Investigation into the circumstances surrounding the death of a man at HMP Bullingdon in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

This is the report of an investigation into the death of a man at HMP Bullingdon. He was found in his cell in the early hours of the morning of 9 January 2009, having made cuts to his neck with a razor blade. At the time of his death he was in the midst of his trial at Crown Court for the alleged murder of his wife. He was 49 years old.

I extend my condolences and those of my colleagues to the man's family. I hope that my report goes some way to answering any questions they may have. I must also apologise for the delay in completing this report.

The investigation was carried out on behalf of the Ombudsman by one of his investigators. A clinical review of the man's healthcare at Bullingdon was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am most grateful to the clinical reviewer and his review is annexed to this report. I would also like to thank all of the staff at Bullingdon for their cooperation with my investigation. I would particularly like to thank Governor A for her assistance. This is the sixth apparently self inflicted death to have taken place at Bullingdon since the Ombudsman started investigating such deaths in April 2004.

It is evident from my investigation that the man was a quiet man who, for the most part, kept himself to himself and was respectful to staff. He apparently committed suicide towards the end of the first week of his trial. When he arrived at Bullingdon he was placed on an Assessment, Care in Custody and Teamwork (ACCT) document, being observed constantly due to his attempt to harm himself at the time of the offence. However, he spent the last six months of his life on one of the prison's regular units.

The murder of a close relative or partner is an acknowledged risk factor of suicide, as is a history of self harm and the additional stress of the trial. On 7 January during his trial staff at the prison were informed that, due to comments made by the man to his solicitor in court, a Suicide Self Harm Warning Form had been raised. However, having been assessed on his return to Bullingdon by a nurse, who concluded that he was not at risk of harming himself, no further action was taken by the prison. Sadly he was found in his cell, in the early hours of 9 January, having apparently taken his own life.

As a consequence of his circumstances, the man was a prisoner at high risk of harming himself. However, from the nurses assessment of his general demeanour at the time, I do not believe that his death could have been reasonably predicted by staff at Bullingdon. I make a number of recommendations, the most significant being the importance of referring prisoners who have committed a violent offence to a psychiatrist. Other recommendations include the completion and referencing of prison records and a reminder to staff of the actions to be taken during an emergency at night.

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
Deputy Prisons and Probation Ombudsman **February 2010**

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SUMMARY

On 2 June 2008, the man who is the subject of this report was remanded into custody at HMP Bullingdon having been charged with the murder of his wife. Because he appeared to have harmed himself after the alleged offence, he had been placed on a constant watch whilst in police custody.

The man was placed by prison staff on an Assessment, Care in Custody and Teamwork (ACCT) document. (The ACCT document is used to assess, observe and support prisoners at risk of harming themselves.) He was assessed by a nurse and it was decided that he should be located in the prison's healthcare unit under constant observation.

Whilst in healthcare he continued to speak of harming himself, telling staff that he was a clever man and knew how to kill himself. During his time in healthcare regular reviews of his situation took place and in the days after his admittance he continued to express thoughts of self harm. However, over time his mood lifted and his ACCT observations were reduced. On 17 June, he reported to staff that he was settled, felt well and was happy to be transferred to one of the prison's main units, Blackthorn unit. Three days later the ACCT document was closed.

Little is known of the man's time on Blackthorn unit. Staff reported that he was a quiet man who was well behaved, quiet and polite. He appears to have spent most of his time in his cell and did not mix with other prisoners on the unit. His personal officer said, "… most of the time you wouldn't even know he was here, spends all his time behind his door apart from going on visits".

Having appeared at court on a number of occasions over the preceding months, His trial began on 5 January 2009. On 7 January, the man's solicitor told staff at Crown Court that the man had said "If you see me tomorrow you will, if you don't you won't". Staff raised a Suicide Self Harm Warning form and, when he returned to Bullingdon, he was assessed by one of the reception nurses. They considered whether an ACCT document should be opened, but based on his presentation, decided that it was not necessary.

The man returned to court the following day, appearing to be in good spirits that morning. On his return to the prison that evening he was again reviewed by a member of healthcare staff, who reported that he was fit and well.

At approximately 5.42am on 9 January, a member of staff found the man lying on his bed, when his cell was unlocked, having cut his neck. On raising the alarm, other officers attended along with nursing staff. However, no resuscitation was attempted as it was evident that he was dead. His death was confirmed by the prison doctor at 7.30am.

My report on the man's death makes a number of recommendations, the most significant of which are highlighted in the clinical review, namely that during the man's time at Bullingdon no psychiatric assessment was completed despite the nature of his alleged crime. In addition to addressing a number of issues

regarding staff entering cells at night, I draw attention to the failure to record significant events in his wing history sheets. Very little is known of the man during his time at Bullingdon, highlighting failures in the operation of the personal officer scheme at the prison.

THE INVESTIGATION PROCESS

1. The investigation following the man's death was carried out by one of the Ombudsman's investigators. He opened the investigation on 14 January 2009 when he visited HMP Bullingdon. He met the Governor of Bullingdon, the chair of the IMB, and the chair of the Prison Officers Association. The investigator also met Detective Sergeant C. During the course of the investigation the investigator provided verbal and written feedback to the Governor and other members of staff at the prison.

2. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Bullingdon. The notices were displayed around the prison and invited staff and prisoners to contact the investigator should they wish to do so. The investigator obtained documentation relating to the time that the man spent at Bullingdon and visited the prison on several occasions to conduct interviews with both staff and prisoners.

3. A clinical review was commissioned from the local Primary Care Trust (PCT). A copy of the report can be found in Annex 1.

4. One of the Ombudsman's family liaison officers contacted the man's family to discuss the purpose and scope of the investigation and to give them the opportunity to raise any questions or concerns they had about his death. The family raised a number of questions when they met the family liaison officer and the investigator. I hope that this report helps clarify the family's concerns and any other issues that remain unclear, helping them to better understand what happened to the man in the time leading to his death. Other issues raised by his family but not dealt with directly in this report have been addressed separately by the investigator and another of the Ombudsman's family liaison officer's who took over liaison with the family. They include that the man had not had access to the prison canteen (shop) over the Christmas period, that routine blood samples went missing and that some of his property was not returned.

