Circumstances surrounding the death of a man, a prisoner at HMP Bristol, in October 2006

Report by the Prisons and Probation Ombudsman for England and Wales

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This is the report of an investigation into the circumstances of the death of a man in October 2006. The man was found hanging in his cell at HMP Bristol at 2.05 pm. Cardio pulmonary resuscitation was carried out and he was taken to the local Infirmary at 2.51 pm. Sadly, at 3.04 pm, he was pronounced dead.

The man was a life sentenced prisoner who had absconded from an open prison in July 2006. Having been detained in Jersey on 21 September, he was remanded to HMP Bristol following a court appearance. At the time of his death he was 35 years old.

I would like to offer this public expression of condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man's family raised a number of matters with one of my Family Liaison Officers. I hope my investigation begins to offer answers to these questions.

The investigation was led by my colleague who was assisted by another of my investigators. A clinical review was conducted by the Clinical Governance Lead at the local Primary Care Trust, and I am very grateful for his assistance. I also thank the Governor and staff at HMP Bristol for their co-operation with this investigation.

The man had attended the Magistrates' Court 48 hours before his death. There he told his solicitor that he had swallowed razor blades and this information was repeated to Reliance Custodial Services staff who are contracted to manage the court cells. However, no action was taken as a result. The scope of my investigation was broadened to include these events, and I am grateful to the Reliance staff who agreed to be interviewed by my investigators. Reliance's Area Manager for the South West, conducted his own internal investigation.

In addition to my serious concerns about the inactions of staff belonging to Reliance Custodial Services, other aspects of my investigation reflect poorly upon HMP Bristol. In particular, the man's cell appeared not to have been cleaned for some time and was festooned with pornography that evidently pre-dated his reception. The prison's family liaison following the man's death also fell far short of what should be expected.

In sum, the man presented as a quiet man who did not draw attention to himself. However, he was a life sentenced prisoner who had come close to release but now faced many more years in custody. On attendance at court he indicated that he was suicidal. Troublingly, staff at HMP Bristol were not informed, and the man hanged himself two days later. Unsurprisingly, my report contains a number of recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2007**

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Summary

At the age of 21, the man was sentenced to life imprisonment with a 12 year tariff. In 2004, he was transferred to HMP Prescoed, an open prison in South Wales, and began the final stages of applying for release on life licence. In June 2006, his application for release was refused by the Parole Board after he had breached the conditions of his temporary release licence on two separate occasions.

The man had a paid community placement which was suspended by Prescoed following the breaches. He returned to work in May. On 11 July 2006, he failed to return to prison.

On 21 September 2006, the man was arrested in Jersey. He appeared at the Magistrates' Court on 23 September charged with being unlawfully at large. In addition, he was the suspect in a number of robberies. He was not questioned about these alleged offences at the time, but police intended to speak with him at a later date. Unable to return to open conditions, he was sent to HMP Bristol. He was located on A wing.

On Friday 29 September, the man returned to the Magistrates' Court. In the court cells, he told his solicitor that he had swallowed razor blades and did not want to go into court. The solicitor relayed this information to Reliance staff managing the cells. However, in interview, none of the staff was able to recall being told anything of significance about the man. Notwithstanding this, a transcript of a telephone call between the Supervising Custody Officer (SCO) and the Control Room indicated that the SCO was aware of what the man had told his solicitor.

Reliance staff did not open a 'Suicide/Self-harm warning form', and the man travelled back to Bristol as a routine prisoner being returned from court. In the absence of any warning markers, he was processed through reception and again located in cell A3-19.

Two days later, on 1 October, the man was discovered hanging when staff were unlocking for exercise at approximately 2.05 pm. Staff and paramedics conducted cardio pulmonary resuscitation (CPR) where he was found. At 3.04 pm, he was pronounced dead at the Infirmary.

This report is critical of a number of matters, including the disappointingly poor quality of family liaison following the man's death.

The investigation process

1. My colleague conducted a preliminary visit to HMP Bristol on 5 October 2006 and visited the cell where the man died. All the relevant documentation was reviewed and a chronology of events established. Feedback about the findings of the investigation was given to the Governor on a regular basis.

2. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my colleagues. No-one came forward as a result.

3. My investigators met with representatives of the local branch of the Prison Officers' Association (POA). The Independent Monitoring Board (IMB) was also contacted on three separate occasions and a voicemail message left each time. Unfortunately, no-one from the IMB responded to these messages.

4. Fourteen members of staff, both discipline and healthcare, were interviewed at Bristol by my investigators. Five prisoners, who were in neighbouring cells to the man, were interviewed informally. A prisoner who had shared the man's cell at Bristol, but had been released a few days prior to his death, was written to twice asking him to make contact with my office. The cellmate did telephone the office on 21 January but regrettably neither investigator was available. He was not able to leave a telephone number and said that he would ring back the following day. Despite being written to for a third time he has not called again.

5. The Clinical Governance Lead at the local Primary Care Trust, undertook a clinical review of the healthcare provided for the man whilst at HMP Bristol. He also conducted one joint interview with a member of the healthcare staff. Transcripts of all the interviews with healthcare staff were sent to him.

6. The Lifer Manager and the man's personal officer at HMP Prescoed were telephoned and provided my investigator with useful background information. My investigator also contacted the police in an attempt to collate the man's custody record from his arrest in Jersey. Some, but not all, of the documents were forthcoming. A second police force were also contacted for background information.

7. My investigator contacted the man's solicitor, who had represented him at both his court appearances at the Magistrates' Court. The Clerk of the Court was also contacted in light of information provided by the solicitor. My investigator then contacted Reliance Custodial Services who operate the court escort services and manage the cells at the Magistrates' Court. The South West Area Manager for Reliance conducted his own investigation into the actions taken by his staff at court. My investigators also conducted a number of interviews with Reliance court staff and viewed the cell area where the man was held.

8. One of my family liaison officers (FLOs) made contact with the man's sister offering the opportunity to meet. My investigator and FLO met with the man's mother, sister, brother, and their solicitor at his sister's home.

