental health team decided that Mr Coughlan did not need any further input and discharged him from their care. The entry did not record who attended the meeting.

40. Prison staff completed the seven-day ACCT post-closure monitoring form daily. Mr Coughlan did not express any concerns and staff noted that he was polite and mixed well with other prisoners on the wing.

Events of 15 and 16 May

41. On 15 May, Mr Coughlan did not attend his secondary health screen because wing staff did not collect him. Staff did not record in the wing observation book why this had happened.

42. At approximately 4.45pm, Mr Coughlan collected his evening meal and returned to his cell. A prison officer completed the afternoon routine count at 5.50pm. Mr Coughlan was in his cell and did not raise any concerns.

43. At approximately 8.30pm, an OSG completed the evening routine count. He told the investigator that he looked through the observation panel and saw Mr Coughlan in his cell. Mr Coughlan did not ring his cell bell during the night and staff had no reason to check him.

44. CCTV shows that the OSG went to Mr Coughlan's cell again at 5.12am on 16 May to carry out the first routine check of the day. He spent a few seconds looking into

Mr Coughlan's cell and shone his torch through the observation panel. He told the investigator that he knocked on the cell door and used his torch to look in the cell. He could not remember what he saw in Mr Coughlan's cell. He said that he waited for a verbal response from Mr Coughlan before he moved to the next cell.

45. At 7.25am, an officer went to Mr Coughlan's cell to complete the second routine check of the morning. In a written statement, he said that he looked through the observation panel and saw Mr Coughlan hanging from the window with a ligature around his neck. He radioed an emergency code blue (indicating a prisoner is unconscious or has breathing difficulties) and control room staff called an ambulance immediately. He went into Mr Coughlan's cell and cut the ligature.

46. At 7.27am, two nurses arrived at Mr Coughlan's cell. They agreed not to start CPR as it was evident Mr Coughlan was already dead. One nurse noted that Mr Coughlan was cold to touch, and rigor mortis was evident in his legs. The paramedics arrived at 7.32am and, at 7.39am, they confirmed that Mr Coughlan had died.

47. The police found two envelopes in Mr Coughlan's cell. One contained documents relating to his imprisonment, his court case and instructions to prison staff about his property and finances. The other was a note to his ex-partner and a diary. The police also found a letter from Mr Coughlan to a friend. Mr Coughlan said he had no family support in prison and asked his friend to contact his parents. Mr Coughlan also left a note to his children which said he loved them, and he apologised for his actions.

Contact with Mr Coughlan's family

48. The prison appointed a family liaison officer (FLO). As Mr Coughlan had not provided next of kin details when he arrived at Bristol, the FLO contacted Mr Coughlan's solicitor. The solicitor said that Mr Coughlan did not have contact with his family. The FLO asked the police for assistance.

49. On 16 May, the police visited the last known address of Mr Coughlan's family and were informed that they had moved abroad over ten years ago.

50. A few weeks later, Mr Coughlan's mother contacted Bristol and asked if Mr Coughlan had died (she apparently saw a news article about his death). The FLO offered her condolences and support.

51. The prison contributed towards Mr Coughlan's funeral in accordance with prison instructions.

Support for prisoners and staff

52. 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.

53. After Mr Coughlan'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.

54. The prison posted notices informing other prisoners of Mr Coughlan'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 Coughlan's death.

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

Post-mortem report

56. The post-mortem report concluded that Mr Coughlan died from compression of the neck caused by suspension by ligature (hanging).

57. The pathologist commented that it was not possible to determine from the medical evidence when suspension occurred or the precise time of Mr Coughlan's death. He said that in general terms, rigor mortis takes a few hours to develop but may be more rapid in warm environmental temperatures and, on occasions, without any particular explanation. The rapid fatal sequence expected following ligature compression of the neck means that death may occur between even frequent checks in a prison setting.

Findings

Assessment of Mr Coughlan's risk of suicide and self-harm

58. Mr Coughlan had been at Bristol for eight days when he died. He had a number of risk factors that increased his risk of suicide and self-harm. He was on remand for a violent offence against his ex-partner and had a history of relationship instability. Mr Coughlan was a vulnerable prisoner due to the impact of his TBI and he had no support from his friends or family. He felt angry that the charges against him were harsh and he was worried about his trial.

59. Mr Coughlan was supported by ACCT procedures when he arrived at Bristol, after he told staff he intended to self-harm in prison. Staff stopped ACCT monitoring at the first case review the next day. Mr Coughlan was due a post closure case review on the day he died.

