Investigation into the circumstances surrounding the death of a man at HMP Bristol in May 2008

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is the report of an investigation into the apparently self-inflicted death of a man in the custody of HMP Bristol on 8 May 2008. On 7 May, he was arrested at his parents' home and taken into police custody. The next day, he was sentenced to 27 months for perjury. He was taken to HMP Bristol where he died eight hours later. The man was 26 years old, and had been addicted to heroin for ten years. It was his first time in prison.

I offer my sincere sympathies to the man's parents and sister, and to all those affected by his loss. I must also apologise for the delay in completing this investigation. I trust this report will address all the concerns that the family has raised.

I appointed an investigator from my team to investigate the circumstances surrounding the man's death on my behalf. I would like to thank the Governor of Bristol and the investigation liaison officer for the support they gave to the investigation process.

I am also grateful for the clinical review conducted into the man's medical care for the short time he was in prison, commissioned by Bristol Primary Care Trust (PCT).

I was seriously concerned by what this report reveals about reception procedures at HMP Bristol, and I understand they are now under review. My report also examines the prison's new detoxification unit, opened just two days before the man died, and where he was found hanging.

While in court cells, the man had been subject to constant supervision and a suicide and self harm warning form had been completed. In retrospect, it is utterly clear that the man should also have been subject to monitoring and support under the Prison Service's ACCT system. I make six recommendations.

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

CONTENTS

Summary	4
The Investigation Process	6
HMP Bristol	7
Key Events	8
Issues	17
Conclusion	26
Recommendations	27

SUMMARY

The man was taken into custody by the police on 7 May 2008. He had failed to appear for court in April in connection with a charge of perjury. The man was in police custody overnight and there were no concerns that he was at risk of self harm. The following morning, he was taken to Crown Court and at 11.00am was sentenced to two years and three months. It was to be his first time in prison.

Despite appearing to be cheerful when he left the court room, the man was later found in his cell by court staff to be in an agitated state. When a court officer noticed red marks around the man's neck, she checked his records and found that he was said to have no previous history of self harm. Nevertheless, she made the man subject to constant supervision and completed a suicide and self harm warning form.

The man was collected from court and taken to HMP Bristol where he arrived at about 1.00pm. The reception officer signed to acknowledge receipt of the court's suicide and self harm warning form, but thought that the man was particularly relaxed considering that it was his first time in prison. He did not open the prison's suicide prevention measures.

While in reception, a nurse conducted a first reception healthscreen during which she identified that the man needed to go through detoxification. (The man had been addicted to heroin for ten years and frequently drank alcohol.) She spoke to him about his physical and mental health and he told her that he had no thoughts of self harm. The nurse did not have the court warning form while conducting the healthscreen, but was given it afterwards. The nurse spoke to the man about the court staff's observations and he assured her that he was not thinking of harming himself. Despite noticing red marks around the man's neck, and taking into consideration his other risk factors, the nurse did not start suicide prevention measures either. She filed the warning form in a later section of the clinical record and made no note of it.

Two days before the man's arrival, Bristol had opened a new drug treatment unit intended to assess and treat a prisoner's substance misuse needs from their first night in custody. Following the reception nurse's assessment, the man was due to be transferred for detoxification. Before he was moved to the new unit, he had a first night interview with an induction officer in reception. He told the induction officer that he had no thoughts of self harm. The induction officer neither saw the court warning form nor noticed the red marks around the man's neck.

The induction officer escorted the man to the new drug treatment unit at about 3.00pm. They arrived as medication was being distributed so no staff from the unit were free to look after the man. The induction officer was asked to locate him in an empty cell, which he did. The treatment hatch on that cell's door was too high, which obscured some staff's view into the cell. There was also a nail affixed to the wall that served no discernible purpose. The man passed the afternoon in the cell, leaving it once to collect his meal.

The new unit's routine was running late that day. At about 7.00pm, the man was one of three prisoners taken for assessment by the doctor. The doctor prescribed chlordiazepoxide and a low dose of methadone (medication used for detoxification). He made a mental health assessment and did not assess the man as at risk of suicide or self harm. The doctor did not see the suicide and self harm warning form, although he did have the clinical record. In interview, he remembered that there were no red marks on the man's neck.

A prisoner would usually have the opportunity to use the telephone after he has seen the doctor. However, as the regime was running late, the man returned to his cell at about 8.30pm without using the telephone. He was discovered hanging in his cell less than an hour later during the distribution of medication. He had attached a ligature to the nail in the wall. Following resuscitation attempts, the man was taken from the prison in an ambulance. Sadly, he died before he reached the hospital.

My investigation explores the assessment of the man's risk of self harm throughout his brief time in prison. I make recommendations about the first reception healthscreen process and the consideration of risk in reception. I also examine the man's location in the new drug unit, and the physical environment of that unit, and make related recommendations.

THE INVESTIGATION PROCESS

1. I appointed one of my investigators to lead the investigation into the man's death. The investigator visited Bristol on 15 May and met the Deputy Governor, Chaplain, and representatives from the Independent Monitoring Board, the Prison Officers' Association and the Prison Governors' Association. The liaison officer for the investigation provided the investigator with copies of the man's records and arranged for her to be shown around the prison. Notices were posted around the prison inviting staff and prisoners to contact the investigator with any matters of relevance to the investigation. There was no response to the notices.

2. I am grateful to Bristol Primary Care Trust for the commission of a clinical review into the care that the man received during his short time at Bristol. After a review of the paperwork, the investigator and the clinical reviewer returned to Bristol on 17 June to carry out interviews with healthcare staff.

3. During the course of the investigation, matters came to light relating to reception procedures that required urgent attention to ensure the continued safety of prisoners. My investigator kept the Governor informed of such matters as they arose so that he could take action as required.

4. Two prisoners arrived at Bristol at the same time as the man but had been transferred by the time of the investigation. The investigator wrote to them asking for their views on the reception process. Unfortunately, they did not respond to her letters.