9. After the man was remanded into Bristol, a request for his records was made to HMP Prescoed. These did arrive, albeit after his death, but the man's Inmate Medical Record (IMR) was missing. Staff at Bristol, and my investigator, separately contacted Prescoed in an attempt to trace the IMR. My investigator spoke with the Healthcare Manager who explained that the IMR had been collated together with the other records the prison held. He could not offer any explanation as to its whereabouts. To date, the IMR has not materialised.

10. The man's family were most upset at the delay in receiving the notes the man had written to them prior to his death. After waiting a week, they had to travel to a nearby police station to collect faxed copies. These concerns were fed back to the investigating police officers.

11. A draft version of this report was sent to the prison service. An action plan was provided in response. The Prison Service indicated whether they accepted the recommendations or not. The responses can be found under the recommendations section of this report and have been reproduced verbatim.

12. The man's family and their solicitors were sent a copy of the draft version of this report. They raised a number of matters, all of which were dealt with by way of a letter.

The man

13. In October 1992, aged 21, the man was sentenced to life imprisonment with a 12 year tariff (minimum term). In September 2004, he transferred from HMP Shepton Mallet to Prescoed, an open prison. During his time there, he progressed well through the resettlement process and had regular town visits and periods of home leave. He also worked full time in paid employment in the community. Staff at Prescoed said that the man made very good progress whilst there. His personal officer described him as fairly shy when he first arrived and thought that he had found it difficult to communicate with staff. He described the man as making huge strides in his confidence after he lost a large amount of weight, attended the gym, and made friends.

14. Until January 2006, all those involved in the man's assessment by the Parole Board supported his release on licence. However, on two occasions, in January and March, he breached his Release on Temporary Licence (ROTL). He was having a relationship with a local woman, and the first breach occurred at a time when they suffered an unsuccessful pregnancy. The second breach occurred when the man was instructed to collect another prisoner by car from an agreed meeting point, but failed to turn up. In light of these breaches, he temporarily lost his right to work. However, in May he was allowed to return to full-time employment.

15. At his Parole Board hearing in June, the Board concluded that in light of these breaches the man required further testing in open conditions, and could not yet be released on licence. His family said that he was very upset about the result. The Lifer Manager at Prescoed felt that the man had accepted the result and realised he had been foolish.

16. On 11 July, whilst at his work placement, the man absconded and did not return to Prescoed. He had been granted a period of home leave from 21-25 July, which he was aware of at the time he absconded.

17. Available records show that the man was placed on self-harm/suicide monitoring in March 2001 whilst at HMP Shepton Mallet, after he had said that he had swallowed razor blades. He was taken to hospital and an x-ray confirmed this to be true. He was released back to prison three days later. Records indicated that at the time he was upset over a potential move to HMP Dartmoor. His self-harm monitoring form was closed after 14 days. No further previous incidents of self-harming have come to light during the investigation.

HMP Prescoed

18. HMP Prescoed is an open resettlement prison for category D adult male prisoners. In an inspection report in June 2005 the HM Chief Inspector of Prisons, described Prescoed as having "an energetic resettlement programme, a focus on reintegration, and more opportunities for working outside the prison."

HMP Bristol

19. HMP Bristol is an inner city Victorian prison opened in 1883. In 2003, its status changed from a 'core' local, holding high security category A remand prisoners, to a standard category B local prison. Subsequently, it lost its lifer centre although at the time of the man's death a number of lifers remained on B wing awaiting transfer.

20. The top landing (known as the 4s landing) of A wing operates as a dedicated First Night Centre (FNC). In the absence of spaces on the 4s, prisoners are located on other landings or wings. Prisoners undergoing detoxification are also located on A wing, mainly on the 2s and 3s landing.

21. In June 2005, a prisoner apparently hanged himself at Bristol and my office investigated the death. In that case there had been a problem with the resuscitation equipment. This has been revisited and is discussed in detail later in my report. This was the only significant similarity identified between the earlier death and that of the man who is the subject of this report.

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Key findings

22. On 11 July 2006, the man went to his community work placement as usual. At lunchtime, he said that he had a headache and was given permission to go outside for some fresh air. He did not return to either his work place or the prison, and later that afternoon staff at HMP Prescoed contacted the police to report that he had absconded.

23. The man was eventually arrested in Jersey on 21 September. Custody records made available to my investigator begin at 9.56 pm on 22 September when he arrived at the Police Station having been transferred there following his arrest the day before. At 10.52 pm, an entry in the record stated that, 'there is a wanted marker shown on PNC [police national computer] for attempted robbery in July 2006 … [The relevant Police area] intend to produce the DP [detained prisoner] from prison for the offence and question him.'

24. A routine risk assessment conducted by the police identified no risk categories. Records show that the man did not want anyone informed of his arrest and did not want to speak to a solicitor at that time. He was charged with 'being unlawfully at large' and held overnight at the police station.

25. The Prisoner Escort Record (PER), designed to communicate important information between the various criminal justice agencies, indicated that the man's risk areas were 'violence, weapons, escape risk'. In a further section concerning risk issues, it stated 'absconder from Prescoed. Serving a life sentence.' The form clearly said that the man was 'not for release' because he was an absconder.

26. The PER showed that the man was handed to the escort service at 8.50 am on the morning of Saturday 23 September. He arrived at the Magistrates' Court at 8.59 am and had a legal visit from the duty solicitor at 9.21 am. The solicitor, who had no previous knowledge of the man, provided my investigator with his court attendance notes which outlined the nature of the discussion they had. In describing his failed parole application, the man said 'he was going to get released in January 2006 but said that the prison had appealed that and he had another year added to his sentence.'

27. The man told his solicitor that he had been in Jersey as he intended travelling to France. He said that he thought that police might want to speak to him about some robberies, but he had only picked this up in the press and said that he was not involved. In relation to the charge of being unlawfully at large, he said that he would be happy to plead that day. However, the solicitor explained to him that the charge could be upgraded in due course which would result in a Crown Court appearance.

