Investigation into the circumstances surrounding the death of a man at HMP&YOI Gloucester in December 2009

Report by the Prisons and Probation Ombudsman for England and Wales

December 2010

This is a report of an investigation into the death of a man. The man died, apparently by his own hand, aged 57 in Gloucester prison. He had been on remand in the prison for just under a week. I am aware that the nature of the charge brought against the man was deeply upsetting for all the members of his family. I would like to offer my condolences to the man's family and all those affected by his death.

The man's death was investigated by one of my senior investigators. One of the Ombudsman's family liaison officers was also instructed. The Mental Health Commissioning Manager from NHS Gloucestershire provided a clinical review of the man's healthcare treatment during his time in Gloucester. I am grateful for his timely report.

I would like to thank the Governor of Gloucester and all of his staff for their co-operation with this investigation. The man's death was the first apparently self-inflicted death to occur at Gloucester for some three years and I am aware that it impacted greatly on all of the staff. I am especially grateful to one of the Principal Officers at Gloucester who acted as my senior investigator's liaison officer and provided a very high standard of liaison.

I am impressed with the prompt and thorough response of the Governor and his team to the issues raised by the man's death. The case was reviewed and action taken to improve internal systems within hours. I make one national recommendation concerning the heightened risk of suicide posed by prisoners who have recently attempted to kill themselves. I also make two local recommendations and highlight two areas of good practice.

On a less positive note, this case is yet another that demonstrates the pressure that overcrowding places on local prisons and the potential to put the lives of prisoners at risk. I believe that Gloucester is overburdened with vulnerable prisoners and unable to look after all of them in their dedicated vulnerable prisoner unit. A situation therefore exists whereby vulnerable adults are located opposite young adults. This is unacceptable for all concerned. It is difficult to keep both populations safe, and reduces the opportunity to put vulnerable prisoners in shared cells. In hindsight I conclude that the man should ideally have been located in the vulnerable prisoner unit in a shared cell. I have found that the fact that he was not was mostly, but not wholly, attributable to overcrowding.

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.

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

CONTENTS

Summary

The investigation process

HMP&YOI Gloucester

Key events

Issues

Conclusion

Recommendations

SUMMARY

The man was aged 52 years when he died. He suffered from poor physical health, being a diet controlled diabetic and having mobility issues due to operations on his knees and feet. On 14 September, 3 December and 11 December 2009 he was reported to have taken overdoses of paracetamol that required treatment in hospital.

He was arrested on 13 December 2009 and charged with indecently assaulting his stepson between 1986 and 1990. He was given conditional bail but was arrested on 19 December for breaching the conditions. While in police custody, he was diagnosed with depression and prescribed anti-depressants.

The man was remanded to HMP&YOI Gloucester on 21 December 2009. He did not arrive with a suicide and self-harm warning form from the police or court as he should have done. Staff in the prison reception identified him as a vulnerable prisoner and at risk of self-harm. An Assessment, Care in Custody and Teamwork (ACCT) booklet (the form used in prison to monitor and support prisoners thought to be at risk of self-harm) was opened and the man was referred to the mental health team for an assessment.

The man presented as very low in mood. Throughout the reception and ACCT assessment process he described his previous overdose attempts as accidental overdoses of painkillers taken in response to the pain in his knees. Staff accepted the man's explanation and did not seek independent information from outside agencies.

The man was adamant that he wanted to be in a single cell. Staff were not immediately persuaded that this was a good idea but decided after discussion to accede to his wish. Overcrowding on the vulnerable prisoner unit meant that, in order to have a single cell, he was located on the overspill landing away from the vulnerable prisoner unit and its specialist staff.

Throughout his time in Gloucester the man consistently refused to come out of his cell for association, showers, medication or meals. He declined the opportunity to speak with staff. Staff attempted to engage with him and left meals in his cell. I am critical of the recording and sharing of information between discipline and healthcare staff.

The man was found dead in his cell at 5.25am on a morning in December 2009. He had hanged himself. Staff went into the cell promptly and attempted to resuscitate him. The response to finding the man and the care offered to staff was very good. I identify a training need for regular night staff to receive emergency first aid training.

I make one national recommendation concerning the heightened risk of suicide posed by prisoners who have recently attempted to kill themselves. I also make two local recommendations and highlight two areas of good practice.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was allocated to one of my senior investigators on 30 December 2009. As she was on annual leave, another investigator opened the investigation and collected relevant documents from HMP Gloucester on 28 December. My senior investigator contacted the prison on 4 January 2010 and spoke to the Governor. Later the same day my senior investigator spoke to one of the Principal Officers at Gloucester and emailed a list of staff to be interviewed.