5. The Detective Constable (DC) who led the police investigation into the man's death interviewed the court staff and escort officers who had contact with the man on 7 and 8 May. The investigator liaised with the police, who kept her informed of her findings. The DC provided the investigator with the statements taken from court and police staff who had contact with the man in the 24 hours before his death. I am grateful to Avon and Somerset Constabulary for their support during the investigation.

6. My Senior Family Liaison Officer, accompanied the investigator on a visit to visit the man's parents on 25 June. I would like to thank them for their contribution at such a sad time in their lives, and I trust that this investigation report answers their questions.

7. Further interviews were carried out with staff in August and September and the investigator met the operational lead from the Department of Health to discuss the Prison Service's delivery of substance misuse services.

HMP BRISTOL

8. HMP Bristol is a local prison, located in a largely residential area in the middle of the city. It can accommodate up to 606 adult male prisoners. Her Majesty's Chief Inspector of Prisons, Dame Anne Owers, carried out her most recent full announced inspection of Bristol in 2005. The prison, especially in respect of prisoners' detoxification, has changed a great deal since then. At the time of her inspection, the Chief Inspector found that "the clinical management of the detoxification processes was effective," although prisoners undergoing detoxification spent too much of their day locked up. She recommended:

    > "Prisoners undergoing detoxification should be in an environment where they can be observed by specialist staff and have access to a supportive regime. A dedicated detoxification unit should be developed to meet this need."

9. In the Independent Monitoring Board's (IMB's) annual report for 2006/7 they comment, "the physical environment of the reception area is quite unsuitable for the twenty first century."

10. The IMB go on to note the "high quality of staff and prisoner relations". They welcome the commissioning of healthcare by Bristol PCT and the review of the necessary skills mix that accompanied it. The Board consider the new IDTS unit "a requirement".

11. Following my investigator's interim feedback to the Governor, the Prison Service South West Safer Custody Adviser commissioned a review of the first reception healthscreen process. I will discuss the findings of the review later in this report. It is the last annex to the report.

12. The man's death was the only apparently self-inflicted death at HMP Bristol in 2008.

Integrated Drug Treatment Service (IDTS)

13. Bristol opened their dedicated detoxification unit on 6 May 2008. The unit was funded from the new Integrated Drug Treatment Service (IDTS) which has been rolled out nationally over the last two years. The purpose of the dedicated unit is to assess and diagnose prisoners' substance misuse needs on the day of their reception into the prison and provide a structured detoxification programme. Prisoners progress through the regime until they are ready to move to a residential wing. A doctor is assigned to the unit every evening between 6.00pm and 8.00pm and designated nurses are on duty 24 hours a day.

KEY EVENTS

14. The man lived in the Bristol area all his life. He was close to his family, especially his mother, and they spoke every couple of days. Despite his substance misuse problems, his family said that he was never aggressive and they described him as "happy".

15. The man first used heroin when he was 16 years old. On several occasions over the following ten years, he sought medical advice to cope with his addiction, he but never overcame it. He had no criminal record until the events that led to his imprisonment.

16. The man was due to appear in Crown Court on 11 April 2008 charged with perjury. He failed to appear and a warrant was issued for his arrest. For just under a month, the man continued living in the Bristol area but did not present himself to the police. On Wednesday 7 May, the man went to his parents' home. His mother told my investigator that he seemed relaxed but she was worried about his physical appearance. Both parents felt that the man would receive the help he needed to deal with his addictions in prison. They contacted their local police station to notify them of his whereabouts.

17. At about 11.00pm that night, two police constables arrested the man in his parents' home. (Police officers and court staff made statements to Avon and Somerset Constabulary following the man's death, and these were passed to my investigator.) The man was taken to Trinity Road Custody Unit. While on his way to the custody unit, he told officers, "the last time I was in custody I hid drugs in my mouth and I've got something left to eat today." The police officers said in their statements that they thought the man meant he was hiding drugs and ordered a full strip search when he reached the custody unit. The strip search was authorised by a senior police officer. No drugs were found.

18. While police officers were completing the paperwork that evening, the man chatted to them. According to their statements, he seemed "calm and light hearted". He joked with them, asking them to guess what his offence was. The man spent the night at the custody unit subject to hourly checks. (These checks are routine and are carried out for anyone being held at the unit.) None of the officers involved in the arrest or custody of the man that night had particular concerns about his wellbeing.

19. At 8.00am the next morning, two escort officers employed by Reliance Custodial Services, escorted the man from the custody unit to Crown Court. During the journey, the man said he was "tired and a bit cold". He was given his coat to keep warm. According to one of the escort officers, the man "showed no outward signs of any problems". One of the escort officers did not see the man again, but the other stayed at the court to continue her duties. As a matter of routine, the man was checked at least once an hour.

20. The man's solicitor visited him at 9.55am for 15 minutes to discuss his court appearance. At 11.00am, he was sentenced to two years and three months. His parents were at court and told my investigator that they were surprised at the length of the sentence and thought that the man would be too. However, the man's mother remembered him trying to cheer her up as he left the courtroom. He told her not to worry about him and was smiling. The man went back to his court cell at 11.20am.

21. Two court officers were near the cells when the man returned. In their statements, they both recalled that he seemed "upset and agitated". One of the officers went into the man's cell at 11.30am to give the man his lunch. She said: " … he was hiding behind the door, as I opened it he jumped back quickly and put his hands around his neck." One of the court officers gave the man his lunch and then left the cell, closing the door. She asked the other court officer "to keep a close eye" on the man while she checked his records to see if there were any warnings about vulnerability. On checking the paperwork, that court officer found that no concerns had been raised apart from his drug and alcohol misuse.

22. The court officer went back to the man's cell. She and the other court officer then noticed that he had red marks around his neck. The officers searched the man and his cell for any objects that he might use to harm himself. They removed his coat and moved him to a cell where he could be supervised constantly. The first court officer opened a suicide and self-harm warning form on which she wrote the man was displaying bizarre behaviour, seemed very depressed, and had reacted badly to his sentence. (A suicide and self harm warning form records details of the current or past risk of self harm, where relevant, and it accompanies the prisoner as he is transferred to prison.) The officer noted:

> "The man was acting very strange on entering cell. Noticed severe red marks around his neck and looked like he had attempted to strangle himself. Also banging his head on cell wall."