28. Later that morning, the man appeared in court and was remanded into custody until 27 September. Court forms indicated that his next

appearance was to be via video link on 27 September. The man left the court at 1.40 pm. The Magistrates' Court is routinely served by HMP Cardiff but Cardiff was full and he was taken to HMP Bristol.

29. An officer, who was working in reception at Bristol that day, had been telephoned by the Magistrates' Court regarding the man. Given that he was an absconder, the court did not have the necessary warrant and contacted the prison to let them know this prior to the man's arrival. The officer telephoned HMP Prescoed to confirm the man's identity and arranged for the warrant to be faxed to Bristol. The PER was not signed by either receiving staff at Bristol or the escort staff dropping him there, but other records indicated that the man arrived at 3.56 pm.

30. Once at Bristol, the man went through the reception process. The officer working in reception was on the front desk and greeted all the prisoners off the escort van. Some time later, he went through the Cell Sharing Risk Assessment (CSRA) form with the man. The officer assessed him as being of 'low' risk to others, and indicated that he presented with no problems. As a matter of routine, the officer asked the man about any thoughts of self-harm and how he was feeling at the time. He gave him no cause for concern.

31. Form F2050, known as the core record, is completed in reception as part of the reception process. The personal summary sheet asks basic questions about religion, age etc, as well as asking the prisoner to provide the name and address of his next of kin. The man identified his mother and gave contact details.

32. The man was then seen by a nurse for the purpose of completing the First Reception Health Screen (FRHS). Following the man's death, the nurse wrote an account of what she remembered about meeting him and she referred to this during her interview with my investigators. She described his personal appearance as 'well kept and clean clothed' and that he was 'friendly, co-operative and answered questions in a relaxed manner. He had good eye contact which he maintained throughout and showed no signs of agitation.'

33. Part of the FRHS asks about physical health. In response to whether or not he had any concerns, the man said that he had a lump on his testicles. The nurse noted 'testicular pain' on the document. She had previously been the prison's lead nurse on sexual health and so she spent some time explaining to the man the options available to him. Following this discussion, the man chose to be referred to the specialist sexual health doctor, rather than the GP, and the nurse completed a referral for him.

34. The man indicated that he did not use drugs and was a social drinker. Under the mental health section, he said that he had been sectioned in 1992 and had spent some time in a Mental Hospital. He said that he was seen in Prescoed by the mental health team and the nurse then wrote 'no cause for concern'. (In the absence of the man's old IMR, my investigator

spoke to the Head of Healthcare at Prescoed who said that he did not recall the man having any mental health input whilst there. He added that, had there been any cause for concern he would most likely have been returned to closed conditions.)

35. In response to being asked 'have you ever tried to harm yourself?', the man said he had swallowed razor blades in 1999. The nurse asked him if he might consider harming himself now. He said he would not. She was not concerned about him at that time but did refer him to the prison's mental health team. Pressed in interview to explain why she had done this, the nurse indicated that she referred him as part of an awareness exercise and to open up this avenue should he feel he needed help in the future. The nurse partially completed section 3 of the CSRA. She indicated that there was no current indication of risk to others. She did not tick either yes or no to the question, 'following the self-harm assessment have any concerns been raised?'

36. From reception, the man was located onto A wing and into a double cell A3-19 which already had one occupant. Usually new receptions would go onto the 4s landing but, given that there were no spaces, the man was allocated onto the 3s. Section 4 of the CSRA, which should be completed by the locating officer, had not been completed. The induction officer who saw the man that day, in interview, said that the cellmate, a quiet prisoner who kept his head down, was thought to be a suitable cell mate for the man. The induction officer was confident that he had gone through the induction process with the man, albeit a compact version for people who had been in prison before, but did not get him to sign all the paperwork until a few days later. He said that the man told him a little about himself at the time, and he felt that he seemed 'resigned to being back in prison again'. He described him as 'quiet' but felt that he was 'alright'.

37. The induction officer said that he spoke with both the cellmate and the man the next day. The cellmate told him that everything was fine and that the man had told him a little bit about himself. According to the induction officer, the man had said that he was fine when he enquired how he was getting on.

38. Chaplaincy records show that the man was seen, very briefly, in his cell by a member of the chaplaincy as part of the induction process at 11.57 am on 25 September. During these meetings, the chaplain introduces himself, hands out a booklet and asks if there is anything the prisoner needs help with. There is nothing recorded on the register to indicate that the man asked for any help at that time.

39. On 26 September, again as part of the induction process, the man was seen in his cell by an officer from the legal services department. The purpose of his visit was to get basic information about further court dates, solicitor details and whether or not the man had any outstanding issues. The officer wrote that the man, 'states he has no outstanding issues'. The officer remembered the man because he was a lifer. However, he

estimated he was with him for no more than five minutes and he was unable to recall anything of significance. Of interest under next court date and outstanding matters, the officer from the legal services department has written 'none'. Clearly this was not the case. It is not known whether the man was confused or unaware of when he was next due in court, or that he chose not to disclose any information.

40. The man was due to appear before the Magistrates' Court by video link on 27 September. The video link was set up to take place in HMP Cardiff. Since he was actually in Bristol at the time, the video link hearing did not go ahead and the court requested that he be produced in person at court on 29 September. It is not known if the man was aware of what had unfolded and whether he was told that he was going to court on 29 September instead.

41. The man was seen again by the induction officer on 27 September in order to complete the induction paperwork. He described the man as being unconcerned about signing the documents and had said, 'It's up to you boss, it's your time.' The officer said that the man seemed very relaxed about it.

42. Records indicate that the man's cellmate was released from court on Thursday 28 September. No other prisoner was located in the cell and the man remained the single occupant of the double cell.

43. A PER form was prepared by the prison to accompany the man to court on Friday 29 September. He was described as having 'no known risk' and none of the risk categories was ticked.

