Investigation into the circumstances surrounding the death of a man at HMP & YOI Bristol in August 2011

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

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 August 2011. He died three days later whilst in outside hospital. He was 23 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 investigators. A clinical reviewer was asked by the local Primary Care Trust to undertake a review of the man's clinical care, and I am grateful for his contribution to the investigation. I also thank Bristol's Governor and his staff for their co-operation.

Having been arrested and charged with murder, the man was remanded into the custody of HMP Bristol to await further court hearings. This report covers his time in prison prior to his death, the events on the day that he died and the actions of all the people involved in the incident. He had been at Bristol for around three months when he died.

Staff had contact with the man on the morning of his death, around 40 minutes before he was discovered hanging in his cell from a ligature. At that time, he had given no indication to anyone that he intended to harm himself.

The investigation highlights the good quality of care that the man received in prison which compares well to that which he would have received within the community. On a number of occasions appropriate suicide prevention measures were put in place to support him, who frequently said he would not harm himself and about whom there was no evidence that he had ever previously harmed himself. He was clearly a troubled young man, extremely unhappy with the situation he found himself in, but, despite a high level of interaction with staff, this investigation has found that his tragic actions were unexpected.

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.

Nigel Newcomer CBE
Prison and Probation Ombudsman **April 2012**

CONTENTS

SUMMARY

1. The man was a foreign national born in Goa, India who came to the United Kingdom in 2009. He was arrested on 22 May 2011 and charged with murder. While in police custody, he was subject to constant supervision because of concerns that he might harm himself. He had apparently told the police that he wanted to die. The police noted that he had a psychiatric history and had bipolar II disorder[1] and, although he had previously been on medication, had not taken any since the end of 2009.

2. Following his appearance at court, he was remanded into custody at HMP Bristol on 23 May 2011. This was his first experience of prison. Upon his arrival his mood was low. The suicide risk monitoring system, Assessment, Care in Custody and Teamwork (ACCT), was begun and he was located onto the healthcare wing. He was subsequently seen by various mental healthcare nurses and doctors. His ACCT document was closed on 2 June and he was relocated onto a normal residential wing. He was later employed and said to be adjusting to prison regime well. He was scheduled to next appear in court on 26 August.

3. Through the months of July and August ACCT procedures were opened on two occasions for the man. These lasted from 12 July to 18 July and 22 July to 17 August. His mental health had raised concerns and resulted in him being assessed by the prison consultant forensic psychiatrist. He had told staff that, although he had no intention of harming himself, he wanted to die. He requested that, at his trial, the judge impose the death penalty upon him.

4. During his contact with the mental healthcare services within the prison, he was said not to be coping. However, he was not diagnosed with an enduring mental illness, although staff noted that his mood swings did fluctuate. Healthcare staff made extensive enquires to obtain confirmation of his stated illness of bipolar disorder, but to no avail. He had not taken any medication for a period of at least 18 months.

5. Following the closure of ACCT procedures on 17 August, staff had no concerns about him. He was still employed in the prison workshop and said he had the support of his cell mate and family.

6. A few days later, the man attended the Roman Catholic chapel service at 9.45am. He returned to his cell around 10.40am escorted by a member of staff. No concerns were noted when he was locked back into his cell. He was discovered hanging when staff returned his cell mate to the cell at about 11.15am.

7. Healthcare staff quickly arrived at his cell but no signs of life were detected. Cardiopulmonary resuscitation[2] (CPR) was commenced and an ambulance

[1] Bipolar II is a mental disorder where moods shift between two extreme highs and lows.

[2] Cardiopulmonary resuscitation (CPR) is a technique whereby oxygen is pumped around the body using a combination of chest compressions and rescue breaths.

called. Upon their arrival, the paramedics continued with CPR. Finding a faint pulse when checking him, he was taken to outside hospital. Unfortunately having tested and found no brain activity over the weekend, the hospital staff switched off the life support machine. His family were present. His death was later pronounced by the hospital doctor.

8. Despite the tragic circumstances surrounding his death, the report makes no recommendations and highlights that the care the man received was at least equivalent to what he would have received in the community.

