Investigation into the circumstances surrounding the death of a male prisoner at HMP Bristol, on 25 September 2009

Report by the Prisons and Probation Ombudsman for England and Wales

May 2010

This is the report of the investigation into the circumstances surrounding the death of a man. The man was found hanging in his cell on A wing at HMP Bristol on 25 September 2009. He had been in custody for twelve weeks.

An investigator from my office has undertaken the investigation. I would like to thank the Governor of Bristol, and his staff for their participation. Bristol Community Health was commissioned to undertake a review of the man's clinical care while at Bristol. A Clinical Reviewer was appointed by them to conduct the review and I thank him for his report.

I would like to add my condolences to those already expressed by the investigator and the Family Liaison Officer, to the man's family and friends.

The man had been a remand prisoner at Bristol since 4 July 2009 and worked as a landing cleaner on A wing. In late August, a member of staff became concerned about the man and, following an assessment, it was decided he would benefit from a period away from the wing. He was admitted to the healthcare wing where he was diagnosed with reactive depression. He declined the offer of antidepressants but accepted medication to help him sleep. After a week, he returned to A wing and was described as upbeat and talkative. Neither staff nor the man raised any other concerns after his return, but his family consider he might have masked his feelings.

On 25 September, wing staff unlocked prisoners at around 8.10am and began the morning routine. A fellow prisoner, who was also a cleaner on the landing with the man, went to his cell as he had not come out to begin cleaning and discovered him hanging by a ligature from the end of his bed. Staff went into the cell, cut the ligature and checked for signs of life. However, it was apparent to them that the man had been dead for some time and cardio pulmonary resuscitation was not attempted. A prison doctor, (Doctor A) confirmed the man's death at 8.58am.

In the draft report, I said that with hindsight, it might have been appropriate to implement Assessment, Care in Custody and Teamwork (ACCT) procedures, which provide additional support for prisoners at risk of harming themselves. Following the issue of the draft report, the man's family provided new information to the investigator. Further enquiries were then made which revealed evidence that the man's family had raised concerns about his welfare before his death.

Six recommendations were made relating to ACCT procedures and training, mental health assessments, roll checks and information from prisoners' families. Four of these have been fully accepted by the prison and a further two partially accepted by the healthcare department. I make an additional two recommendations in relation to dealing with information from prisoner's families.

Jane Webb
Acting Prisons and Probation Ombudsman **May 2010**

CONTENTS

SUMMARY

The man was remanded into custody to HMP Bristol on 4 July 2009. This was his first time in custody. On his reception at Bristol, a nurse conducted a health screen. The man disclosed no previous physical or mental health concerns during the screening and said that he had no thoughts of harming himself. The nurse advised him to speak with a member of staff if he began feeling less stable at any point.

He was then located onto A4, which is the first night landing. Although prisoners usually only spend a short time on A4 before moving to other wings, the man was considered mature in his approach and offered a job as landing cleaner which he happily accepted. He was also asked to act as an Insider and talk to other new prisoners on their first night in custody. (Insiders are volunteer prisoners who offer advice and support to other prisoners when they first enter custody and at other times as required.)

The man settled in well to the regime and built a good rapport with staff and fellow prisoners. Staff considered him to be coping well and had no cause for concern. In spite of staff perceptions, during visits from his family and in telephone calls he spoke about feeling that he would never get out of prison and appeared to them to be very depressed. The man had been refused bail, which was a shock to him. He began to feel that people were passing information to the police and he had various anxieties about his future. However, despite these concerns, on the wing he portrayed a person who was coping and would happily go about his daily tasks and share a laugh with staff and other prisoners.

On 25 August, the man asked to speak with Officer A who regularly worked on A4 and had known him since he arrived at Bristol. He expressed concerns about his case and Officer A felt that he appeared down and not himself. As a result, the officer asked for a member of the healthcare staff to assess him on the wing. Later that day, a nurse spoke with the man and he confirmed that he was feeling low. He also spoke about a family history of depression and the suicide of his sister, the first time he had mentioned this. The nurse considered that he would benefit from a period away from the wing and arranged for him to be admitted to the healthcare wing later that day. Arrangements were also made for him to be seen by a doctor and the Mental Health In-Reach Team (MHIRT). A mental health nurse assessed him and diagnosed reactive depression (when depression is triggered by a traumatic, difficult or stressful event). The man declined the offer of medication to help with his symptoms. He denied any thoughts of self-harm and returned to A4 landing after a week.

After the man returned to the wing, staff and fellow prisoners commented that he appeared much happier and he continued with his cleaning job. However, in telephone calls to his family he continued to be distressed and spoke of feeling that he would never be released. During visits, his family said they noticed a visible decline in his appearance and described him as low in mood, tearful and paranoid.

On 24 September, the man spent the day cleaning as usual and appeared his normal self, interacting with staff and other prisoners. Although it could not be confirmed, it is likely that he had spent time out of his cell during the evening. He was locked in his cell at 7.00pm. A roll check was carried out at this time and no problems were reported. During the night, no problems were reported and an Operational Support Grade (OSG) carried out a further roll check at 5.30am on 25 September. (An OSG is the grade below a prison officer.) When the OSG checked the man's cell, he observed what he thought was someone in the bed and no concerns were raised. Officers arrived for the day shift at 7.30am, and unlocked all the cells on A4 at around 8.15am. Officer B, who unlocked the man's cell, looked in and also saw what he thought was someone under the bed covers. He said good morning and moved on to the next cell. The two officers then dealt with queries from prisoners.

At 8.40am, a fellow prisoner who cleaned with the man became concerned that he had not seen him and went to his cell to check that he was out of bed. At first, he stood by the door and could not see anything untoward. However, as he walked further into the cell he saw the man hanging by a ligature at the end of his bed. He immediately left the cell and called for the officers to attend.

