Investigation into the circumstances surrounding the death of a man at HMP Bristol in October 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the death of a man who was found in his cell with a ligature around his neck at HMP Bristol on 14 October 2007. The man was on remand for Theft Act offences. He was 27 years old.

I wish to offer my sincere sympathy and condolences to the man's family and friends for their loss.

This investigation was conducted by two of my investigators. I would like to thank the Governor of HMP Bristol and his staff for their help and co-operation during this investigation. I also wish to thank the prisoners who agreed to be interviewed.

The Bristol Primary Care Trust appointed a clinical reviewer to undertake a review of the medical care the man received whilst at Bristol. I am grateful for his report which is annexed to this investigation report.

The man had suffered the loss of his step-father in 2005, and the deaths of his mother and father within months of each other in 2007. His mother's death was particularly traumatic, causing him to suffer from hallucinations and hear her voice. He received a significant level of support from the prison's mental health team and visiting psychiatrists. Unfortunately, two days after his father's funeral he apparently took his own life.

The man emerges from my report as a very sad and vulnerable man. His treatment by HMP Bristol included some very good aspects, but I have also found flaws in the ACCT process and a failure to share information about risk.

I have made eight recommendations which have all been accepted by the prison service and formally identified an example of good practice on the part of one of the officers who first attended to the man.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man was charged with offences under the Theft Act and remanded into custody on 22 June 2007, arriving at HMP Bristol the same day. During the reception process, he was identified as having a substance misuse problem and referred to the substance misuse doctor. The man was put on a ten day subutex detoxification plan. He was not referred for a mental health assessment as he should have been.

As the result of a referral made by a Counselling, Assessment, Referral, Advice and Throughcare (CARATs) drugs worker, the man was seen by a consultant psychiatrist, on 31 July. The consultant psychiatrist diagnosed significant depressive illness with marked anxiety and agitation related to the death of the man's mother. Although the man admitted to suicidal thoughts, an Assessment, Care in Custody and Teamwork (ACCT) document was not opened at that time.

However, an ACCT was opened four days later on 4 August 2007 by one of the prison doctors, as the result of reading the psychiatrist's report and talking with the man. Two days later the man smashed his television, cut his hand and tried to bite an officer. The man began to talk about seeing his dead mother in his cell and being told by her to kill someone to bring her back to life. The man was assessed by a nurse from the mental health team and continued to see the consultant psychiatrist.

The man was seen to have a cut on his arm on 17 August, and he was very tearful and agitated. As he was being led to a gated cell the man handed staff a sharpened plastic knife that he had been using to self-harm.

On 5 September, the man was assaulted by another prisoner. He returned to healthcare awaiting a move to D wing (the vulnerable prisoner wing). At the case review on 12 September it was decided by the staff and the man that the ACCT should be closed.

The man was told that his father had died on 30 September and another ACCT was opened. The man was concerned about the pent up emotions he was feeling and was caught trying to hide his valium in his hand (known as palming) on two occasions. He explained that he was only intending to save the drugs to use at night when he would find them more beneficial.

On 6 October, the man cut both his wrists with a piece of glass. He would say to the consultant psychiatrist that, "I cut my wrists seriously and my cell mate saved my life."

The man attended an ACCT review on 11 October. The summary was generally positive with the man saying that he was looking for closure from the funeral and then hoping to move on with his life. The next day the man went to his father's funeral, telling staff on his return that he was proud of himself for being able to stand up and talk about his father.

The man was found in his cell at 3.36pm three days later on 14 October with a ligature around his neck. He was pronounced dead by paramedics at 4.07pm.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my senior investigators, on 23 October 2007. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.

2. My investigator and his colleague, formally interviewed a number of members of staff and prisoners regarding the man's death. The transcripts of those interviews are attached at the end of this report.

3. One of my family liaison officers, contacted the man's sister as his acting next of kin. She offered the opportunity to meet with her and my investigator to discuss the purpose of the investigation and to enable the family to raise any concerns or questions they would like explored or addressed. My family liaison officer and investigator met the man's sister and brother at their solicitor's office on 27 November 2007. They asked the following questions:

   - Was a suicide note found and if so what happened to it?
   - Exactly how had the man died?
   - Had the man been on a 'suicide watch'?
   - How was his mental health being monitored and who by?
   - Had he been on any medication whilst at Bristol?
   - Had the man had been given any sedation prior to attending his father's funeral?
   - Why the ACCT observations were reduced from every 15 minutes to every 30 minutes just two days after his father's funeral?
   - Was the man on a detoxification programme whilst in custody?
   - When had the man previously self-harmed (cut his wrists) and what action was taken?

4. The solicitor acting for the family also requested advance disclosure of the relevant prison documentation. It was provided a short time later. I have done my best to address the questions raised by the man's family, and I hope this report helps them to better understand the events leading to his death on the afternoon of 14 October 2007.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in preparing for the inquest into the man's death.

6. Bristol Primary Care Trust was asked to prepare a clinical review of the care that the man received whilst at Bristol. The Trust appointed a member of the PCT's Professional Executive Committee to undertake the review.

HMP BRISTOL

7. Bristol is an inner city Victorian prison located in the Horfield area of the city. It first opened in 1883. It is a category B prison with an operational capacity of 606. There are seven wings with accommodation being a mixture of Victorian galleried landings and two wings designed in the 1960s. Provision of healthcare within the prison is the responsibility of Bristol Primary Care Trust. The healthcare unit has 20 in-patient beds. The man's location at Bristol is shown in the table below.

The man's location at Bristol	
22/6/07	B wing
6/7/07	D wing
30/7/07	A wing
4/8/07	Healthcare
4/9/07	G wing
5/9/07	Healthcare
10/9/07	D wing
6/10/07	Healthcare
7/10/07	D wing
9/10/07	D wing single cell

8. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, writes in the forward to her March 2008 short follow-up inspection report of Bristol:

> "HMP Bristol is a local prison, holding around 600 prisoners – 26% above its uncrowded capacity. It suffers from many of the problems associated with population pressure: 300 prisoner movements a week, some unsuitable accommodation, insufficient activity spaces and difficulties in resettlement planning for a transient population. It is a measure of the task facing managers that, although this inspection did find improvements, the prison still remained deficient in relation to safety, respect and purposeful activity… Managers at Bristol had succeeded in reversing the decline we recorded at the last inspection. As a consequence, we were able to raise two of our assessments. However, in spite of these efforts, the effects of continued population pressure meant that Bristol was not yet performing well enough in three crucial areas – safety, respect and activity."

9. In her previous report in 2005, Ms Owers had been critical of the mental health arrangements at Bristol and made a recommendation. In her 2008 report she writes that the recommendation had been achieved:

> "**The area manager should commission a review of mental health need and management, to examine the need for a court diversion scheme, ensure an integrated health care provision (including day care) and identify and provide for staff training needs.**
>
> "**Achieved.** Mental health services were provided by the Avon and Wiltshire Partnership Trust. A senior manager from the Criminal Justice Liaison Service worked closely with the magistrates' court and mental health

providers to ensure that the court diversion scheme worked successfully. Senior mental health workers were based at the court and carried out assessments and referrals. They had excellent links with the prison and ensured that detainees or prisoners attending court were managed appropriately. Any detainees with a history of mental illness who were remanded in custody by the courts were seen by the team, and all relevant information passed on to the prison. It was evident that there was good joint working between the courts and prison systems.