44. The man arrived at the Magistrates' Court at 9.00 am. According to the PER form, at 10.03 am he had a legal visit with his solicitor which finished at 10.11 am. The next entry reads 'cell check' at 10.41 am, and then at 10.43 am 'refused to go to court, dealt with him in his absence'. Entries follow saying 'cell check' every half hour, which is routine procedure, until 3.20 pm when the man was placed in the van for his return journey to Bristol. The entries then indicate that he was 'alert and ok'. He arrived back at Bristol at 5.05 pm according to prison records. Again this is not recorded on the PER form by either receiving staff at Bristol or the escort staff.

45. What actually occurred in the court cells is very different from the account given on the PER. Again, his solicitor has provided his attendance notes. These indicate that the solicitor explained to the man that he could plead that morning to the lesser charge of being 'unlawfully at large'. (This in itself would have been good news as the maximum sentence he could have received at the magistrates' court for this offence was six months imprisonment.)

46. Whilst taking some additional details with regard to mitigation, the man 'indicated that he wondered whether he actually had to attend in court

because he was not feeling very well. He did not want to attend. He then said that he was suicidal and in fact had swallowed razor blades that morning and wondered if he could see a doctor. Enquired whether he was authorising me to tell Reliance of his condition and he confirmed that he was. I therefore notified the Reliance officers so that they could take appropriate steps.' The solicitor told my investigator that he then spoke to a member of Reliance staff in the cells to tell them what the man had told him.

47. Following this, the solicitor went up to see the Clerk of the Court. She provided my investigators with a written account of what she did:

> 'On that day I was approached by [the man's solicitor] with regard to [the man]. [The solicitor] requested that [the man] be the first custody matter of the day as he had alleged to have swallowed a razor blade and Reliance wanted to have his case dealt with as soon as possible. I consented to this".
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> 'The magistrates were notified of the position prior to coming into Court. Upon calling the case, I rang the cells and was informed that [the man] had refused to leave his cell. In light of the information [the solicitor] wished to enter a guilty plea on[the man's] behalf and have him sentenced in his absence.'

48. Some legal discussions followed, before the court decided to adjourn the case for a week until 6 October. The solicitor did not return to the cells to see the man.

49. An enquiry by Reliance, and indeed my investigators' own questioning of the staff at the court cells, revealed that no one could recall anything about the events at court involving the man and his solicitor. The solicitor was not able to say which staff member he spoke with. However, through listening to calls made to the Control Centre, the Reliance enquiry found that Supervising Custody Officer (SCO) had telephoned his Control Centre at 11.00 am. The following is a transcript of the telephone call:

> 'Anything coming in, I've got a guy here [the man], he is a lifer and absconder from HMP Prescoed. He came from HMP Bristol this morning. He told his solicitor he had swallowed razor blades. His solicitor doesn't think so and neither do I but that's not the point really. He's refusing to go to court and the court are dealing with him at the moment in his absence so if you've got anything passing at all so I can get him from here. He's a disaster waiting to happen.'
>
> 'Ok mate.'

50. In interview, the Supervising Custody Officer was unable to recall making the telephone call nor had any memory of the man in the cells that day. (The outcome of the internal investigation is discussed in the issues section of this report, below)

51. In any event, it appears that a van did not make a special trip to collect the man. A suicide/self-harm warning form was not completed and he was placed on the escort van at 3.20 pm along with other prisoners. My investigator spoke with the supervisor of the two escort van drivers, also Reliance employees. He explained that both drivers had been asked about the man and whether they remembered being briefed about him by their court colleagues. They did not, and had had no other reason to have concerns about him.

52. Upon the man's return to Bristol, he went back through reception. As a prisoner returning from court, his time there would have been brief and contact with staff limited. My investigators observed this process and noted that each prisoner was spoken to by the reception officer as they were handed over by the escort staff. They were asked how they had got on at court. The PER was also checked. A Senior Officer was the reception officer when the man arrived back at reception on 29 September. He could not recall anything about the man.

53. Given that staff were unaware of what had happened at court, the man was processed through reception and returned to the wing. Again, he was located in cell A3-19.

54. That same afternoon, the man's mother had been telephoning the prison. She was concerned that she had not heard from him since his arrest. Her mobile phone bill indicated that she rang seven times between 3.19 pm and 5.29 pm. Having explained her worries to the receptionist, she was put through to the chaplaincy but there was no answer. The man's mother did not speak directly to any prison staff that day.

55. An officer who regularly works on the 3s landing on A wing, remembered speaking to the man two or three days before his death. He did not know whether this would have been before he went out to court or after. However, the officer said the man was alone in the cell and we know that his cellmate was released on 28 September. The officer was aware of the man's presence on the wing because it was unusual to have a lifer there, and also he stood out as being a 'model prisoner'. He described going to see the man in his cell and asking him if he had any problems. The man told him that he was an absconder and had been picked up in the Channel Islands. The officer said he was 'quiet' but felt that he was 'ok'.

56. An officer works as the Cleaning Officer on A wing. This involves supervising prisoners as they collect the food. In this capacity, he would have seen the man at least twice a day when on duty. He recalled the man as being 'very quiet, well mannered and polite'.

57. My investigators spoke with a number of prisoners located near the man's cell. None of them was able to recall speaking to him. One prisoner said that he spoke to the man on Sunday morning (1 October) as he "looked

down" and that he gave him a cigarette. The man's family said that he did not smoke.

58. Another officer recalled that on 1 October he had spoken to the man at approximately midday when he gave him lunchtime sandwiches. At lunchtime, all prisoners are offered the opportunity to come out of their cells and 'water up'. This allows prisoners to fill their flasks with hot water before they are locked back into their cells. After this time, the prison goes in to patrol state and a limited number of staff remain on the wing. The officer said that he asked the man if he wanted to 'water up' and he replied that he did not. He then asked him if he was sure and he recalled the man saying, 'no that is alright boss, thanks.' This was the last time that he was seen alive.