23. An escort officer collected the man from his court cell at 12.30pm. When he arrived at the prison, he was shown to a holding cell to wait for his details to be checked. There were two other prisoners who arrived with him that afternoon and they were called one by one. The man was called to the reception desk and a reception officer checked his personal details. The reception officer had access to the man's prisoner escort record (PER) and his warrant. The escort officer brought a copy of the suicide and self harm warning form to Officer the reception officer's attention because it had not been signed upon his first arrival. The reception officer signed to acknowledge its receipt at 1.00pm. The escort officer took a copy of the form and returned it to the court for their records. The reception officer remembered asking the man about the suicide and self harm warning form and he dismissed the suggestion that he had self harmed while at court. (A cell sharing risk assessment is carried out in reception to determine whether it is safe for a prisoner to

share a cell with another prisoner, or if it would place the prisoner or his cellmate at risk.) Overall, the reception officer assessed the man's risk to others as "low", although noted his substance misuse needs.

24. The man's possessions were recorded and placed in a sealed plastic bag. He was strip searched (as are all prisoners coming into prison) and issued with prison clothing. At about 2.30pm, the man was taken to a private room for his first reception healthscreen. (A first reception healthscreen is an interview by healthcare staff which takes place when a prisoner arrives at the prison. It should determine any physical or mental health conditions that require treatment, any substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.)

25. At the time, the reception healthscreen nurse was a Prison Service nurse who had worked at Bristol since 1997. From 2003, her main duty was to complete first reception healthscreens and train other healthcare staff in their completion. She explained to my investigator that the healthscreen is a conversation with a prisoner. She does "not generally" have the prisoner's custodial file, unless there is some healthcare information from a community or court doctor.

26. The nurse said that the man may have been the first prisoner she interviewed that day and there were only three prisoners in reception at the time. The reception healthscreen nurse asked him about his physical health. He told her that he had not seen a doctor for a few months and had no outstanding appointments. He added that he was not receiving any prescribed medication. The man said that he had problems with "epilepsy or fits". During interview, my investigator asked the reception healthscreen nurse for more information about the type of fits that the man had, but she could not recall the exact detail. She said she thought that his fits were probably related to his use of alcohol, and she knew that the man would see the doctor in the IDTS unit for a further examination later in the day.

27. No concerns about the man's physical appearance were recorded on the healthscreen. The man told the reception healthscreen nurse about his substance misuse. He said that he drank four to five cans of premium lager daily. (According to NHS guidelines this is between 16 and 20 units of alcohol. Men should not regularly drink more than three to four units of alcohol per day.) He used heroin three to four times a day and cocaine/crack on a daily basis. The man had taken drugs intravenously. The nurse remembered he was "pale" during the healthscreen, but otherwise did not observe any signs of withdrawal.

28. The next section of the healthscreen explores a prisoner's mental health and vulnerability. The reception healthscreen nurse asked the man whether he had ever received treatment in the community for mental health problems and he said that he had not. She asked if he had tried to harm himself either in prison or outside prison and recorded that he

had not. The man told the nurse that he was not thinking of harming himself. When asked to record her impression of the prisoner's behaviour and mental state, the reception healthscreen nurse indicated that there was "nil of note".

29. When asked during interview what kind of behaviour she would record in that section, the nurse explained: "if somebody was tearful or crying or very, very low in mood, very poor eye contact, anything like that". If the reception healthscreen nurse thought the man had ever tried to harm himself or was considering self harm, the form would have prompted her to consider opening an ACCT document. (ACCT, Assessment, Care in Custody and Teamwork, is the Prison Service's system used to monitor and support prisoners at risk of suicide or self-harm.) She did not open an ACCT document following the healthscreen.

30. When the healthscreen was complete, the reception healthscreen nurse went on to complete the healthcare section of the cell sharing risk assessment. She did not complete questions one or two of the section which asked whether there was evidence to suggest that the man was at risk of harming others. In response to the question: "following the self-harm assessment have any concerns been raised?" the reception healthscreen nurse responded that none had been identified. However, she went on to write "detox" on the large blank section of the form. The form was then passed to the induction officer who conducted the man's first night assessment and located him in his cell on C-wing.

31. As part of the reception screening, the reception healthscreen nurse took a urine sample to test for drug use. The man's urine sample tested positive for opiates (heroin), cocaine and benzodiazepines (sedatives). The results were known immediately and filed for assessment by the doctor later that day.

32. After the reception healthscreen nurse completed her assessments, the man was shown to a holding room where he waited on his own to be taken to the IDTS unit. A few moments later, the nurse was handed the self harm warning form completed by court staff earlier that day. The reception officer had noticed it lying in the tray where the paperwork is prepared for the healthscreen. He thought the nurse had accidentally left it in the tray but judged it was important and so brought it to her attention. When he did so, the reception officer remembered telling the reception healthscreen nurse that he thought it odd how relaxed the man appeared, despite it being his first time in prison.

33. The reception healthscreen nurse went to speak to the man about the information from the court staff which was recorded on the form. The man told her that he was fine. The nurse noticed that he had red marks around his neck but did not ask him about them. Again, she did not open an ACCT document. She asked the man whether he was going to harm himself and he assured her that he was not. My investigator asked the reception healthscreen nurse whether she considered anything other

than the man's verbal responses, such as his body language, when considering his risk of self harm. She said: "No, nothing else. I just simply went on what he told me."

34. The IDTS unit had opened just two days before the man's arrival at Bristol. It is a discrete wing for prisoners who need to undergo detoxification. Its purpose is to assess a prisoner's substance misuse needs and begin their detoxification on the day of their arrival. Hence, the man was allocated a cell on C wing, which is where the IDTS unit is located.