2. My senior investigator visited Gloucester on 19 and 20 January and interviewed eight members of staff. She also visited the wing where the man lived during his time at Gloucester. My senior investigator spoke to representatives of the Independent Monitoring Board (IMB) and the Prison Officers Association. I am grateful to the Chair of the IMB for providing my senior investigator with a copy of her internal report on the man's death. On completion of the interviews, my senior investigator spoke at length to the Governor and the principal officer at Gloucester.

3. My senior investigator contacted NHS Gloucestershire and spoke to the Mental Health Commissioning Manager. He agreed to provide a clinical review of the healthcare received by the man in prison. The report was received on 16 March 2010, which is within the agreed time limit.

4. One of my family liaison officers wrote to the man's father, as his listed next of kin, to explain the purpose of my investigation and offer the opportunity to raise any issues or questions about his son's death. The man's family have seen a copy of the draft version of this report but have not made any comment.

HMP&YOI GLOUCESTER

5. HMP&YOI Gloucester is a category B adult male prison and young offender remand centre. It is an old Victorian prison in the centre of Gloucester and has an operational capacity (maximum overcrowded capacity) of 323 prisoners. Part of the accommodation dates back to the eighteenth century.

6. Vulnerable prisoners (VPs) in Gloucester mainly live in a dedicated unit, with their own staff, on the ground floor of B wing. However, more often than not, the number of vulnerable prisoners exceeds the number of places and some are held on B2 landing. This arrangement, while essentially unavoidable, poses difficulties for both staff and prisoners. The remainder of B2 is used for young offenders (YOs – aged between 18 and 21 years) and a lot of time and effort is spent ensuring that the two populations do not mix. Efforts are made to include the vulnerable prisoners on B2 in the regime on B1 but this is not always possible. Vulnerable prisoners on B2 are readily identifiable from the 'VP' on their cell cards outside their cell doors. An announced inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) in 2007 did not consider B2 landing a safe environment for vulnerable prisoners.

7. The most recent annual report of the Gloucester Independent Monitoring Board (December 2008 to November 2009 – the IMB is an independent voluntary organisation that monitors day to day life in prison) made the following comments on the situation:

> "The Board, while warmly acknowledging the efforts of staff to mitigate the problems, still has three major concerns about the treatment of vulnerable prisoners: first, some of them are routinely accommodated on the same landing as YOs and suffer both from that proximity and by being separated from other VPs; second, they experience a less favourable regime; and third, there are administrative arrangements which make clear to other prisoners those who are categorised as VPs. The Board appreciates there may be no easy answers, but that fact does not make the situation acceptable."

8. This is the fifth apparently self-inflicted death to occur at Gloucester since the Ombudsman took over responsibility for investigating deaths in custody in 2004. The previous four deaths all occurred in 2005. I draw some parallels between two of these and the man's case relating to information being passed into the prison and how staff respond to it. Suicide prevention and safer custody at Gloucester has received praise from HMCIP and my investigator was impressed with the initiatives being taken by the principal officer and his team.

ACCT (Assessment, Care in custody and Teamwork)

9. Prisons are run under a series of documents called Prison Service Orders (or PSOs). PSO 2700 governs procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used to identify, monitor and support prisoners at risk of self harm. The ACCT process is used in all prisons in England and Wales. Any member of staff can start the ACCT process by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located, and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training.

10. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions necessary to keep the prisoner safe and who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.

KEY EVENTS

11. On 14 September 2009, the man was reported to have taken an overdose “that required medical intervention”. He was treated in hospital and assessed by an approved social worker before being discharged to his GP. On 3 December, the man was assessed by the Mental Health Liaison Team in outside hospital having taken an overdose of paracetamol. The assessment took place in the presence of two police officers who had arrested him in order to take him to hospital. The man was de-arrested after the assessment and discharged from hospital on 6 December.

12. The man was admitted to an Acute Care Unit at outside hospital on 11 December after he took a further overdose of paracetamol. The next day he was transferred to a police station where, at the behest of the police, he was interviewed by the senior mental health practitioner from a crisis resolution home treatment team. He reported that the man’s mood was low with some evidence of mild depression. He said the man “was still intent on ending his own life”.

13. On 13 December, the man was charged with indecently assaulting his stepson between 1986 and 1990. He was given conditional bail, one of the terms of which was that he have no contact with his stepson or his daughter. Evidence from the man’s prison record suggests that he responded to a text message from his daughter with the result that he was arrested on 19 December for breach of bail and taken to a police station.

14. A police force medical officer (MO) completed a detainee risk assessment and care plan the same day. The MO wrote that the man had undergone surgery to his knees and feet and suffered pain as a result. He also suffered from arthritis, diabetes (non-insulin dependent) and depression. His depression had recently been diagnosed and he had yet to start treatment for it. The MO wrote that the man had taken an overdose a week previously and had been taken to hospital. He prescribed citalopram (for depression) and pain relief and anti-inflammatory medication for the man’s other problems.