THE INVESTIGATION PROCESS

9. One of the Ombudsman's investigators opened the investigation into the man's death on behalf of another of the office's investigators. He visited Bristol on 31 August 2011 and met with the Governor, liaison officer and a representative of the Prisoner Officer Association (POA). A member of the Independent Monitoring Board (IMB) was not available although the investigator's contact details were left should they have any issues they wanted to discuss. Notices of the investigation and the Ombudsman's terms of reference were sent in advance of the visit.

10. The investigator visited the man's cell on G wing and spoke to his cell mate. No other prisoners came forward in response to the notices about the death. The investigator also collected copies of his prison and medical file which were passed to the other investigator.

11. The investigator wrote to the local Primary Care Trust (PCT) to commission a clinical review of the man's medical care while he was in custody. A clinical reviewer was appointed to carry out a review of the clinical care and treatment on behalf of the PCT. We are grateful to him for his contribution. The investigator also contacted the Coroner's officer and a copy of this report will be sent to the Coroner to assist his enquiries. We would also like to extend our thanks to the Wiltshire Police who provided him with some information following their investigation.

12. The investigator attended Bristol on 7 October, and 3 and 7 November 2011, to interview prison and healthcare staff. At this stage, feedback was provided to the Governor, covering some of the main issues which had arisen during the course of the investigation.

13. One of the Ombudsman's family liaison officers contacted the man's family through their legal representatives and, during the consultation period, met with them along with the investigator. The family made a number of comments about the draft report which were subsequently addressed in a letter to the family. I hope that along with this report, it offered the family further explanation into the events leading to the man's death. The family remain concerned about the lack of diagnosis of his illness at the prison, whether a "safer cell" should have been considered and also about the timing of the closing of the ACCT procedures. The family said that he may have been overlooked as he caused staff no trouble.

HMP BRISTOL

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

Reception

15. All prisoners go through reception procedures when they enter a prison. A cell sharing risk assessment (CSRA) is opened by the reception officer who completes the initial details. The form is first handed to First Night Centre staff who conduct a confidential interview. The document is then passed to healthcare staff. The CSRA is intended to provide consistent and continuing risk assessment regarding sharing cells. The initial healthcare screen concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

Suicide and self harm monitoring

16. The Assessment, Care in Custody and Teamwork (ACCT) system is the prison service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself.

17. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff believe the risk of harm to be very high, the prisoner may be constantly supervised, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of supervision may be several times an hour or day. Supervision can also take place during the night. As part of the process, a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is also included in review meetings.

Her Majesty's Chief Inspector of Prisons

18. The last inspection of Bristol by Her Majesty's Chief Inspector of Prisons was an announced inspection in January 2010. 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."

Independent Monitoring Board

19. 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, for the period 1 August 2009 to 31 July 2010, Bristol's IMB findings included:

> "HMP Bristol is working with a cut, from last year's budget, of 4.52%. There is the prospect of a further budget reduction in the autumn. Whilst it is understood that the national debt has to be addressed, there is a concern that any further reductions will put serious constraints on the ability of the prison to manage its prisoners in the proper way. Despite the excellent management undertaken, to ensure that any disruption to routine is kept to an absolute minimum, staffing has been a difficult issue over the reporting period which has affected the lives of prisoners. Any further cuts to the prison budget will, no doubt, have a serious and detrimental effect to the routine and prospects of the prison."

20. In reference to foreign prisoners, the IMB's conclusion was:

> "There has been a significant rise in the number of foreign nationals held in the prison. When language difficulties and differing cultural background are taken into account, this adds considerably to the burden on staff. This should be recognised in the context of budget constraints."

Previous deaths at HMP Bristol

21. Since April 2004, when the Ombudsman took responsibility for the investigation of every death in prison custody, there had been seven self-inflicted deaths at Bristol before that of the man. The circumstances of the previous self-inflicted deaths were not similar to his.

KEY EVENTS

Prior to arriving at HMP Bristol

22. The man was born on 18 March 1988 and was 23 years old at the time of his death. He was brought up in Goa, India and came to the UK in July 2009 to join his parents, who had come to the UK two years prior to this. He left school with no formal qualifications or skills. While in Goa, he contracted malaria. He was hospitalised for a period and prescribed medication to treat the illness. From his police statement, his brother said that this illness later caused him to experience mood swings and sleeping problems to which he was referred to a psychiatrist. Following his arrival in the UK, he gained employment in a warehouse.