"Mental health services had improved considerably since our previous inspection. An in-reach team had been established and two well qualified and experienced registered mental health nurses provided a high level of care to prisoners. The team worked well with the primary care mental health team and there was evidence of good multidisciplinary joint working between all those involved in the care of prisoners with mental health needs. Access to professional training for staff was fully supported and provided where necessary. Mental health awareness training for generic prison staff was provided through a rolling programme delivered by members of the mental health team. Day care was now provided."

10. Each prison has an Independent Monitoring Board (IMB) whose members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. Writing in the latest IMB report for Bristol (2006-2007), the chairperson says:

"Many in-patients have severe mental health problems. They are often volatile and need a good deal of care. Avon and Wiltshire Partnership Trust has been recently appointed to provide mental care provision, which includes Mental Health Inreach programme, and covers 7 days a week. New clinics that have been set up within the last year,

- In the Single Point Entry Clinic all agencies/ departments meet together to focus on the treatment plans for individual prisoners.
- Depot Clinic focuses on longer lasting medicines for mentally ill patients.
- Triage Clinic is held weekly so that all mental health referrals are prioritised by need.
- Secondary Healthcare Screening is now in place for every one who wants it within 7 days.
- Well Man Clinic focuses on obese prisoners looking at exercise and diet.

"Day Care is a busy and thriving department offering counselling and treatment up to 4 hours per day depending on availability of different skills and needs of the prisoners."

11. Since I was given responsibility for investigating all deaths in prisons in April 2004, there have been 12 deaths at Bristol prior to that of the man. Three were self-inflicted, eight were from natural causes, and one was the result of an illicit drug overdose. The issues raised in my reports into those earlier deaths are not relevant to this one.

KEY FINDINGS

12. On 22 June 2007, the man was remanded into custody by North Somerset Magistrates Court for Theft Act offences and taken to HMP Bristol. He had been in prison and young offender institutions many times before and had been released from Bristol four months earlier in February 2007.

13. During the reception process the man was seen by a reception nurse who completed the First Reception Health Screen (FRHC). The man told the nurse that he had not seen a doctor in the last few months and that he was not receiving any prescribed medication. He said that he usually drank six or seven cans of lager each day. When asked about illicit drug use, the man told the nurse that on a daily basis he used heroin, diazepam and crack cocaine.

14. The man said he had not received treatment from a psychiatrist outside prison, nor had he been prescribed any medication for mental health problems. He did admit to harming himself outside prison by cutting his face a “long time ago”. The man said that he did not feel like harming himself but the nurse recorded the following on the form: “Says he’s still upset at his mother’s death four months ago from a heroin overdose. Says he needs to grieve properly. Doesn’t want to self-harm.”

15. The nurse recorded the man’s pulse as 88 beats per minute and wrote that he felt sweaty. He was given 135mgs of mebeverine for stomach cramps, 7.5mgs of zopiclone to help him sleep, 200mgs of carbamazepine to help with alcohol detoxification and 400mgs of ibuprofen for general aches.

16. The reception nurse referred the man to see a doctor regarding his substance use and also to the drugs service. He should have been referred for a mental health assessment as he answered ‘yes’ to the question about self-harm outside prison, but this did not happen. In her interview with my investigator, the reception nurse said that she does not know why she did not refer the man for the assessment, but emphasised that she did not have any concerns regarding his mental health at the time. The man was allocated a cell on G wing.

17. The following day, a prison doctor went to see the man regarding his substance use but he was not in his cell as he had gone to change his clothes. The doctor wrote that he would see him the next day.

18. The doctor saw the man on 24 June. He prescribed a ten day buprenorphine (subutex) detoxification plan, which the man completed on 4 July. The doctor completed an electronic substance use form on 25 June, in which he noted that the urine sample given to the reception nurse tested positive for benzodiazepines and opiates. He noted that the man had been using the drugs during the four months he had been out of prison and that he complained of insomnia, aches and sweats.

19. On 26 June, the man was assessed by a substance misuse nurse who completed a detoxification care plan. The nurse asked him when he expected to be released from prison. The man said that he thought he would be

sentenced to five years imprisonment when he went to court in three days time. He told the nurse that he had been using heroin since he was 14 years old and had spent the majority of the last 11 years in prison. He also said that he had lost both his parents to heroin and alcohol.

20. On Friday 29 June, the man was taken to Bristol Crown Court and was further remanded until 28 September.

21. The next day a prison officer wrote in the man's wing history sheet that he was always polite on the wing. The one matter of note at that time was that the man was keen to find work.

22. On 6 July, a second officer saw the man after he had asked to be moved to D wing. (D wing is the area of the prison where prisoners are housed who are thought to be vulnerable either due to the nature of their offence or because they are being bullied or in debt.) The man told the officer that he had been told to bring a package into the prison on a visit. He had refused and said that he had been threatened. The man named the two prisoners making the threat.

23. The man was assessed by the second officer, who also completed a Cell Sharing Risk Assessment (The CSRA is a form used to help staff decide on the apparent risk a prisoner poses to any other person sharing a cell. There is a choice of high, medium or low risk.). The officer considered the man as low risk and moved him into cell 1-23 on D wing. It is clear that the man felt comfortable talking to the wing staff and that he was supported by an immediate move to D wing.

24. A third officer gave the man a verbal warning on 14 July. The warning was for having pictures on the cell wall and ones too large for the picture board. He was also told about having blankets up at the window. The officer wrote that the man became confrontational and she told him he would be given an official IEP warning if he did not act on her advice. (IEP stands for incentives and earned privileges. If a prisoner gets three such warnings he will be put onto a basic regime thereby losing gym, association and other privileges.)

25. At 9.45am on 17 July, the man was taken to Weston-super-Mare Police Station in connection with an investigation into a robbery and a number of burglaries. He returned to the prison at 3.40pm.

26. On 21 July, the man was expecting a telephone call from his girlfriend, a prisoner at HMP Eastwood Park, but the call was not made. A fourth officer contacted the prison to ascertain the reason and was told that the prisoner had not asked to make a call. The officer gave that information to the man who said he would write to his girlfriend.

27. A fifth officer spoke with the man on 24 July. The man told her that he felt things were not going too well and that he had got in with the 'wrong crowd' as a way to fit in. The officer wrote that the man was feeling a 'bit down' and they decided on a plan of action to get him working. The officer also warned him that his poor behaviour was being watched.

28. The man was also seen by a member of the CARATs team, that day. (CARAT stands for Counselling, Assessment, Referral, Advice and Throughcare. Everyone coming into prison identified as having a drug problem is assessed, given advice about their misusing, and referred to other services such as drug treatment programmes, housing and employment.) The man told the CARATs worker that he had been prescribed medication for depression a while ago, and that since being in prison he had not slept much. A mental health referral form was submitted and the level of urgency was marked as routine. An appointment was made for the man to see the consultant psychiatrist, a consultant psychiatrist, on 31 July.

29. On 25 July, the man made an application to see a doctor. He wrote:

> "I suffer from bad depression and I would like to see the doctor. So I can get some help again as things are starting to get really difficult for me again, thank you."