15. The next day, on 20 December, police officers asked the MO to examine the man again because he had not eaten since being taken into custody. The MO measured the man’s blood sugar and reminded him of the need to take a regular light diet in order to manage his diabetes.

16. The man appeared at a Magistrates’ Court the next day and was remanded into custody and taken to HMP Gloucester. The Clerk of the Court wrote on the man’s warrant, “NB Defendant has attempted suicide twice *<u>SUICIDE RISK</u>*”.

17. A Person Escort Record (PER) form was completed for the man's journey from the police cells to the Magistrates' Court to HMP Gloucester. On the risk indicator page "has taken overdose one week ago" is written in the suicide/self harm risk box. Further down the same page the risk box for 'health –mental' contains the entry, "depression, previous suicide attempt". (In these circumstances it is a requirement that a suicide/self harm warning form should be completed by court custody staff. The form would then accompany the person to prison and alert reception staff to a risk.) It does not appear that such a form was opened on the man during his time at court.

18. On arrival in Reception at HMP Gloucester, a cell sharing risk assessment form (CSRA) was completed. The first part of the form was completed by an officer who wrote, "Attempted suicide three weeks ago. States feels depressed but not suicidal" in the observations and concerns box. The form was then passed to the leader of the primary care mental health team and a qualified mental health nurse (RMN). The leader of the primary care mental health team completed the medical assessment section and also completed the man's first reception health screen.

19. At interview the leader of the primary care mental health team said she remembered seeing the man's warrant because it highlighted that he might be at risk of suicide or self harm. She said the man spoke abruptly and offered minimal information in his answers. He was hostile, flat in mood and his appearance was unkempt. The man told her that his low mood was because of the circumstances he found himself in. She asked him to talk about the two recent overdoses highlighted on the warrant. The form indicates that the man said that the first overdose happened three weeks previously and was a reaction to "work, health and family" problems. The man told her that the second overdose had taken place two weeks previously. He said he had called his daughter who "guessed" what had happened and made sure he went to hospital. The leader of the primary care mental health team said she concluded that the overdoses were "cries for help" rather than determined attempts by the man to end his life.

20. The leader of the primary care mental health team said that the man denied any intention to harm himself. He said he was fed up but "wanted his day in court". At interview the leader of the primary care mental health team said she thought the man had been at moderate risk of attempting suicide. She said he had demonstrated some forward thinking in his desire to be heard in court. Because she considered that there was some risk that the man would seek to harm himself she opened an ACCT form (Assessment Care in Custody and Teamwork – the procedure used in prisons to monitor and support prisoners thought to be at risk of suicide or self harm). On the concern and keep safe page at the front of the ACCT, she wrote that she had opened the ACCT procedures because the man had taken two

overdoses in the previous three weeks, presented as very flat in mood and had said that he was very fed up and felt depressed.

21. The leader of the primary care mental health trust also referred the man to the doctor for a physical health assessment and to the primary care mental health team. She did not mark this referral as urgent because she knew that the man would be assessed as part of the ACCT process the following day and would also see the doctor. She wrote a comprehensive summary of her conversation with the man in his clinical record. She also completed a disability questionnaire with the man. He described mobility issues due to problems with his knees and feet. She put on the form that the man should be located "flat" (meaning that he should be given a cell on the ground floor).

22. The man agreed to accept vulnerable prisoner status because of the nature of his offence. (Prisoners deemed to be at risk from other prisoners because of the nature of their offence or other reasons are categorised as vulnerable prisoners. Vulnerable prisoners are kept separate from the rest of the prison population). Because of this and because an ACCT form had been opened, the man was taken to the vulnerable prisoner unit (VPU) on B1 landing.

23. An officer based on the VPU confirmed at interview that he had spoken to the man for about an hour on 21 December in his capacity as a trained ACCT assessor. The officer said he had taken notes at this meeting. During the meeting the man was adamant that he wanted to be in a single cell. The officer said he was not immediately persuaded that this was a good idea. However he discussed it with a senior officer and they decided that, because the man was so adamant and because of his age, he should be put in a single cell. There are no single cells on B1 so accommodating the man's request on B1 would have meant moving two prisoners upstairs to B2 (where the overspill from the VPU are housed). Therefore the man was located in a cell on B2 landing. The senior officer and the officer who was based on the VPU agreed that the man's ACCT should be checked every hour during the night and that staff should record three conversations with him during the day.

24. The next morning the officer based on the VPU interviewed the man again, going through his notes with him, and completing the assessment interview section of the ACCT form. The man told the officer that he felt the same as he had done the previous evening. The officer wrote on the ACCT form that the man said he had taken an overdose of paracetamol about three weeks previously. The man said this had been because of his health problems. A week later he had been charged with indecent assault of his stepson dating back several years.

25. The man told the officer that he felt low but would not take an overdose in prison because he would not be able to get hold of enough tablets.