59. At approximately 2.05 pm, two officers were at opposite ends of the 3s landing unlocking prisoners for exercise. When the first officer looked through the flap of cell A3-19 she saw the man hanging from the end of the nearside upper bunk bed. She immediately shouted 'Code Blue' twice, which indicates to staff that someone needs resuscitation. In addition, she pressed the general alarm bell which was at the far end of the landing. In reality, this was only a short distance away as cell 19 is the second cell along from the end. The sounding of a general alarm requires all available staff to attend immediately to the scene. The first officer was not carrying a radio and had to use other means to summon staff. She then put her key in the door and, upon seeing the second officer making his way towards her, unlocked the door and entered the cell.

60. The man was positioned directly behind the cell door. Once inside the cell, the first officer was immediately joined by the second officer and they grabbed the man and held him up in an attempt to support his weight. The first officer described the man as being cold to touch and his lips had a blue tinge. The second officer described his lips as puffy and blue. They were quickly joined by a third officer who helped to support the man's weight. Similarly, the third officer described the man as having very blue lips. The first officer put her finger between the man's neck and the ligature to try and loosen the ligature but described it as 'fiercely tight'. None of the officers was carrying anti-ligature knives (known as fish knives) and someone shouted out for one.

61. Responding to the general alarm, two more officers arrived at the cell. Hearing the shout for a fish knife, the fourth officer called again for one. Within 10-20 seconds, one was collected from the wing office and the cleaning officer passed it into the cell. The fourth officer cut the ligature, first from the bed and then from around the man's neck. Given the limited space within the cell, the officers quickly moved the man out onto the landing.

62. By now a number of other staff had arrived at the cell. A SO used his radio to put out a Code Blue call. (This indicated to staff the nature of the problem. Code Blue means that someone is not breathing.) In interview,

he said that he checked for signs of consciousness and, because he was unable to find any, the officers commenced cardio pulmonary resuscitation (CPR). A PO began giving breaths using a plastic mask whilst three of the other officers rotated the chest compressions.

63. A nurse was in healthcare and responded to the Code Blue. She grabbed the oxygen bag and went to the man's cell. She was the first nurse to arrive, closely followed by a second nurse. The nurse who was first on the scene removed the plastic mask the officer had been using and inserted one from the oxygen bag. She began giving breaths whilst the officers continued with the compressions. Meanwhile, the second nurse on scene took out the oxygen equipment. The tubing had not been attached between the cylinder and the bag. The first nurse on scene fitted the tubing and administered oxygen. At one stage, the man vomited and had to be turned onto his side and the suction apparatus was used. A third nurse also attended but then left immediately to collect the defibrillator. Once attached, the machine advised not to shock. The nurses and officers continued to give CPR until the paramedics arrived.

64. The ambulance arrived at 2.14 pm, having been called at 2.07 pm. The paramedics administered adrenaline to the man. In conjunction with the paramedics, staff continued to administer CPR whilst he was carried to the ambulance. The ambulance left the prison at 2.51 pm with the fifth officer in attendance as escort. Sadly, the man was pronounced dead at the local Infirmary at 3.04 pm.

65. The man had left four notes in his cell: one addressed to the Governor, and one each for his mother, his sister and a friend. The note to the Governor read:

> 'To Governor, Sorry for any inconvenience or distress to your staff. No one is to blame for what I have done. Thanks for having me. P.S Can you make sure my family and friend get the letters I have prepared. Thanks, [signed]'

66. The duty governor was responsible for coordinating the death in custody contingency plan. Given that the man did not die in prison, he said in interview that he did not feel that the contingency plans were entirely relevant. As such, some actions that should have taken place did not.

67. Following news of the man's death, a debrief was carried out at 3.30 pm. The services of the prison's Care Team were put in place to provide support for those involved in the discovery of him and the attempted resuscitation.

68. An SO was tasked with finding the man's core record so that his next of kin could be established and contacted. As it was a Sunday, the discipline office where files are held was not staffed, and the SO was unable to locate the file in the office.

69. It appears that contact details for the man's sister were made available later by HMP Prescoed. At 5.20 pm, a Father from Bristol's chaplaincy telephoned the man's sister to break the news of her brother's death.

Issues considered

The man's initial reception on 23 September

70. The man's police custody records indicated that he was wanted in connection with a number of robberies, thought to have been committed whilst he was unlawfully at large. Officers intended to arrange to interview the man at a later date. Unfortunately, this information was not recorded on the Prisoner Escort Record and staff at Bristol were unaware of this development. Had they known, the man would not have been perceived simply as a category D prisoner who had absconded.

I recommend that the Governor shares this report with the relevant Constabulary so that arrangements can be made to improve the quality and quantity of information on the PER form.

The man's needs as an absconder

71. Prior to absconding, the man had spent nearly two years in open conditions. Upon his arrest and return to the prison system, he found himself in a local prison. However, from informal discussions with staff at Bristol, my investigators were of the impression that staff perceive absconders as being familiar with the system and hence not especially vulnerable. It is understandable how such a perception has developed. However, in my view, it would be prudent to consider the return of an absconder to closed conditions as 'a change in circumstances', and for prisoners to be monitored accordingly. For example, when a remand prisoner receives a life sentence, they are often placed in the prison's healthcare wing for enhanced monitoring, despite the likelihood that they have spent many months in the same prison on ordinary location. Monitoring an absconder would include an explicit consideration of welfare and risk of self-harm. Whilst this may not be required in all cases, it would certainly be wise for lifers.

72. In the man's case, specific questions about his reasons for absconding, and how he felt about being returned to prison, might have elicited some indication of underlying distress. When he was arrested, he had plans to flee the country and was aware that he was wanted for other offences. The man did not make any phone calls or send out any visiting orders whilst in Bristol, indicators which, if monitored, might have suggested a heightened vulnerability.