30. The man saw a doctor two days later on 27 July. Again he said that he had lost both of his parents. He also said that he was only sleeping two to three hours a night and having nightmares. He denied any thoughts of self-harm. The doctor prescribed the man 20mg of citalopram, an anti-depressant.

36. Three days later on 30 July, the man was moved to A wing at his own request. The following day the man was seen by the consultant psychiatrist and moved into the healthcare centre. The man told the psychiatrist that his father had drank himself to death in 2005, and that his mother had died from a heroin overdose in March 2007. He said that he was experiencing panic attacks and paranoid feelings that were getting worse. The man revealed that he had suicidal thoughts, but said he did not want to kill himself.

37. The consultant psychiatrist's diagnosis was as follows:

> "The man appears to be suffering from a significant depressive illness with marked anxiety and agitation. This has occurred in the context of bereavement (his mother died in March) and following a detoxification regime. He has a strong family history of mood disorder and alcohol and substance abuse."

38. The consultant psychiatrist increased the man's citalopram prescription to 40mg a day and prescribed 50mg of chlorpromazine for agitation and 7.5mg of zopiclone at night to help with his sleep. He did not open an ACCT document. In his interview with my investigators, the consultant psychiatrist said this was because he did not think the man was a high suicide risk. He added that if he thought someone was suicidal he would recommend that an ACCT was opened.

39. ACCT stands for Assessment, Care in Custody and Teamwork. The plan encourages staff to work together to provide individual care to prisoners in distress, to help defuse a potentially suicidal crisis or to help individuals with long-term needs (such as those with a pattern of repetitive self-injury) to better manage and reduce their distress.

40. There are entries in the man's medical record by the doctor on 1 and 2 August stating that there was no change in the man's condition. The next day the doctor wrote: "Rather anxious. Waking at 3am – seeing image of his deceased mother in his cell. Distresses him. Advised to allow time for citalopram to have effect."

41. On 4 August, the man was seen by another doctor who decided after talking to him to open an ACCT. The observations were to be visual every two hours, recorded every four hours. In an interview with my investigators, the doctor explained the reasoning behind his decision to open an ACCT:

> "Well because he was very disturbed and I thought his condition to be impulsive and that his delusion was round about the death of a parent rather than pink elephants or anything. And so I thought the combination of the type of delusion he was having, plus [the consultant psychiatrist's] assessment, which I've written *'In view of [the consultant psychiatrist's] assessment'*, so there was the previous consultant's opinion that he might possibly be impulsive. The combination of those three factors made me feel we should open an ACCT, possibly move him to a safer cell. He wasn't kept in a safer cell; it was just for a period before he moved out again."

42. A senior officer conducted the ACCT assessment interview on 5 August. Section three of the form asks about any previous acts of self-harm or suicide attempts, and the man said that he had tried to overdose after his mother's death. The senior officer expanded on this in her interview with my investigators:

> "We covered if there had been previous acts of self harm or suicide attempts and he informed me that in mid-May he had taken an overdose of heroin and valium because he wanted to be with his mum and he was actually found but was very unhappy about being revived."

43. The prison doctor saw the man again on 5 August. He wrote: "Agitated. Try increasing chlorpromazine to 100mg morning and 50mg in the afternoon. Working diagnosis – drug induced psychosis."

44. During the afternoon of 6 August, loud screams were heard coming from the man's cell in the healthcare centre. Staff saw that he had smashed his television and cut his hand. When officers entered the cell the man tried to bite one of them. The man was restrained and taken to the segregation unit where he was searched for sharp objects. The man was then returned to healthcare and put into a gated cell (a cell that has a clear Perspex covered barred gate in place of the usual solid metal door.)

45. A registered mental health nurse employed by Avon and Wiltshire Mental Healthcare Trust as a Forensic In-Reach Practitioner, explained in her interview what happened when the man returned to his cell:

> "He was obviously in a stressed and agitated state, so we had a visiting Psychiatrist coming in that afternoon a Consultant Forensic Psychiatrist

> from Fromeside Clinic and I asked him to see the man as an emergency. The man was complaining of hearing his dead mother's voice, stated that the reason he smashed the television was that she had appeared on the television in front of his eyes, so that distressed him so he smashed it. He admitted that he knew that this couldn't be true, however it felt real to him at the time. The consultant forensic psychiatrist's assessment was that he didn't feel that this was a psychotic illness, but he was suffering from an extreme grief reaction and some withdrawal from illegal substances. Medication was adjusted and the consultant forensic psychiatrist felt that the man should remain in the healthcare centre."

46. The nurse saw the man the next day. He told her that he had heard his dead mother's voice and she was telling him to kill someone so that she could come back to life. At the same time he was aware that the voice was not real.

47. In the afternoon the man asked to see the senior officer. He told her that he now realised that it was not D wing making him feel low, it was his grief and anger. He wanted to leave the healthcare centre and return to D wing when he was fit, as he felt that he could not function properly due to problems with other prisoners. These problems may have been related to information that the man had given to staff.

48. The nurse saw the man again on 9 August. She wrote in his medical record that, while he remained agitated, distressed and had chronic low self-esteem, he was beginning to understand the reasons for his feelings. She added that he had started to open up to his deep rooted issues, although he was still guarded about revealing his full history.

49. At 10.30am on 11 August, the man was present for the first ACCT case review. The Healthcare Officer wrote that the man was more settled but needed to control his temper when discussing his moods. It was decided to keep the observation levels the same as when the ACCT was opened (that is, once every two hours).

50. At 9.00am on 14 August, a sixth officer made a long entry in the man's ACCT document. He wrote that the man was very tearful, and had asked for a move to D wing once his time in healthcare was over as he had problems that followed him around the prison. The man also said that he found it very hard coming to terms with his mother's death. The sixth officer spoke with the chaplaincy regarding some counselling. The officer recorded that he was told by the chaplaincy that they were not taking any new referrals at that time.

51. The man saw the consultant psychiatrist again as a routine follow-up on 14 August. The man was very distressed about the visions he was having of his mother. During the interview with my investigators, the consultant psychiatrist described how the man presented:

> "I found him very anxious, agitated, seeing visions and hearing voices, 'always my mother' he said 'felt like my mother was crawling all over me', which as I said was quite striking and unusual for a bereavement reaction. Found it very distressing, even saw her on the television, he said 'I thought

I was going to explode' and at that point he said 'that's why I smashed up the room', because that was after he smashed up the cell. 'I've never been like this before' he said, 'I was hoping I was going to get better but actually I'm feeling worse. Some staff seem to disbelieve me, other staff are helpful.' He said he wasn't sleeping, the zopiclone only helped him for a short while, he was waking constantly, though better last night he said, 'crying my eyes out this morning, can't concentrate. Tried to cut myself last night', so obviously there was that first episode of self harm then on the 14th. 'My mother seems so real, like you sitting opposite me.' So my impression was a severe bereavement reaction, quite severe, agitated but not psychotic in the narrow sense and medication, I decided to stop the olanzapine which is an anti-psychotic, it wasn't helping him, it wasn't me, it was somebody else who prescribed that, put him on some promazine which is a phenothiazine drug but is more a sedative drug, it hasn't a very strong anti-psychotic property but it would really help him with sedation because he was very agitated and roused and I thought it would be helpful to calm him a bit, but also to continue the lorazepam which is another sedative drug and the citalopram the anti-depressant and the zopiclone."

