Investigation into the circumstances surrounding the death of a man at HMP Bristol in March 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the circumstances of the death of a man who was found hanging in his cell in HMP Bristol in March 2010. He was 54 years of age.

I extend my sincere condolences to his family and friends for their loss.

The investigation was carried out by one of my colleagues. A clinical review was carried out by the local Primary Care Trust. I should like to thank Bristol's Governor and his staff for their co-operation.

The man was a remand prisoner who had been at Bristol for just six days when he died. On arrival in the prison, he reported that he had attempted suicide two weeks previously and still felt suicidal. As a result, he was placed on the prison's special monitoring and support arrangements which were still in place when he died.

There was a delay discovering the man's death as he had stuffed clothing underneath his bedclothes to make it appear that he was in bed although in fact he was hanging from the end of the bed. (His body was not readily visible from the cell door observation hatch.)

Three letters were found in the man's cell after his death. One was to his family in which he said that he could not "go on" and that the thought of spending any more time in prison was too much for him.

The clinical reviewer has made one recommendation, which I endorse. I make no further recommendations, in part because the Governor has already taken action to remind staff about making proper checks of prisoners when they conduct roll checks.

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 **January 2011**

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SUMMARY

The man was a remand prisoner at HMP Bristol who was found hanging in his cell in March 2010. He had been in prison briefly before. On this occasion he had come into custody six days earlier. He was charged with failing to attend a bail hearing in connection with historical offences regarding sexual relations with a minor. He was 54 years old.

When the man arrived in Bristol on 20 March, he reported that he had attempted suicide two weeks earlier, felt depressed and was still thinking about suicide. Staff opened an Assessment, Care in Custody and Teamwork (ACCT[1]) plan and he was admitted to the prison's healthcare unit for enhanced support

The man spent one day in healthcare. He complained to staff that the unit was very noisy and he asked to move to a standard prison wing. An ACCT review panel was convened on 21 March to consider his discharge from healthcare and all the panel members were content that there seemed no reason why he should not move.

The man was moved to D wing, which is Bristol's vulnerable prisoners' wing (for prisoners who might be at risk from others). An ACCT case review was held shortly after he arrived on D wing, when he said that he felt better and had no present thoughts of self-harm. The staff were reassured by his words and demeanour, although they decided that the ACCT plan should remain open for a while.

Nothing occurred over the following days to cause staff any concern about the man's wellbeing. He had been placed in a shared cell with another man of a similar age and they struck up an immediate friendship.

On the morning of 25 March, the man's cell-mate went to an outside hospital for major surgery. The plan was for him to return to the same cell in due course and, in the meantime, the man would remain the sole occupant of the cell.

At the early morning roll check[2] at 6.00am on 26 March, the man was thought to be asleep and covered entirely by his bedclothes. The cell doors were unlocked about an hour later to allow prisoners to use the showers and to collect their breakfast packs. (At Bristol, packs containing tea bags, cereal, milk, bread and spread are suspended from the external cell door handles allowing prisoners to collect them once the doors are unlocked.)

Over an hour after the doors were unlocked an officer noticed that the man had not collected his breakfast pack. The officer went into the cell to check and found that he had stuffed clothing under his bed sheet to give the appearance of a person asleep in bed. He himself was hanging from a ligature tied to the bed frame. (The end of his bed butted up closely to the front corner of the cell. The oblique angle of vision from the door observation panel to this corner meant that the man's body

[1] ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide.

[2] A roll check is a count of prisoners ensuring that all are alive and are in the correct cells.

could not readily be observed.) When staff examined him, it was apparent that he had been dead for some time and so resuscitation was not attempted.

The man had written three ‘goodbye’ letters which were found in his cell after his death. The most revealing of the letters was addressed to his wife and family. He wrote that the thought of spending any more time in prison was too much for him.

I make no recommendations about the circumstances of the man’s death. I have found that there was no reason why he should have remained in healthcare and the ACCT support was delivered properly. It was a thoughtful decision to allow his cellmate to come back to the cell and meant that he did not have to share with a stranger. Although the staff member making the roll check on 26 March did not see him hanging, the visibility was restricted and the Governor has already reminded staff about checking prisoners who are on ACCT.

THE INVESTIGATION PROCESS

1. An investigator was appointed in this case. He first visited HMP Bristol on 6 April 2010 when he met the prison's Deputy Governor, the Head of Residence, the Head of Operations and a representative from the Prison Officers' Association. The investigator explained the nature and scope of the investigation.