60. We found that staff stopped ACCT procedures prematurely and placed too much emphasis on what Mr Coughlan said rather than his objective risk factors. They had had no time to build a rapport or any sort of understanding of Mr Coughlan and his risks and he was still within his first 24 hours in prison for the first time. It is unlikely that, whether or not he meant that he had no thoughts of suicide, he had any real sense of how he was feeling or coping.

61. Mr Coughlan's care plan listed one action (related to the ADHD referral) and there were no actions relating to his antidepressant medication, history of substance misuse, his TBI, or rebuilding contact with his children, all issues that were discussed at the case review. Staff decided to close the ACCT when Mr Coughlan had not been prescribed his antidepressant medication. Mr Coughlan's next court appearance less than a month later was not recorded as a trigger on his ACCT plan. We consider that the case review team did not balance all of these factors against what Mr Coughlan said about his intentions.

62. In our investigation into a self-inflicted death at Bristol in November 2022, we found that ACCTs were closed prematurely, and 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.

63. In their response, the PGD said that the safer custody team now had an additional member of staff to oversee the ACCT process and to provide additional support to case managers. ACCT quality assurance was discussed at the daily senior leadership meeting and the prison had introduced a fortnightly 100% quality assurance check. A supervising officer completed daily ACCT checks which were monitored by the residential management team.

64. The group safety team visited Bristol twice a month to quality assure Bristol's ACCT procedures and provide a monthly progress report to the PGD. The PGD had also increased the frequency of their visits to Bristol to every three weeks to ensure improvements were embedded.

65. Under normal circumstances, we would make a recommendation to the PGD about the repeated failures in ACCT management demonstrated by Mr Coughlan's death. In light of the PGD response we are satisfied that they have taken the necessary steps to improve the management of ACCT procedures and the prison will require a period of time to assess if the changes are effective.

Mental and physical healthcare

66. The clinical reviewer concluded that Mr Coughlan's clinical care at Bristol was of a reasonable standard and equivalent to what he could have expected to receive in the community. She considered the decision of a nurse to refer Mr Coughlan for an ADHD assessment as best practice. The clinical reviewer did, however, identify some concerns.

67. Mr Coughlan had a history of anxiety and depression and often struggled to understand questions due to his TBI. During the case review, a nurse asked Mr Coughlan about the impact of his brain injury and noted that he spoke quickly. Mr Coughlan said that he was vulnerable to recurring head injuries, but he did not need any additional support.

68. The clinical reviewer found that the nurse relied on Mr Coughlan's demeanour and his response to questions rather than considering his objective risk factors. The case review did not fully explore Mr Coughlan's risk and vulnerabilities. We recommend:

    The Head of Healthcare should consider ways of encouraging staff to have greater professional curiosity about a prisoner's risk factors before supporting the decision to stop ACCT monitoring.

69. When Mr Coughlan failed to attend his secondary health assessment, there was no evidence that healthcare staff attempted to find out why, or that they arranged another appointment. The clinical reviewer considered that this was a missed opportunity to fully assess Mr Coughlan's vulnerabilities.

70. During a mental health team crisis meeting on 11 May, healthcare staff decided that Mr Coughlan did not need further input or support because his suicide history appeared to be based on impulse rather than planned attempts. The clinical reviewer found that the entry in Mr Coughlan's medical record did not document who attended the review or evidence that healthcare staff fully considered Mr Coughlan's risk factors before he was discharged from their care.

71. The clinical reviewer has also made recommendations about record keeping, training and secondary health assessments, which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Good practice

72. Prison staff gave Mr Coughlan a single cell on the vulnerable prisoner's area of the induction wing due to the unknown challenges caused by his TBI This ensured that Mr Coughlan was located close to the wing office and staff were aware that he may need extra support. (However, there is no evidence to suggest that he did, in fact, receive any additional support.)

73. When the officer saw that Mr Coughlan had ligatured in his cell, he made a rapid dynamic risk assessment and quickly unlocked and went into Mr Coughlan's cell.

74. The decision of prison and healthcare staff not to attempt cardiopulmonary resuscitation was appropriate and demonstrated that they were aware of the Resuscitation Council's guidelines on when resuscitation was likely to be futile and ensured that Mr Coughlan's dignity was preserved.

Inquest

75. At the Inquest, which took place on 1 September 2025, the Coroner concluded that Mr Coughlan died by suicide.

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