35. Every prisoner at Bristol goes through a first night assessment with a member of the induction team. For those who are allocated to the IDTS unit, the first night assessment takes place in the reception area. An induction officer carried out the man's first night assessment in private in the holding cell. The man told the induction officer that he was "probably" expecting to be in prison that day, but that this was his first time in prison. He said that he was "slightly concerned" about being in custody and described himself as an "addict". The man told the officer that he had "never" committed any acts of self-harm and he did not feel at risk of doing so. The induction officer recorded that the man was "polite" and "co-operative" during his interview.

36. As part of the assessment, the induction officer asked the man if he felt at risk of suicide or self harm and he assured him that he was fine. During his interview for this investigation, my investigator showed the induction officer the court staff's suicide and self harm warning form. The officer had not seen the form before the interview. He said that if he had seen the warning form he would have discussed it with the nurse and reception staff and started the ACCT process. The induction officer said he had the man's wing history sheet. He also had an induction information pack to give to the man. There was no mention of the suicide or self harm warning form in the papers. During interview with my investigator, the officer could not recall noticing whether there were red marks on the man's neck during their conversation.

37. Sometime between 3.00pm and 3.30pm, the induction officer took the man to the IDTS unit. When they arrived, medication was being dispensed to prisoners. Usually, the officer escorting the prisoner from reception to the IDTS unit would hand over to a nurse who would allocate the prisoner's cell. On this occasion, the nurses were busy dispensing medication and so the induction officer located the man in a cell away from the treatment hatch. The officer said that he walked into the cell with the man and remembered that there were bunk beds in there, joking that the man had the choice of beds. There was a radio in the cell, but no television. The man had the induction pack to read through. The induction officer recalled:

> "I said make yourself comfortable, chill out now, have a fag if you like because he was unable to smoke down in reception and I'd

given him the smokers' pack, he could now have a fag. Gave him all the paperwork, reminded him to read it and then I said shortly you'll be having your tea and then the staff will see to your needs later."

38. My investigator asked the induction officer whether he recalled a nail in the wall opposite the cell door or that the treatment hatch was unusually high. The officer did not recall either of these facts. In fact, there was a nail in the wall next to the window. It served no discernible purpose, but must have been there since the refurbishment of the unit. Some of the cells had also been fitted with incorrect doors, leaving the treatment hatches too high for some staff to clearly make observations. The nurse in charge of the unit told my investigator that there were cells with correctly fitting doors which were used by IDTS staff in preference to those with higher treatment hatches. However, the man was not located in his cell by a member of the IDTS unit and was located in a cell with a higher treatment hatch. The induction officer did not usually work on the unit and had no reason to know about the problem with the doors, and IDTS staff were occupied with the distribution of medication and running the unit's regime.

39. The man's family were concerned that they had not been telephoned by him on the night that he arrived at the prison. They asked my investigator to ensure he had the opportunity to use the telephone. The induction officer had explained the telephone system to him and issued a code to enable him to use the telephone as part of the induction process. The man was given 50p telephone credit, sufficient to make one telephone call, in accordance with normal procedure. The induction officer explained that, on the induction wing, the man would have had the opportunity to use the telephone at tea time, around 5.00pm. The nurse in charge of the unit told my investigator that prisoners normally get the chance to use the telephone once they have had their medical assessment. The man's telephone records show that he made no telephone calls that afternoon or evening.

40. The man remained in his cell for most of the intervening four hours, only coming out to collect his meal. He was not subject to ACCT procedures (the system to manage risk of suicide or self harm) and so he was not checked. Prisoners on the IDTS units are checked at irregular intervals and the nurse in charge of the unit estimated that the man would not have gone for longer than 40 minutes without someone observing him. Observations are not recorded unless there is something of note. No observations were recorded in the man's clinical record that afternoon.

41. At about 7.00pm, the new prisoners on the IDTS unit were taken to the doctor's waiting room. (As part of the IDTS scheme, a doctor must assess the substance misuse needs and mental health of each prisoner requiring detoxification on the unit on the day they arrive.) During his interview with my investigator, the doctor recalled that the man was the last of the three prisoners to be assessed that evening. He used the

“Initial GP Screen”, “Hypno-Sedative Withdrawal Scale” and “Clinical Opiate Withdrawal Scale” to assess and record the man’s symptoms and needs. (These are forms used to record a patient’s symptoms of withdrawal from drugs to assess their level of dependency.) During interview, the doctor said that the man appeared to have mild symptoms of withdrawal, including moist skin, agitation and uncertainty about the date. The doctor had access to the man’s medical record, including the nurse’s first reception healthscreen. The doctor understood that the man would withdraw from alcohol and prescribed chlordiazepoxide to treat the symptoms of alcohol withdrawal. He said that he was satisfied that the man’s urine sample indicated a genuine need for detoxification. The doctor explained that the policy at Bristol is to prescribe a low dose of methadone and gradually increase the amount, in accordance with the prisoner’s needs. He said, “we are very cautious to prescribe [methadone] and of course the patient himself may not give you the accurate dates.” In accordance with his usual practice, the doctor prescribed the man 10mg of methadone that night.

42. The man’s family told my investigator that they were concerned that he had not understood that he would receive methadone that evening. It was their opinion that he would not have self-harmed if he knew he would receive methadone, even such a low dose. My investigator asked the doctor if he explained to the man that he would receive methadone that evening. The man could not recall whether they specifically discussed the dose but was confident that the man knew he was going to receive methadone.

43. As well as assessing the man’s substance misuse needs and prescribing appropriate medication, the doctor assessed the man’s mental health. The doctor is experienced in mental health treatment. He told my investigator that such an assessment will always take into account whether the prisoner is at risk of self-harm or attempting suicide. He said that he examined the head area as a matter of routine and did not see any red marks on the man’s neck. Despite having the man’s medical record to inform his assessment, the doctor did not see the suicide and self harm warning form. It is likely that the document was in the medical record at the time of the assessment. My investigator looked at the original copy of the medical record and a copy of the form was filed in a later section, with no reference made on the front page, entitled “Significant Events”. The doctor did not assess the man as being at risk of self harm. He explained to my investigator that he thought that the man was “not in the slightest” at risk of self harm.