2. The investigator visited the man's cell and was shown around the wing. He examined the man's prison and health records. Notices were issued to staff and prisoners informing them about the investigation and inviting them to contact the investigator if they wished to be involved in the investigation.

3. The investigator subsequently interviewed 13 members of staff and one prisoner. No other prisoners came forward in response to the notices about the man's death.

4. The investigator contacted the Coroner's officer and a copy of this report will be sent to the Coroner to assist her enquiries.

5. The clinical reviewer carried out a review of the man's clinical care and treatment on behalf of the local Primary Care Trust.

6. One of the Ombudsman's Family Liaison Officers contacted the man's wife. She said that her husband was a heavy drinker. She asked if he was suffering from alcohol withdrawal symptoms when he came in to prison and, if so, whether he was offered support. She said that her husband had suffered with depression for some years and she wanted to know if the correct treatment was offered to him. She also said that the family were upset about her husband being left on his own when his cellmate went to hospital. They though he should have been more closely monitored when this happened. I hope that my report offers further explanation into the events leading to her husband's death.

HMP BRISTOL

7. HMP Bristol is a 19th century local prison holding just over 600 prisoners. It receives adult male prisoners and a limited number of young offenders, both convicted and remand, from all the local courts. .

8. The last inspection of Bristol by Her Majesty's Chief Inspector of Prisons was an unannounced short follow-up inspection in March 2008. In the concluding paragraph of the introductory section of the report the Chief Inspector wrote:

> "Managers at Bristol had succeeded in reversing the decline we recorded at the last inspection (in 2005). As a consequence, we were able to raise two of our [assessment ratings]. However, in spite of these efforts, the effects of continued population pressure meant that Bristol was not yet performing well enough in three crucial areas – safety, respect and activity."

9. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. In their most recent report which is for the period 1 August 2008 to 31 July 2009, Bristol's IMB concluded that the prison had improved over the reporting period. The IMB commented on the fact that the prison had achieved 'Level 3 status' (prisons are rated on a scale from 1 and 4 with Level 4 being the highest rating).

10. Since April 2004 when my office took on the responsibility for the investigation of every death in prison custody, there had been five self-inflicted deaths at Bristol before that of the man's. The circumstances of the previous self-inflicted death were similar in that there was a delay in the discovery as that prisoner had also made up his bed to make it appear occupied when he was actually hanging from the end of the bed frame. (He was not in prison at that time and I have no reason to believe that he knew about the earlier circumstances.)

KEY FINDINGS

11. The man was born in Dublin in July 1955. He subsequently left Ireland to move to England and settled in the West Country. He later married and had two children.

12. In early 2007, the man notified officials that one of his brothers might have been involved in criminal activities in his workplace. The brother was subsequently found in possession of goods, apparently taken from work without due authority. The following day the man's brother was found dead at his home. His death was subsequently subject to consideration at a Coroner's inquest when the Coroner recorded a verdict of "suicide while the balance of his mind was disturbed".

13. The man had previously spent time in prison custody, both times in Bristol and both for comparatively minor offences. The first occasion was in 1995 when he was in custody for ten days. The second occasion was in 2009 when he was in custody for 17 days.

14. On Friday 19 March 2010, the man was arrested for failing to attend a bail hearing in connection with a number of offences relating to sexual acts with a minor which were alleged to have occurred many years earlier. The man spent that night in police custody and, on the following morning (Saturday 20 March), he was taken to Magistrates' Court where he was ordered to be remanded into HMP Bristol.

15. During the routine healthcare reception process at Bristol, the man reported feeling depressed, adding that he had a previous history of this illness. He also reported having current thoughts of suicide and said that he had attempted suicide by overdose two weeks earlier. In response, staff opened an ACCT plan. The man denied having misused illicit drugs but reported that he drank very heavily. He was prescribed a number of medicines, including two to help combat depression (fluoxetine and amitriptyline). All of his prescribed medicines were re-prescribed and he was also prescribed chlordiazepoxide for alcohol withdrawal symptoms. Once the reception process was completed, he was moved to the healthcare unit for enhanced support. His ACCT plan detailed that he should be observed by staff once an hour during the day and half-hourly at night.