He said he did not want to commit suicide because he was denying the charges against him and he wanted to have the opportunity to appear in court. The officer was aware that the man was due to appear in court via videolink the next day on 23 December. At interview the officer described the man as ‘flat’ and not very talkative. His answers were monosyllabic and it was not easy to get information from him.

26. Immediately after the officer concluded his interview, he and a senior officer discussed the man. Together they spoke to him in his cell to complete the action following assessment review section of the ACCT document and to agree on a CAREMAP (a care and management plan). This particular senior officer is not based on the VPU but was responsible for managing it that day. He has previously managed the VPU for three years. The senior officer told my investigator that the man presented as “very flat”. He said he tried to establish what the man’s needs and concerns were. The man had talked about why he was in prison and denied that he had done anything wrong. He repeated that he wanted his “day in court”. The senior officer described the man as “not disinterested” but said he had not wanted any help from staff. He asked the man what he would do if he did not get bail at his hearing the next day. He said the man replied that he did not know. The senior officer said he had not said this in a despairing way but rather as if he had not known what the process would be.

27. The senior officer discussed the man’s location on B2 with him. He was concerned that he would be isolated and wanted him to have the opportunity to mix with other vulnerable prisoners. He said the man was adamant that he wanted to be in a single cell and made it clear that he was not interested in mixing with other prisoners. The senior officer recorded on the ACCT form that he had told the man that staff would encourage him to interact and support him if he needed it. The man had shrugged his shoulders in response.

28. The senior officer said in interview that he was aware that the man had taken two overdoses in the few weeks previously. He said that the man had told him that these were accidental and not suicide attempts. He thought the man appeared “gutted” by his situation. At the end of the action following assessment section of the ACCT form, the senior officer and the officer based on the VPU concluded that the man presented a low risk of attempting to harm himself. The CAREMAP (a plan of how to manage and reduce a prisoner’s risk of self-harm) was completed and identified self-isolation as an area of concern. The officer based on the VPU made an appointment for the man to attend the safer custody group (a support group for prisoners with open ACCT forms) to try to mitigate this. A case review was scheduled for 29 December. An entry was written in the wing observation book alerting wing staff that the man’s attendance at court on 23 December might represent a trigger for him to harm himself again.

29. At 4.00pm the same afternoon, the man attended an appointment with the doctor. An officer recorded on his ACCT form that she had spoken to him while he was waiting but that he had not been talkative and appeared to be in a low mood. A further officer recorded a conversation at 6.45pm. He said the man had told him his first day had gone “OK” but he did not initiate any conversation. Later that evening a nurse gave him his evening medication. She said the man spoke abruptly to her, asking what she was giving him.

30. The next day, 23 December, when the cells were unlocked the man declined the opportunity to go to the VPU for a shower and also said he did not want to choose an evening meal. The officer (signature illegible) recorded on the ACCT form that the man told him he was not very hungry and not in a talkative mood. Later the same morning he was asked if he wanted to attend the safer custody group but he said he preferred to be on his own. At lunchtime the man attended his bail hearing via videolink. He was refused bail and remanded until 20 January 2010. In recognition of the entry in the wing observation book referred to above, a member of staff spoke to the man on his return from the videolink. The officer (signature illegible) reported that the man did not want to talk and wanted to be alone. Later that afternoon the man did not collect his tea meal. He again told staff he was not hungry and was recorded as not being talkative.

31. On 24 December, the man again said he did not want to go to the VPU for a shower. Later the same day he said he did not want to leave his cell for association on the VPU. At 5.45pm he told an officer he was happy on his own. The next morning, Christmas Day, the man again refused a shower and told the officer that he was going back to sleep. He later told an officer that he did not want any lunch. The officer asked him how he was and he replied that he did not know. The officer recorded on the ACCT that he had reminded the man of the services offered by the Samaritans and Listeners (prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress).

32. The nurse who had given the man his evening medication on 22 December, remembered giving the man his medication at the treatment hatch on the mornings of 22, 23, 24 and 25 December. She said he was supposed to collect more medication from the hatch after the teatime meal but noticed that he did not. On 25 December, the nurse asked the man why he did not come down in the afternoons and he replied, “I will come down if I want it.”

33. The on-going record section of the man’s ACCT shows that, on 26 December, he said he did not want any lunch because he was not hungry. At 4.00pm he was unlocked for the teatime meal and again said he was not hungry. A meal was put in his cell but the on-going record does not show whether the man ate anything. At 5.45pm an officer tried to speak to the man. The officer wrote in the ACCT that he

had asked the man if he would like to talk to a Listener. He wrote, “He [the man] said he was alright and would I go away”. This is the last recorded conversation on the man’s ACCT.