44. The man went back to his cell at about 8.30pm. The doctor and the IDTS nurse on duty that night went to the healthcare centre to collect methadone ready to dispense. Methadone is measured in the healthcare centre and brought over to the unit ready to be dispensed.

45. The doctor remembered that there were only about five prisoners on C wing that night. He put the man’s medication outside his door for ease

and continued to distribute the medication to each prisoner on the wing with the IDTS nurse. The man's was the last cell that they came to at 9.15pm. The IDTS nurse opened the observation panel. Due to the height of the panel, the nurse mistakenly thought that the man was standing by the window with his eyes closed. The nurse called to the man several times. There was no response.

46. The nurse realised that something was wrong and ran to fetch an officer. (Nurses do not carry cell keys during an evening shift.) The doctor also looked through the observation hatch and saw the man hanging. The doctor ran to the telephone in the landing office and dialled 222, the number used to contact the communications room in an emergency. He then made his way to the first landing, down two flights of stairs, to get the emergency treatment kit including a defibrillator. Following a request from an officer, an ambulance was called two minutes after the emergency call at 9.20pm.

47. In the meantime, the IDTS nurse had asked an Operational Support Grade (OSG) to open the man's cell for him. The OSG looked through the observation hatch and saw the man hanging. He could see a white ligature that "looked like a sheet" around his neck. The OSG made a radio call of "Code Blue" which means medical emergency - breathing difficulties. He then asked for permission to break the sealed pouch issued to staff on a night shift which contains a cell key. Permission was granted and he went into the cell. The OSG took the man's weight and cut the ligature with the anti-ligature knife attached to his belt. The IDTS nurse and the OSG lowered the man to the floor. The OSG removed the ligature from around the man's neck and started chest compressions, while the IDTS nurse performed mouth to mouth resuscitation.

48. The doctor returned to find the two members of staff performing cardio-pulmonary resuscitation (CPR). The doctor applied the defibrillator, which instructed him not to use it. The doctor thought that the defibrillator was not in full working order so he instructed the nurse to obtain another defibrillator. The doctor took over chest compressions and administered the ambu-bag (a device used to introduce oxygen via the mouth). The doctor then applied a second defibrillator but there was still no cardiac activity and he was again instructed not to shock.

49. The paramedics arrived around 20 minutes after the ambulance was called.

50. An officer was stationed by the prison gate ready to escort the ambulance and the paramedics to the man's cell. The paramedics took over resuscitation attempts, and the doctor remained in the cell. During interview, he said that the paramedics' treatment was excellent. They inserted an airway into the man's throat and, due to a small output on their heart monitor, decided to take him to hospital. The officer by the gate was asked to help the OSG carry the man downstairs on a stretcher.

51. The doctor said in interview that he was not optimistic about the man’s chance of survival when he left the prison. In fact, the paramedics stopped CPR in the ambulance. The officer accompanying the man rang the prison at 10.17pm to tell them that the man had been pronounced dead. The ambulance continued to the hospital and a hospital doctor certified the man’s death on arrival at 10.35pm.

Contact with the family

52. The man’s parents were informed of their son’s death at about 1.00am. As noted, the prison had been informed at 10.17pm by the officer who had gone with the man in the ambulance. However, the police advised prison staff not to break the news to the family without a police escort. Prison Service Order (PSO) 2710 – Follow Up to Deaths in Custody (the Prison Service’s guidance for family liaison) recommends that the news of a prisoner’s death should be given in person by a Prison Service representative. The PSO goes on to acknowledge that the police may advise that an escort is necessary.

53. Given the police advice, it was appropriate for the prison to wait for a police escort before breaking the news of his death to the man’s family. Unfortunately, the police did not arrive at the prison to escort the chaplain and the prison family liaison officer (FLO) to the man’s family home until 12.30am. Although the prison FLO was the designated family liaison officer, the family requested that their main point of contact should be the Chaplain.

54. After breaking the news, the chaplain returned to the prison for the hot debrief. (This is a meeting between all staff involved in a death in custody to discuss what happened and share any concerns.) The meeting was convened at about 4.00am. Around five minutes into the meeting, the man’s family arrived at the prison, wanting to speak to someone regarding their son’s death. The Duty Governor asked the chaplain and the Night Orderly Officer to meet them. The family were told that due to security restrictions, they could not come inside the prison during the night. They agreed to return the next day.

55. The family were particularly concerned by the Night Orderly Officer’s manner during their exchange. They felt that he did not take their situation seriously. When my investigator put this to him during interview, the Night Orderly Officer was surprised that they had interpreted his manner in that way. He assured my investigator that he tried to deal with the situation sensitively. The Night Orderly Officer has not had training in family liaison, but I trust that he did his best and the family misunderstood his manner. Although my investigator did not speak to the Duty Manager during the investigation, he responded to this issue following the advance disclosure of the report. The governor explained that his decision not to speak to the family personally was based on “a number of reasons, including the security of the prison,

following contingency plans and the care of staff". However, I am still surprised that the Duty Governor did not speak to the family himself. If such a tragedy should occur again in the future, I would expect the most senior member of staff in the prison to deal with it personally.

56. The following morning, the Governor, Deputy Governor and Head of Residence met the family. The family asked to visit the cell where the man had died and collect his property. Their visit was arranged for the following week. The Governor offered to pay for the man's funeral expenses, in accordance with national policy.

57. The man's family were concerned that the information they received on the early morning visit to the prison was inaccurate. They had been told that the man had been found hanging by a doctor, but their understanding was that no doctor worked in the prison at such a late hour. In fact, the IDTS unit requires that a doctor is on site from 6.00pm until 8.00pm every evening. The late running of the newly opened unit meant that the doctor was still carrying out his duties at the late hour of 9.15pm.