52. At 3.40am on 17 August, the man was very anxious and sat on his bed with two figurines on a plate next to him. When a seventh officer asked who they were, the man replied that they were his parents and that they wanted a sacrifice. At 4.00am, the man was still awake but said that he was okay. At 4.30am, the man was still agitated. He told the officer that he was continuing to hear voices and his mother was telling him to be prepared. The officer then saw that he had made a small cut to his right arm.

53. At 10.30am, a second nurse wrote in the medical record:

> "At around 10.00am the man became very agitated in his cell. He was pacing up and down with clenched fists saying that the voices would not go away, the man was crying throughout. He went on to explain that the voices were telling him to harm others which he did not want to do, so therefore he felt he would have to harm himself. The man then walked to the gated cell with nursing staff ..."

54. When the man was moved to the gated cell he handed a sharpened plastic knife to staff. His CSRA was increased to high risk until approval for sharing was given by medical staff. The man's ACCT observation levels were increased to every hour.

55. An hour later the man was seen by the prison doctor. The doctor wrote that the man was a lot calmer but was still agitated and holding his head whilst pacing the cell. The man told the doctor that he had been up all night as he had visions of his parents being in the cell with him. The prison doctor prescribed an additional 50mg of chlorpromazine for his agitation to be administered at the discretion of the nursing staff.

56. The rest of the day passed without incident, but at 3.40am the next morning (18 August 2007) it was noted in the ACCT that the man was awake and saying he was hearing voices.

57. Whilst out of his cell for exercise at 11.30am, the man approached a second senior officer and told him that he recognised another prisoner who had assaulted him about 18 months previously over a dispute about an ex-girlfriend. The second senior officer submitted a Security Information Report (SIR). It was decided staff should be informed about the situation and the two men should be kept apart.

58. The man was given 50mg of chlorpromazine during the morning of 19 August as he was agitated.

59. On 20 August, the prison doctor saw the man in healthcare. He wrote that the man was still agitated and was repeatedly folding his clothes. The man told the doctor he was worried he would lose control and harm someone. The nurse had requested that diazepam be substituted for chlorpromazine as the dose can be more easily tolerated. The prison doctor agreed and stopped the prescription for chlorpromazine and lorazepam. He started the man on 10mg of both diazepam and olanzapine. He also wrote that he would consider a mood stabiliser later.

60. Two days later the man attended another ACCT case review. It was recorded that his level of suicidal and self-harm tendencies had greatly reduced. The man said that he was very apologetic for his recent actions. The review panel decided to change the observation level to once every two hours.

61. The next few days passed without incident. On 28 August, the prison doctor wrote that the man was worried that he would become addicted to diazepam. The doctor reassured him but reduced the morning dose to 5mg. The man said he was thinking of returning to a wing but wanted a single cell. During the afternoon there was another ACCT review. The panel decided that the observation level could be reduced to three times during the day and night.

62. On 30 August, the prison doctor wrote that the man was happy with the reduction of diazepam but he would like to continue with the zopiclone for a few days.

63. The next day, a second consultant forensic psychiatrist, talked with the man at the request of his solicitors. The psychiatrist concluded that the care the man had been receiving over the previous few weeks had begun to improve his mental state.

64. The mental health nurse wrote in the medical record that the man should remain in healthcare until he was reviewed by the consultant psychiatrist. However, on 3 September the man spoke with the nurse about returning to G wing because he did not feel that there was enough activity in healthcare. The man moved back to G wing the next day.

65. At 11.05am on 5 September during a period of unlock, an eighth officer responded to a cell bell at the man’s cell. He saw the man holding a bloody tissue to the right side of his face. The man told the officer he had been cut. The officer saw that the man had a one inch vertical cut above his right eye and another about one and a half inches long below the same eye. The man said

he had been in a friend's cell on the 'ones' landing drinking tea when another prisoner came in and, after a brief argument, cut his face. The man refused to name the prisoner responsible but said that it was because of what had happened earlier in the year (when he had been asked to bring drugs in). The man was returned to healthcare and it was decided that he would remain there until space became available on D wing.

66. Also that day, a governor decided not to proceed with any disciplinary charges relating to the man smashing a television and biting an officer on 6 August. The man appeared to be in good spirits with no thoughts of self-harm over the next few days. The prison doctor wrote in the medical record that the cuts to his face were healing well and the man was asking for sleeping pills, although there was no evidence of insomnia.

67. The man moved to D wing during the afternoon of 10 September. He went to court the following day and was remanded again until 18 September.

68. An ACCT case review was held on 12 September when it was decided to close the document as the man said he had no more thoughts or intention of suicide or self-harm. He said he got on well with his cellmate and he would ask for help if he felt himself 'going down hill'. The post closure interview with the man was set for 19 September.

69. A ninth officer made an entry in the man's wing history sheet on 16 September saying that he had settled into the wing routine very well. The officer added that the man was a very quiet person who did not leave his cell when the door was left open because his cellmate was a cleaner.

70. The ninth officer was the man's personal officer at the time. (At Bristol a small number of cells are allocated to each wing officer. Those officers then introduce themselves to the prisoners in the cells as their personal officer. That officer is then the prisoner's first port of call if they have questions, complaints or need advice. If a prisoner moves out of a particular cell he may have another personal officer allocated to him.)

71. On 18 September, the man was further remanded until 28 September. During a cell search later that day a mobile telephone charger was found hidden behind the picture board in the man's cell. Both the man and his cellmate were put on disciplinary report. The next day the man pleaded guilty to the charge. He wrote a confession saying that he had found the charger in the bin and had stupidly kept it, intending to use the wire to get a better reception on his radio. A second governor found the charge proved and decided that the man should lose 80 per cent of his earnings and his canteen privileges for 21 days as punishment. (Canteen is the name given to purchases via the prison shop such as sweets, tobacco and personal articles.) The ACCT post closure interview with the man, scheduled for 19 September, did not take place as planned.

72. On 28 September, the man was further committed to Bristol Crown Court and remanded until 10 December.

73. On 30 September, a Reverend who is a member of the prison chaplaincy team, went to see the man. He told the man that the prison had received a call from his sister to say that his father had died. The man took the news badly, saying he could not continue with life and that he would rather be dead. The man was offered and made a telephone call to his sister. He was later put into a safer cell as a precaution, and the Reverend asked staff to open an ACCT as he thought that the man was suicidal. (A safer cell is a cell where places to attach a ligature have been designed out as far as possible.)

74. A tenth officer opened the ACCT document. The man said he did not want to go back to healthcare as he would prefer to stay with his cellmate. This was agreed by a third governor. The man was informed that he could use the Samaritans phone or the Listener system. (A Listener is a prisoner who volunteers to be trained by the Samaritans to carry out a similar role within the prison.) It was also decided to set the ACCT observation levels at every 15 minutes with frequent conversations through each shift.

75. An eleventh officer wrote the following entry in the ACCT document at 3.30pm:

> "The man appears to be in shock at present and has very mixed feelings about the news of the death of his father. Following his mother's death in March, the man became very unstable and feels he will go down the route again. Suggested he requests a visit from his sister as that may help him deal with the news. Assessment delayed until tomorrow, when hopefully the man will be able to articulate further how he is feeling emotionally."