16. During the early morning of 21 March, a healthcare worker made an entry in the man's records indicating that he had had an untroubled night. A few hours later the man saw one the prison's doctors who made a detailed record of his alcohol consumption and noted that he should be referred to the Counselling, Assessment, Referral, Advice and Throughcare team (the CARATS team assists prisoners with problems of drug or alcohol addiction).

17. The ACCT process includes an in-depth assessment interview between the prisoner and an officer trained as an ACCT assessor within 24 hours of the ACCT plan being opened. The man had an assessment interview with an ACCT assessor on the morning of 21 March. The ACCT assessor told my

investigator that he met him in the healthcare association room. The interview lasted around an hour during which time he spoke about his alleged offences and his feelings of shame. He also spoke about feelings of sorrow for his family.

18. The man reported that he suffered from depression and described himself as an alcoholic. He said that he had attempted suicide two weeks previously. He mentioned that he was finding healthcare extremely noisy and the ACCT assessor told him about D wing. The ACCT assessor explained that D wing was Bristol's vulnerable prisoners' wing, holding prisoners who might be at potential risk from other prisoners. He told the man that it would be best for him to move to D wing and the man agreed. Not long after this interview a nurse recorded that the man asked to move out of healthcare due to the noise.

19. Before a prisoner on ACCT can be discharged from healthcare, a 'pre-discharge case review' must be held. The man attended such a review in the early afternoon of 21 March. The case review was chaired by the segregation Senior Officer (SO). He told my investigator that the segregation unit was adjacent to the healthcare unit and due to the physical proximity he usually chaired ACCT case reviews for prisoners in healthcare.

20. As the segregation SO did not know the man, he tried to find out a little about him before the review. This was in keeping with his usual practice. The segregation SO understood from his enquiries that the man was quiet and nothing had occurred in his first 24 hours in prison to suggest that he would harm himself. The segregation SO also understood that the man wanted to be discharged from healthcare due to the noise. The segregation SO explained to my investigator that healthcare frequently held prisoners with mental health problems and it could be a noisy environment. The other panel members were a Registered Mental Nurse and a Healthcare Assistant, both of whom told that investigator that they could not remember the man. At the review, the man was polite and co-operative and gave no indication of any significant concerns. The segregation SO said that he always took account of the views of the other staff at the review and all agreed that it was reasonable to discharge the man from healthcare.

21. Following the review, the man transferred to D wing where another ACCT case review was held upon his arrival. The purpose of the earlier case review was solely to consider whether the man was fit for discharge from healthcare. This next review was to consider the problems that might be causing him to be having thoughts of suicide or self-harm and what should be done to address these problems.

22. The D wing SO chaired the ACCT case review. He told my investigator that on 21 March he was contacted by healthcare and asked if there was space on D wing for a prisoner who had arrived the previous day and was ready to be discharged. The D wing SO said that it was a regular occurrence for a prisoner to spend their first night in healthcare for initial assessment and to settle into the prison, and for then be discharged within a day or so. There was therefore nothing unusual in about the request for him.

23. The D wing SO said that during the review the man spoke about the support he was getting from his wife. He spoke very coherently and came across as being at low risk of self-harm. The D wing SO noted in his summary of the review that the man felt much better after a shower and a hot meal and that he had no current thoughts of self-harm. However, the D wing SO did not think that ACCT monitoring should cease. In part, this was because the process had only been open for one day. In addition the man had just arrived into prison and had yet to come to terms with everything surrounding his imprisonment. The D wing SO reduced the observations to three times during the day and three times during the night. He noted on the ACCT form that the next case review would be on 28 March. The D wing SO said that the likelihood was that the monitoring would be closed at that review if all remained well in the meantime.

24. The ACCT assessor was also at the review on D wing that afternoon. The ACCT assessor told my investigator that he briefed the D wing SO before the review. At the review the man seemed in better spirits compared to how he had been in the morning.

25. Following the review, the man was moved to a shared cell with another prisoner. The D wing SO told my investigator that the cellmate was a “very sensible” prisoner and of a similar age to the man. He thought that they would get on well and that proved to be the case. He came out of his cell for association that afternoon and his cellmate introduced him to some of the other prisoners. The D wing SO said that his shift ended at 5.00pm that day and, as he was not on duty for the next several days, he did not see him again.

26. The following day, another officer made two entries in the man’s ACCT form. The first was at around midday and the second entry in the afternoon. The two entries were:

    “No problems throughout this morning, appears to be settling in well and getting on with his cellmate. Chatting to staff … Collected his lunch.”