58. In addition, his parents were also worried that the man was able to hang himself from what appeared to be a nail left in the wall during the refitting of C wing. Understandably, they found it hard to believe that the man's risk of self-harm or suicide had been identified at court, but that this risk was not monitored at the prison. I will examine these matters in detail later in the report.

Staff Support

59. As I have said above, a hot debrief was held at 4.00am. It is a difficult balance for prison management to hold a timely meeting in such circumstances without compromising the police investigation or placing too great a demand on staff. Staff all told my investigator that they understood that the debrief was necessary and they found it helpful. They said they were well-supported on the night and could access the staff care and welfare team if they needed to.

ISSUES

Should the prison have identified the man as at risk of suicide?

60. The man was identified as at risk of self harm at Crown Court. He was subject to constant supervision in the court cell. Information about his alleged attempt to harm himself was recorded using the suicide and self harm warning form. The reception officer acknowledged receipt of the warning form when he interviewed the man in the reception area of the prison, shortly after his arrival.

61. The reception officer told my investigator that he remembered the form and had asked the man about it. He is experienced at working in reception. Upon receipt of such a form, the reception officer told my investigator that he assesses a prisoner's risk of suicide or self harm. He said that he remembered the man as being surprisingly relaxed about his first time in prison. He recalled seeing red marks on the man's neck but described them as "superficial", as if the man had repeatedly rubbed his neck. The officer did not think the marks could have been a result of self harm.

62. The reception officer is trained in ACCT procedures. However, he said that when he considers a prisoner to be at risk of self harm, he usually brings it to the attention of the first reception healthscreen nurse rather than opening an ACCT himself. Taking into account the man's relaxed demeanour and his denial of thoughts of self harm, the reception officer did not consider the man at risk of harming himself. The reception officer put the self harm warning form with the man's file ready to be collected by the nurse for the first reception healthscreen and did not bring it to her attention at that time.

63. Prison Service Order (PSO) 2700 – Suicide Prevention and Self-Harm Management sets out the requirements for managing prisoners identified as at risk of self harm. There is a section in the PSO relating to prisoners who have been received into prison with a suicide or self harm warning form. The warning form is on carbon paper which duplicates three times. The top white copy should go into the clinical record. The third pink copy goes with the escort staff, and was taken by the escort officer in this case. The PSO requires that the second yellow copy should go into an ACCT document, if one is opened. If an ACCT is not opened, then the yellow copy of the suicide and self harm warning form should be put in the core record. A note should also be made in the case notes section of the wing history record. The reception officer did not put a copy of the suicide and self harm warning form into the man's core record.

    The Governor should remind reception staff of the requirement to file a copy of any suicide and self harm warning form in the prisoner's core record.

64. The nurse that completed the first reception healthscreen told my investigator that the purpose of the healthscreen is to determine the immediate needs of a prisoner. The reception healthscreen nurse was confident in ACCT procedures and said she had opened many ACCT documents in her role. According to the reception officer, when the reception healthscreen nurse first collected the man's files to inform her healthscreen, she did not pick up the self harm and suicide warning form. The reception officer remembered noticing the form in the tray and interrupting the man's healthscreen to pass the form to the nurse. The nurse remembered being given the form after the healthscreen had finished. When he gave her the form, the reception officer said he also mentioned to the nurse that he thought that the man's relaxed presentation was at odds with it being his first time in prison.

65. The reception healthscreen nurse said that she assessed the man's risk according to his presentation and what he told her during the healthscreen. During her interview with my investigator, she said that she does not take into consideration a prisoner's body language as a measure of their risk. After being given the self harm warning form, she went to speak to the man in the holding cell. She noticed the red marks on the man's neck but did not ask him what happened at court earlier that day. The nurse acknowledged to my investigator that she knew it was the man's first time in prison, that his substance misuse needed immediate treatment, and that she was aware of the attempted self harm earlier at court. Despite these significant risk factors, the reception healthscreen nurse did not consider the man to be at risk of self harm. The nurse had been employed as a Prison Service nurse at Bristol for 11 years. For the previous five years before the man's death, her principal role was carrying out first reception healthscreens. I am extremely concerned about the reception healthscreen nurse's judgement in this case.

66. During the investigation, the clinical reviewer and my investigator discussed the adequacy of the first reception healthscreen. The clinical reviewer concluded that the reception healthscreen nurse's assessment was "significantly below" the standard needed for a first reception healthscreen. Their conclusions were fed back to the Governor and an agreement was reached that he should consider a disciplinary investigation into the actions of that nurse. In such cases, where recommendations might have an immediate impact on the safety of prisoners, early notice is given to the Governor. When my investigator contacted her liaison officer to explain that a disciplinary recommendation would arise from the investigation, she was informed that the reception healthscreen nurse had already resigned from her post. I therefore make no further recommendation.

67. The reception healthscreen nurse was given the suicide and self harm warning form, she initialled and filed the form in the clinical record. PSO 2700 sets out the following requirement:

> "Upon receipt of the suicide and self harm warning form and the PER, the reception healthcare screener must decide, having spoken to the prisoner and considered all other information available, whether to open an ACCT plan. If the prisoner has self-harmed during the time spent that day (or possibly longer if a new arrestee) under escort supervision, at court, in transit, or while in police custody then the reception healthcare screener must open an ACCT plan."

Despite noticing red marks on the man's neck, the nurse believed his account that he had not self-harmed at court. As a result, she did not open an ACCT, but she should have considered doing so. She assured my investigator that she considered that the man was not at risk of self harm and so did not open an ACCT document.

68. The reception healthscreen nurse did not make any record of the warning form on the front page of the record, which is a sheet entitled "Significant Events". As she was given the warning form after she had completed the healthscreen, she did not amend the first reception healthscreen to record the additional information about the man's risk.

The Head of Healthcare should remind healthcare staff completing first reception healthscreens that all information about risk of self harm or suicide should be noted on the "Significant Events" page of the clinical record.