5. A copy of this report will be sent to the Coroner to assist him with his enquiries.

6. At the beginning of September 2009, when my draft report was about to be published a prisoner at Bullingdon contacted the investigator with information about the man's death. In particular the prisoner alleged that on 8 January, Listeners and Insiders working in reception that evening were asked to return to their wings early. (Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. They are available 24 hours every day and will meet prisoners to listen to their concerns. Insiders are also prisoners, who usually work on first night and induction centres, where they offer guidance and information to new prisoners. Unlike Listeners, Insiders have no formal training.)

7. The prisoner said that, as a consequence of the Listeners and Insiders leaving reception early, a number of new prisoners returning from court, including the man who died, were not seen. The investigator spoke with the prisoner on the telephone and asked Governor B, Head of Prisoner Community with responsibility for the Listeners and Insiders, to respond to the issues raised by the prisoner. I address these matters in the Issues section of my report at paragraph 93.

HMP BULLINGDON

8. HMP Bullingdon is a category C training prison holding convicted and un-convicted adult male prisoners. The prison serves the courts in Oxfordshire and Berkshire.

9. Bullingdon was opened in 1992 and can accommodate up to 1124 prisoners. The prison is made up of six wings or units which are made up of both single and shared cell accommodation. Four of the units are made up of three spurs with a fifth, added in 1998, having two spurs. An additional wing was constructed in 2008 comprising of two spurs accommodating a first night centre and enhanced prisoners.

10. The prison has a range of work, education and training opportunities delivering key skills and vocational qualifications. Bullingdon also runs a number of offender behaviour programmes.

11. Healthcare at the prison is provided by the local Primary Care Trust (PCT). There is a 24 bed inpatient facility at the prison which is staffed throughout the day and has two nurses on duty during the night. An outpatient's facility delivers a daily triage system referring prisoners to a doctor as necessary. A doctor is available every weekday and there is an on-call system during weekends and at night.

12. Since April 2004, when the Ombudsman started investigating all deaths in custody, he has investigated six self inflicted deaths at Bullingdon, including this man's. Four of the reports do not identify any similar issues to those in this report into his death. However, I note that two recommendations, made as a consequence of the Ombudsman's investigation into the death of a man at the prison in December 2004, are similar to two in this report. These recommendations relate, firstly, to the reviewing of night instructions, and ensuring that night staff are aware of the instructions and their duties and, secondly, to the operation of the personal officer scheme on Blackthorn unit.

Independent Monitoring Board report

13. The Independent Monitoring Board in their most recent annual report, 2007/2008, said that, despite the pressures caused by the high population at Bullingdon, the positive improvements made to the treatment of prisoners and to the regime at the prison had continued.

14. The IMB also reported that there was a sound Assessment, Care in Custody and Teamwork (ACCT) process in place although it was noted that the ACCT coordinator was quite stretched at times. The IMB were pleased to note that, however late it was, newly arrived prisoners were treated with care and consideration, assessed by healthcare and given a hot meal by staff. The report observed approvingly that staff were both hard working and dedicated, ensuring the decent treatment of prisoners in

the reception area.

Her Majesty's Chief Inspector of Prisons' report

15. Her Majesty's Chief Inspector of Prisons carried out an announced inspection of Bullingdon in January 2008. She reported that, despite considerable change over recent years, overall the prison was performing relatively well. She said that it was to the prison's credit that it had risen to many of the challenges posed by the complex and diverse demands placed on it. She was well aware that there was inevitably plenty more still to do, adding that this should not obscure the progress made, or the fact that it had been sustained at a time of considerable pressure.

16. However, HM Chief Inspector of Prisons noted that relationships between staff and prisoners were mixed and, although the interactions that she observed were good, personal officer work was underdeveloped. She said entries in personal files were mostly about behaviour and displayed little awareness of prisoner's personal and individual circumstances, or their resettlement objectives. Until recently there had been long gaps in entries in some files. She found that personal officer entries on Edgcott unit were noticeably better than the rest of the prison and concluded that entries in records would be improved by a better functioning personal officer scheme. (The man who died did not live in Edgcott unit.)

17. HM Chief Inspector of Prisons also reported relatively few incidents of self-harm. However, she said that delays in receiving investigation reports from the last deaths in custody, over a year prior to her inspection, had hampered learning at the prison. She observed that there were some good examples of multidisciplinary ACCT procedures and high- risk prisoners on constant watch were well supported by the Mental Health In-Reach team (MHIRT).

KEY FINDINGS

18. On 26 May 2008, the man who is the subject of this report was charged with the murder of his wife. After the attack he wounded himself, by cutting his throat, and was treated in hospital for his injuries. On 2 June, he appeared at Magistrates' Court and was remanded into custody at HMP Bullingdon that afternoon.

19. The Prisoner Escort Form (PER form – a document used by escort staff to record a prisoner's known risks and other information) completed by escort staff noted that the man was at risk of suicide due to the nature of his offence, that he was low in mood and had been continually observed whilst in police custody. On his arrival at Bullingdon staff recorded his personal details, including the details of his next of kin. A Cell Sharing Risk Assessment (CSRA) indicated that he was, "quite distressed and unpredictable at the moment. Needs some time to sort his head out". (A CSRA is used to assess the risk that a prisoner would present to others when sharing a cell.)

20. During the reception process Staff Nurse D, Registered General Nurse (RGN), conducted a first reception health screen on the man. Nurse D noted on the Egton Medical Information System (EMIS) that an Assessment, Care in Custody and Teamwork (ACCT) document had been opened on the man as a consequence of his offence and high profile. (EMIS is the patient electronic medical record and the ACCT document is used to assess, observe and support prisoners who are at risk. It highlights the problems and possible trigger points of a prisoner at risk of harming themselves and makes a multidisciplinary plan to give support and help through a period of crisis.) He told Nurse D that he wished he had not been saved after cutting his throat. It was decided that he should be placed on a constant watch in the prison's healthcare unit. (Unfortunately the ACCT document opened by staff at Bullingdon appears to have been lost. References to the ACCT document in this report have been taken from the entries of nursing staff on EMIS.)