    “Did not attend exercise this afternoon, but no concerns. Collected his tea. Talked to staff and other prisoners.”

27. The officer told my investigator that he thought that he might have been a little apprehensive, but only as many prisoners can be when they first come into prison or as any person would be when in a new environment. The officer thought that might have been the reason that the man declined to go to exercise in the afternoon. The officer asked him if he wanted to go out but the man replied that he was content to stay in his cell watching television.

28. Bristol has a Muslim chaplain who is part of the multi faith chaplaincy team. One of the team meets each new prisoner and the chaplain introduced himself to the man on 22 March and gave him a chaplaincy card with details of the various faiths supported, the names of the chaplains and the times of religious services.

29. My investigator spoke to the cellmate who briefly shared a cell with the man. He said that he had been the sole occupant of a double cell on D wing when the man joined him on 21 March. He said that they were similar in many respects and they formed an immediate bond. The man was apprehensive, but only in the sense that he found himself in an alien environment. The cellmate introduced the man to some of the other prisoners on the wing and he thought that he would have settled if "he had given it a chance".

30. The man's cellmate was on a list awaiting heart bypass surgery and, on the night of 24 March, was told that he would be going out to hospital the following day. He told the man about this and he replied that it was a shame as they were getting along so well. The cellmate told the man not to worry as he would return from hospital in a week or so and would come back to the same cell. (Officers confirmed with my investigator that it was their intention to reserve his bed pending his return.) The cellmate said that he did not anticipate that the man might take his life.

31. Another officer told my investigator that he was the workshop instructor for workshop 3. He said this was a workshop restricted to prisoners from D wing with a woodwork section and a section that recycles spectacles for distribution to developing countries. He added that one of his other tasks was to supervise D wing's morning medication queue. He said that he saw the man in the queue on the morning of 25 March and thought that he would fit in well in the workshop as he was mature in years, quiet and polite.

32. The workshop instructor introduced himself to the man and asked him if he would be interested in coming to the workshop. He told the man that he would come to the workshop with other D wing prisoners. The thought for a few seconds and accepted the offer. The workshop instructor then went to collect a radio and by the time he returned to D wing the labour move was underway. (The labour move is when prisoners who work or attend education are escorted to their workshops and classrooms.) The man approached the workshop instructor that he had changed his mind and did not want to take a job. Remand prisoners are not required to work and the man did not explain his reason for changing his mind. The workshop instructor told my investigator that it is not uncommon for prisoners to turn down the offer of a job. He said that there was nothing about the man's refusal, or his demeanour to cause him concern.

33. Another of the wing officers met the man on 24 March and made two entries in the ACCT plan that day suggesting that the man was settling well into the wing. At midday on 25 March, the officer made a third entry in his ACCT saying:

> "Collected lunch and hot water … refused a job due to his mental state but seems in good spirits. Asked to make a phone call at teatime."

34. The officer told my investigator that the man approached him that morning saying that he had been offered a job in workshop 3 but he did not want to take it. He made a comment along the lines that it was due to his "nerves", or that his "head was not right". The officer said that his interpretation of what the man

had said was simply that he was still "finding his feet" and was not yet ready to take a job. The officer spoke to the man once more later that day when he was sitting in his cell eating his evening meal. The officer asked if he had everything he needed and the man replied that he had.

35. My investigator asked the officer about the man's request to make a telephone call as his understanding was that he had made no calls. The officer explained that, due to the nature of his offence, it was likely that the man would have been barred from making telephone calls pending approval and clearance of each individual number by the prison's Public Protection Unit. The officer added that the process takes several days to complete.

36. The ACCT assessor made entries in his ACCT plan in the late afternoon and early evening of 25 March. These were:

> "… stayed in cell all afternoon, didn't want exercise due to poor weather. Said he is fine."
>
> "… collected his meal and medication. Stayed in cell this evening watching TV. Said he is fine."

37. The ACCT assessor told the investigator that the man did not spend much time out of his cell, preferring instead to stay in his cell watching television. The ACCT assessor had no reason to believe that the man was frightened of other prisoners as he did see him associating on occasions. He added, however, that when all the prisoners are unlocked for association it can be very noisy which is "not to everyone's liking". The ACCT assessor said that the last time he saw the man was when the nurse came to issue the evening medication at around 7.30pm. The ACCT assessor un-locked the man's door and asked him how he was. He replied that he was fine and the ACCT assessor wished him goodnight and re-locked the door.