23. The man was arrested on Monday 22 May 2011 and held at Swindon police station. He was subsequently charged with murder. Whilst in custody, the police completed a person escort record[3] (PER) and noted that he was originally from Goa, India and had a psychiatric history. The PER also referred to a letter from a psychiatrist (dated in 2009) stating that he had Bipolar II disorder which was obtained when the police searched his home address. He said that, although he had not taken any mediation since 2009, he was at the time prescribed:

    - Pregabalin 75mg 2 x daily (used for neuropathic pain, therapy for partial seizures and can be effective for generalized anxiety disorder).
    - Lithium carbonate 400mg 2 x at night (an antipsychotic, antimanic medication used in treatment of manic episodes associated with bipolar disorder).
    - Quetiapine 25mg at night (used for schizophrenia 'highs' and 'lows' in bipolar disorder, also alongside other treatment in depression).

24. Whilst in police custody, it was recorded that the man said: “he would rather die, he has had a nice life”. He had also refused to eat. He was placed on constant supervision and prescribed diazepam[4] 5mg by the police doctor to help him sleep.

25. The next morning, the man was escorted to appear at Magistrates Court. The PER form that was initiated in police custody accompanied him included a reference that he was a suicide risk. The court subsequently remanded him into prison custody.

[3] The PER form accompanies staff on all prisoner escorts and it provides a chronological record of the escort, e.g. meals served, times journey started etc. It also serves as a communication tool about risks a prisoner poses on escort or transfer.

[4] Diazepam is commonly used to calm severe anxiety and agitation. For example, it is known to be effective at quickly reducing the symptoms of anxiety and agitation that occur in a manic episode of bipolar affective disorder.

The man's arrival HMP Bristol

26. The man arrived at HMP Bristol at approximately 2.25pm. As with all new prisoners, he went through a reception screening process and was interviewed by reception staff. Officer A noted it was his first time in prison and saw the police comments on the PER relating to his suicide risk. He did not want to discuss this. His mood was described as low and he avoided any eye contact with the officer.

27. The officer also completed the cell sharing risk assessment (CSRA). He considered that the man presented as no risk to others. He also expressed a wish to share a cell with another prisoner. The officer recorded on the CSRA that he was a standard risk and noted "First time in prison. History of mental health issues. Open ACCT – serious offence."

28. The officer had concerns regarding the man based on his mood and behaviour and began Assessment, Care-in-Custody and Teamwork (ACCT) procedures. This included completing an immediate action plan to ensure he was supported. A Developing Prison Service Manager (DPSM), who was also the safer custody manager, interviewed him and concurred with the officer's assessment. He contacted the First Night centre who identified a suitable prisoner that could share a cell with him. He also arranged for a Listener and Insider[5] to offer support to him.

29. The man was interviewed by an officer who completed the document "First Night Urgent Needs Assessment and Induction Passport"[6]. He noted that he could read and write English adequately and was polite and co-operative. Although he was a foreign national prisoner, an interpreter was not deemed necessary when communicating with him.

30. The man received a first reception health screening carried out by a nurse. This is designed to find out what, if any, health concerns the prisoner has. She was aware that Officer A had begun ACCT procedures. She tried to elicit information from him about his medical history and recorded this in his prison medical record. He appeared tired and upset and told her that he was depressed and angry with himself. He denied having any previous or current thoughts of suicide, although his behaviour was noted as unusual. He said that he had been diagnosed with bipolar in India and was on medication, although he could not remember what it was. She made a referral for him to be seen by the mental health team because of his depressed mood and his reference to having bipolar. In relation to his CSRA, she recorded that there were no healthcare risks associated with him sharing a cell.

[5] Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners and offer support, particularly for prisoners at risk of self harm. Insiders are experienced prisoners who welcome new prisoners, highlight any concerns they may have, and explain the processes they may encounter during the early days of their custody.

[6] As part of the induction process, staff must ensure that any remaining pressing concerns and warning signs are identified, recorded and dealt with appropriately.

31. Nurse A, a registered Mental Health Nurse (RMN) was responsible for co-ordinating the healthcare wing by assessing prisoners who were suffering from a mental illness or a perceived mental illness. He told the investigator that he received the mental health referral from reception staff about the man. He, because of his offence, was also considered to be a potential Category A prisoner and, as such, it was standard local procedure to locate him in a safer cell[7] on the healthcare wing. He was therefore located to healthcare. All cells on the healthcare wing were single occupancy.