Officer A was the first to go into the cell, and initially he could not see a problem, the man was at the back of the cell and a locker had been placed to hide him from view of the doorway. As he went further into the cell, he saw the man and called for Officer B to assist him. The two officers tried to lift the man and Officer A cut the ligature attached to the man's neck. Once the ligature had been removed the man was checked for any signs of life, but no pulse or breathing could be detected. Officer A said that it was clear to him, from the man's appearance that he had been hanging for sometime.

Additional staff arrived, including healthcare workers who also checked for signs of life but again concluded the man had been dead for sometime and that cardio pulmonary resuscitation would not be of any benefit. Doctor A, confirmed the man's death at 8.58am.

Prison staff broke the news to the man's family and kept in regular contact with them during the subsequent arrangements.

My recommendations cover appropriate implementation of ACCT and mental health assessments, as well as updating the documents for roll checks and the handling of concerns raised by prisoners' families.

THE INVESTIGATION PROCESS

1. Notices informing both staff and prisoners of the investigation were issued on 28 September. They invited anyone who had information about the man's death to contact the investigator. No responses were received.

2. The investigator, telephoned the prison initially on 25 September and again on 28 September. He spoke with the Deputy Governor, to arrange for the man's prison and medical records to be made available to him. The investigator visited Bristol on 30 September with a colleague, when they met the Deputy Governor and members of the senior management team. The investigator also viewed the cell occupied by the man on A wing and briefly spoke to staff and prisoners who had known him.

3. The investigator and his colleague visited Bristol again on 4 November, and conducted interviews with four members of staff who were in regular contact with the man or involved with him during his time at Bristol. Transcripts of these interviews are attached as annexes.

4. Bristol Community Health were commissioned to conduct an independent review of the medical care that the man received in custody at Bristol. The man had very little contact with healthcare while in custody and the Clinical Reviewer was asked to look at the mental health assessment that the man had in August 2009. I would like to thank the Clinical Reviewer for his report.

5. The next of kin details provided by the prison indicated that the man had been separated from his wife for some time but they were still close friends and in regular contact. The man's father and partner also remained in regular contact. The Family Liaison Officer telephoned and wrote to the man's family and they accepted her offer to visit them at their home.

6. During the visit on 10 November, the Family Liaison Officer explained the investigation process again and the investigator apprised the family of his investigation to date. The man's family said that they were concerned that prison staff had not noticed the deterioration in the man's mental wellbeing sooner and that he had not been subject to closer monitoring. These and other matters raised by the man's family are addressed within the report. I hope the findings provide them with a better understanding of the events leading up to his death.

7. The investigator contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem. The post mortem concluded that the man died as a result of hanging.

HMP BRISTOL

8. HMP Bristol is a local prison, located in a largely residential area in the middle of the city. It can accommodate up to 606 adult male prisoners across seven wings with an additional healthcare unit. The first night centre is located on A wing along with the induction landing and detoxification. A regular staff group work on the first night centre and cover additional duties in the reception in the evenings.

9. Bristol PCT provides healthcare and the healthcare centre provides 20 in-patient beds. Mental health services are provided by Avon and Wiltshire Partnership Trust and six registered mental health nurses provide support to prisoners on a full-time basis.

10. HM Chief Inspector of Prisons carried out an unannounced inspection in March 2008 following a previous inspection in 2005. She reported that the Inspectorate "were extremely encouraged by the significant developments in all aspects of health services". In a recommendation regarding the transfer of healthcare services at Bristol, HM Chief Inspector of Prisons said:

> "There were robust links between the establishment and the PCT. Health services were strongly supported by the Governor and there was robust and effective operational and clinical leadership. Health services were fully assimilated into the regime and there were innovative working practices in the healthcare department. All health services staff were employed by one of three organisations: the PCT, the Avon and Wiltshire Partnership Trust or the prison. However, from May 2008, staff would only be employed by either the PCT or the Avon and Wiltshire Partnership Trust. Staffing and managerial issues were beginning to reach a steady state and there were only two nursing vacancies at the time of the inspection. There had been a lengthy period of staff sickness but this had been addressed through the occupational health service. Administrative support was efficient, and current staffing levels and skill mix were good, and included registered nurses, healthcare officers and healthcare assistants. PCT bank nurses were used where necessary and the number of agency nurses had been significantly reduced."

11. With regards to self-harm and suicide, HM Chief Inspector of Prisons had recommended in her initial inspection that there should be a safer custody strategy to help reduce the risk of self-harm and clarify the role and responsibilities of Listeners. (Listeners are trained by the Samaritans to provide emotional support to fellow prisoners in distress. ACCT is a process for monitoring and supporting prisoners at risk of self-harm and suicide.) During the follow up inspection the HM Chief Inspector of Prisons found that the prison had achieved this and in her report said:

> "The prison had recently written a new safer custody policy document which was comprehensive and outlined, among other things, the role and responsibilities of Listeners. It also provided information about the detailed systems for supporting prisoners on open Assessment, Care in Custody and Teamwork (ACCT) documents."

12. Every prison in England and Wales has an Independent Monitoring Board (IMB). The members are volunteers who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. The Bristol Independent Monitoring Board's (IMB) annual report 2006/07noted the "high quality of staff and prisoner relations". They welcomed the commissioning of healthcare by Bristol PCT and the review of the necessary skills mix that accompanied it. They also refer to Safer Custody provision and conclude:

> "Safer Custody and Violence Reduction are handled with professionalism and enthusiasm by the allotted team in conjunction with the PSO 2700 guidance.
>
> "It is, however, worth observing that prison officers should not have to cope with the many mentally ill prisoners in an establishment not designed for purpose, whilst they do handle such prisoners with care and respect, they are not mental health nurses albeit they receive some mental health training."

13. Since 2004 when the Ombudsman began investigating all deaths in prison custody there have been five deaths at Bristol, which were self-inflicted. There were, however, no direct similarities between these and that of the man.