38. An Operational Support Grade[3] officer told my investigator that he works permanent nights and his primary role is to check and patrol prison wings. He said that he arrives at the prison at just after 8.00pm and his first task is to carry out a roll check. At that point he introduces himself to any prisoners with open ACCT plans. On the night of 25 March, the OSG recalled that the man was watching television when he first encountered him and he acknowledged his (the OSG's) greeting.

39. The man was still awake at 11.00pm, which was the time of the first ACCT check for the night. At the next check at 2.30am, the OSG noted that the man appeared to be asleep lying on his right hand side. At the final check at 6.00am, the OSG noted that the man appeared to be asleep and was lying on his left hand side.

[3] The Operational Support Grade (OSG) does not receive the same level of training as prison officers and has limited direct contact with prisoners.

40. Another officer told my investigator that he was working a day shift on 26 March and arrived on D wing at about 6.20am. By that time the OSG had carried out the morning roll check to confirm that the correct number of prisoners were in the cells. The officer said that he was not required to conduct a reconciliation check to make sure that the night staff figures were correct, but he did check the three prisoners on open ACCT plans including the man. He said that it was still fairly dark at that time and he therefore switched on the low wattage in-cell lights so that he could see inside. Once he had done that, the OSG was able to go home.

41. My investigator asked this officer about his practice when making such checks to assure himself that each prisoner is alive and well. The officer said that he would "hope to" observe some movement to confirm the prisoner is well but it would not "be considered acceptable these days to bang on the door" to wake the prisoner. The officer made an entry in the man's ACCT plan at 6.40am saying:

> "Checked on handover from night patrol. Appears to be asleep. [Nothing to report]."

42. Following the usual practice, staff unlocked the cell doors at just after 7.30am, leaving the doors slightly ajar. Breakfast packs were hung on the external door handles for prisoners to take and consume inside their cells. The ACCT assessor told my investigator that at around 8.25am he began to go around the wing relocking the doors of prisoners who did not work and leaving open the doors of prisoners who would be going on labour movement.

43. As the ACCT assessor approached the man's cell, he noticed that the breakfast pack had not been taken. He went into the cell and once inside, noticed that the bulge that he had assumed to be the man in his bed "did not look right"[4]. The ACCT assessor then saw the man in a slumped position hanging from a ligature tied to the end of the bunk-bed.

44. The ACCT assessor shouted for assistance and announced a Code Blue[5] incident on the radio. The man had used a bed-sheet to form a ligature and he used his anti-ligature knife to cut the sheet. (An anti-ligature knife is specifically designed to cut tough or thick material. The blade is enclosed within a toughened plastic moulding to prevent it from being used as an offensive weapon.) The man was wedged between the wall and the bed so he did not fall to the floor when the ligature was cut.

45. Other officers came into the cell. One checked for his pulse but could not find one. A nurse entered the cell within two minutes of the Code Blue call being called. She subsequently made the following entry in the man's clinical record:

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[4] The man had stuffed clothing beneath his bed cover to make it appear that he was lying in bed.

[5] A Code Blue incident indicates an emergency incident where a prisoner is hanging or otherwise has significant breathing difficulties.

> "Attended Code Blue at [approximately 8.25am]. On entering the cell [the man] was hunched over the end of the bottom bunk, ligature around neck. I immediately checked if there was a pulse, I was unable to find one and I listened for breathing. He was very cold and stiff to touch, he was unrousable. At [approximately 8.30am] another nurse attended. I asked her if she could double check for a pulse, she also was unable to find one. Doctor arrived … [approximately 8.40am], he checked for a pulse and listened for breathing, confirmed [death]."

46. The man had named his wife as next-of-kin and in the late morning the duty governor, together with a colleague, drove to her home in Swindon. The duty governor told my investigator that there was no answer when they pressed the doorbell, nor did they get a reply when they rang the mobile telephone numbers for the man's wife and his adult son. The duty governor said that they tried without success to obtain information from neighbours about the family's whereabouts.

47. The man's son then telephoned the duty governor, having realised he had 'missed a call'. It emerged that he worked night shifts and had been asleep in his parents' home. The duty governor and his colleague went back to the house to break the news. The son explained that his mother worked in a factory and it would not be easy to contact her at work without causing great worry. He thought it best to wait for her to finish work as normal and he would break the news to her when she got home.