21. The next morning, 3 June, the man was seen by Nurse E, Registered Mental Health Nurse (RMN). He told the nurse that he was thinking about harming himself again, adding that he would not tell her of his plans as she would then know as much as he did, adding that he was a clever man and knew ways to take his life.

22. Later that morning, he was assessed by Dr F, one of the prison doctors. She too reported the man's ongoing thoughts of harming himself and said that he had told her that he was a clever man who new how to kill himself. He told Dr F about his previous contact with a psychiatrist, after some marital problems, when he had refused to take the medication which was prescribed. Dr F noted that the man had not been admitted to a psychiatric hospital, did not want to take any medication and that there was no evidence of any psychotic symptoms.

23. During an ACCT review later that day, the man told Nurse E that he believed in the philosophy of a, “life for life”, and had every intention of dying. He said that he was not afraid of dying and repeated that he was a clever man who, “… had ways in which he would be able to do it”. He remained on a constant watch in the healthcare unit.

24. The man was seen by Dr G, another of the prison doctors, on 4 June. Dr G recorded on EMIS that he showed no signs of mental illness. However, in the light of his strong feelings of remorse and in view of his serious suicide attempt, Dr G took the decision that he should remain on a continuous watch.

25. During an ACCT review later that day, the man told Nurse E that he wanted to remain being watched continuously and still thought about harming himself. Nurse E reported that, although he remained isolated, he was engaging with staff. That afternoon, he spent time sitting in the exercise yard reading a book. During the night the man told Nurse H that it was stupid to leave a plastic knife in his cell as he could break it and use it to harm himself. The cutlery was removed and Nurse H noted that she felt the man was letting her know that he was still thinking of harming himself.

26. Throughout his time on the healthcare unit, the man’s neck injuries were treated. On 5 June, after an examination by Dr F, the staples (sutures) used to heal his neck injuries were removed. Later that day the man was seen again by Dr G. He noted in EMIS that the man denied any active suicidal thoughts, but had said that his feelings remained unstable, adding that he would just have to take every day as it came.

27. Over the following days he remained on constant observations and took part in frequent ACCT reviews. During one such review, following a visit by his brother on 5 June, he was said to have avoided eye contact with staff. However, when seen by Dr G the following day, the man, although subdued, expressed no thoughts of harming himself. Dr G noted on EMIS that, in view of his fairly controlled and calm character, it was difficult to assess his suicide risk. The ACCT review on 8 June decided that he should be continuously observed, due to his appearance at court the following day.

28. On 9 June, the man appeared at Crown Court. On his return to Bullingdon, Nurse D noted on EMIS that he appeared settled. Although there were no issues to report, he remained on constant observation. At an ACCT review the next day, 10 June, he told staff that he felt much more positive, could see a future and had no current or recent thoughts of harming himself. It was agreed with Dr G that the continual observation of Russell could come to an end and be replaced by half hourly observations.

29. At an ACCT review on 11 June, the man said that he was fine and felt great, though Nurse E noted his mood as being slightly high. He spent a

lot of time reading in the healthcare unit garden and there were no significant concerns at the time. Because he remained settled over the following days, spending most of his time reading in his cell and keeping himself to himself, the ACCT monitoring was reduced to hourly observations.

30. During a review with Dr F on 17 June, the man reported feeling well and settled, saying that he would be happy to be transferred to one of the prison's main units. A discharge sheet was prepared and, later that day, he transferred to Blackthorn unit, the remand unit in the prison. A CSRA completed by SO I, noted that the man was currently subject to an open ACCT and being observed every hour. SO I provided him with a brief induction to Blackthorn unit and he was told that his personal officers would be Officer J and Officer K.

31. On 20 June, Russell's ACCT document was closed. (Due to the missing ACCT document I have been unable to review the considerations made by staff when closing the ACCT. However the Safer Custody Manager, has confirmed that a post closure interview did take place.)

32. Officer J, the man's personal officer, wrote in his wing history sheets on 19 July, that during the short time he had been on the unit he had been polite and well behaved and had expressed no concerns.

33. The man attended court again on 4 August. On 8 September, Officer J wrote that the man continued to be well behaved and polite, spending most of his time in his cell and did not mix with his peers. On 25 October, Officer J wrote that the man, "… continues to be well behaved, most of the time you wouldn't even know he was here, spends all his time behind his door apart from when going to visits".

34. During November and December, he reported to healthcare for a number of tests and was seen by Dr F. In the clinical review, the clinical reviewer notes that on 12 November, he was seen by Dr F regarding a painful right shoulder and was prescribed anti-inflammatory medication and routine blood tests were taken. During this time there was no indication to nursing staff that he had attempted or expressed any thoughts of harming himself.

35. On 2 December, Officer L wrote in t he man's wing history sheets that he had recently moved to another (single) cell on the unit and had no issues. (The investigator was unable to establish the reason for the move.) It was suggested to him that he might want to get a job in the prison to keep himself occupied. However, Officer L noted that he was not keen on the idea and that he sat in his cell most of the time. (Remand prisoners are not required to work whilst they are in prison custody.)

    In response to the draft report the man's family said that they had been told by the man when visiting him at Bullingdon that he had been moved from his original cell for not giving a urine sample in front of prison

officer's but he was willing for the to take a blood sample. After this incident they say that he was moved to another cell.

36. Following a number of court appearances since 2 June, the man's trial commenced on 5 January 2009 at Crown Court. The PER form used for his transfer to court indicated that he was on trial for murder and that his last ACCT document had been closed on 20 June 2008. The PER form noted that he was both vulnerable and at risk of harming himself. On his return from court he was seen by Nurse M who noted on EMIS, "Returned from court, states fit and well, no issues reported."

37. A prisoner on Blackthorn unit, told the police that he had known the man who died for about four months, adding that the man only spoke with him and his brother. He said that the man would stay in his cell for many hours and not socialise with other prisoners, but appeared to be dealing with prison life. He said that he last saw and spoke with the man on 3 January during visits, when he appeared normal and did not appear to be down or depressed.

38. The man who died went to court for the second day of his trial on 6 January. There is no indication either in EMIS or on his wing history sheets that he was assessed by a member of healthcare on his return.