34. An Operational Support Grade (OSG) came on duty at about 8.45pm. He received a handover from the officer who had asked the man if he would like to talk to a Listener and remembered the officer telling him that the man had told him to go away earlier in the evening. The OSG said it is his practice to check all prisoners on ACCT forms as soon as he has received his handover. The OSG was required to check the man every hour and record his checks on the ACCT form. He remembered the man was asleep on his bed on every occasion he checked him between 8.40pm that evening and 4.40am the following morning. At about 5.25am the OSG checked the man again and saw him hanging by a ligature from the window.

35. The OSG said he immediately used his radio to put out an urgent call for assistance. The control room daily log sheet shows an urgent message for the night orderly officers to attend B2 landing for a ‘code blue’ at 5.24am. He then opened his sealed pouch containing a cell key (OSGs on night duty are not issued with keys for security reasons but carry a cell key in a sealed pouch for use in emergency.) He was joined very quickly by the Night Orderly Officer – the officer in charge of running the prison at night and the only night officer to carry a full set of keys), and a further two OSGs. The OSG who had discovered the man hanging opened the cell door and they all entered the cell.

36. The man had used his bedsheet to make a ligature and had tied it to the cell window bars. Between them the staff supported the man’s weight and used one of the OSG’s cut down tool to cut through the ligature. They placed the man on the floor of the cell and the night orderly officer and one of the OSGs who had arrived with the night orderly officer in the cell began emergency aid. The night orderly officer administered rescue breaths and the OSG started chest compressions.

37. The assistant night orderly officer also responded to the call for emergency help on B2. He arrived shortly after the night orderly officer and the OSGs had entered the man’s cell. He took the key from the night orderly officer and went to the healthcare centre to collect the emergency response nurse. On the way the nurse collected a bag of emergency aid equipment from the centre. She felt for the man’s pulse and checked his breathing. The nurse told my investigator that, in her opinion, the man was already dead. A further officer arrived in the cell at this point and he and the nurse took over emergency breaths and chest compressions and continued until paramedics arrived. The control room log shows that the paramedics came into the prison at 5.40am. They pronounced the man dead shortly before 6.00am.

38. The prison's death in custody contingency plans were followed and all relevant persons were informed of the man's death. A hot debrief was held the same morning and members of the prison's care team were available to offer support to the staff who had found the man.

39. The prison family liaison officer and a senior officer informed the man's parents of his death in person later the same day. The prison family liaison officer visited them again the following day to deliver a personal letter from the Governor. The prison assisted the man's family with the funeral costs and a member of staff attended.

ISSUES CONSIDERED

The assessment of the man's risk

40. Staff in Reception at Gloucester speedily identified from his warrant and PER that the man presented a risk of suicide or self-harm. The reason identified on both forms was that he was known to have attempted to take his own life twice in the community in the previous few weeks. The leader of the primary care mental health team opened an ACCT form appropriately and identified the man as a vulnerable prisoner. She recognised that his mood was flat and that he looked unkempt. She completed a referral for a mental health assessment. She said in interview that she did not mark it as urgent because she knew that the man would be examined by the prison doctor the next day and that he would be interviewed by trained staff as part of the ACCT process.

41. I consider that the leader of the primary care mental health team did all that was required of her during the reception assessment process and that a referral to the mental health team was certainly required. I note that a suicide self-harm warning form was not opened on the man in court and it is therefore to her credit that she properly examined the documents that travelled with the man and recognised him as at risk. However, I do not consider that an appointment with the doctor and assessment by officers as part of the ACCT process was a logical reason not to mark the referral to the mental health team as urgent. Neither the doctor nor the ACCT trained officers are mental health professionals.

42. The question of whether the man would have engaged with the mental health team is a moot point. His general presentation in Gloucester would suggest not. I doubt too whether an urgent referral to the mental health team would have prevented the man's death. As well, even if the referral was marked urgent, the holiday period might well have meant that an appointment could not have been arranged. Nevertheless, the fact that the man was known to have attempted suicide in the recent past meant that he presented a heightened risk of attempting suicide again. I therefore consider that it is good practice for such prisoners to be urgently referred for a mental health assessment.

43. One of the officers based on the VPU spoke at length to the man on his first night. The next morning the same officer and a senior officer completed the action following assessment and CAREMAP sections of the ACCT. They spent some considerable time with the man and tried to obtain as much information from him as possible. They concluded that he presented a low risk of attempting to harm himself in the future.

44. From their conversations with the man, all three members of staff (the leader of the primary care mental health team, the officer based on the

VPU and the senior officer) were left with the impression, based on information provided by the man, that his previous suicide attempts were accidental overdoses of painkillers that he was taking for his physical health problems. The man told all of them more than once that he "wanted his day in court", which they took to mean that he wanted to move forward and be able to defend himself against the allegations.

45. Hospital records show that in fact the man had made three attempts to take his own life since September 2009 and the two most recent had required hospital treatment and assessment. In outside hospital on 12 December, after the last of his three attempts, the man was reported to be "still intent on taking his own life". Reviews undertaken by the Mental Health Liaison Teams two outside hospitals concluded that the man presented a high risk of attempting to take his life again.