48. The duty governor subsequently spoke by telephone to the man's wife as well as visiting her at her home. He returned to the family the man's belongings and cash. The family subsequently visited the prison. The family were told that the prison would assist with the funeral expenses. At the family's invitation, the duty governor attended the funeral where he met other family members.

49. The man's cellmate was notified in person about his death. The prison held a hot debrief on the morning of the death for the staff to share information and the support of the prison care team was made available to them. A cold debrief was held later to consider any potential learning points.

50. Three letters were discovered in his cell after his death. One letter was addressed to his wife and children. He referred to his love for them all and of his grandchildren. He explained, however, that he could not face the prospect of spending any more time in prison. He also wrote that: "… even if I got out of prison next week, it will still be hanging over me …". Another letter was a brief farewell to his cellmate with whom he had shared a cell for several days. The final letter was addressed to the victim of his alleged offences.

ISSUES

The man's brief stay in healthcare

51. Once he had gone through the reception process after arriving at Bristol, the man was placed on the healthcare unit. This was intended to provide enhanced support, given the concern over his potential risk of self-harm. He remained in healthcare for less than 24 hours before being transferred to D wing.

52. It was the man who hastened his own departure from healthcare. He found it to be a noisy environment and so he asked to move out. Before his move was sanctioned he attended an ACCT review to consider his fitness for discharge. He was found suitable for discharge and, when he arrived on D wing shortly afterwards, another ACCT case review was held. Staff on D wing did not consider the man to be at high risk and saw no reason to suggest that he should return to healthcare. He was clearly discontented with healthcare and I am satisfied that to transfer him out was the correct thing to do.

Assessing the man's risk of harming himself

53. When the man was seen in reception at Bristol, he reported that he felt depressed and suicidal and disclosed having attempted suicide a fortnight before. An ACCT plan was opened and he was moved to healthcare. The level of staff observations did not suggest that they thought him at especial risk: he was to be observed once an hour during the day and twice per hour at night.

54. Having spent the first night in healthcare, the man was moved the next day to D wing where he attended an ACCT case review. The D wing SO chaired the review and his evidence was that the man was not giving any indication that he was at heightened risk. The ACCT observations were reduced to three times in the day and three times at night. This is the level at which the observations remained from this time onwards.

55. The man was then moved to a shared cell. Staff believed that he would get on well with his cellmate and this proved to be the case. This was confirmed by the cellmate whose evidence included that the man seemed apprehensive at being in a strange environment, but the cellmate thought that he would settle down.

56. Staff had quite a lot of contact with him over the course of the next several days. A lot of the contact was driven through the requirements of the ACCT process, but that was not the only reason. For instance, the workshop instructor happened to notice him in the medication queue and spoke to him about taking a job. He was also seen by staff, including a chaplain, as part of the induction process. None of the staff in their interactions with the man recognised any signs suggesting that he was at high risk. Nor, of course, did his cellmate. I am satisfied that staff made appropriate judgements based upon the information before them.

Whether the man should have been allowed sole occupancy of a cell

57. When the man's cellmate went to hospital for his planned operation, the man remained as the sole occupant of the cell. The two had struck up an immediate friendship and the plan was that the cellmate would return to the cell on his discharge from hospital. This was anticipated to be around seven days later. I believe that this was a thoughtful decision for the sake of both prisoners, which meant that he did not share with a stranger. However, it did mean that he would remain the sole occupant of the cell for a period of time.

58. Prison Service Order (PSO) 2700 deals with suicide and self-harm prevention and it includes guidance on the ACCT process. The PSO advises that cell sharing is recognised to be a protective factor against suicide as it can help to reduce feelings of loneliness. In addition, the cellmate will be able to alert staff if they are concerned about their companion. The PSO also acknowledges however, that a single cell might be appropriate where the risk of self-harm is low and that the decision on where to locate any prisoner must be based on individual need.

59. Although he was on an open ACCT plan when his cellmate went into hospital, the man was not believed to be at significant risk of harming himself, so there was no obvious reason for him to be placed with another prisoner pending his return. Although being the sole occupant increased the opportunity for him to harm himself, I have not seen anything to suggest that the likelihood would be higher because the man was on his own.