73. The particular needs of prisoners recalled to prison are beginning to be recognised, and such prisoners should be viewed as potentially vulnerable. In her 2005 report, 'Recalled prisoners: A short review of recalled adult male determinate-sentenced prisoners', the Chief Inspector highlighted the legal services scheme at Bristol as an example of good practice because recalled prisoners were seen within 24 hours of their arrival. The purpose was to help them to understand the process specific to them. The man, of course, was not a recalled prison, but nevertheless the impact of finding

himself back in custody may have manifested itself in the same way. I intend no criticism of HMP Bristol in this regard, but rather I draw attention to what I consider to be an important issue for the development of safer custody strategies on a national level.

Events at court on 29 September

74. It is well documented that the man's assertion that he had swallowed razor blades was passed on to both a member of Reliance staff and to the Court Clerk by his solicitor. The clerk also telephoned the cells and spoke to a member of Reliance staff. Consequently, it is puzzling and disappointing that none of the cell staff can recall anything about these events. It was a busy morning and they were not working with a full complement of staff. However, given that they were experienced staff used to working in a pressured environment, Reliance's South West Area Manager did not feel that this was of great significance. The transcript of the telephone call made by the SCO to the control room showed that he, at least, was aware of what the man had said. However, the cell area at the Magistrates' Court is very small and it is unlikely that in such a limited space he was the only member of staff with knowledge of what was going on.

75. After interviewing the Reliance staff, my investigators were confident that staff were fully aware of how, and when, the Suicide/Self-Harm Warning form should be completed. This document is used to communicate self-harm/suicide concerns between the cells and escort and prison staff.

76. I regard it as manifest that staff at the Magistrates' Court should have completed a Suicide/Self-Harm Warning form in the man's case. This form would then have been handed to the escort van drivers, who in turn would have passed it to reception staff at Bristol. Once in reception, staff would have made an assessment about whether or not to place him on suicide/self-harm monitoring in light of all the available evidence. I am extremely uncomfortable with the failure of Reliance staff to have completed the warning form.

77. Having been alerted to the situation by my investigator, Reliance Custodial Services was swift to conduct its own investigation and make their staff available for interview by my colleagues. Their investigation has been completed and they have been open and transparent with their findings. I welcome this.

78. Whether the SCO believed that the man had swallowed razor blades or not, I am concerned that the man was not given the opportunity to see a doctor at court. His solicitor said that the man had asked to see a doctor. Given that staff cannot recall the events, it is difficult to make any judgement about this. Speaking with Reliance's Area Manager, the author of the Reliance report, my investigators were confident that staff knew how to arrange for an on-call doctor to attend the cells and were assured that this has been done on previous occasions.

79. Information that the man might have swallowed razor blades at court did not come to light until some weeks after his death, and a considerable time after the post-mortem. There is nothing in the post-mortem report to indicate any internal damage. However, this would not have been specifically looked for at the time. As such, I am unable to draw any conclusion as to whether he actually had done so.

The Prisoner Escort Report form for the man's court appearance on 29 September

80. The Reliance report concluded that the PER form, which arrived with the man from the prison on 29 September and identified 'no known risk', may have given the staff a false perspective of him. I am concerned about this as all staff involved with prisoners should be trained to recognise that someone can become vulnerable to self-harm at any stage of their imprisonment.

The report makes the following recommendation:

> 'The Reliance Cascade Training Document 'Assessment, Care in Custody and Teamwork Plan, be amended to specifically include action to be considered when information is received from a 3rd party, about a prisoner who up to that point is formally recorded as no known risk on the PER.'

81. I welcome this recommendation. A copy of my report should be sent to the Prisoner Escort and Custody Services (PECS) to ensure that all training for escort services includes an understanding that risk factors can change at any time and for their consideration generally.

A copy of this report should be sent to the Prisoner Escorts and Custody Service for their information and consideration.

82. However, it is clear that information was missing from the PER form on 29 September. When the man arrived in Bristol on 23 September, his PER identified a number of risk factors, namely 'violence, weapons, escape risk'. When looking through his prison files, my investigators came across the earlier PER with carbon copies still attached. Had the PER been processed through Bristol and all the information put into the prison database, these carbon copies would have been filed separately and would not have been attached. I conclude that, for some reason, the man's paperwork had not yet been inputted into the computer system.

83. The person who completed the PER for the man's court appearance on 29 September, explained the process to my investigator. He said that the computer database would be checked as well as any security records. Any risk areas identified would be written on the PER. If there is nothing to suggest to the contrary, the 'no known risk' box would be ticked. Given we know the paper documents had not yet been processed, the database would not have shown any risk warnings.

The Governor should undertake an internal review of the PER system to identify any problem areas and remedy them.

Cut-down scissors or fish-knife

84. Neither the first officer on scene, nor any of the subsequent officers who found the man, carried any tool which could cut through a ligature. The first officer on scene tried to loosen the ligature with her fingers. After shouting for a fish-knife, one was very quickly collected from the office and used to release the ligature from the bed and the man's neck. I do not think that this had any bearing on the outcome for him. However, this is not always the case, and any hindrance could waste valuable seconds.

85. It would be better and safer for all staff working with prisoners to be issued with a pair of cut-down scissors, or a fish-knife, which are specifically designed for the purpose of cutting ligatures. I welcome the fact that in November 2006 the Prison Service issued a mandatory instruction requiring all frontline staff to carry such equipment. I therefore make no further recommendation. This instruction was not in place at the time of the man's death.

Efforts to resuscitate the man

86. There were no written statements by healthcare staff who attended to the man after he was discovered. According to local instructions for healthcare staff following a death in custody, staff should 'write a comprehensive record of the circumstances of the death and any Healthcare actions in the Inmate's IMR.'

The Chief Executive of the local Primary Care Trust should remind all healthcare staff of the importance of writing a statement following a death in custody.

87. Without these statements, my investigators had to try and piece together who had been involved and the action each nurse had taken. A comment had been made by an officer in interview about a problem with the oxygen tubing. This was of particular concern as my report into the death of a prisoner at Bristol in June 2005 indicated that the oxygen tube had not fitted properly and a nurse had had to hold it in place. This was not found to have had any adverse effect on the resuscitation attempts at that time. Following the death in 2005, systems were put into effect to ensure that the equipment was tested daily.