KEY FINDINGS

14. The man was remanded into custody at HMP Bristol on 4 July 2009. This was his first time in prison. On arrival at the prison, a nurse assessed him and completed an initial health screen. The nurse asked various questions about his existing and previous health concerns. The man replied that he was not receiving treatment at that time and had no medical problems. The nurse also explained that some people find coming into custody difficult and might consider harming themselves. She asked him if he felt that way, to which he replied, "I don't think so". In relation to his mental health, the man said that he had no problems and clarified that he had never been seen by a psychiatrist or received medication for his mental health. The nurse recorded in the man's medical record that there were no notable medical needs and that she had advised the man to speak to either an officer or wing nurse if he felt less stable.

15. Following the reception process, the man was located onto A4 landing, which is the first night centre. Over the next few days, the man went through a full induction during which he was informed of the rules and services on offer at the prison, including access to the Samaritans and other support services. It is normal for prisoners to move on to one of the other wings once they have completed the induction. However, the man was considered by staff to have the right attributes/qualities to become a landing cleaner and also offer advice and support to other new prisoners. This is a role known in the prison as an 'Insider'. He was pleased to be given the opportunity to work so soon after arriving and was said to be happy to provide support to fellow prisoners.

16. Staff on A4 landing described him as a very likeable man who was hard working but could also be quiet and was careful who he spoke to about personal matters. Officer A had known the man since he arrived at Bristol and worked regularly on A4 landing. He told the investigator, that he would often speak with him about his case or his family and he always appeared upbeat. The man was also well thought of by other prisoners who knew him from the local community. Although located on different wings shortly after his arrival, some of them put together a few items to help him settle in, as they knew that he had arrived with very little. He received regular visits from his father, wife, children, partner and friends. The man also telephoned his children regularly.

17. The man worked hard in his role as landing cleaner and received favourable reports from wing staff. He remained positive when dealing with both staff and other prisoners and gave no cause for concern. However, after his death the investigator had the opportunity to listen to telephone calls made during the man's time in custody. It is apparent from the calls that he was not coping with being in custody and being away from his, family as well as he had led people to believe. Although prisoners are advised on reception that telephone calls may be monitored, not all calls are routinely listened to. Only those prisoners

who are subject to certain restrictions or considered a security risk will have all telephone calls listened to. The man was not considered to be in either of these groups. The man's father told the investigator that he found it difficult to understand why his son's telephone calls were not subject to routine monitoring, given that his case was considered serious enough for him to be refused bail. As mentioned above, the criteria for monitoring telephone calls is based on the need for public protection and security, and not necessarily the circumstances of individuals' offences.

18. The man had been refused bail as the court considered he might escape. The decision might have been influenced by the fact that he owned property abroad. The refusal to grant bail was something that caused him concern. The man was worried that he would never get out of prison and he expressed these concerns to his family during visits. He also reportedly spoke to another prisoner on A4 landing with whom he had been friends in the community. He spoke of his concern that he was going to lose everything that he had worked so hard for and his family would be left with nothing. During these conversations, the man spoke about a confiscation order against him.

19. The investigator contacted the police officer dealing with the man's case to ask what actions were being taken against him. The officer confirmed that the man was held on remand for possessing an imitation firearm as well as a second charge of allowing premises to be used for the cultivation of cannabis. The officer said that the police were still in the process of investigating the case when the man died. The officer explained that a confiscation order would only be made if he had been convicted of a drugs offence. Given there had been no conviction, the police had not considered this or mentioned it to the man.

20. The man's wife told the investigator that she visited her husband with her daughter in August and they were concerned by his appearance. She said that he was looking very down and it was like "the lights were on but no one was in". She said that she reported her concerns to an officer on duty in the visits room who initially said that nothing could be done unless the man himself asked for help. However, after insisting that her husband was spoken to, officers asked him whether he was all right and he replied that he was. The man's wife felt that her husband was unlikely to say anything different in this setting. She said that he kept asking questions and seeking reassurance that she would look after his mother and children. She said that, in hindsight, it seemed as though he was making sure that everyone would be looked after.

21. The man's wife also said that another prisoner, in custody at the same time as her husband, mentioned an occasion when the man had to be helped from the shower. He had been seen standing, motionless, in the shower for a long time and prisoners alerted staff who intervened and helped him back to his cell. The investigator spoke about this to Officer B who worked regularly on A4 landing. Officer B said that he was not aware of any such problem with the man and had not seen anything

documented about this. He believed that if this had taken place it was significant enough for all regular landing staff to have been made aware of it. It is not possible to clarify whether the events described took place, as there is no documentary evidence.

22. The man's father also told the investigator that he had been concerned about his son when he visited him. He explained that his son appeared to become very low and repeatedly said that he was not going to get out of prison. He could not understand why his son kept saying this and continued to reassure him that everything would be all right. The man's family said that during a visit he told his daughter that he had some 'good news' and appeared optimistic. However, his father told the Family Liaison Officer that when his son spoke to his partner on the telephone the following day he was in tears and very low. The man's father was concerned that something had happened to him during this period to affect his mood. During the investigation, no evidence was found to suggest that anything of significance happened to explain the change in the man's mood.

23. The investigator was also told by the man's father that his mother had contacted the prison via a telephone helpline (described later in this report) in order to inform them of the family history of depression. She left a message and was told that someone would contact her, but the man's father said that to his knowledge this did not happen. The investigator examined the log of calls received by the prison helpline during the period the man was in custody and no calls are recorded in relation to him.

24. However, following the issue of the draft report, the man's father contacted the Family Liaison Officer, and provided a telephone number that the man's mother had called on 24 August. The Family Liaison Officer shared this information with the investigator who in turn contacted the Deputy Governor at Bristol. The Deputy Governor said that he would attempt to identify the telephone number, as it did not appear to be a recognised prison contact, and get back to the investigator.