46. One of the greatest indicators that a person is at risk of taking his or her own life is if they have attempted to do so in the past. Staff at Gloucester recognised that the man presented a risk for this reason and properly opened an ACCT form. However, the information that they relied on to quantify the man's risk was confined to his PER, his warrant and information gained from speaking to the man himself. The PER and warrant offer bald statements that he had made two previous attempts to kill himself. Again as noted above, the man himself passed off his previous attempts as accidental overdoses. He was adamant to staff that he wished to contest the charges against him in court.

47. Based on the information immediately available to them, I consider that the leader of the primary care mental health team, the officer based on the VPU and the senior officer came to a reasonable conclusion about the level of risk the man posed. However, had they contacted outside agencies they would have found that the man's previous attempts were not accidental overdoses as he claimed. In making their assessment all three members of staff accepted the man's version of events.

48. This is an inherently dangerous practice and is an issue that was also raised in the apparently self-inflicted death of a man in Gloucester in June 2005. If there is evidence that a person has made a previous attempt on their life then it is good practice to find out as much detail as possible from independent sources about the nature of that attempt. Had the leader of the primary care mental health team and the officer based on the VPU and the senior officer been privy to the information possessed by the police and community mental health services about the nature of the man's previous attempts to kill himself, then I have no doubt that they would have evaluated the man's risk differently. They might well have decided that he was not in fact suitable to occupy a single cell on B2.

I recommend that the National Offender Management Service (NOMS) amend chapter 4 of PSO 2700 (Suicide Prevention and

Self-Harm Management) to highlight the heightened risk of suicide presented by those prisoners who are known to have attempted suicide recently. Guidance should be offered to staff on how best to gather information about recent suicide attempts from hospitals, community mental health teams and other appropriate sources.

NOMS should consider whether it is appropriate for such prisoners to have a mandatory assessment from a mental health professional within seven days of their arrival in prison.

[This recommendation was rejected by NOMS at draft stage. The full response is reproduced in the Recommendations section at the end of this report.]

49. Outside agencies also bear a responsibility to pass pertinent information about a prisoner's risk to prison staff. I have seen too many instances since 2004 of important information not finding its way into the possession of the staff who are required to try to keep prisoners safe. In this case no suicide/self-harm warning form was opened at court. The information was available to the court because the Court Clerk noted the man's warrant and there was a marker for self-harm on his PER. The most effective way of alerting a prison to a prisoner's risk is via a self-harm warning form. It is not the first time that information available to the courts has not been passed to the prison.

50. Paragraph 4.4.2 of Chapter 4 of PSO 2700 states:

> "Any difficulties concerning information sharing and Suicide/Self-Harm Warning Form, ACCT or PER procedures in relation to contracted escort or police staff should be forwarded to the Safer Custody Team leader, for discussion at the Safer Custody Team meeting and follow-up with the contractor and/or the appropriate PECS Contract Manager or the establishment Police Liaison Officer."

51. The Governor and Safer Custody Team leader might wish to decide whether an approach to the appropriate prisoner escort monitor is necessary.

The man's location in a single cell on B2 landing

52. The officer based on the VPU spoke to the man for about an hour on 21 December when he was first taken to the vulnerable prisoner unit. The man was determined to have a single cell. The officer was not immediately convinced that this was a good idea and discussed the situation with a senior officer. After some discussion they decided that, given the man's age and his strongly expressed views, he should be placed in a single cell. All of the cells in the vulnerable prisoner unit on

B1 are shared. Staff were faced with a difficult choice. Locating the man in a single cell on B1 would mean moving two other vulnerable prisoners from B1 to B2.

53. The next day, as part of the ACCT assessment process, a further senior officer also discussed the man's location on B2 with him. The senior officer was concerned that the man would become isolated if he was located away from the vulnerable prisoner unit.

54. I consider that both the officer based on the VPU and the senior officer were right to be concerned about the man's location in a single cell on B2. The man appears to have been determined not to interact with staff or mix with other prisoners. His location on B2 meant that there was little opportunity of challenging this and also that the man was not under the direct care of officers dedicated to looking after vulnerable prisoners.

55. Both the officer based on the VPU and the senior officer told my investigator that they had reservations about the man's location on B2. At the time there were no spaces on B1 and keeping the man there would have involved at least one other vulnerable prisoner being moved to B2 in his stead. The pressure on vulnerable prisoner spaces at Gloucester presents staff with an intolerable balancing act juggling the various needs of prisoners at risk. With the benefit of hindsight the appropriate location for the man was probably B1 in a shared cell regardless of his preferences. At the time and in the context of an overburdened unit, I can see why he was located on B2 on his own. I make no recommendation but the Governor will wish to consider the adequacy of places for vulnerable prisoners.