88. Each wing and the healthcare unit has oxygen bags. Whilst there appeared to be a system for checking the equipment daily, it was not clear whether all nursing staff were checking for the same things. The clinical reviewer looked at this matter in some detail and made the following comments in the Clinical Review:

‘Was resuscitation adversely affected by delay in connecting the oxygen tubing?

The oxygen tubing had not been connected to the mask and oxygen cylinder. Although there was a small delay while this was connected it did not make a difference to the resuscitation. All the correct pieces of the oxygen system were present. Oxygen tubing should be connected to have a functioning system at all times as connecting in the emergency situation is always more difficult due to the pressure present. There is no evidence of a single process across the wings and healthcare to ensure that a fully connected oxygen system is available at all times. There are processes but they appear to be different on the wings and the healthcare unit.’

The clinical reviewer makes the following recommendation, which I fully endorse.

A single process should be used with consistent documentation across the prison to ensure a fully connected functioning oxygen system is always available.

89. My investigators had to put in a number of requests to healthcare management for documents that were needed to explore what the problem had been. At one stage, they interviewed a nurse having been given documents which suggested she had been responsible for checking the oxygen equipment. During the interview, it came to light that they had been given the wrong information about which wing the oxygen bag had been brought from. My investigators were left with the impression that no one within the healthcare management had taken a lead in overseeing the incident and learning any lessons.

Following a death in custody, the PCT should identify a manager within the healthcare team to co-ordinate the response to the death.

Family liaison

90. It is regrettable that the man’s core record could not be found in the discipline office following his death. Had it been a weekday, a member of staff in the office would have been available to find the file and next of kin details. It is not entirely clear to my investigators exactly how details of the man’s sister were located. It was reported that a phone call was made to HMP Prescoed. In the absence of a paper record, the prison’s database system should have had details of the next of kin as given by the man. He had nominated his mother as his next of kin and it is she who should have been contacted.

91. Following the man’s death, the duty chaplain was tasked with breaking the news to his family. From the duty governor’s interview with my investigators, it is clear that little, if any, discussion took place with the duty chaplain prior to him making the call. One of the most important requirements is that the family are given a named member of staff and

direct telephone line number so they can call the prison and immediately speak to someone. The duty chaplain told my investigators that no specific details were given to the family.

92. The following day, a Reverend from Bristol's chaplaincy rang the family and, at their request, agreed to conduct the service at their local church. I commend him for this. He was accompanied by a governor from the prison. Naturally, the family had many questions. Amongst the many questions that the family asked was in relation to the funeral costs. My understanding is that in the first instance the family were offered £1,000. This was subsequently increased when my investigator drew staff's attention to Prison Service guidance which gives the Governor the discretion to offer up to £3,000. The man's family actually received £2,000.

93. Prison Service Order 2710 'Follow up to deaths in custody' was implemented on 4 January 2006. Chapter 4 provides clear guidance on the prison's responsibilities in the matter of liaison with a bereaved family. The PSO says that the prison should offer to pay reasonable funeral expenses, regardless of whether the family are entitled to apply for a grant from the Social Fund. The PSO also requires a contact log to be kept recording all contact between the prison's Family Liaison Officer and the family.

94. Further upset was caused to the man's family when monies remaining in his cash account were sent to his family by the finance clerk at Bristol. A badly typed covering letter of just two lines stated, 'This was money due to you on the unfortunate death of your son.'

95. This was an ill-considered and insensitive way to return the man's money to his family. The letter should have come from the Governor and certainly should have been written in a much more understanding and careful way. Initially, the family believed that the money was 'compensation' for the man's death.

96. The man's family had numerous questions about the regime at Bristol. Having not been given a named Family Liaison Officer at the prison, they put these questions to my FLO and investigators. An investigator reported this to the Governor and suggested that someone be allocated as the prison's FLO. The Governor agreed but to date nobody has been in touch with the family. Bristol had trained FLOs available so it is unclear why someone did not contact the family.

97. I was sorry to learn that the prison did not make any further contact with the man's family. At such a difficult time, I would expect the prison to take the initiative. It is the prison's responsibility to provide a liaison officer for the family. No family liaison log was kept and I am unable to say what, if any, consideration was given to the man's family after his death.

98. I consider that the standard of family liaison offered by the prison in this case was extremely poor and failed to comply with the instructions in PSO 2710. Given the many strides taken generally by the Prison Service in respect of family liaison matters in recent years, this is all the more disappointing.

The Governor of Bristol should review, with immediate effect, the prison's policy on responding to the needs of families after a death in custody. She should produce a local protocol explaining what support will be offered to a family bereaved by a death in custody. She should ensure that bereaved families are provided with trained liaison staff who have a thorough understanding of the provisions of PSO 2710. A family liaison log must be kept in all cases.

The Governor should ensure that all duty governors are familiar with the death in custody contingency plans and PSO 2710.

<u>The man's mothers phone calls to the prison</u>

99. On Friday 29 September, the man's mother made seven calls to the prison in the hope of being able to speak to someone about her son. She had not heard from him since his arrest and was worried. However, she was not ringing to express concerns that she believed he would hurt himself.

100. My investigators learned that phone calls made to HMP Bristol are answered by a call centre which looks after several prisons in the area. Once the nature of the enquiry is established, calls are put through to the relevant department. The man's mother was diverted to Bristol's chaplaincy. Whilst this may have been entirely appropriate, her call did not go through to their switchboard which is manned throughout the day. Had this been the case, action would either have been taken by someone in the chaplaincy, or the man's mother would have been given advice about who best to speak to about her son. Instead, she was diverted to an individual line for the chaplain, who, unbeknown to staff at the call centre, was not in attendance at the prison at the time.

101. The chaplain told my investigators that his colleagues receive calls all the time about all sorts of miscellaneous things that do not fit easily within any other department of the prison. This includes enquiries about lost property. Whilst they make admirable attempts to deal with these calls, this is not their function.