76. The third officer conducted the assessment interview on 1 October. The man said he was suffering from shock at the news of his father's death but wished to be treated normally and to lead a normal prison life. When asked about any previous acts of self-harm, the man said he had cut his wrists whilst in healthcare some seven months previously on hearing of his mother's death. (The man did not mention the overdose attempt he had spoken about to the senior officer.) Later that day, a third senior officer and the third officer conducted an ACCT case review when the following was recorded:

> "The man is obviously deeply shocked by the whole scenario. He appreciates that staff are here to help and assures us that he will seek help if required. Sleep is his only release at the moment and therefore 3x day & night observations are appropriate. He will be seeking to go to the funeral in due course."

77. The rest of the day passed without incident. The man appeared to be coping as well as could be expected. There is an entry in the ACCT document by the third officer at 8.00pm saying that the man had been quiet all evening, watching television and chatting to his cellmate.

78. The next morning, the tenth officer wrote the following entry in the ACCT document:

> "Had a lengthy chat with the man. He feels a lot of pent up tension and does not want to feel this way. Is having difficulty explaining himself and

exploring his feelings after his loss. Have explained about a single cell and other options open to him."

79. Later that morning, the man spoke to the chaplain who described him as tense and concerned about when his father's funeral was to be. The man went to his work as an industrial cleaner in the afternoon but became upset and tearful. The twelfth officer told the man's personal officer, who spoke with the man when he returned to the wing 15 minutes later. She wrote the following entry in the ACCT:

    "The man is very upset today, stated it is all too much, being in prison and having to rely on others for information. He does not know when the funeral will be, or if he can attend. This is getting him down. I have told him to put applications in tomorrow for emergency pin credit to be put on and his sister's new number. At least he will be able to chat with her himself. Also I have told him to put in an app [application] to see the chaplain again. He thanked me for talking to him."

80. The man spent a quiet night and did make the applications the following morning (3 October 2007). The chaplain went to see the man that afternoon and told him the details of the funeral. At 5.15pm, the third officer wrote that the man had had a reasonable afternoon and was feeling a lot easier now that he knew the date of the funeral. She added that when he collected his tea meal he seemed fine.

81. On 4 October, the man attended a stress management group and appeared to enjoy it. The next day it was noted in the ACCT that the man appeared to be in good spirits throughout the day.

82. When the man collected his medication from the treatment hatch on 6 October, staff observed that he did not swallow the diazepam (valium) tablet but tried to walk off with it. When challenged, he dropped the tablet to the floor and showed his empty hands. The staff warned him that he would be put on disciplinary report if he did it again. The man spoke to his personal officer afterwards and gave her the impression that it had not been the first time he had 'palmed' his diazepam. The man explained that he needed them more at night.

83. The man apologised to the staff at the treatment hatch that afternoon and assured them he would take his medication correctly. However, staff saw him take the tablets from his mouth and conceal them in his night in-possession medication bag. The man told staff he had been doing it for some time. He said that it was not to sell his medication but to take it at night when he needed it more. The man was put on an IEP warning and told he would be given his medication in the evening to help him sleep.

84. At 7.00pm, staff saw that the man had cut both of his wrists with a piece of glass. The man told the nurse who treated his injuries that he had cut himself as the result of feeling very low due to the death of his father. There was one cut to his right wrist which required pressure to be applied for four minutes to stem the blood flow. There were two cuts to his left wrist which were not

bleeding when the nurse attended. The nurse wrote that the man had full sensation, colour and movement to his fingers and thumbs. The man was placed in the gated safety cell in healthcare overnight with his radio. He told staff he would like to speak to the mental health team as he felt he was ready to talk about his parents' deaths.

85. At 8.00am the next morning (7 October), a thirteenth officer wrote in the ACCT that the man was up and about saying he felt stupid about what had happened the night before. The personal officer spoke with the man later that morning. She wrote that the man said he did not mean to mess staff about or flare up at them. He said he felt he was 'losing it' as he had done before. The man told the officer he really wanted to return to his cell. She replied he could do so once he had seen the doctor.

86. The man was seen by the doctor later that morning and returned to his double cell. At 2.10pm the man attended an ACCT case review. The third senior officer wrote that the man was obviously very distressed about the death of his father, and wanted to get the funeral over with so that he could move on. The man said he could not explain why he had cut himself the previous evening, but claimed not to be suicidal. The man and the staff discussed the need for trust on both sides.

87. At 5.00pm, the fifth spoke with the man. The officer then contacted the mental health team and explained that the man had not yet been seen. He was told that the mental health nurse was on leave but they would arrange for someone to see the man before his father's funeral.

88. At lunchtime on 8 October, the man spoke to the third officer about moving into a single cell so that he could 'get his head together'. He assured the officer he would not self-harm. The man's personal officer had a similar conversation with the man at 5.20pm. The man assured her that he desperately needed some time to himself and would not do anything to jeopardise that. The following morning, the man thanked the man's personal officer for letting him move into a single cell.

89. The consultant psychiatrist saw the man again on 9 October. He remarked on the fact that the man had gained weight since he had last seen him, but agreed with one of my investigators that it could have been a side effect of the chlorpromazine he was taking. He said the man was still receptive and keen for help. In interview, the consultant psychiatrist read from the notes of his last consultation with the man:

> "'I don't understand why it's all happening, to lose my step-father, mother, father all in two years. I cut my wrists seriously and my cell mate saved my life' he said. 'No point in going on living, the little hope that I had is now gone, it's been dashed.'"

90. Later in his interview, the consultant psychiatrist spoke about whether, in his opinion, the man's intention was to end his life:

> "I have little doubt from what I know of how his death occurred, that this was a deliberate and it's picking up the negative bits. I mean people in this situation as we all are, are ambivalent, part of them wants to live, part of them wants to die you know, there's a weighing up and for him. What was striking in his mental state was fluctuating as well and there was both parts of him as it were, if you like, in battle, the part that wanted to live, that had hope you know, but his hope after his father's death was clearly dashed, and although he was talking about due in court 10 December, I mean that's not a statement of somebody who has decided at that point to kill himself. I'm quite sure when I interviewed him, he had no intention of killing himself, but with the background of impulsiveness, and I don't know what happened in detail between when I saw him and his death but, of course we know the funeral happened in between but, and the sense of being bereft in this world and all this happened to him. But the tragedy is, people like this often, the mental state fluctuates and part wants to live and part, at times wants to die, and of course if they act on the point, at their lowest, that can result in their death, notwithstanding there were parts of them that. It's quite different from someone who has got a severe enduring depressive illness with suicidal ideation, that's a different thing, that clearly, you can treat that depression, but someone like this, a grieving reaction against a background of vulnerable personality, it's going to fluctuate a lot."

91. As a result of his consultation with the man, the consultant psychiatrist prescribed a 5mg increase of diazepam and reintroduced 100mg of chlorpromazine.

92. The ninth officer wrote in the ACCT document at 11.55am on 10 October: "in work all morning. Did not raise any concerns." It was recorded later by The tenth officer that The man was out on association that evening.