Assessment, Care in Custody and Teamwork

56. I consider that the man's ACCT form was completed to a high standard. The officer based on the VPU and the senior officer sought to engage with the man and, despite his unwillingness to do so, managed to complete a thorough assessment. I am especially pleased to see that, having identified a court appearance by videolink on 23 December as a potential trigger point for self-harm, an entry to that effect was made in the wing observation book and this in turn prompted a member of staff to visit the man when he returned to his cell. This is good practice.

Following up the identification of a trigger point for self-harm by making an entry in the wing observation book is good practice.

The clinical care given to the man

57. The clinical reviewer's overall conclusion is that the man received appropriate care while in Gloucester. However, the clinical reviewer makes a number of recommendations in his conclusion designed to

enhance the level of care provided in the prison. I believe these should be considered by the Governor and the Head of Healthcare at Gloucester, in conjunction with the Primary Care Trust.

58. The clinical reviewer's conclusions reflect my own in that there is room for some improvement in communication between primary healthcare staff, primary mental health staff and wing staff and healthcare staff. In this man's case, my investigator was told that wing staff were aware that he was not collecting meals or going for showers and was isolating himself. They tried to address these issues by putting meals in his cell, attempting to speak to him regularly and offer him access to support from the Samaritans and Listeners. However, it does not appear that healthcare staff were told that he was not eating or maintaining his personal hygiene. Given that the man was a diet controlled diabetic and that not eating or washing are common signs of depression this was extremely useful information for mental health staff to have in their possession.

59. Similarly, healthcare staff responsible for giving the man his medication were aware that he did not collect his afternoon medication. The emergency response nurse told my investigator that she asked the man about this directly. I can see no evidence that this information was recorded or passed on to mental health staff or to the prison doctor. Had all of this information been documented it would have painted a picture of a man who was staying in his cell, not taking his medication, not engaging with staff or peers, not keeping himself clean or eating properly.

60. The clinical reviewer also notes that the man did not have his baseline clinical observations taken or a secondary health screening or older man's assessment in accordance with prison performance health quality indicator (PPHQI) guidelines.

I recommend that the Governor of Gloucester and the Head of Healthcare ensure that the recommendations made by the clinical reviewer are examined and acted upon appropriately. They should look especially at ways to improve communication between wing and healthcare staff when prisoners are isolating themselves and refusing food.

[This recommendation was accepted by HMP Gloucester at draft stage. The full response is reproduced in the Recommendations section at the end of this report.]

61. The clinical reviewer highlighted three examples of good practice. I draw particular attention to the second of them, the prompt case review commissioned from the Head of Healthcare. She completed her investigation within 24 hours of the man's death. Prompt internal assessments play an important role in learning lessons from such sad events.

The prison's response to finding the man

62. I consider that the response from staff to finding the man hanging was very good. They entered his cell promptly and local instructions for supporting his weight, cutting him down and laying him on the floor were followed. The night orderly officer began Cardio Pulmonary Resuscitation (CPR) immediately despite not having a mask as a barrier to protect her mouth. She deserves credit for doing so. (I understand that staff at Gloucester have now been issued with masks with non-return valves.)

63. The emergency response nurse attended the scene as quickly as possible in the circumstances. She performed the correct number of compressions to breaths (30:2) according to the latest guidelines from the Resuscitation Council. I note that the defibrillator was not automatically brought to the scene. It was not required in this man's case as he was quite clearly dead by the time he was discovered. However, a defibrillator is the only clinically proven method of starting a non-beating heart. The Governor should therefore consider whether the local guidance should be amended so that a specific person is tasked with ensuring that the defibrillator is brought to all code blue emergencies in the future.

64. All the staff interviewed expressed great satisfaction with the post-incident care offered by the Care Team and management. However there was general agreement amongst the staff interviewed that the local incident report forms are too prescriptive. I am aware that they have made this known and, for the future, blank forms are to be used. The hot debrief and critical incident debrief were completed in good time and staff told my investigator that they found both meetings helpful.

65. The majority of the staff interviewed who responded to the emergency and arrived at the man's cell first expressed a desire for emergency response training. The night orderly officer had last been trained 23 years previously and one of the OSGs who arrived with the night orderly officer to the man's cell had never been trained at all. I recognise that it is unfeasible and prohibitively expensive for prisons to ensure that every member of staff has an in date emergency response qualification. However, given that a significant proportion of prison deaths occur during the night shift, I consider it prudent for Governors to prioritise staff who most regularly work at night for training. I understand that this is already in hand at Gloucester. I make the following recommendation in support of this:

I recommend that the Governor of Gloucester ensures that staff who most regularly work during the night shift receive emergency response training as a priority. This should include senior

officers acting as night orderly officers, assistant night orderly officers and operational support grades (OSGs).

66. The Governor and senior management at Gloucester acted promptly to analyse the care offered to the man and to look critically at it. A comprehensive review was undertaken within hours of the man's death. The speed with which issues were identified, lessons learned and new practice put in place is impressive and another example of good practice.