102. The use of a call centre may make good economic and administrative sense. However, as these events show, there is a danger that local knowledge and an awareness of how prisons really operate may be lost.

The Governor should issue revised guidelines to telephone staff at the call centre about how to deal with calls regarding the welfare of prisoners.

The cell and A wing

103. My investigator was shown the man's cell on her initial visit to Bristol. This was the first time the cell had been opened since it was locked following his death. She immediately noticed that newspapers had been stuffed into the crack between the cell door and the door frame. Whilst it is not possible to say for certain whether these were placed there by the man, they created a barrier for anyone trying to see into the cell. The man had hung himself immediately behind the door.

104. Upon entering the cell, my investigator was shocked at the explicit pornography displayed on the walls. She estimated that there were at least 20 images on the cell wall. There is no suggestion that the man had displayed these pictures himself, and from their tatty appearance it looked as if they had been there for some time. Prisoners are entitled to have pornographic magazines in possession but should not display them on the walls.

105. My investigator also found personal letters and documents addressed to at least four other prisoners besides the man, in the cell. These turned out to be previous occupants of the cell. This suggests that the cell had not been cleaned for some time. There is no doubt that these two factors would have been a depressing environment for anyone upon entering the cell.

106. Of course, there is a high turnover of prisoners on a remand induction wing and it remains a constant challenge to keep the cells clean. However, cells are the fabric of prison life and can be indicative of the regime as a whole. Many officers spoke of staff difficulties on the wing with few regular officers working there. A wing houses both the First Night Centre and detox wing, albeit on different landings, but my colleagues described the wing as a whole as appearing to lack structure.

107. There was a notice outside each cell door with the name of the occupant's personal officer. The personal officer is a named member of staff who will have a number of prisoners to look after. Again, in discussions with staff from A wing it was clear that the personal officer scheme was not running as intended.

108. My colleagues fed back their impressions to the Governor. She indicated that she would look into them and I welcome her willingness to take immediate action.

Record keeping

109. During the course of my investigation, it was found that a number of documents had not been completed in full. These include the Cell Sharing Risk Assessment and the Prisoner Escort Record. In themselves, these did not have any bearing on the man's death. However, if information is not recorded, it has to be assumed that a task has not been completed.

The Governor and the PCT should remind staff of the need to complete the appropriate records in full when engaging with prisoners.

<u>The Clinical Review</u>

110. A clinical review was undertaken of the medical care the man received whilst at Bristol. As previously discussed, a recommendation was made regarding the oxygen system. Additionally, the clinical reviewer found that a resuscitation training update was overdue for the nursing team although this did not affect the abilities of the nurses present. However, he recommended that resuscitation training should be provided annually.

111. The clinical reviewer found two examples of good practice which I endorse:

The First Reception Health Screening was provided in an effective manner by an experienced nurse with evidence of a high standard of interaction. Record keeping was also of a high standard.

The resuscitation was carried out calmly and effectively by the combined team of nurses and healthcare officers and later with paramedics.

RECOMMENDATIONS

I recommend that the Governor shares this report with the relevant Constabulary so that arrangements can be made to improve the quality and quantity of information on the PER form.

Accepted. A copy of the report has been sent to the Chief Constable of the relevant Constabulary.

A copy of this report should be sent to the Prisoner Escorts and Custody Service for their information and consideration.

Accepted. A copy of the report has been sent to PECS.

The Governor should undertake an internal review of the PER system to identify any problem areas and remedy them.

Accepted. There has been a national review of PER documents and a new user handbook has been distributed to all staff that are required to complete them. These new handbooks are now included in all escort packs. However, an internal review will be undertaken to measure the quality and effective completion of forms.

The Chief Executive of the Primary Care Trust should remind all healthcare staff of the importance of writing a statement following a death in custody.

Accepted. A copy of report sent to CEO Primary Care Trust.

A single process should be used with consistent documentation across the prison to ensure a fully connected functioning oxygen system is always available.

Accepted. Daily check list is now in place, to be countersigned by Primary Care manager on a weekly basis.

Following a death in custody, the PCT should identify a manager within the healthcare team to co-ordinate the response to the death.

Accepted. The practice manager has been identified to co-ordinate the response. The Head of Healthcare will complete this task in the absence of the practice manager.

The Governor of Bristol should review, with immediate effect, the prison's policy on responding to the needs of families after a death in custody. She should produce a local protocol explaining what support will be offered to a family bereaved by a death in custody. She should ensure that bereaved families are provided with trained liaison staff who have a thorough understanding of the provisions of PSO 2710. A family liaison log must be kept in all cases.

Accepted. Death in Custody contingency plans have now been rewritten to include instructions on how to utilise trained Family Liaison Officers. This is in addition to the provision of specific guidelines for the deployment of FLOs and information booklets for bereaved families.

The Governor should ensure that all duty governors are familiar with the Death in Custody contingency plans and PSO 2710.

Accepted. All senior managers are scheduled for training.

The Governor should issue revised guidelines to telephone staff at the call centre about how to deal with calls regarding the welfare of prisoners.

Accepted. Guidance being developed bi-laterally with a call centre manager.

The Governor and the PCT should remind staff of the need to complete the appropriate records in full when engaging with prisoners.

Accepted. Added to the next programmed PCT/Prison Governors meeting.

Recommendations from the Clinical Review

Resuscitation Training should be provided annually.

Accepted locally. Annual training is commencing on May 18 2007 for healthcare and discipline staff. This is being provided by the local PCT.

A single process should be used with consistent documentation across the prison to ensure a fully connected functioning oxygen system is always available.

Accepted. Daily check list is now in place, to be countersigned by Primary Care manager on a weekly basis.

Evidence of good practice

The First Reception Health Screening was provided in an effective manner by an experienced nurse with evidence of a high standard of interaction. Record keeping was also of a high standard.

The resuscitation was carried out calmly and effectively by the combined team of nurses and healthcare officers and later with the paramedics.