32. The nurse examined the man once he was taken to the healthcare wing. He noted that he had "slight anxiety", however his interaction was good. He said he been diagnosed with bipolar disorder, although he had not taken any medication for over six months. He also had sleeping problems. The nurse said his mental state appeared settled and he would refer him to see the doctor and psychiatrist. The nurse also agreed to ask the doctor to prescribe him a sleeping tablet for his first night in prison.

33. At the nurse's request, a doctor prescribed the man zoplicone (used for short term treatment of insomnia) for a period of four nights. The doctor noted on his medical record that he should be assessed in due course by the forensic psychiatrist. No concerns were noted about him during his first night in prison custody.

34. The following morning (24 May 2011), the man was seen by a consultant psychiatrist. She told the investigator that as part of her role, she provided general adult and psychiatric services for HMP Bristol, amongst other prisons. She attended Bristol one and a half days a week. At the time of his death, this was on a Tuesday morning (to undertake a ward round in the inpatient healthcare wing) and all day Thursdays (to run the routine clinics).

35. The psychiatrist's first contact with the man was during the morning mental health ward round. Nurse A accompanied her. Ward rounds were generally held in the association room (located at the end of a corridor on the healthcare wing), which was considered to be a more relaxed and therapeutic environment, and lasted around 15-20 minutes each. On this particular morning, because of security issues elsewhere within the prison, all prisoners had to remain locked in their cells. Interactions with prisoners were restricted to the use of the cell flap of the door. His assessment was therefore carried out in this way.

36. When the psychiatrist saw the man, she noted that there was very little information recorded about him. The prison had a copy of the police's detained person's form which highlighted that he had been seen in police custody by a doctor where it was recorded he had Bipolar II[8] disorder. This was supported by the police doctor who had written that he had seen a copy of a letter from a psychiatrist in India, dated in 2009. He had also apparently been given a six

[7] Safer cells are designed to make the act of suicide or self-harm as difficult as possible. This is achieved chiefly by reducing ligature points.
[8] Bipolar II is a mental disorder where moods shift between two extreme highs and lows.

month supply of various mental health medications in 2009 whilst in India to bring to the United Kingdom to last for a period of six months. There was no indication from him that he had been on any medication for the last 18 months. However, a copy of this letter had not been sent to the prison and Nurse A was asked to try to obtain a copy of it.

37. When speaking to the man, the psychiatrist said that he appeared to understand what she said by the responses he gave, and she felt there was no need for an interpreter to be present. He denied having had any hospital admissions for his mental health when he was in India. His doctor (GP) in the UK was based in Swindon and he was happy for the prison to contact his GP's surgery. When asked about the symptoms he had in India which resulted in him seeing a psychiatrist, he found them difficult to describe. He did say that his head had been feeling "very badly" at the time and he had not been sleeping well.

38. In terms of how the man was currently feeling, he said that he was okay and denied having any thoughts of suicide or harming himself. Later during their consultation, he contradicted himself and described his mood as bad, and that he was "angry" and was not "a violent person". He said he had not slept well for around seven years. He provided no details about having bipolar disorder, apart from stating that his doctor believed he had the illness. He also said he had not taken any medication for around 18 months. The psychiatrist said she would review him again the following week during her ward round (although this did not materialise because he subsequently moved onto a residential wing).

39. The psychiatrist said that the healthcare unit conducted a weekly single point of entry meeting (SPEM). It was a meeting where all prisoner mental healthcare matters were discussed and included discussions about referrals and discharges. As well as herself, the mental health in-reach team and a senior member of staff from the healthcare wing attended and decisions were made about follow up treatments. This included referrals for prisoners to see the consultant forensic psychiatrist, who worked half a day a week at Bristol. The psychiatrist made a referral for him to be seen by the consultant forensic psychiatrist in a letter dated three days after the ward round. This was done in view of the seriousness of the criminal charge he faced, along with the uncertainties the team had over whether he had a past psychiatric history.

40. During the afternoon, the man was relocated to another cell within healthcare which gave him access to a television. Nurse A recorded no concerns with him, who communicated and interacted with staff. His appetite was good and he displayed no evidence of psychosis[9]. The nurse noted that staff should contact his community GP and the police station to try to elicit more information about his medical history.