25. While he was awaiting the man's response, the investigator contacted the man's father to try to gain more information about the call. The man's father explained that his ex wife had obtained the number from a leaflet that she had received from the prison. The investigator identified that the leaflet related to the Prison Advice and Care Trust (PACT) who run the visitor's centre at Bristol. The investigator then telephoned the Deputy Governor, who had by this time also identified that the call had been made to PACT. He told the investigator that he had spoken with the member of staff who runs the visitor's centre (Staff A) and that he was looking back through the records to trace the notes of any calls received.

26. Staff A found the notes that he had made following the concerns raised by the man's family, which also documented the action that he had

taken. The Deputy Governor passed these to the investigator. Staff A's notes say:

> " … The man's mother rang because she is concerned about change in his behaviour since he came in. When she visited last Thursday, he and stared into space most of the time. Said he is not sleeping. People who have visited since say that he has got worse. He said he is ok. I gave her the self-harm number to ring if she sees him again on Friday and is still concerned.
>
> I rang Mental Health team who will put him down for assessment. It could just be normal reaction and adjustment, but they will put on list so it could be either Tuesday or Thursday. Gave them mothers' telephone number but they will not necessarily ring …"

27. There is no evidence that the information received by Staff A on 24 August was shared with wing staff. On A wing, the impression that the man portrayed to staff did not give them any cause for concern. Regular wing staff said that he continued to go about his cleaning work as usual and, although never overly talkative, would chat with staff as he did so. However, on 25 August, the man asked to speak in private with Officer A, who also worked regularly on A4. The investigator asked Officer A if he could recall what the man wished to talk about. He replied that the man told him that the police had asked him about dates, mobile telephone numbers and bank accounts. He was concerned that there was a conspiracy against him or someone had been "grassing him up". Officer A said that the man appeared to struggle to understand where their information had come from. Officer A told the investigator that he did not know the man's case so was unable to offer any real advice.

28. In response to the draft report, the man's father also raised concerns that his son was being placed under undue pressure from the police in relation to his case. He asked whether his son would have been interviewed by the police without his solicitor present. When an individual is in custody and the police are continuing to make enquiries into the alleged offences, they can arrange to visit the prison to conduct an interview. The police will book the visit with the prison in the same way as other legal visits and the prisoner will be notified so they can arrange legal representation. If a prisoner has no legal representation, prison staff will ask the individual to confirm they are happy to proceed before the interview takes place. It is not clear when the police visited the man, but it is unlikely that such a visit would have been conducted without his solicitor being present.

29. The investigator asked Officer A if their conversation had led him to have concerns about the man. The officer said that a prisoner discussing his case would not in itself cause concern as this often happened but he had felt that something was not right. He was concerned about the way the

man carried himself and considered he was very quiet, even though he was talking. Officer A said the man seemed to be having a conversation with himself, trying to work things out and just needed someone there to listen.

30. Officer A said that after the conversation, he telephoned the healthcare department to ask someone from the Mental Health In-Reach (MHIRT) to go and speak with the man. No one was available but, the nurse who took the call agreed to speak to him and did so within the hour. The nurse recorded:

> "… Has been in prison for approximately seven weeks, working as cleaner on 4's landing but last few days officers have been worried that he has become withdrawn. Spoke with the man, very withdrawn, and unkempt, wringing hands and head in hands. Says that he has history of depression in his family and sister committed suicide at the age of 26, mother clinically depressed. The man has never been in custody before. Never been treated for depression. Not eating at present and has lost a lot of weight. Not sleeping well and has not telephoned home to wife and children for last couple of days. To be admitted to healthcare for full mental health assessment. Feels helpless at present and unable to make a decision for himself. Is agreeable to being admitted to healthcare, Doctor A informed …"

31. From the entry made by the nurse it would appear that she was unaware of the call made by the man's mother, and the conversation that Staff A had with the Mental Health team. This was the first record of the man mentioning his family history of mental health problems. When asked about the man's reaction to being told that he was to be admitted to healthcare, Officer A said he thought that the man was looking forward to spending some time away from the wing to be able to reflect on things. The man was admitted to the healthcare wing later that afternoon.

32. The man's father asked about the qualifications and suitability of nursing staff conducting mental health assessments. It is the case that not all nursing staff in the prison have a mental health background, but general nurses are able to assess an individual's need for further intervention by trained mental health staff and this was the purpose of the nurse's referral.

33. During the meeting with the investigator and the Family Liaison Officer, the man's wife said that a friend had gone to visit her husband the day that he was admitted to healthcare. The friend was informed that he was unwell and therefore would not attend the visit. The man's wife had also visited around the same time and told a female member of staff of her anxiety. She was concerned that her husband had visibly declined in both appearance and mentally. She was desperate for someone to help

him, particularly given the history of suicide and mental health issues in his family. The man's wife said that the person to whom she had spoken made a note of her concerns but she was unaware of any other action being taken as a result. The investigator made enquiries to try to identify the member of staff, but no recorded information could be found and no one was identified amongst the visit centre staff.

34. On 26 August, the day after the man was admitted to the healthcare centre, a Doctor assessed him and recorded in his medical record:

> "… Feeling flat and drained for 3-4 weeks. Suicide of sister and worried about his family. No thoughts of self-harm. Used Cocaine for many years at weekends. History of depression in family. Does not wish to take offered anti-depressants. Prescribed Zopiclone 7.5mg at night …"

35. The information supplied by Staff A following the draft report also notes a telephone call that he received from the man's wife on 27 August:

> "… Call from the man's, wife. They heard he had been moved to healthcare wing and were worried about him. I also had calls from the man's mother and from a cousin or aunt. Said that I would telephone his wife and ask her to pass information on. They told me that the man's mum is having a breakdown and that they had called a doctor out to see her this afternoon, but not to tell him, as it would make him worse.
>
> Went to healthcare, as they did not return my call. Would not comment but told me to see him. The man cried as soon as I said something kind. He said to tell his family he was low and that he loved them. I telephoned the man's wife and asked her to talk to the rest of the family, which she said she would do. I told her what he had said and that he was in tears. The man's wife said that her husband had never asked for help before. He has children of 17, 16 and 9. I suggested she look up 'Rethink' website for them and that the family contact the carers centre. I said that I would not telephone the man's mother as she is in a bad way …"