69. My investigator originally asked the clinical reviewer to write to the Nursing and Midwifery Council with details of the reception healthscreen nurse's involvement in the man's care. During the draft consultation period, the Chief Executive of Bristol PCT clarified that the nurse was employed by the Prison Service and had resigned from her position.

70. The reception healthscreen nurse was the most experienced first reception healthscreen nurse at Bristol. As part of her role, she trained other nurses to complete the assessments. Following my investigator's concerns about the adequacy of this healthscreen, the Governor contacted the South West Prison Service Safer Custody Adviser to review reception, first night and induction procedures. The interim findings were sent to my investigator and are annexed to this report. The review found many areas in need of improvement, particularly information sharing and communication, and made 22 recommendations accordingly. It was discouraging that when my investigator interviewed the Head of Healthcare, she had not been told about the review. I am assured that the Head of Healthcare is now involved in the review process.

71. The clinical reviewer found that the reception healthscreen nurse's understanding of the first reception healthscreen process might have been undermined by the introduction of the IDTS programme two days before. While I acknowledge that the nurse might not have been clear

about the treatment of the man's substance misuse needs, I do not accept that she was unaware of the importance of accurately assessing his level of risk.

72. During the first night assessment, the induction officer said that he did not consider the man to be at risk of self harm. He said that the man was apprehensive, but not unusually so for someone who had not been in prison before. The induction officer had not seen the suicide and self harm warning form before his interview with my investigator. The officer told my investigator that he would have opened an ACCT document if he had seen the warning form.

73. The doctor described his assessment of the man's mental health which included consideration of the risk that he presented to himself. The clinical reviewer commented that the doctor's assessment was "in-depth" and found that the man "did not reveal any undue anxiety or depression". During his interview, the doctor told my investigator that he looks around the prisoner's neck area as part of his assessment and specifically recalled that there was no redness. The doctor did not consider the man to be at risk of suicide, based on information from the healthscreen and the man's presentation.

74. The doctor had the man's clinical record to inform the medical assessment. However, he did not find the suicide and self harm warning form. He said that his judgement would have been different if he had seen the form and he would have started suicide prevention measures. My investigator looked at the original clinical record as part of her investigation. The suicide and self harm warning form was filed in a separate, later, section of the clinical record to the healthscreen. It is likely that the form was in that part of the record when the doctor made his assessment. This reinforces the importance of my earlier recommendation about recording self harm in the "Significant Events" section of the clinical record.

75. Prison Service guidance, entitled "The ACCT Approach", advises staff how to recognise risk. Alcohol or drug misuse, recent suicide attempts, and a longer sentence than expected are all things to be taken into consideration. This was the man's first time in prison and he was withdrawing from heroin. He had been under constant supervision in the court cell, hours before arriving at Bristol. I am concerned about the reception healthscreen nurse's assessment. I am also concerned that the reception officer would always defer to the nurse when considering whether to open an ACCT. I endorse the ongoing South West Safer Custody Adviser's review into the reception process. In the meantime, I make the following recommendation:

    The Governor and the Head of Healthcare should review procedures and training to ensure that staff in reception effectively consider a prisoner's risk of suicide or self harm.

Did the man know that he would be receiving methadone?

76. The man's family found it difficult to accept that he would have taken his life if he had been expecting to be given methadone that night. My investigator asked the doctor if he could remember telling the man that he should expect a dose, but the doctor could not specifically remember that detail of their conversation. The doctor was convinced that the man would have expected to receive methadone following his medical assessment. The clinical reviewer found that there was no evidence to suggest the man was not expecting to receive methadone, but he was concerned at the lack of documentation recording this fact. He made the following recommendation, which I endorse:

    The Head of Healthcare should ensure that details of communication with prisoners about the likely next steps, including medication to be prescribed, should be documented.

Was the man located in the right place?

77. As part of the investigation, my investigator contacted the Department of Health's section head for substance misuse. He explained that the purpose of IDTS is the early identification and treatment of prisoner's substance misuse needs. IDTS was launched in 2006 and continues to be rolled out across prisons. The first IDTS units opened in July 2007. Bristol was in the second wave of prisons to receive funding, which was in April 2007. Bristol therefore implemented the IDTS unit in just over a year, which the Department of Health Head of substance misuse described as "a fairly brisk implementation".

78. In order to implement an IDTS service, a prison must complete a planning tool kit. There are three main factors in respect of safer custody in the planning toolkit for local prisons:

    - There must be a dedicated unit sufficient for each prisoner to stay on the unit for a minimum of five days.
    - There must be unrestricted observation, through large observation hatches on cell doors.
    - There should be a 24 hour healthcare presence, so a night nurse must be on duty.

79. The first night assessment and prescription is also designed to promote safer custody. A doctor carrying out the first night assessment might assess someone as quite comfortable, depending on the amount of drugs still in their system. In this case, they might not prescribe anything. According to the substance misuse lead, "if someone is assessed as in withdrawal then they should get robust medical treatment on their first night."

80. The IDTS programme does not specify that all cells in the units must be safer cells. (Safer cells have specially designed furniture and fittings to

reduce the number of ligature points.) The large treatment hatches in the doors could be viewed as ligature points and may give prisoners access to other points outside the cells. A judgement was made that, on balance, larger treatment hatches on the IDTS units (that enable more effective monitoring and the easier dispensation of medication) would be prioritised over the eradication of ligature points. It should be noted that, even in safer cells, ligature points cannot be entirely removed.

81. The man was located in his cell by an induction officer. It was the third day that the IDTS was in operation and, understandably, the officer did not know the routines for dispensing medication. Ideally, the man would have been met by an IDTS nurse and shown to an appropriate cell. Unfortunately, the induction officer did not know about the problems with the treatment hatches on one side of the unit. Although the higher treatment hatches did not entirely obstruct the view into the cell, it was not ideal and other cells were being used in preference. The IDTS nurse said that he was initially confused when he looked through the treatment hatch and saw that the man was hanging. The delay was moments. I do not think the higher treatment hatch would have affected his treatment or the outcome of resuscitation attempts. However, I am pleased to record that all of the doors were replaced in the month following the man's death.