41. As part of the ACCT procedures, an officer conducted an ACCT assessment of the man. The officer noted on the assessment interview form that he felt guilty

[9] Psychosis episode are a set of symptoms that include delusions, hallucinations – hearing voices, for example – and confused or disturbed thoughts.

about the offence he was charged with and was feeling in a low mood. He said he had not harmed himself nor did he have any intention of harming himself. He said he had last taken medication for his mental health issues in March 2009, when he saw a doctor in India. The officer noted that this information would be passed to healthcare staff. After the assessment, the officer reduced his ACCT observations to once every two hours.

42. The man attended court the next morning (25 May). Following the previous evening's instructions, Nurse B checked the medical computer system RIO. The RIO system covered the Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) catchment area and should be able to identify whether he was receiving any mental healthcare services from any of the AWP teams. No trace was found. She also contacted his doctor (GP). The doctor's surgery confirmed that they had not prescribed any medication to him. She also contacted Wiltshire police station in search of any documentation they might hold, relating to his mental health history. The police said that no documents had been left at the police station that related to him.

43. When the man returned from court later that day, an ACCT review was carried out in the healthcare unit. The duty manager, Nurse B and he attended. A note was made that he was to return to court on 26 August. The nurse noted on his medical record that he was slightly anxious and was unable to answer questions clearly. She was unsure whether this due to him being in shock or if it was due to a language barrier. His mood was described as "neither clinically depressed or elated". As he said he had not taken any medication since the end of 2009, she noted that an assessment would take place over the next few days within healthcare. He wanted to be transferred to an ordinary residential wing (because he wanted to be able to smoke in his cell), but was to remain in healthcare unit at least until his next ACCT review, scheduled for Friday. The psychiatrist's letter referred to when he was in police custody appeared to be missing, as she searched for this and found no evidence of it in his records or property.

44. Over the next two days (Thursday 26 May – Friday 27 May), the man received a secondary health screening, where further details about his medical history was recorded. He appeared to settle on the healthcare wing and staff reported no concerns about him. He interacted with healthcare staff and displayed no signs of mental illness or any intentions to harm himself. The ACCT review conducted on 27 May concurred with this and recommended that he could now be relocated to a residential wing, preferably the First Night Centre. The ACCT procedures were to remain active, although his observation levels were reduced to three conversations throughout the day and five observations during the night.

45. On the afternoon of Monday 30 May, the man was discharged from the healthcare wing to A wing, the induction unit. Nurse B completed the ACCT "Review to Discharge From Healthcare" form and noted that he had been assessed during his stay in healthcare and was mentally well with no physical concerns. The mental health in-reach team would follow up any further care arrangements at the weekly SPEM now that he had been discharged.

46. At his ACCT review meeting on 2 June, it was noted that the man had settled into the prison regime on A wing. He shared a cell and was getting on well with his cell mate. He received support from his family and said that he had no current thoughts of harming himself. There were three members of staff at the ACCT review, including his personal officer. All agreed that the ACCT procedures could be closed.

47. From around 12 June, the man complained of having sleeping problems as well as feeling mentally unwell. When queried by nurses on the wing about this, he said bad thoughts were troubling him and consistently complained of having a pain in his head. He wanted to see a psychiatrist. A subsequent referral was made to the mental health team citing his painful head.

48. On 24 June, the man was seen by a nurse. The nurse told the investigator that during his interview and assessment, he was anxious but forthcoming with information about himself. He gave a history of being treated for bipolar disorder in India with lithium but had not been assessed in the UK. His eye contact, body language, conversation tone and content were all considered appropriate. During the interview, he repeatedly touched his head and said it was painful although the nurse noted that it was difficult to assess his definition of this. He denied hearing any voices or experiencing any other thought disorder.

49. The nurse believed that the man had a complex set of symptoms that were difficult to assess during the interview. He agreed that he should have an in-depth assessment carried out by a forensic consultant psychiatrist, as recommended by the psychiatrist, and this would be discussed at the SPEM. He was discussed at the SPEM on Thursday 30 June 2011 and it was agreed to refer him to the consultant forensic psychiatrist to carry out a full assessment. He was also to be referred to a prison doctor for his head pain.