36. Nurse A, a mental health trained nurse, conducted a mental health assessment with the man on 30 August, five days after his admission. It is unclear whether this assessment was as a result of the man's admission to healthcare or the call made to Staff A on 24 August. As part of his assessment, Nurse A recorded the following about the man's mood:

> " … Coming to prison was a shock to him as first time in prison. His low mood started on the wing whenever he thinks about being in prison and being the 'bread winner'. Most significantly,

> he misses his children a lot because he is very close to them. He described his mood as terrible before coming to healthcare setting, loss of energy and feeling run down. Everything appears gloomy and hopeless. He tries to avoid mixing with other prisoners because he prefers to be on his own and reminisce …"

Following the discussion about the man's perception of his problems, Nurse A questioned him in more detail and recorded the following:

> " … His mood has no underlying diurnal variation, neither being worse in the morning nor improving as the day goes on, and remains the same. **Guilt**: Feels that he let the family down especially his children and as the breadwinner. **Suicide**: Has no suicide ideation and never made any attempt in the past. **Fatigability**: Loss of energy and being easily tired. **Insomnia**: Unable to sleep but having had zopiclone for 3 nights appears to have restored his sleep pattern. **Anorexia**: Loss of appetite to begin with but now regaining it back. **Thought disorder**: No evidence of any form of thought disorder, no evidence of any form of hallucinations, hostility or suspiciousness …"

Nurse A concluded:

> " … The man has been suffering from reactive depression as first time in prison, guilt (breadwinner) and missing his children. States coming to healthcare setting gave him a break and relaxing atmosphere and he is ready to be moved onto normal location. He declined to take any form of anti-depressant medication when first suggested by the doctor …"

37. At interview, the investigator asked Nurse A whether he considered opening an Assessment, Care in Custody and Teamwork (ACCT) document, given the man's response, particularly as he made reference to being hopeless and gloomy. (Any member of staff working in a prison who has concerns about the welfare of a prisoner can open ACCT documents.)

38. The information from Staff A was not available to the investigator when he interviewed Nurse A, but Nurse A did not indicate that he was aware of the concerns that had been raised by the man's family. There is also nothing documented in the man's medical notes regarding the information passed to the healthcare team by Staff A.

39. Nurse A said that he had discussed with the man any thoughts of self-harm and he had no concerns that would require the opening of an ACCT. The investigator asked Nurse A whether the factors such as first time in prison, feelings of guilt and missing his children would have increased the man's level of risk of self-harm. Nurse A confirmed this and said that an assessment would normally lead to a review by a

doctor. The doctor and nurse would jointly decide on appropriate treatment. He added that, if the man had required additional monitoring at that time he would have opened an ACCT document. The investigation found no evidence that the review process described by Nurse A took place in relation to the man.

40. Staff on A wing told the investigator that, when the man returned to his wing on 1 September, it was like having "the old man back". He had mentioned that the time spent in healthcare had been useful. His job on the landing had been kept for him although he was located a different cell. This reportedly caused no problem for him. He was sharing a cell with another prisoner with whom he appeared to get on well. The man went about his daily work in his usual efficient way and staff had no cause for concern. He continued to telephone his family regularly. During the investigation, the investigator had access to the recordings of these calls and it was apparent that the man was missing his family. The man's wife told the investigator and the Family Liaison Officer that her husband was a very difficult person to read and good at hiding his feelings.

41. The prisoner with whom the man shared a cell was released towards the end of September. Staff told the investigator that, as he was out of his cell most of the day, they did not want to place a newly arrived prisoner with him and asked if he would rather remain on his own. This would have changed if the prison had a large intake of new prisoners but at this time numbers were reportedly quite low. The man told staff that he would appreciate some time to himself.

42. On 24 September, the man was unlocked from his cell as usual and spent the day cleaning. Staff said he appeared to be his usual self and raised no concerns. That evening, it is likely that he and the other cleaners were unlocked from their cells for a period of association. (Association is the time when prisoners are allowed out of their cells to socialise, make telephone calls or shower.) If so, he would have been locked up at 7.00pm and a roll check, to count the number of prisoners, would have taken place. However, the investigator could not confirm whether the cleaners had association that evening as no regular members of landing staff were on duty at that time.

43. During the night of 24 September, Operational Support Grade (OSG) A was on duty on A wing. OSG A has worked at Bristol for around 12 years and been permanently on night duties for the last year. At interview, OSG A explained that when he arrived for duty it was normal for him to be given a handover from the day staff before he started to check all the cells. The investigator asked OSG A whether he checked that all cells were secure and also counted the prisoners. OSG A replied that this was not necessary as the day staff would have already counted the prisoners at 7.30pm and reported the numbers to the control room.

44. OSG A confirmed that he had no reason to go to the man's cell during the night. At around 5.30am on 25 September, OSG A conducted the next routine roll check, checking each cell and confirming that the correct number of prisoners were in each. OSG A reported his numbers to the control room and confirmed no problems on the wing. The investigator asked OSG A whether he could recall checking the man's cell, and he said that he had no recollection of it in particular. OSG A explained that his aim when conducting a roll check is to ensure that the correct number of prisoners are in each cell.

45. OSG A finished duty at around 7.30am when he was relieved by the day staff. In response to a question by the investigator, he said that the check he carried out and reported at 6.00am is the only roll check during the morning. The day staff also confirmed that they are not required to conduct a roll check when they start duty.

46. Officers A and B both arrived for duty on A wing at 7.30am on 25 September. After attending the morning briefing with other staff, they went to the fours landing. Each officer went down one side of the landing, unlocking all the cells. Officer A unlocked the side where the man's cell was located at around 8.15am.