82. When the induction officer walked into the cell with the man, he did not notice the nail in the wall opposite the door. My investigator spoke to the man in charge of works for Bristol, and also to the Department of Health substance misuse lead about the responsibility to ensure that any such unnecessary ligature points were removed from cells before the IDTS unit became operational. Both were shocked to discover that such a nail could remain in the cell following refurbishment work. However, it was not clear whose responsibility it was to check each cell's fitness for use. Not only was there a nail in the wall, but my investigator found the cell to be in a state of disrepair that was surprising for a newly opened unit.

83. The Department of Health substance misuse lead explained that there is an IDTS performance management structure, with prison health performance indicators. However, the indicators do not refer explicitly to the physical environment of a prison because there are many other performance measures. The only requirements in that respect are that the IDTS unit is dedicated, the size of the unit must meet the needs of prisoners, there should be adequate observation hatches and sufficient healthcare staff are detailed to work overnight.

The Governor and the Head of the IDTS unit should ensure that the physical environment in the IDTS unit is improved to reflect its therapeutic purpose.

Did the man have the opportunity to make a telephone call?

84. The man did not telephone his family while he was at Bristol. He arrived at the unit at a busy time, in the middle of the dispensing of medication. He had no opportunity to telephone his family then and was taken straight to his cell. He collected his dinner and returned to his cell. The next opportunity for a telephone call would have been after the doctor made a medical assessment of the man, but the unit's regime was running late and he was taken straight back to his cell.

85. I am concerned at the possibility that the man had no chance to speak to his family that night. He knew that his mother was concerned about him as it was his first time in prison. My investigator was assured by the nurse in charge of the IDTS unit that the importance of a prisoner's contact with his family on the first night was understood. Efforts were made to ensure that every prisoner had the opportunity to make a telephone call when they first arrive in prison. Although I understand that the IDTS unit was newly opened and its regime was unsettled, I believe that it might have had an unacceptably damaging effect on the man's frame of mind that he could not speak to his mother.

    The Governor and the Head of the IDTS unit should review procedures to ensure that all prisoners have access to the telephone on their first night in prison.

Were resuscitation attempts timely and appropriate?

86. The clinical reviewer found the resuscitation efforts to be an example of good practice and writes that: "The resuscitation was carried out calmly and effectively by the combined team of nurses and healthcare officers and later with the paramedics." I agree that staff reacted quickly to the discovery of the man hanging in his cell.

87. I was particularly pleased to find that an OSG went into the cell and cut the man's ligature. Often in my investigations, Operational Support Grade staff are reluctant to have contact with prisoners. It is to the OSG's credit that he was prepared to act quickly in the interests of trying to save the man's life.

88. I was surprised to discover that a defibrillator was not located on the top floor of the IDTS unit, and one had to be retrieved from three floors down. While I do not think this would have affected the outcome in this case, I hope that consideration will be given to locating a defibrillator in the IDTS office on the third landing of the unit.

89. The doctor requested a second defibrillator because he was worried that the first was not working properly. In fact, the instruction was exactly the same when he applied the second defibrillator. In his interview, the doctor reflected that he was being over-cautious by requesting the

second defibrillator and there was nothing wrong with the first piece of equipment. I recognise the doctor's thorough approach in this matter.

90. In their response to the draft of this report, the family raised the following concern:

> "It is clear that the cell was locked and that permission had to be obtained to get a key to gain access. It may well be that speed was of the essence at that stage. The procedure for opening up a cell and providing immediate medical help at night appears to be somewhat unclear and does not appear to accommodate what might be, as in this case, a medical emergency."

In response to this concern, my investigator contacted the prison and requested sight of any instruction to staff about the use of sealed key pouches. The prison have a clear instruction to staff that is updated annually. The instruction is clear that the Night Orderly Officer must be present before the sealed pouch can be broken to access a key, to ensure that the security of the prison at night is preserved. However, "where there is, or there appears to be, immediate danger to life", the sealed pouch may be broken without the Night Orderly Officer's presence, but the prison's control room must be notified by radio. The prison has far less staff on duty at night, which makes the importance of preserving a secure environment to manage prisoners crucial. It is reasonable that staff should notify the central control room that they are breaching the night state to enter a cell at night. However, it is also reasonable that this situation was deemed sufficiently life-threatening to break the sealed pouch.

CONCLUSION

91. The man's short time at Bristol came at a time of change for the prison, especially in its approach to detoxification. But that cannot excuse the failings that this investigation has revealed. Tragically, the inadequate reception healthscreen, incomplete communication of the man's behaviour at court, and a poorly prepared physical environment, meant that little was done to safeguard him from the risk that he presented to himself.

92. Had a properly informed assessment been made at the time, it is manifest that the man would have been monitored and supported under the ACCT system.

RECOMMENDATIONS

The Prison Service did not send a response to these recommendations prior to the issuing of the final report. The Chief Executive of Bristol Primary Care Trust, wrote to my investigator describing the recommendations as "reasonable" and assuring her that the Head of Healthcare had already begun to address some of the issues raised.

1. The Governor should remind reception staff of the requirement to file a copy of any suicide and self harm warning form in the prisoner's core record.

2. The Head of Healthcare should remind healthcare staff completing first reception healthscreens that all information about risk of self harm or suicide should be noted on the "Significant Events" page of the clinical record.

3. The Governor and the Head of Healthcare should review procedures and training to ensure that staff in reception effectively consider a prisoner's risk of suicide or self harm.

4. The Head of Healthcare should ensure that details of communication with prisoners about the likely next steps, including medication to be prescribed, should be documented.

5. The Governor and the Head of the IDTS unit should ensure that the physical environment in the IDTS unit is improved to reflect its therapeutic purpose.

6. The Governor and the Head of the IDTS unit should review procedures to ensure that all prisoners have access to the telephone on their first night in prison.