50. At the beginning of July, the man was located onto G wing, a normal residential wing. A G wing landing officer described him as a quiet man who never raised any concerns with her and followed wing rules. Other staff noted that he was a quiet prisoner who tended to keep himself to himself and caused no concerns. On 3 July, his personal officer noted on his prison record that he continued to be quite and polite, worked in the prison workshop and presented no concerns.

51. The consultant forensic psychiatrist carried out an initial assessment of the man on 11 July. His mood was initially low and became more animated and emotional as the interview went on. He was vague when he talked about his past psychiatric history, but said it was around four years ago when he first had a problem. He was prescribed medication by a psychiatrist at the time which was helpful and this medication lasted until around six months after his arrival into the UK. He had not had any contact with any mental health services in the UK. Following the examination, the psychiatrist said that healthcare staff should try to ascertain contact details for his psychiatrist in India to see if he could be contacted to obtain further details about his treatment. The psychiatrist concluded his report by stating that he did not think he was acutely

unwell and there was no further need for review unless any relevant information was forthcoming from his psychiatrist in India.

52. On the morning of 12 July, the man approached an officer. His mood was very low and he wanted the officer to contact his solicitor to request the death penalty when he returned to court on 26 August. A Senior Officer (SO) was informed and spoke with him. The SO told the investigator that this was the first time that he been brought to his attention. Although he understood him, he found it difficult to get any information from him, as it was hard to "distinguish what he was trying to say was wrong with him". His mood was low and he said he was feeling sick. He also made reference to having nothing to live for and mentioned the death sentence.

53. The SO telephoned the healthcare department to ask a nurse to come to the wing to see the man. A nurse responded to the SO's request and interviewed him in the wing treatment room. She told the investigator that she was aware of who he was as his cell was next door to the healthcare treatment room and they would exchange pleasantries whenever he walked by.

54. During the interview, the man was polite and maintained good eye contact and body language. He denied having any thoughts of suicide or self-harm. He said he did not want to live but had no intention of doing anything to hurt himself or take his life. He described his life at present as awful and wished that the death penalty was available. Aware of his previous contact with the mental health team, the nurse contacted them and explained his mood. She was informed that they had identified no immediate risk of self-harm when he was examined.

55. Because of the concern both officers and the nurse had about the man, ACCT procedures were immediately opened. He was placed on hourly observations and offered access to the telephones and Listeners. He said he was receiving good support from his cell mate.

56. The man reiterated his feelings to the SO and an officer at the ACCT assessment and review that followed. He said he was not well and was getting weaker. He could not say what was wrong with him but said he suffered from a mental illness. It was noted that he had gained employment in one of the prison workshops and it was hoped this would help his mood and keep him busy. The officer told the investigator that he saw him regularly on the wing. He would speak to the officers some days and on others he would be quiet. He was not the type of person that would generally socialise with lots of prisoners.

57. At the man's ACCT review a week later (18 July), it was noted he was in much "better spirits". He had no current thoughts of self harm or suicide and said he did not wish to die. He was also in contact with his family. He said that he had been seen by healthcare and the mental health team and no longer felt unwell. He also enjoyed working in the workshop. As well as the man, the SO and an officer attended this review. All agreed that it was appropriate for the ACCT procedures to be closed, with a post-closure ACCT review interview scheduled to take place on 25 July.

58. On Friday 22 July, the SO reopened the man's ACCT. His mood had been low and staff as well as prisoners had raised concerns. A prisoner told the SO that, whilst working in the workshop, he had enquired about different methods of suicide with other prisoners. An ACCT review meeting was convened with the SO, and an officer attended. The workshop manager contributed by phone. The man said he had no intention to take his own life and did not know how, if he did, he would do it. His mother had arranged to visit him on Sunday and he was looking forward to this. He talked about his next court appearance in August and said that if he received a long sentence he did not want to live. Concerned about his mental health, the SO telephoned the mental health team describing his moods swings as high and low.

59. A Registered Mental Health Nurse (RMN) took the SO's telephone call and reviewed the man's medical records. She was aware that he had seen the consultant forensic psychiatrist on 11 July and made a note to discuss his case at the SPEM meeting. She contacted his office to inform them of the man's current mood and he subsequently arranged to review him again. This information was passed to G wing.