39. The man attended court again on 7 January. In a statement to the police the practice manager for the man's Solicitors, said that after a legal visit, at around 4.45pm, he told Prisoner Custody Officer (PCO) N and PCO O that the man had said, "If you see me tomorrow you will, if you don't you won't." In his statement to police, PCO N said that the practice manager told himself and PCO O that he was concerned about the man's comments and felt that they ought to know.

40. PCO N said he was aware that the man had previously been on an ACCT document and so he asked PCO O to raise a Suicide Self Harm Warning form. (The prison was unable to provide a copy of the Suicide Self Harm Warning form. However, the police obtained a copy of the document from Reliance, the prison escort contractor.) On the form PCO O had indicated that the man seemed very depressed and so had been monitored intermittently. PCO O said that he telephoned Bullingdon advising them of the situation and reported that a Suicide Self Harm Warning form had been opened.

41. The man returned to Bullingdon at 6.15pm. Officer P said that he booked him in and briefly asked him if he was okay, which he confirmed. Officer P said he was given a meal and put in one of the holding cells. Officer P told the investigator that he had no immediate concerns about his welfare. The officer said that he alerted Nurse Q, Senior RGN, explaining that the man had just returned from court on a Suicide Self Harm Warning form and asking if he could be prioritised by healthcare. Later that evening Officer P asked Nurse Q if the man was okay and Nurse Q confirmed that

he was fine.

42. Sister R, RGN, told police that during the afternoon of 7 January, she learnt that court staff had contacted Bullingdon reception staff, advising that they were concerned about the man and that a Suicide Self Harm Warning form had been raised. When he returned to Bullingdon Sister R wrote on the PER form that she had seen the Suicide Self Harm Warning form. Sister R discussed the man with Nurse Q and they decided that Nurse Q would speak with him to assess him. Sister R said that she also spoke with Nurse Q later that evening. Nurse Q told her that he had no concerns about the man and confirmed that he could return to Blackthorn unit.

43. On the copy of the Suicide Self Harm Warning form, obtained by the police, sections seven and eight, details of reception officer and confirmation of action taken by healthcare screener, are incomplete. During interview Officer P told the investigator that he was certain he had signed the form, as did Nurse Q. Given that Bullingdon's copy of the form is missing, the investigator was unable to establish whether or not the form was signed by Officer P and Nurse Q. Sister R informed the investigator that, although she had had no verbal contact with the man that afternoon, she saw Nurse Q sign the Suicide Self Harm Warning form.

44. Nurse Q told police that he spoke with the man briefly in the holding cell, asking him if he was okay. He said that he did not have an in-depth conversation with him at this stage because other prisoners were present. Nurse Q said he read the Suicide Self Harm Warning form and spoke to SO P before calling the man through to the nurse's interview room. Nurse Q told police that the man told him he had had a tough day. He claimed that he had not meant anything by what he had said to the solicitor practice manager in court, though he added that he did "fancy a lie in". Nurse Q told the police that the man was polite and behaved appropriately, assuring him that he had no thoughts of harming himself. He had no concerns about him, who assured him that he would speak to staff and other prisoners if he needed to. Nurse Q reminded the man about the Listeners scheme and how to access it. (Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. They are available 24 hours every day and will meet prisoners to listen to their concerns.) On leaving the interview room the man gave Nurse Q a slap on the back, telling him that he was fine. Nurse Q said that he saw the man the next evening in reception but did not speak with him, saying that there was no indication that anything was amiss.

45. Nurse Q noted on EMIS that the man made no specific reference to harming himself or having any suicidal intentions. Nurse Q wrote that, when asked about the comments made at court, the man said:

> "… YES it had been a tough day but he didn't mean anything by what

he had said. He said that he did fancy a lie in though!!!!!!!!! He was polite and appropriate and assured me that he had no thoughts of self harm. When asked he also assured me that if he did start to struggle he would talk to someone. He said that he had people on the Wing he could talk to, both prisoners and staff. I reminded him about the Listeners system too, if he needed to make use of it. No concerns raised at this time."

Nurse Q did not enter any of his interaction with the man that afternoon in the wing history sheets, including that he judged him fit to return to Blackthorn unit.

46. The man went back to court the following day, 8 January. The PER form noted that he was at risk of suicide/self harm and had previously been on an ACCT document. He returned from court at 6.20pm. Officer P was again on duty in reception that evening. He said that there were no issues that day were brought to his attention and no healthcare issues were reported.

47. One of the unit officers, Officer S, unlocked the man's cell so that he could go to court on 8 January and the preceding days. He said that during this time he appeared to be in good spirits and showed no signs of someone likely to take his own life. Officer T, who had also unlocked the man for court over the previous three days, described him as polite and compliant, never giving cause for concern.

48. The man was reviewed by Healthcare Assistant Ms U, who although she had received training, was working for the first time on her own in reception that evening. She noted on EMIS at 7.04pm, "Returned from Court. Trial continuing. States fit and well". Ms U also wrote in his wing history sheets that he had been seen by healthcare staff. She told the investigator that he appeared relaxed saying that, "… he didn't appear anxious or upset or anything, he just said he was fine". Ms U told the investigator that when she assessed him she did not refer to previous entries on EMIS, not having access to a terminal. She said that any notes about her assessment of a prisoner would be made later on EMIS when she had the opportunity.

49. In the week before his death, the man spoke to another prisoner on Blackthorn unit. The prisoner told the police that they discussed his court case and his fear that it was going against him. The prisoner said that the man kept himself to himself, staying in his cell most of the time. He thought that the man found it difficult to speak with people. The prisoner said that, during the week of his trial, the man seemed to be a bit low. He last saw the man when he returned to the wing on 8 January.

50. Officer V had a brief conversation with the man who died when he locked his cell up that night at about 8.00pm. Officer V told the police that he had known him for a number of months on the wing and he seemed no different that night from usual. Officer V asked him if he was alright. He

said that although he admitted he was a little tired as he had to get up early for court, he did not appear down or depressed. Officer V said that he kept himself to himself and did not socialise with other prisoners, preferring to stay in his cell. He believed that if he had any problems he would have alerted staff. Officer V told the police that he believed that the ACCT document had been closed before the man arrived on Blackthorn unit, as he could not recall making an entry in it.