93. The next day the ninth officer made three entries in the ACCT document. At 8.45am she wrote that the man spoke to her saying he was alright, laughing and joking with her. At 11.50am she gave him a verbal warning for having a towel up at his cell window for the second time. Finally, at 5.05pm, the ninth officer wrote about a long chat with the man. He told her that he had been to stress management and explained how he was intending to use the relaxation techniques. The officer reminded the man about the relaxation CDs available and the man said he would ask if he wanted one. I note the man's attendance at the stress management session is not mentioned either in the ACCT or in his medical record.

94. At 7.30pm, the third senior officer and the man's personal officer conducted another ACCT case review with the man. The third senior officer summarised the review as follows:

> "The man is looking for closure after the funeral tomorrow, and then moving on with life. Being in a single cell seems to have helped him through this and we will review this on Monday. He assures us that he will tell staff how he is feeling when he returns from the funeral tomorrow."

95. The officers decided that the next ACCT case review should be held the following Monday when they were both back on duty. It was decided that the frequency of the observations on the man would remain at three times during the day and three times during the night.

96. On 12 October, the ninth officer wrote in the ACCT document that the man had been awake since 3.30am and was extremely worried. He said his stomach was turning over but he was trying to use his stress management techniques. The officer advised him to go to work even if he did not feel like it as he would be with his friends. At 10.10am the ninth officer made another entry stating that the man had gone on exercise instead of work - which staff felt was good as it got him out of his cell.

97. The man's sister asked my investigators if the man had been sedated to attend the funeral. He had not, but he was taking a number of drugs and just two days previously the consultant psychiatrist had re-introduced chlorpromazine which can have a sedating effect.

98. At 1.00pm on 12 October, when the man returned from his father's funeral, he told staff it had gone well. He said he was proud of himself for getting up and speaking briefly about his father. He also said he was looking forward to his next stress counselling session when he could talk about the funeral then.

99. The man attended stress management that afternoon. The sessions were run by a trainee psychologist. After the session the trainee psychologist wrote in the ACCT document:

> "Spoke to the man for over an hour regarding his anxiety and stress management issues. He presented as less anxious, as normal and reported to be feeling numb following the funeral. He finds the PMR relaxation technique useful and said he used it before the funeral today. I have encouraged him to use this over the weekend and I will see him next week. He is talking about his future and has requested info on therapeutic communities. To follow up next week."

100. It is interesting to read in the trainee psychologist's interview with my investigators that the man described the occasion when he cut his wrists as a suicide attempt. That echoes what the consultant psychiatrist recorded during his last session three days before: "Cut my wrists seriously – my cellmate saved my life". Both are in contrast to his statement to staff at the case review, the day after he cut his wrists, when he said he could not explain the reason for self-harming but claimed that he was not suicidal.

101. At 5.20pm, the ninth officer made a further ACCT entry which said that she had spoken at length to the man. He thought his talk with the trainee psychologist had helped him a lot and felt very positive at that time. The ninth officer told the man that if he wanted to talk he could speak to her or a Listener, and have access to any of the stress management CDs or books.

102. I am pleased to see written evidence of the increased concern by staff in the ACCT document at 8.30pm. The night patrol officer recorded that there were "concerns given due to the man going to his dad's funeral".

103. It was recorded that the man slept through the night of 12/13 October. At 12.00 midnight an ACCT entry states: "quiet as normal, but stated he is feeling ok". The tenth officer recorded that the man was watching television in his cell after collecting his tea and there were no apparent problems. The man passed another quiet night.

14 October 2007

104. On 14 October, a fourteenth officer wrote the last two entries in the ACCT document:

> "09.20 the man unlocked for kit change & shower, very quiet, spoke to other prisoners and collected medication. No issues at present.
>
> "11.15 Unlocked for lunch, no issues, just quiet at present, declined exercise."

105. At about 3.36pm, the fourteenth officer was unlocking the cells on the two's landing on D wing. He looked through the observation hatch window of cell 2-14, the man's cell. He looked down and saw the man's back. At first he thought the man might be bending down to get to his locker. He started to open the door carefully and then realised that the man was lying on the floor. The officer called for assistance and the fifteenth officer, who was nearby, responded. They got into the cell and turned the man onto his back at which point they saw a ligature of torn bed sheet around his neck.

106. The fifteenth officer shouted out of the door that there was a 'code blue' and then cut the ligature free, using the safety knife issued for that purpose. (A code blue call alerts other staff to an emergency medical situation involving a severe breathing problem.) The officers also noticed that both of the man's wrists had strips of torn bed sheet wrapped around them, although there did not appear to be any blood. The fifteenth officer thought that the man had attached the bed sheet ligature to the cell ceiling light fitting and it had given way under his weight.

107. The ninth officer and the second officer heard the call. The second officer immediately relayed the message to the control room on his radio. The ninth officer collected the emergency bag from the treatment room and alerted the nurse. Meanwhile the initial two officers had commenced cardio pulmonary resuscitation (CPR) on the man. The actions of the fifteenth officer at this time showed professionalism and compassion. I particularly commend the speed with which he began mouth to mouth resuscitation without the use of a protective mask. I believe this was in the highest traditions of the Prison Service, and the Governor will wish to consider if the fifteenth officer' actions should be formally recognised.

108. The ninth officer and other staff arrived at the cell and she set up the automatic defibrillator. Over the next few minutes the machine went through its checking cycle but did not at any time indicate that a shock should be administered. (The machine works by correcting flawed rhythms in the heart, if detected, by administering an electric shock.) Nursing staff arrived and took over CPR from the officers. They in turn were relieved by the paramedics who arrived at 3.53pm having been called by the control room. Despite the efforts of the paramedic team they pronounced the man dead at 4.07pm. The staff did not find any letter of intent in the man's cell.

109. One of the nursing staff, who went to the man's cell, told my investigators that in her opinion the man had been dead for some time. The ninth officer reported that she could not get the plastic airway into the man's throat as she could not open his jaw, and the paramedics recorded that they were unable to insert an airway due to rigor mortis. (Rigor mortis is a natural post death change in a body causing stiffening of the muscles.)

110. The staff involved at the man's cell were later brought together for a 'hot' debrief. The Governor was present. (The purpose of a 'hot' debrief is to acknowledge what happened, acknowledge the role of the staff involved, normalise the situation, and ensure that the immediate needs of the staff have been met.)

111. The man had listed his grandfather as his next of kin. A fourth governor and the eleventh officer went to his listed address to tell him of the death of his grandson. They arrived at 7.10pm but were unable to pass the news. They wrote in a decision log that the man's grandfather was an elderly man who would not answer the door. They reported back to the Governor who agreed that enquiries would be made to determine other next of kin. Staff were aware that the man's sister had been in contact recently and efforts were made to find an address. The following morning, the Reverend and the second governor were unable to get an answer from the telephone number they had for the man's sister. They then went back to his grandfather's address. Eventually, the man's grandfather answered the door and he contacted his grand-daughter, the man's sister, who arrived and was told the sad news.

112. The Reverend spoke with family members on several occasions after 15 October, and the second governor visited the family again on 29 October. The prison contributed towards the cost of the man's funeral.