47. The investigator asked Officer B to explain the procedure he followed when opening a cell door. Officer B explained:

> "I'll open up the observation hatch, which is the small window on the outside of the door, to make sure that there is no one waiting at the door. I did this, and with the man's cell, it did appear that he was in bed at the time. I said good morning, which I do to every cell, and then carried on to the end of the landing."

48. In response to the draft report, the man's family asked what level of response is required from a prisoner when staff unlock their cells. Officers will normally check the cell via the observation panel before opening the door and then open the door, but not so that it is fully open. Staff try to ensure that a prisoner's dignity is maintained and when unlocking in the morning some prisoners may be undressed. However, staff are not required to obtain a response from every prisoner unless they have specific concerns about an individual or the individual is subject to self-harm or other monitoring procedures.

49. Officer B said that as the man was a trusted prisoner and landing cleaner, it was not unusual that he would still be in bed so he would not go into the cell to tell him to get up. After unlocking the cells, Officers A and B returned to the end of the landing and began collecting applications from prisoners. (Applications are written requests for an item or service.)

50. A fellow prisoner (Prisoner A) and cleaner on A4 landing, made a statement to the police after the man's death. The investigator also

spoke briefly with him during his initial visit to Bristol. In his police statement, Prisoner A said that he had shared a cell with the man. He said that they had been close and discussed meeting up when they were released. They continued to share the cell until the man was admitted to the healthcare wing. Prisoner A says that when the man returned to the wing he appeared to be back to "his old self" and life on the wing continued as normal.

51. On 22 September, the man's cell mate was released. Prisoner A said that the man did not mention any concern about being in a cell on his own. In fact, he had commented that he was looking forward to "having his own space". Prisoner A said that their routine was well established. The man would go to his cell in the morning to make sure that he was out of bed and they would have a drink before starting their cleaning tasks.

52. On the morning of 25 September, Prisoner A said that things were different as the man did not go to his cell. He walked past the man's cell and looked in. He could not see him, assumed that he had gone for a shower, and did not go into the cell. A short while later, other prisoners asked about him so Prisoner A went to his cell again. He could see the man's shoes on the floor and said that the bed looked as though someone was under the covers. The lights in the cell were off and the room was still quite dark. Prisoner A noticed what appeared to be a foot sticking out from behind the end of the bed and walked into the cell. As he walked to the back of the cell, Prisoner A saw the man hanging from the end of the bunk. He immediately ran from the cell and called to Officer A.

53. Officer A told the investigator that he was at the showers when he heard a prisoner call him and, although he was not immediately aware of what had happened, he could tell from the urgency that there was a problem. He ran to the man's cell and said that when he first looked in he could not see any problem. As Officer A took a few steps into the cell, he saw the man at the end of the bed in a seated position with a ligature around his neck. He immediately called for Officer B to assist him. He tried to lift the man and cut the ligature using his anti-ligature knife. (All prison staff are issued with an anti-ligature knife, which they are required to carry at all times.) Officer A said that, at this point, he did not know whether the man was alive and his priority was to remove the ligature.

54. Officer B assisted Officer A and between them they checked the man's pulse and for any signs of life. Both officers told the investigator that it quickly became apparent that the man had been dead for sometime and that CPR would not be of any benefit. Officer B left the cell and called down to the senior officer on the wing to alert him to the problem. Officer B confirmed to the investigator that neither he nor Officer B were carrying radios and that they were not designated a radio call sign. Officer C, who had been alerted by a prisoner shouting to him, also went to the cell at 8.45am. On seeing Officer A in some distress, he advised

him to leave the cell. Officer C also checked the man for any signs of life and found that his body appeared to be stiff. Two Senior Officer's quickly joined him. The Orderly Officer in charge of the prison also went into the cell.

55. Other staff alerted by Officer C via his radio, including healthcare staff, arrived on the landing. A Nurse entered the cell at 8.54am, and again checked for signs of life, but none could be found. At 8.58am, the prison doctor, Doctor A, attended the cell and confirmed that the man had died. The Orderly Officer had requested an ambulance and when the paramedics arrived, they were informed that Doctor A had confirmed that the man was dead.

56. When interviewed, Officers A and B said that the man had moved his locker to a position that hid him from the view of anyone looking into the cell from the doorway. He had also placed a blanket over the end of the bed and another in the bed to give the impression that someone was under the covers.

57. The cell was closed and sealed to await the arrival of the local police. The police arrived at 10.30am and searched the man's cell. No apparent suicide note was discovered and the police identified nothing to indicate that anybody else had been involved in the man's death. The police removed a number of items to be used as evidence from the cell, including the ligature. A photograph of this was given to the investigator and shows it to be intricate in nature, made up of torn bedding woven together to produce a thick rope.

58. A Governor was appointed as the prison's family liaison officer to communicate with the man's next of kin. The Governor told the investigator that it was also brought to his attention that the man's partner was due to visit that afternoon, therefore priority was given to visiting her home before she left for the visit.

59. The Governor and his colleague, visited the address given, but the man's partner was not at home and they were unable to contact her by telephone. They then visited the man's wife where they informed both her and the man's father of his death. The Governor spoke with the family about what would happen next and what help and support was available to them. This included information about the independent organisation, INQUEST, which provides support and advice to families bereaved following a death in custody.

60. The Governor maintained regular contact with the family. The prison contributed to funeral costs and the prison chaplain officiated at the man's funeral. At the request of the family, no other prison staff attended the funeral. Letters of condolence were also received by the family from prisoners who had known the man, for which they were grateful.

61. Staff at Bristol told the investigator that they had been appropriately supported following the man's death and that a debrief had been conducted to highlight any immediate concerns.

ISSUES

Assessment, Care in Custody and Teamwork (ACCT)

62. Officer A was concerned about the man after they spoke on 25 August. He contacted healthcare staff and documented his concerns in the man's wing history file so that other staff could be aware. He wrote that, if the man deteriorated further, consideration should be given to opening an ACCT. However, he told the investigator that he did not feel such monitoring was required at that time.