51. Another prisoner told the police that at approximately 8.00pm on 8 January, he spoke with the man when he got back from court about closing his cell door. He said that he seemed happy at that time and thanked him for closing his cell door. The prisoner also added that the man appeared no different from normal. He said the man:

> "… kept himself to himself and didn't socialise with other prisoners, he didn't come out of his cell that much. In the times I had occasion to speak with him he never seemed down or depressed he was just getting on with his remand period."

52. In a letter postmarked 9 January 2009, the man who died wrote to his solicitors, thanking them for their assistance and stating his innocence of his wife's murder.

53. At around 5.30am on 9 January, Operational Support Grade (OSG) W was completing his night duties, part of which involved waking prisoners who were to attend court that day. OSG W said that he left the man till last, as on the previous few mornings, he had already been up making tea. OSG W told the investigator that when he arrived at his cell at 5.42am he saw him:

> " … lying on the bed, his arm hanging over. And I knocked on the door, called out his name, saw no movement. I banged on the door, and you rattle it by the handle, and I watched and he never moved at all. Then I actually gathered a few more kicks just to make sure; never saw any movement. And I stepped right up to the glass and put my eye right against the glass to look in, to see what I could see. And all I could see was a stain on the floor, it could have been water but you know straightaway you know there's something wrong because he should have been up; he was up every other morning. So I presumed that it was blood and I called Oscar 1, Bravo1 (which is myself), Level 1, which makes him know that it's something very serious. And then I ran upstairs and I could hear him running along the passage. This was, I think I put the call out at 5.46am."

54. OSG W told the investigator that he persisted in trying to obtain a response from the man, trying to wake him up for three or four minutes before raising the alarm. OSG W said:

> "You've got to make sure they're awake. You see I can't call Level 1 [The emergency response code] unless I'm sure there's something

wrong. So I’ve got to really hammer at the door. Some of these guys sleep very heavily and you’ve got to bang the door to get them to answer you.”

OSG W said that he realised that there was something wrong when he noticed a stain on the floor and used his radio to make an emergency call for further assistance. He then made his way to the centre office, on the landing above, to await the arrival of assistance.

55. Senior Officer (SO) X was the night orderly officer (Oscar1), the most senior officer on duty in the prison. He had an assistant night orderly officer, Officer S (Oscar 2). SO X had just left his office and was walking towards the house blocks with Officer S and Officer T. At 5.46am, the communications room log records, OSG W made an emergency Level 1 call for him to attend Blackthorn unit immediately. (The emergency Level 1 call alerts staff to a life threatening incident or event). As the officers responded SO X asked Officer Y, who was also in the vicinity, to collect the nurses from the healthcare Unit. (Nurses do not carry keys at night for security reasons and rely on prison staff to unlock the gates for them in emergencies.)

56. On their arrival on Blackthorn unit at 5.48am, the officers were directed by OSG W to the man’s cell on the landing below. Officer T arrived at the cell first and, looking through the cell observation flap, saw the man lying on the bed with his right arm under his body. His head was turned to the left and his arm was hanging down. There was a pool of blood on the cell floor. Officer T went into the cell, followed by SO X and Officer S. SO X tried to obtain a response from the man, but there was none. Officer Z arrived on the wing as SO X, Officer T and Officer S were leaving the cell. SO X said he let Nurse A RGN, and Nurse B RGN, into the cell at 5.58am. All of the officers believed that the man was already dead.

57. Officer Y, who had been instructed by SO X to collect and escort the nurses from the healthcare unit to Blackthorn unit, told the investigator that she proceeded to healthcare, arriving two to three minutes after the alarm had been raised.

58. Nurse A, who was working in the healthcare unit, heard OSG W call a Level 1 emergency code. In her incident statement Nurse A said that she collected the emergency equipment and arrived at the man’s cell at about 5.58pm along with her colleague Nurse B. They went into the cell to assess the man. They agreed that there were no signs of life and that nothing further could be done to save him. Resuscitation was not attempted. In the clinical review it says that the decision not to attempt resuscitation was appropriate and that the information to support this was clear and well documented.

59. The ambulance service received an emergency call to go to Bullingdon at 5.54am, arriving at 6.19am. My investigator has been unable to ascertain with any certainty who made the request for the ambulance to attend.

The man was pronounced dead by one of the prison doctors at 7.30am.

60. I understand that a blade taken from a razor and a letter were found in the man's cell and were removed by the police.

61. The staff who discovered the man and responded to the emergency were invited to a hot-debrief. (A hot-debrief is a meeting held as soon as possible after a major incident.) A review of prisoners at risk of harming themselves was completed by staff. I also understand that the officers and staff involved in the incident were approached by the care and welfare team. Several officers said during interview that they felt the care offered was beneficial, supportive and helpful.

62. The man's family were told of his death by Gov A, Chaplain C and Governor D that morning.

ISSUES

Psychiatric assessment

63. Because the man who died had been charged with murder, and because of the wounds he made to his neck before his arrest, he was considered to be at a high risk of harming himself and so was monitored constantly by staff whilst he was in police custody. On transferring to Bullingdon, he continued to be observed constantly for over a week in the prison's healthcare unit.

64. In the clinical review, the clinical reviewer concluded that the ACCT document was managed sensitively, according to the medical records available, and was appropriate. The clinical reviewer's opinion was that the gradual reduction in levels of observations and the man's return to the main prison were well judged. The clinical reviewer said:

    "At all times the man was treated with care, concern, and professionalism and judgements made about his risk of self-harm appear to have been thoughtful and carefully considered."

65. The clinical reviewer observed that, although there was nothing to suggest that the man was suffering from any psychotic illness:

    "… in a less secure environment, i.e. not in prison, a man with such clear suicidal ideation would have been referred for a psychiatric assessment. Such an assessment might have revealed further insights regarding his mental state, or instigated different follow-up that could have helped him, and might have influenced his management at the time of his trial and successful suicide attempt."