ISSUES

113. When the man first arrived at Bristol he was seen by the reception nurse who completed a First Reception Health Screen (FRHS). When asked about any self-harm outside prison the man said that he had cut his face a long time before. He did not mention that he had tried to commit suicide by using a drugs overdose. However, the answer he gave should have triggered a referral to the mental health team as required by a section in bold type after question ten on the form. This was a very regrettable oversight, although in fact I do not believe it made any material difference to the quality of care the man received.

114. The reception nurse had been working at Bristol for ten years and was responsible for training other nurses to complete the FRHS. During her interview for this investigation, she admitted she had not made the referral and could not give an explanation for the omission. I am aware that in a more recent death at Bristol the reception nurse also omitted to make the necessary referral after a positive answer to question ten on the FRHS.

115. My investigators in this case immediately brought the matter to the attention of their liaison officer who assured them it would be dealt with as a training issue. (The reception nurse is no longer employed at Bristol.)

The Governor, together with the Healthcare Manager, should commission a sample audit of recent First Reception Health Screen forms and ensure that any necessary remedial staff training is swiftly completed.

116. On 23 June, the prison doctor went to B wing as he intended to see the man regarding his substance use and to start a detoxification regime. At the time of the doctor's visit the man was not in his cell. As a result the man was not seen until the following day. There is no evidence that starting his detoxification regime a day later had any detrimental effect on the man's physical or mental health. However, in a number of deaths that I have investigated the delay in starting a detoxification regime was significant.

The Governor should ensure that prisoners are made available for medical consultations whenever possible.

117. The man saw the consultant psychiatrist on 14 August 2007, and during the consultation told him he had tried to cut himself during the night. Although that information was written up in the consultant psychiatrist's notes in the medical record, the self-harm information was not written in the ACCT document. In fact, there is no mention of the consultation itself in the ACCT. There is also no evidence that knowledge of the man's attempted self-harm was passed to any of the discipline staff or other medical staff.

The Governor should ensure that all persons having contact with prisoners on ACCT documents are aware of the requirements and responsibilities for entries in that document.

118. The above information would probably be treated as information given in confidence. As I have discovered in many of my investigations, medical confidentiality is usually the reason cited by healthcare staff for not sharing information given with discipline staff. Prison staff and visiting doctors (not only at Bristol) appear to believe that they are not allowed to share medical information.

119. Whilst I am conscious of the importance of medical confidentiality, I think that, when the need arises, prisoners might sensibly be asked to sign a consent form allowing information to be shared with senior wing staff. Having a clear policy for disclosure will help prison healthcare staff to recognise that in certain circumstances such disclosure is both lawful and beneficial. Prison Service Instruction (PSI) 25/2002, 'The Protection and Use of Confidential Health Information in Prisons and Inter-agency Sharing,' which is still in force, laid much of the groundwork for such a policy. However, in the six years since its introduction I wonder if the views and actions of prison healthcare professionals have changed sufficiently.

120. I am pleased to see that the latest version of Prison Service Order (PSO) 2700, published on 26 October 2007, highlights this issue in Section 6:

> "There are strong links between self-harm and mental ill health, drugs/alcohol problems, and experience of abuse. Other problems such as bereavement and, especially for women, the loss of children to the care system are common causes of distress to prisoners. All are issues that staff caring for prisoners need to be aware of and watch for; both in terms of the related risks to the prisoner, and around what specialist support is available to help the prisoner. Also, the often repeated findings from PPO investigations into deaths in custody and HMIP reports cannot be emphasised enough, concerning the need for <u>healthcare staff to share risk and basic care information with discipline staff who manage a prisoner"</u> [emphasis in the original]."

121. Annex 8V of the PSO adds:

> "**Information-sharing between healthcare and other staff**
> Safer Custody Team Leaders, Health Care Managers and Mental Health Managers should be working together to ensure that information is appropriately shared between healthcare and residential and other prison staff … <u>sharing risk and basic care information with discipline staff who manage a prisoner is not breaking medical confidentiality [emphasis in original]."</u>

122. In May 2008, the Director of Offender Health, Department of Health, wrote a letter to PCT Prison Health Leads, Prison Governing Governors, and others. He wrote about ten best practice issues arising from detailed analysis of 120 of my reports. Number 8 in the list was as follows:

> "**Promoting an integrated approach to the care of people in prisons**

The reports have demonstrated that some differences in the aims and cultures of NHS and Prison Service at local level may compromise working relationships on the ground. For example, evidence exists in the care of people with mental illness that a lack of willingness to share information may reduce opportunities to identify significant changes in mood and warning signs of decline in mental health."

The Governor, together with Bristol PCT, should draw up and publicise widely a procedure for the obtaining of consent and the subsequent disclosure of prisoners' confidential medical information in appropriate circumstances to realise both the letter and spirit of Section 6 of PSO 2700. The effectiveness of the new arrangements should be formally reviewed within six months of their introduction.

123. In many of my investigations I have noted that the personnel involved in ACCT case reviews are often those staff who happen to be available, rather than those who have the greatest knowledge of the prisoner concerned. In this case, the ninth officer, who was the man's personal officer for a while, said she is very rarely asked to take part in a case review for one of her prisoners or even approached for an opinion. When the nurse from the mental health team was asked by my investigator if she had been invited to the case reviews, she replied:

> "No, I hadn't been invited. Unfortunately, being in the healthcare centre and not on the wings all the time, we don't know when the reviews are due; unless we are invited we don't know when they are happening."

124. I believe that every effort should be made to include staff with knowledge of the prisoner and those able to make meaningful contributions on case review panels.

125. Annex 8G (sections 14 and 17) of PSO 2700 states:

> "14 - The first case review must be attended by the Unit Manager and the Case Manager (where different from the Unit Manager). Wherever possible, it should be attended by the Assessor. When considering who to invite to the case review, the Unit or Case Manager ought not to be restricted by thinking only of staff who have met the prisoner; they should try to think of who else could positively contribute. It should also be attended by a member of staff who knows the prisoner well (such as personal officer or the officer who raised the initial concern). Where it is clear that there are mental health or drug/alcohol issues, an appropriate member of healthcare staff must be invited to make a contribution to the first review, in writing or by telephone if they are unable to attend at such short notice. The appropriate member of the Chaplaincy Team must also be invited to attend. Each case must be treated individually and attended by staff involved in the care of the prisoner, and where a provider of any specialist service (e.g. healthcare, mental health services, substance misuse, Probation, psychology, family advice, bereavement counselling) is referred to or otherwise involved in the care of a prisoner on an ACCT Plan, that specialist must be invited to contribute to the ACCT case reviews of that prisoner.

"17 - The second and subsequent case reviews usually take place under less pressure of time than the first one. Therefore it is possible that a wider range of staff and specialists (see 14 above) may be able to attend. One of the attendees must be the named Case Manager (and failing that, the Manager responsible for the prisoner's location), one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff …"

The Governor and the Safer Custody Manager should ensure compliance with PSO 2700 Annex 8G sections 14 and 17.

126. On 5 August 2007, during the ACCT assessment interview, the man told the senior officer that he had tried to commit suicide in May by overdosing on heroin and valium as he wanted to be with his mother who had died a few months before. He added that he was not happy to have been revived. That information was not known by the officers who were making decisions about the man's risk level after the death of his father as he had given different information to the third officer on 1 October. During her interview, the man's personal officer said that she really did not know whether possession of that information would have changed her attitude towards the man's risk of self-harm.