60. The SO conducted the man's ACCT review on 28 July. He expressed his desire to receive the death penalty should he be found guilty when he attended court. However, he said he had made no plans to kill himself, citing his religious beliefs as one of the reasons for this. His mood was described as "very up and down and could be seen as Bi Polar". The ACCT remained open with the next review scheduled for 6 August.

61. The consultant forensic psychiatrist again saw the man on 1 August. Healthcare staff had still not been able to elicit any further information about his contact with a psychiatrist in India. They had also contacted his mother. He disclosed to the psychiatrist that he thought the name of the illness he had was bipolar affective disorder. When he spoke to the doctor he was "coherent and rational albeit distressed about the situation". The psychiatrist assessed that, despite him struggling with the situation he found himself in, he did not appear to have a severe or enduring mental illness. He considered that medication was not appropriate at this time and his case would be kept open to try to resolve getting his psychiatric history from India.

62. When the SO conducted the ACCT review on 6 August, he noted that the man felt much better. He had experienced no thoughts of wanting to harm himself but said if he were to remain in prison, he did not see the point of being alive. He smiled and was open to questions. He said he would however wait until the outcome of his court case on 26 August. His family and cell mate continued to provide support for him. The review decided to maintain ACCT procedures.

63. The following ACCT review was conducted by the SO on 11 August. The man's mood was considered "low" but he said he did not want to harm himself. The SO had spoken with the mental healthcare team and confirmed that he had an upcoming follow-up appointment with them.

64. The SO conducted a further ACCT review on 17 August. As well as the man in attendance, three other members of staff were present, including the safer custody manager. A nurse contributed to the review by telephone. She told the investigator that G wing staff conducted the ACCT review and telephoned the mental healthcare team seeking information to contribute to this about his mental health and to assist with their decision making. She reviewed his medical record and told the SO that he had been assessed by the psychiatrist and was considered to have "no serious enduring mental health issues". The psychiatrist had requested that he remain on the mental health in-reach team's caseload and, following her conversation with the G wing officer, she sought to ensure he was allocated to a mental health nurse on the team. (This was done the next day)

65. The ACCT review concluded that the man was "in much better spirits than previous reviews". He said he had no current thoughts of harming himself and did not want to die. He continued to enjoy working in the workshop and received support from family and other prisoners. He told the ACCT review panel that he no longer needed the support of the ACCT document and, if his mood became low for any reason, he would approach staff for support. The decision was taken that the ACCT document could be closed and was done so that afternoon at approximately 2.00pm.

66. The next day, 18 August, the man had an appointment with the doctor. He complained of a poor sleeping pattern and pains in his whole body. He said he still enjoyed working in the workshop but was not eating much. The doctor noted that his mood appeared low, but his speech was reasonable and he was "well presented". He noted that medication to aid his sleep was not appropriate as he appeared to be managing well during the day. He did however prescribe him Kalms tablets[10] (for seven days) to take at night which would help him to relax. He also suggested he should see the nurse should he want pain killers.

67. The man attended the Roman Catholic chapel service at around 9.00am. His cell mate remained in their cell until between 10.00am to 10.15am, when he left to go to the exercise yard. He returned to the wing at approximately 10.40am. He asked an officer if he could return to his cell which was locked. The officer told the investigator that the man appeared okay and did not show any signs of distress. He unlocked his cell so he could go in, after which he locked it again. His cellmate had not yet returned from exercise. He then continued with his normal wing duties.

68. There were no recorded concerns from the Roman Catholic chaplaincy relating to the man's attendance at the chapel that morning. The chaplain was a visiting chaplain and not permanently located at the prison. The investigator attempted to contact the chaplain but to no avail. The duty Governor at the time said he had tried to contact the chaplain after the man's death but was also unable to do so.

[10] "Kalms is a traditional herbal remedy, which helps to relieve worry, irritability and the stress and strains of everyday life.

69. Shortly after 11.10am, a number of prisoners returned from association and exercise. Officer B said he saw Officer C escorting the man's cellmate back to his cell. Officer C said that she looked through the observation panel on the door before opening it and no one else appeared to be in the cell. She had a short conversation with the cellmate whilst he stood in the cell doorway. As he closed the cell door, he shouted to her "what's this?". Unable to see exactly what he was trying to explain, she entered the cell to find the man hanging behind the door. He had used torn bed sheets as a ligature and attached it to an air vent, which was quite high up on the wall behind the door. His feet were not touching the ground.