    In his clinical review, the clinical reviewer recommended that,

    Prisoners alleged to have committed a violent murder, who have violently attempted to take their own life and who express suicidal ideas should be referred to the Forensic Psychiatry Team.

    The clinical reviewer said that such action would provide further specialist assessment, and ongoing support, both for the prisoner and for the Primary Health Care Team. I agree with his findings and endorse his recommendation.

Missing ACCT and Suicide Self Harm Warning Form

66. During the investigation the investigator was advised by staff at Bullingdon that both the ACCT document opened on the man's arrival at the prison and the Suicide Self Harm Warning form raised at court just two days before his death had been lost. The loss of these documents is extremely regrettable and concerning.

67. The loss of the ACCT document means that I am unable to make a considered judgement about the actions and observations by staff during the three weeks it was open. However, thanks to the quality entries made in EMIS by Nurse E, the investigator was able to discover that the man's ACCT document was reviewed frequently.

68. The disappearance of the ACCT also meant that the investigator was unable to establish what actions were taken by wing staff after Russell transferred to Blackthorn unit on 17 June, and the reasons and consideration behind the closure of the ACCT three days later on 20 June.

69. Additionally Bullingdon was unable to provide the investigator with a still more important document, the Suicide Self Harm Warning form opened by escort staff at Crown Court on the afternoon of 7 January. However, the investigator was given a copy of the document by the police, who obtained it from Reliance, the prison escorts contractor.

70. The investigator asked the Safer Custody Manager what should happen to a Suicide Self Harm Warning form when it arrives at reception with a prisoner. She said that when a prisoner comes in with a warning form and an ACCT is not opened, the top white copy of the form should be placed in the prisoner's medical record and the yellow copy filed with the wing history sheet to alert staff on the wings that a warning form had been raised. I have found no copies of the form in the documents identified by the Safer Custody manager and I therefore conclude that the correct process was not followed on 7 January.

71. I am concerned whenever documentation in prisons goes missing. However, I am particularly alarmed on this occasion that documents as important as the ACCT and Suicide Self Harm Warning form have both disappeared. I accordingly make the following recommendation.

    The Governor should remind all staff of the importance of treating all documents, and in particular those relating to a prisoner's risk of harming himself, with care. The Governor should ensure that all such documents are processed and filed correctly by staff.

Wing history sheets

72. As with so many of the investigations completed by the Ombudsman's office I am obliged to comment on the lack of quality entries in the man's wing history sheets. During the investigation the investigator was unable to establish any detail about the time that the man spent in custody at Bullingdon and, as a consequence, I am unable to answer fully many of the questions asked by his family. I note that only four significant entries were made by staff between the date of his location on Blackthorn unit on 17 June and the start of his trial seven months later on 5 January 2009.

73. In addition to a lack of general weekly entries and observations about the man, staff on Blackthorn unit also failed to make entries in his wing history sheets about several significant events that occurred during his period on remand. There was no reference to closure of the ACCT document on 20 June, or to the post closure interview that subsequently took place. Additionally, neither reception nor healthcare staff referred to the Suicide Self Harm Warning form opened on 7 January, and after his return from court on 6 and 7 January, healthcare staff failed to note that he had been assessed as fit for normal location.

74. It saddens me that prisoners such as the man who died, who present no trouble and remain under the "radar" of most prison staff, go unnoticed and as a consequence less is recorded about them. This leads me to conclude that they have equally less interaction with staff.

    In response to the draft report the Prison Service wrote: "There is no evidence to suggest that it was defiantly the case that the man was not noticed by staff."

75. Bullingdon's own personal officer scheme expects a minimum of one quality entry in a prisoner's history sheets at least once every two weeks. (The investigator was unable to establish who his personal officer was at the time of his death. Although Officer J and Officer K were assigned as his personal officers when he first arrived on Blackthorn unit, after his movement to another cell it is not clear who the allocated personal officer was.) I would also expect any significant events and entries to be highlighted in the unit's observation book. The absence of staff entries in his wing history sheets and the unit observation book clearly prevented their colleagues from accessing important information about him.

    The Governor should remind all staff of the importance of completing wing history sheets and observation books, noting their interactions with prisoners and other pertinent information.

    The Governor should satisfy himself that the Personal Officer Scheme is operating effectively and in accordance with the local protocol.

The man's return from court on 7 and 8 January

76. Shortly before the man's return from court to Bullingdon on the afternoon of 7 January, Reliance prisoner custody officers opened a Suicide Self Harm Warning form because of comments made by him to his legal representative. In addition, the prisoner custody officers telephoned reception staff at Bullingdon to advise them of the situation.

77. The investigator established that, on his arrival at Bullingdon, staff in reception were aware of the Suicide Self Harm Warning form that had been opened. Officer P asked him how he was felt on his return to the prison. Soon afterwards he was assessed by Nurse Q as to whether or

not an ACCT document should be opened. The nurse decided that opening an ACCT document was not required.

78. With the benefit of hindsight it would be easy to conclude that Nurse Q should have opened an ACCT. However, Nurse Q made a significant and detailed entry on EMIS about his assessment of the man. I am satisfied that Nurse Q made a full and considered assessment about whether or not to open an ACCT document based on the man's presentation, assurances and his responses to questioning. In his clinical review, the clinical reviewer also noted, with regard to the man's contact with Nurse Q, that:

    "The notes are appropriate, appear contemporaneous, and clearly reflect an appropriate conversation on which the judgement that no additional intervention was needed at the time was made."

79. No issues were raised by staff, either at court or on the man's return to prison the following evening, 8 January. Ms U, who assessed the man that evening, said that he appeared relaxed and claimed that he was fine. However, she added that she had not been aware that he had come into the prison the previous evening on a Suicide Self Harm Warning form. Ms U did not have access to EMIS when she was reviewing prisoners. She said that, had she known about the warning form, she might have reached a different conclusion.

    I recommend that all nurses have access to EMIS during reception screening so that they can review previous entries and enter the notes of their assessment at the time of the interview.

80. Prison Service Order (PSO) 2700 provides guidance on Suicide and Self Harm Prevention. The PSO highlights in section 4.10 that prisoners charged with murder and/or sentenced to life are at a higher risk of suicide than other prisoners. The PSO says that the care of such prisoners requires close monitoring of trigger points such as trials and sentencing.