63. The nurse who assessed the man documented his past family history of both suicide and depression. She decided that it would be beneficial for him to spend time on the healthcare wing. There is no mention of ACCT being considered at this time. Nurse A conducted a mental health assessment, but this did not take place until five days after the man had been admitted. During the assessment, he talked about feeling "gloomy" and "hopeless" and said that he felt as though he had let his family down. However, he denied any feelings of suicide and the nurse did not consider there to be a need for an ACCT to be opened.

64. Following the additional information supplied to the investigator, it is now clear that the prison were made aware of the family's concerns about the man. Staff A passed the information to the Mental Health team and he was told that an assessment would be carried out. We have been unable to establish whether the assessment that followed was because of this information or the fact that the man had been admitted to healthcare. Regardless of what triggered the assessment, when it was carried out Nurse A appeared to be unaware of the concerns raised by the family or the comments made to the nurse about previous family history. Had these factors been properly shared and documented, they would have added to the bigger picture and enabled a more informed decision to be made on the necessity to place the man on ACCT monitoring.

65. The decision to implement ACCT monitoring requires staff to exercise their judgement, taking account of the prisoner's appearance, responses and potential triggers. In this instance, neither member of staff considered that the man warranted such monitoring, but they were sufficiently concerned to take steps to obtain a mental health assessment and healthcare supervision. Based on the subsequent knowledge about the family's concerns and the man's disclosure of a family history of suicide, there was enough evidence to warrant serious consideration of opening an ACCT document. However, this did not happen due to an apparent breakdown of communication between those responsible for the man's care.

66. The clinical reviewer, makes reference to both ACCT and the mental health assessment:

"… I am of the opinion if an individual presents in such a setting with symptoms of an acute onset moderate/severe depression, that a Mental Health Assessment should be achieved within 24-48 hours once the need has been identified, and that an ACCT should be initiated, irrespective of the patients declared lack of suicidal ideation or self-harm intent …

"… I am of the opinion that a Mental Health Assessment, once the need was considered, based on concerns about depression would have been achieved more expeditiously in the wider community than that achieved in the prison …"

67. As a result of the investigation and those concerns highlighted by the Clinical Reviewer, I make the following recommendation:

I recommend that the Governor issues a Notice to Staff reminding them of the importance of opening an ACCT document when there are serious concerns about a prisoner's welfare.

The Head of Healthcare must ensure that when a prisoner requires a mental health assessment it is carried out within 48 hours and, where this is not possible, the reasons are clearly documented.

68. The man's family expressed concern that, although a mental health assessment had been conducted, staff had not contacted them for further background information on his history. They considered that they would have been in a position to share their concerns about his deterioration in the previous weeks and that this may have been beneficial in deciding on his care. The ACCT procedure allows family members to be involved in the care planning process if the prisoner gives their permission. This input might have been helpful but would only be possible had ACCT been in place.

69. Nurse A confirmed that the man's description of his feelings would normally have raised concerns about his wellbeing and should have triggered a review by a doctor. There is no indication that this happened in the man's case despite the negative feelings that he expressed. According to his family, he tended to hide his feelings so it is possible that no action would have been taken even if he had seen a GP. However, if this is an agreed process it should be followed.

The Head of Healthcare should ensure that when mental health assessments are conducted an immediate follow up with a doctor is carried out and the results are documented.

70. OSG A told the investigator that he had not had ACCT training since taking up his role conducting night patrol. Given that staff working at night can do so in isolation and have responsibility for the monitoring of prisoners in their care on open ACCTs, it is essential that they are

provided with appropriate training. The investigator was told that OSG A was due to have ACCT training in the next few months.

The Governor should ensure that all staff who have direct contact with prisoners have appropriate ACCT training and that all permanent night staff undergo the foundation training in ACCT procedures.

71. ACCT documents cannot guarantee prevention of self-harm or suicide, but the process gives additional support and highlights to staff the need for the individual to be watched more closely. The lengths that the man went to, firstly to make a ligature that appeared to have taken sometime and then to conceal his actions suggest to me that an open ACCT is unlikely to have prevented his death. The family have said in response to the draft report that they feel that if the man had been on an ACCT then he would not have been placed in a single cell and this would have prevented or at least made it difficult for him to self-harm.

72. I agree that sharing a cell with another prisoner would have made it harder for the man to self-harm without being discovered. However, I cannot assume that this would have been sufficient to prevent the man taking his life, as unfortunately self-inflicted deaths of prisoners in shared cells do occur. The family have also commented that guidance set out in the Prison Service Order (PSO) 2700 on Suicide and Self Harm provides staff with advice on placing those prisoners considered 'at risk' in single occupancy cells. I cannot comment on this as ACCT procedures were not in place for the man, therefore this guidance was not applicable when the decision to allow the man a single cell was made.

Roll checks

73. During the investigation, it became apparent that the profiled roll checks at Bristol do not require staff taking over a shift to confirm the roll already submitted by outgoing staff. This system is now common across the Prison Service. OSG A had carried out the last roll check at 5.30am and saw nothing that gave cause for concern as he had seen what he believed to be somebody in the bed. When Officer B unlocked the cells at 8.15am, he made a point of looking into the cell, but he also saw what he believed to have been someone in the bed. Following the man's death, the roll check procedures at Bristol were reviewed but I have not been advised of the results of the review.

74. The description by staff, as well as information from the police following the man's death, would indicate that he had died several hours before he was eventually discovered. I do not believe that a roll check at 7.30am would have made a difference in this case. However, the forms for recording roll checks at Bristol still indicated that a roll is to be taken at 7.30am even though this no longer happens. This document should be amended to avoid confusion.

The Governor should review the wing daily diaries and amend the roll check times indicated to show only those that are actually to be carried out.

Provision for families to raise concerns

75. When the man's wife first raised concerns about her husband during a visit, she said that the officer told her nothing could be done unless a prisoner directly asked for help. The family were concerned about this and, although a member of staff eventually approached him in the visits room, they felt that in such an environment he was unlikely to disclose anything that was bothering him. It is important that concerns raised by prisoners' families are taken seriously. They should have been documented and passed to the man's wing staff so that they could be followed up or monitored.