CONCLUSION

67. The man's death highlights some sadly familiar issues. Once again there is an example of crucial information not being passed to the prison from the courts. Again I see an example of the negative impact of overcrowding on the ability of prison staff to keep prisoners safe. In this case I am relieved to see that staff at Gloucester recognised the man's risk through a combination of paying attention to the documents that travelled with him and observation and interaction during the reception screening process. They deserve credit for this. They deserve credit too for attempting to look after the man and encourage him to interact. My investigator saw clearly that the man's death affected staff at Gloucester deeply.

68. With the benefit of hindsight I believe that more should have been done to obtain information about the man's previous suicide attempts. Had this happened, I have no doubt that it would have affected the assessment of the man's risk and his location. Nevertheless, he made a determined attempt to kill himself when he could be confident that he would not be found in time for staff to revive him. In cases such as these it is difficult to think of any practical way in which the death can be prevented.

69. I am impressed with the prompt commitment demonstrated by the Governor and his staff to reviewing the man's case and learning lessons for the future.

RECOMMENDATIONS

National recommendation

1. I recommend that the National Offender Management Service (NOMS) amend chapter 4 of PSO 2700 (Suicide Prevention and Self-Harm Management) to highlight the heightened risk of suicide presented by those prisoners who are known to have attempted suicide recently. Guidance should be offered to staff on how best to gather information about recent suicide attempts from hospitals, community mental health teams and other appropriate sources.

   NOMS should consider whether it is appropriate for such prisoners to have a mandatory assessment from a mental health professional within seven days of their arrival in prison.

   [This recommendation was rejected by NMOS at draft stage. They responded:

   "PSO 2700 Chapter 4 deals with early days in custody risks and explains that in addition to risk information recorded in the paperwork accompanying the prisoner, that other sources of information may be received and used to identify existing or potential risk factors. Chapter 8 explains the response where information is received to indicate that an individual may be at risk of harm to themselves. Existing policy **adequately covers the** increased risks presented by **previous suicide attempts** and this information can be obtained **either directly from prisoners or from their records.** This is emphasised **to all staff as part of the ACCT Foundation Training and is also described inside the ACCT document**, (page 6 Suicide/Self Harm Risk Guidance)

   "The PER form is the recognised official document for communicating risk information to and from all relevant parties when a prisoner leaves and enters custody. Once in custody, the reception screening process and any subsequent referrals to a doctor or mental health service (if necessary) are also in place to determine any risks posed. If necessary, and as part of a consultation, any and all information given should be followed up.

   "**As far as the report describes, the establishment** and escort contractor **missed several opportunities**, (and failed to comply with a number of policy areas) **to identify the heightened risk posed i.e.**

   - **a self harm warning form should have been raised** by the court contractor in response to the FME actions and the warning raised on the warrant
   - **A mental health assessment could have been completed if it had been marked "urgent"**

- **A case review** should have been **held after his bail decision** on the basis of a change in circumstances."]

Local recommendations

1. I recommend that the Governor of Gloucester and the Head of Healthcare ensure that the recommendations made by the clinical reviewer are examined and acted upon appropriately. They should look especially at ways to improve communication between wing staff and healthcare staff when prisoners are self-isolating and refusing food.

   [This recommendation was accepted by HMP Gloucester at draft stage. The prison responded:

   "In liaison with Healthcare, Inreach and kitchen staff the lack of information sharing has been addressed. A system will be introduced where these departments will pass on any relevant information to the orderly officer or Senior Officer in charge of the wing. This information will have to be recorded as well as any action taken.

   "Training will be arranged between Healthcare and DPSM (Development Prison Service Manager) for prison staff highlighting changes in behaviour by prisoners for example, lack of personal hygiene, refusing meals and what action or support is appropriate. "]

2. I recommend that the Governor of Gloucester ensures that staff who most regularly work during the night shift receive emergency response training as a priority. This should include senior officers acting as night orderly officers, assistant night orderly officers and operational support grades (OSGs).

   [This recommendation was accepted by HMP Gloucester at draft stage. The prison responded:

   "Staff will receive local training in emergency response. This was initiated and will continue. [The] DPSM to liaise with Healthcare. They have all the facilities to do this training but need to be given allocated times on training days. [The] DPSM to discuss with HRBP (Human Resource Business Partner) to make this a priority on training days. The priority will be SOs, OSGs and B wing staff initially then A and C wing staff."]

Good practice

1. Following up the identification of a trigger point for self-harm by making an entry in the wing observation book is good practice.

2. The Governor and senior management at Gloucester acted promptly to analyse the care offered to the man and to look critically at it. A

comprehensive review was undertaken within hours of the man's death. The speed with which issues were identified, lessons learned and new practice put in place is impressive and an example of good practice.