81. In his clinical review the clinical reviewer concludes that it was highly probable that, having determined to take his own life, no intervention would have stopped him from doing so. However, he goes on to say that, in hindsight and in the context of his previous serious attempt to harm himself after the offence with which he was charged, and the stress of his court appearances, there remained the possibility that closer observation of the man might have altered the outcome.

82. The clinical reviewer recommends that when a prisoner is identified as being at a heightened risk of self harm, such as when a Suicide Self Harm Warning form is opened during trial, consideration should be given to a more formal reception process for men returning from court so that any change in their mental state can be detected. The clinical reviewer, appreciating the many prisoners moving in and out of prison every day,

suggests that EMIS could be used to identify those prisoners who might benefit. I agree with his findings and recommend that:

The Governor and Healthcare Manager should consider introducing a more formalised reception process for prisoners returning from court who are identified as at risk of self harm.

Raising the alarm and going into the man's cell

83. OSG W went to wake the man at 5.42am ready for him to go to court. Unable to obtain a response and noticing a stain on the floor, he radioed for emergency assistance at 5.46am. OSG W did go in to the man's cell, but returned to the wing office on the landing above to await the arrival of other officers. My investigator asked OSG W if there was any reason why he did not enter the cell immediately upon discovering the man. OSG W replied:

    "Well there's no reason for me to enter the cell. Its not part of my duties to start with; the cell only gets entered by an officer accompanied with a couple of other officers. They train in case they go into a cell and someone attacked them; they're trained for that, I'm not. So it's got nothing, as I say to do with me."

84. It was apparent to the investigator from his interview with OSG W that he was unaware of the local procedures to be followed regarding entering a cell at night in response to a suspected death or similar emergency. OSG W was also unclear as to the circumstances regarding when to enter a cell at night and the use of the emergency cell key, which is carried by all OSGs. OSG W said he was not aware of any circumstances or instructions to enter a cell. He believed that it was for the orderly officer to assess the situation and decide whether to enter or not. The OSG said he had been told in training never to enter a cell on his own and had not been trained to do so. When asked if he was aware of any instructions explaining the duties of the OSG during the night, OSG W acknowledged that there might be one, but indicated that he had never referred to it. OSG W told police that it was the role of the officers to enter the cell to see what the problem was.

The Governor should ensure that all Operational Support Grades and other staff working night duties are aware of their roles and responsibilities, especially regarding going into cells in the event of an emergency.

85. The investigator obtained the Night Folder containing various instructions and guidance for OSGs working during the night, and I have also had an opportunity to review these instructions. I believe that Local Instruction 2.79, Nights – Opening Cells published on 1 August 2008, lacks clarity in explaining the procedures to be followed in the event of opening a cell at night, the circumstances in which the cell can be opened by a single

officer and the circumstances such as a fire or a suicide attempt.

86. Similarly Local Instruction 2.89 Nights – Death in Custody/Suspected Death in Custody, also published on 1 August 2008, is unclear with regard to the procedures to be followed by staff who discover a death in custody. In particular, the instruction lacks guidance as to when a cell should be entered and the action to be taken upon discovering a prisoner in distress.

87. Although I appreciate that the Night Folder for OSGs does cover some of these issues in other documents, I believe a more structured set of night instructions and guidance would benefit all night staff.

The Governor should review Bullingdon's night instructions and other guidance for OSGs contained in the Night Folders. Particular attention should be focused on those procedures relating to the discovery of a death or suspected death, when a cell can be unlocked and the staffing level that is required to do so. The Governor should ensure that all night staff are aware of these instructions.

Delay calling an ambulance

88. The ambulance was not called until 5.54am, six minutes after the responding officers arrived on the unit. The investigator made enquiries as to who authorises the call for an ambulance in an emergency and when this is done. When asked if an ambulance should be called as soon as a Level 1 emergency call is made, Officer T said,

> "No, the Orderly Officer will call the ambulance … on assessment of the situation and from advice from the healthcare staff and nurses he will then call the ambulance …"

SO X said that an ambulance would not automatically be requested for a Level 1 call, confirming that the orderly officer would attend and assess the situation before hand. Officer S also said that an investigation and assessment of a Level 1 response is made before an ambulance is called.

89. It is essential that ambulances are called immediately to situations such as a Level 1 emergency call when there is a serious threat to life. Relying on the night orderly officer's assessment before calling an ambulance will undoubtedly cause considerable delay and any such delay. Any delay can have a significant impact on a person's chances of survival. The ambulance can always be cancelled at a later time. A letter to Governors from the Director of Prison Health in March 2004 advised that it was their responsibility to ensure a protocol existed to facilitate immediate access to the paramedic services. The letter advises that:

> "It is also essential that internal procedures should not waste undue

time in summoning emergency assistance. It should not; for example, be a requirement in every case for a member of the Health Care Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrives with the patient and deems that an emergency ambulance response is not required."

The Governor and Healthcare Manager should ensure that a local protocol is in place that provides clear advice about how and when the Ambulance Service should be called.

Delay by nursing staff reaching the man's cell

90. Nursing staff who were on the healthcare unit when the emergency call for assistance was made did not reach the man's cell until 5.58am. The investigator made enquiries about the apparent delay of 12 minutes before healthcare staff reached the cell. Officer Y, the escorting officer, said that she could not recall any delay, adding that it was a Level 1 and that all staff knew of the severity of the emergency. She said that nursing staff collected the emergency packs immediately and she then escorted them to Blackthorn unit. Officer Y said that this would have taken no longer than a couple of minutes. When asked a similar question by the investigator, Nurse A said that she too could not recall a delay in responding to the emergency call. Nurse A assumed that the discrepancy in time was due to the incorrect synchronisation of clocks and watches. Nurse A asserted that there was definitely no delay between the nurses' response to the emergency alarm being raised and their arrival at the man's cell.