    I recommend that the Governor issues a Notice to Staff setting out the correct procedures to be followed when a member of staff receives concerns from a prisoner's family.

76. The man's father said that his ex-wife had telephoned the prison about her concerns and had left a message. However, they had received no response. The investigator asked the prison about their arrangements for families to telephone with concerns. He was told that a helpline is in place and the number and instructions for its use are advertised in the visits centre and visits room. In addition, all visiting applications sent out to visitors contain information about the helpline. The helpline is checked daily, responses made to all calls and, where necessary, followed up by the prison's safer custody team. The investigator was given copies of the documents advertising the helpline and these are attached as annexes to this report. In addition, he was also provided with a copy of all calls received to the helpline during the man's period in custody. No calls relating to him are shown. I am unable to explain the discrepancy between the family's account and the prison records. It is unfortunate that wing staff seem to have been unaware of the family's anxieties and so did not recognise that the man might be withholding any worries.

77. The new information supplied to the investigator by both the family and the prison following the draft report, confirms that the family had raised concerns with the prison. The initial reason that the prison were unable to identify the calls was the belief that the family had contacted the Safer Custody Helpline. In fact, the calls had been made to the Prison Advice and Care Trust (PACT) located in the visitor's centre. Staff A from PACT had taken the calls and followed these up by speaking with the Mental Health team and also with the man himself.

78. While the follow up actions by Staff A were wholly appropriate, I am somewhat concerned about the confusion that could be caused to families where two helplines are advertised. The man's family believed that they were calling a helpline specifically for raising concerns about a prisoner's welfare. There is also no evidence that the concerns raised by the family were shared by Staff A with anyone else such as wing staff or the safer custody team. In view of this I make the additional recommendations:

The Governor should liaise with the Prison Advice and Care Trust to ensure that the leaflets they provide to prisoner's families includes the safer custody hotline number.

The Governor should liaise with the Prison Advice and Care Trust to agree the procedures to be followed when concerns are received by them about the welfare of an individual prisoner.

CONCLUSION

79. Although this was the man's first time in prison, he appeared to settle in quickly. He had a job in which he took great pride and got on well with both staff and other prisoners. He was a mature man who was considered ideal to speak with new prisoners and help them with any concerns.

80. He was described as a private man who chose not to discuss his personal life in too much depth. His family described him as "difficult to read". His fears about what would happen to him at court were clearly of great concern. He believed that the charges against him would result in a lengthy period in custody and he would lose all that he had worked hard for. Despite his family's reassurance that this was unlikely, he continued to feel that things were hopeless. During his mental health assessment, he spoke of letting his family down and feeling gloomy and hopeless. Although offered, he declined anti-depressant medication. The circumstances suggest that monitoring under the ACCT process should have been considered, and these views are strengthened by the information that has been shared since the issue of the draft report.

81. I believe that the man was capable of masking his true feelings in the presence of wing staff and his friends in prison. However, in telephone calls to his family he was still clearly upset and feeling that he would never get out of prison. The ligature that the man used can be described as intricate and would have taken some time to make. It is clear from this alone that he had been considering harming himself for sometime. That said he went to great lengths to portray to those he saw daily that he was coping. It is not clear why the man chose to take his own life, but the belief that he was not going to get out of prison and that he had let his family down are likely to have influenced his decision.

82. In response to the draft report, the National Offender Management Service (NOMS) said that they had no comments at that time and would reserve comment until the concerns raised by the man's family had been added to my report. However, a response to the initial recommendations was provided and is detailed below.

RECOMMENDATIONS

1. I recommend that the Governor issues a Notice to Staff reminding them of the importance of opening an ACCT document when there are serious concerns about a prisoner's welfare.

   The Prison Service accepted this recommendation and a Notice to Staff was issued on 3 March 2010.

2. The Head of Healthcare must ensure that when a prisoner requires a mental health assessment it is carried out within 48 hours and, where this is not possible, the reasons are clearly documented.

   The Healthcare partially accepted this recommendation and said:

   In the most serious of cases, assessments will be conducted within 48hours by a RMN and will be seen by a doctor.

   We cannot generalise all mental health assessments into this time scale from the wing due to resource implications and therefore, it would not be appropriate to undertake all of these assessments within this time frame.

   This is as per Avon and Wiltshire Partnership policy

3. The Head of Healthcare should ensure that when mental health assessments are conducted an immediate follow up with a doctor is carried out and the results are documented.

   The Healthcare partially accepted this recommendation and said:

   Not all mental health assessments will need to be seen by a doctor however, in the most serous of cases this will occur in conjunction with the RMN.

   This is as per Avon and Wiltshire Partnership policy

4. The Governor should ensure that all staff who have direct contact with prisoners have appropriate ACCT training and that all permanent night staff undergo the foundation training in ACCT procedures.

   The Prison Service accepted this recommendation and said:

   '… There is currently a continuous training package delivered by Training to ensure all staff are up to date with ACCT Foundation. 90% of all staff have been trained and 100% of all night staff have been trained …'

5. The Governor should review the wing daily diaries and amend the roll check times indicated to show only those that are actually to be carried out.

The Prison Service accepted this recommendation and new diaries have been ordered and a Notice to Staff issued on 10 March 2010.

6. I recommend that the Governor issues a Notice to Staff setting out the correct procedures to be followed when a member of staff receives concerns from a prisoner's family.

   The Prison Service accepted this recommendation and a Notice to Staff was issued on 3 March 2010.

7. **The Governor should liaise with the Prison Advice and Care Trust to ensure that the leaflets they provide to prisoner's families includes the safer custody hotline number.**

8. **The Governor should liaise with the Prison Advice and Care Trust to agree the procedures to be followed when concerns are received by them about the welfare of an individual prisoner.**