The Prison Service should consider amending PSO 2700 to require ACCT assessors to review recently closed ACCT documents relating to the same prisoner when a new ACCT document is opened.

127. After the man's ACCT document was closed on 12 September, a post closure interview was scheduled to take place a week later on 19 September. The man was present at a disciplinary adjudication at that time, and there is no evidence that the post closure interview took place either that day or any other. At least one post closure interview is required as part of the ACCT plan.

The Governor and the Safer Custody Manager should ensure that ACCT case managers are aware of their responsibilities regarding post closure interviews.

128. On 11 October, the day before the man's father's funeral, an ACCT case review was conducted. At that time the levels of observations were set at three times during the day and three times during the night. The two officers who conducted the review decided to schedule the next case review for 15 October, three days after the funeral.

129. I am aware that Prison Service Order 2700 says in annex 8:

> "Wherever possible the Case Manager should arrange subsequent reviews at a time that he or she can be present, in order to provide some continuity of care for the prisoner. Where the named Case Manager cannot attend, they must explain to the prisoner who is to take their place at the review, and record that they have done this."

130. The man's personal officer explained in interview that both of the reviewing officers were not back on duty until the following Monday (15 October), but informal arrangements were made for staff to speak with the man on his return from the funeral. On the inside front page of the ACCT document there is a section entitled 'Triggers/ warning signs to prompt immediate review and person/ department to be called: to be considered as part of each Case Review'. When the ACCT was opened on 30 September, the senior officer wrote "Funeral and inquest of the death" in that section (referring to the future inquest into the man's father's death).

131. Annex 8G – section 47 of PSO 2700 states:

> "Where an ACCT trigger/warning signal is activated (i.e. event actually occurs), or there are other concerns such as increases in frequency or lethality of repetitive self-harm, changes in mood, and other factors or events which may increase risk of suicide, the ACCT Plan must be referred to and the planned course of action followed. The concern and the action taken must be noted on the ACCT Plan, and the Case Manager must be informed about the raised risk."

The Prison Service should amend PSO 2700 to require an ACCT Case Review if a trigger/ warning signal is activated or the prisoner experiences a major life event.

132. In conclusion, it seems highly probable that the man decided to end his life whilst grieving over the death of his father. About a month after his arrival at HMP Bristol, the man had been identified with mental health problems. They appeared to centre on his bereavement reaction to the death of his mother in February 2007 and to that of his step-father in 2005.

133. The man also had a long history of drug abuse, and the effect of his detoxification on his mood cannot be discounted.

134. I judge that the man received considerable input from the prison's mental health team, including assessments by a consultant psychiatrist. However, this report has highlighted a lack of communication between those caring for the man, as well as some shortfalls in the ACCT process.

Clinical Review

135. The clinical review was not available when the draft report was issued but it is now annexed to this report. The clinical reviewer draws a number of conclusions as set out below and makes three recommendations and highlights two areas of good practice.

136. Conclusions:

   1. The man suffered a serious episode of depression largely due to a severe bereavement reaction
   2. There was no evidence of psychotic disease
   3. The depression had significantly resolved by the time of the man's death

4. The man hanged himself in an impetuous act of suicide
5. There were several factors identified within the clinical review that should be addressed which are noted below. I do not believe that any of these factors were relevant to the outcome
6. Resuscitation was carried out calmly and effectively.

RECOMMENDATIONS

National

The Prison Service should consider amending PSO 2700 to require ACCT assessors to review recently closed ACCT documents relating to the same prisoner when a new ACCT document is opened.

Accepted - Assessors, in the ACCT training course, are encouraged to obtain as much information as they can before they speak to an at-risk prisoner. The assessment interview explores previous acts of self-harm/suicide attempts which would provide additional information for the ensuring case review. There is currently a review of ACCT on-going and this point will be considered as part of it. Target date for completion (TDC) End September 2009.

The Prison Service should amend PSO 2700 to require an ACCT Case Review if a trigger/ warning signal is activated or the prisoner experiences a major life event.

Accepted (already in place) - PSO 2700, Annex 8G, currently states (at paragraph 47):- "Where an ACCT trigger/warning signal is activated (i.e. event actually occurs), or there other concerns such as increases in frequency or lethality of repetitive self-harm, changes in mood, and other factors or events which may increase risk of suicide, the ACCT Plan must be referred to and the planned course of action followed. The concern and the action taken must be noted on the ACCT Plan, and the Case Manager must be informed about the raised risk "

Local

The Governor, together with the Healthcare Manager, should commission a sample audit of recent First Reception Health Screen forms and ensure that any necessary remedial staff training is swiftly completed.

Accepted - The Healthcare Manager is currently developing auditing systems with particular reference to First Night Health Screening. TDC 1/3/09

The Governor should ensure that prisoners are made available for medical consultations whenever possible.

Accepted - A review of prisoner availability and access to medical appointments has been carried out to ensure prisoners are available for consultations where ever possible. TDC 1/3/09

The Governor should ensure that all persons having contact with prisoners on ACCT documents are aware of the requirements and responsibilities for entries in that document.

Accepted - The Personal Officer policy has been fully reviewed and relaunched. Management checks are now carried out weekly by residential win managers, and monthly by Residential Governors. The Safer Custody Manager is currently reviewing the ACCT case review process, to highlight the need for a full multi

disciplinary approach. Compliance will be monitored via the Safer Custody Continuous Improvement Plan. TDC 1/3/09

The Governor, together with Bristol PCT, should draw up and publicise widely a procedure for the obtaining of consent and the subsequent disclosure of prisoners' confidential medical information in appropriate circumstances to realise both the letter and spirit of Section 6 of PSO 2700. The effectiveness of the new arrangements should be formally reviewed within six months of their introduction.

Accepted - Other establishments have been contacted for information and guidance on what type of form they utilise to ensure this information is within Prison and Healthcare provision. A new form will be introduced and a Notice to Staff issued when the form has been devised. TDC 1/3/09

The Governor and the Safer Custody Manager should ensure compliance with PSO 2700 Annex 8G sections 14 and 17.

Accepted - The Local strategy will incorporate this section. TDC 1/3/09

The Governor and the Safer Custody Manager should ensure that ACCT case managers are aware of their responsibilities regarding post closure interviews.

Accepted - Post Closure reviews are now monitored by the Safer Custody team to ensure they are completed within the required timeframes. Compliance will be monitored via the Safer Custody Continuous Improvement Plan. TDC Complete and ongoing.

Good Practice

The actions of the fifteenth officer showed professionalism and compassion. I particularly commend the speed with which he began mouth to mouth resuscitation without the use of a protective mask. I believe this was in the highest traditions of the Prison Service, and the Governor will wish to consider if the fifteenth officer's actions should be formally recognised.

Accepted - The fifteenth officer has been nominated by the Safer Custody team through the Employee of the Month scheme, the official performance recognition scheme at HMP Bristol.

Clinical Review Recommendations

The processes triggering referral to the mental health team from the First Health Screen should be clarified.

Processes of communication and documentation into the health record should be reviewed

Documentation should always be legible

Evidence of good practice

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

The assessment, care and support of the man was to a high standard through the health and mental health teams.