Response codes

91. Although the nurses were aware that they were responding to a Level 1 emergency, the most serious of emergency calls, they were not aware of the specific nature of the emergency that they were attending. Although I appreciate that there are no mandatory requirements to use any specific emergency code system, many prisons use a call system such as red (for blood loss) and blue (for breathing difficulties). The codes inform staff of the nature of an emergency in language that is easily understood. I make no formal recommendation, but I invite the Governor to consider a review of the code system for emergency calls.

Healthcare record keeping

92. In his clinical review, the clinical reviewer noted that,

"The quality of the nursing and medical notes is by far the best I have encountered in undertaking a clinical review, and the medical and nursing staff should be commended regarding such an improvement.

Listeners and Insiders

93. One of the prisoner's at Bullingdon, who worked as an Insider in reception said that on 8 January, the Listeners and Insiders were returned to the wings before all the prisoners had been seen. He said that he protested and asked to see a member of the Suicide Prevention and Self Harm Management Team. He said that Governor B saw him a week or so later to discuss his concern that Listeners and Insiders were repeatedly sent back to the wings early without seeing all the new arrivals in reception. The prisoner said that he stated strongly to Governor B that the man's death could possibly have been prevented. The prisoner said:

    "I stated that while it's not clear that anything that I or the Listener on duty could have said or done anything to prevent him from taking his own life, the opportunity to do so was not allowed us. The Listener or I may have recognised enough signs to warrant enough concern to report them to staff."

94. The investigator put the prisoner's concerns to Governor B. Governor B said she was unable to confirm whether the prisoner was working on the evening of 8 January, whether the Listeners and Insiders were returned to the wings early that day or whether the man had developed a supportive relationship with the prisoner. Governor B said, "At no time during any conversation with the prisoner did he register any concern with me about the lack of Insiders in Reception being linked to the death of the man." Governor B added that:

    "I am confident if the prisoner had expressed these concerns to either of us [the Safer Custody Manager] that we would have taken him seriously and investigated his concerns thoroughly and promptly."

    Governor B said that she was approached by the prisoner about his concerns and, having addressed the situation with the Reception Principal Officer, was satisfied that the matter was rectified and the issue had not been raised again. Governor B said:

    "I have no further recollections of this being raised with me as a concern or issue and am confident that the Insiders are now firmly embedded along with Listeners in the Reception and First Night processes."

95. Having reviewed the prisoner's concerns and Governor B's response, I cannot confirm whether or not the man was seen by either a Listener or an Insider on the evening of 8 January. However, Governor B has confirmed that around January 2009 there was a problem with Listeners and Insiders being returned to the wings and that this had now been rectified. It is clear that the man was aware of the scheme, having been reminded of it during his assessment by Nurse Q on the evening of 7 January.

96. I appreciate the prisoner’s concern and am grateful to him for drawing it to my attention. However, given the lack of substantive evidence, I am unable to say whether the absence of Listeners and Insiders in reception that evening led to the man taking his life, or indeed if it was a contributory factor.

CONCLUSION

97. On the man's arrival at Bullingdon from police custody, staff immediately identified that he was actively suicidal. The support and care that he received during his first week of custody in the healthcare unit were described by the clinical reviewer as demonstrating care, concern and professionalism. However, the man was not referred for a psychiatric assessment. It is evident that when he was moved to Blackthorn unit he had little involvement in prison life, preferring to remain in his own cell. Staff interaction with him was seldom recorded and consequently little is known of his time on the unit.

98. The man's circumstances reflected some of the characteristics of a prisoner at high risk of harming himself. He was facing trial for murder, his victim was his wife and he had attempted to take his own life at the time of the alleged offence. However, given his appearance to staff in the days leading to his death, and in particular during the assessment made by Nurse Q. I am satisfied that the man had made up his mind to end his life and convinced the nurse that he was fit and well. I do not believe that staff could have foreseen what he was about to do.

RECOMMENDATIONS

1. Prisoners alleged to have committed a violent murder, who have violently attempted to take their own life and who express suicidal ideas should be referred to the Forensic Psychiatry Team.

   Partially Accepted – Referrals to forensic psychiatry would only happen if when the crime was committed there were mental health concerns. We have a stepped care system for mental health. We hold regular review meetings to discuss clients for referral to forensic psychiatry involving our mental health teams.

2. The Governor should remind all staff of the importance of treating all documents, and in particular those relating to a prisoner's risk of harming himself, with care. The Governor should ensure that all such documents are processed and filed correctly by staff.

   Accepted – A notice to staff will be periodically issued to remind all staff of the importance of handling all documentation appropriately.

3. The Governor should remind all staff of the importance of completing wing history sheets and observation books, noting their interactions with prisoners and other pertinent information.

   Accepted – A notice to staff will be issued on a regular basis to ensure that staff and managers remain vigilant when entering details in case notes (replaces history sheets) and observation books.

4. The Governor should satisfy himself that the Personal Officer Scheme is operating effectively and in accordance with the local protocol.

   Accepted – The personal officer policy was reviewed in 2009 and is due for a review again in January 2010. Management checks of this will establish how well this scheme is working.

5. I recommend that all nurses have access to EMIS during reception screening so that they can review previous entries and enter the notes of their assessment at the time of the interview.

   Accepted – This is now in place.

6. The Governor and Healthcare Manager should consider introducing a more formalised reception process for prisoners returning from court who are identified as at risk of self harm.

   Partially Accepted – Formal processes for assessment are in place. Assessments are carried out in conjunction with the ACCT process.

7. The Governor should ensure that all Operational Support Grades and other staff working night duties are aware of their roles and responsibilities, especially regarding going into cells in the event of an

emergency.

Accepted – A notice to staff was issued shortly after the death of the man to remind the relevant staff of their duties however this will be reissued in light of this report.

8. The Governor should review Bullingdon's night instructions and other guidance for OSGs contained in the Night Folders. Particular attention should be focused on those procedures relating to the discovery of a death or suspected death, when a cell can be unlocked and the staffing level that is required to do so. The Governor should ensure that all night staff are aware of these instructions.

   Accepted – This work is currently underway.

9. The Governor and Healthcare Manager should ensure that a local protocol is in place that provides clear advice about how and when the Ambulance Service should be called.

   Partially Accepted – Formal process exist however these will be reissued to all staff to ensure consistence of approach no mater what the time of day.