Roll checks and checks of prisoners on ACCT

60. The instructions at Bristol stated that when conducting the morning and night roll checks (at 6.00am and 9.00pm respectively) staff should:

    "… assure themselves that prisoners are in cell by obtaining a clear view of their faces – if necessary by waking them."

61. The instructions on observation of prisoners subject to suicide/self-harm monitoring through the ACCT process stated that at the time of each check staff should note the prisoner's position, whether they are awake or asleep and noting any exchange of conversation. The instruction goes on to say that, if it was not possible to view the prisoner, every effort should be made to gain a response from him. However, if it was not possible to obtain a response, the duty officer in charge should be contacted.

62. The evidence of the OSG was that the man was still awake at 11.00pm (on 25 March) but was asleep at the time of the two subsequent checks – sleeping on his right hand side at 2.30am and on his left hand side at 6.00am. When interviewed by my investigator, the OSG said that he was not sure before the man's death whether he knew about the instruction about viewing prisoners' faces. He had since been reminded of this instruction. He added that the problem with the instruction was that prisoners often wrapped themselves up in

their bed clothing. He did not recall seeing any movement, or gain a response or notify the duty manager.

63. After the 6.00am roll check, cell doors are opened by the day staff at around 7.30am. Staff do not conduct a roll check at that time.

64. The man was not found hanging until almost 8.30am and was only found then because the ACCT assessor noticed that he had not taken his breakfast pack. We do not know when he died, but the condition of his body when found suggests that he probably died some hours before. Precisely when he died, however, would be speculation and it cannot be said for certain whether he was already dead at the time of either the 2.30am and 6.00am checks.

65. In direct response to his death, Bristol's governing Governor issued an instruction to staff about the monitoring of prisoners on open ACCT plans. Staff were informed that they need to obtain full sight of the prisoner through the night. If a prisoner's face cannot be seen nor any sign of movement detected for a time, staff must obtain a response from the prisoner. Failing that, staff must enter the cell to check on the prisoner's wellbeing.

66. The instruction went on to say that:

    - Where [the prisoner's] … cell sharing situation changes [e.g. his cell mate is sent to court, transferred etc], this must be considered as a change in circumstance with possibly a raise in risk. As such he must be assessed by the unit manager and the result of that assessment recorded in the ACCT.

    - All [prisoners on] ACCT should be checked at unlock … by staff speaking with them. Those not subject to ACCT must be visually accounted for, as a minimum, by the unlocking staff."

67. In the light of the action already taken by the Governor, I make no recommendation of my own.

Clinical care

68. The clinical review found that the man received appropriate care and treatment. Specifically, the clinical reviewer found that the healthcare team's initial assessment of the man's level of risk was in depth and covered the appropriate issues. The clinical reviewer found that there was evidence of good practice in assessing and managing the man's stated alcohol consumption. Nothing was recorded to suggest that he suffered any withdrawal symptoms. The clinical reviewer also found that the man's risk of self-harm was managed appropriately through the ACCT process. He has however commented that there is some evidence that individuals with a history of high consumption of alcohol might be at higher risk of self-harm. He recommends that consideration should be given to enhanced levels of supervision of prisoners who have withdrawn from high volumes of alcohol.

CONCLUSION

69. It seems clear from the letter that the man wrote to his family that he did not wish to spend any more time in prison. Nor, perhaps, did he wish to carry on living given the allegations that had been made against him. The letters were found after he died and prison staff were not aware of his thought processes. The man had reported having suicidal thoughts when he came into prison, and the ACCT support was put in place. Reviews and monitoring took place as expected and, less than 24 hours later, he spoke about feeling better.

70. The man was left alone in his cell when his cell-mate went to prison, but nothing occurred in the following days to cause any staff to be concerned about him. His death surprised both the staff and his cell-mate. The Governor has already reminded prisoners of what is meant by ACCT checks, and so I make no recommendations in my report.

RECOMMENDATIONS

71. The following recommendation was made by the clinical reviewer, which I endorse: The Service response is included in italics below the recommendation

    1. The Head of Healthcare should consider a greater degree of supervision of patients who have withdrawn from extreme volumes of alcohol.

       Recommendation accepted: All prisoners are screened for alcohol misuse in reception and then again in the secondary health screen completed 48 hours later. This determines the care pathway that they should then follow. They will then transfer to IDTS (Integrated Drug Treatment System) for monitoring and to commence a regulated detoxification programme. These care pathways ensure that this group of patients have a greater degree of supervision and support.