70. Although Officer C had not received any prison service first aid training, she was a member of the Territorial Army and had received similar training techniques for emergencies. She immediately tried to reach the ligature to release the man but was unable to do so. She stepped out of the cell onto the landing. Officer B was only yards away on the other side of the landing. She shouted "Code Blue[11]". The officer responded by immediately using his radio to contact the Control Room (recorded on the incident log as occurring at 11.16am) to inform them of the emergency and made his way to the cell.

71. When he arrived in the cell, he saw the man hanging behind the door, facing the wall. The ligature was tied around his neck to the air vent on the wall. He took Officer C's cut down tool[12] (which she had already taken out) and cut the ligature away from the air vent. Another officer entered the cell at this point and supported his body to the floor and placed him onto his back. Having checked him for any signs of life, Officer B found he was not breathing and had no pulse.

72. Nurse B was the first nurse to arrive and entered the cell at this point. She told the investigator that she was in the G wing treatment room when she heard the Code Blue emergency call over her radio. She immediately responded and collected the two emergency bags (which included oxygen and the defibrillator) and made her way to the man's cell, arriving within around 20 seconds of the emergency alarm. Very quickly after this, along with Officer B, Nurse C had begun cardio pulmonary resuscitation (CPR) on him. Nurse B carried out chest compressions whilst Officer B performed mouth to mouth resuscitation. Another nurse also attended the cell and took over the mouth to mouth resuscitation from Officer B. Two other nurses also arrived to assist in the resuscitation attempts. The defibrillator machine[13] was used to assess his condition. However it advised staff not to shock him but to continue CPR.

73. The control room called an ambulance at 11.19am. Staff continued to try to resuscitate the man and completed approximately ten cycles of CPR by the time the paramedics arrived at 11.32am. His condition had not changed. An air ambulance doctor who was an Accident and Emergency Consultant also arrived soon after to assist. Upon entering the cell, staff briefed the paramedics

[11] Emergency codes are used to summon staff to deal with a particular situation. At Bristol, a Code Blue is used to indicate a life threatening incident or a prisoner is not breathing.
[12] Cut down tools, also known as ligature knives are designed for safely cutting ligatures and are carried by all officers and healthcare staff who are in contact with prisoners.
[13] A defibrillator is a machine which may shock the heart to restart it.

on his condition and they took over his care. They proceeded to administer him with intravenous drugs.

74. The duty governor arrived on the wing within a minute of hearing the emergency Code Blue. There were a number of staff already at the man's cell where he could see CPR was being carried out. Prisoners were returned to their cells. After being briefed on the circumstances of the emergency, he ensured a log keeper was in place and made his way to the command suite[14] to initiate the contingency plans following a serious incident. This included the collection of the man's prison records. Another SO also attended the command suite to assist him.

75. At 11.41am, the paramedics detected some signs of life in the man and prepared to transfer him to outside hospital. The duty governor arranged for prison escorting staff to be made available to assist and travel with him to hospital. The ambulance left the prison at 12.17pm en-route to hospital. No restraints were applied to him. A nurse updated his medical records with the events of the morning.

76. The man's next of kin were identified as his parents. The duty governor told the investigator that he would have preferred to have passed on information about their son's condition to the family in person. However, he was conscious that his condition appeared serious and his family lived some distance away from the prison. He therefore contacted the family by telephone, initially speaking with his mother, then his brother who spoke fluent English.

77. The duty governor held a hot de-brief at 1.30pm in the chapel. All staff who had been involved in the discovery and resuscitation attempt of the man attended. The care and support team were also in attendance. Arrangement was made for the cell mate to receive support from staff and listeners. All other prisoners on the wing were also offered support.

78. The man's family (mother, father and brother) arrived at the hospital at around 2.45pm. The duty governor had arranged to meet them there and spoke to them offering as much information as he knew about the events leading up to his hospitalisation. The hospital doctor provided an update of his condition, which was considered to be critical. The family left the hospital soon after and planned to return the following day.

79. The prison escort officers informed the prison of the man's condition every four hours. He had been placed on a life support machine in a medically induced coma. Over the forthcoming days, his condition remained unchanged.

80. Following further tests the hospital consultant confirmed the man's death at 12.17pm. His family were present. The escort officers immediately informed the Deputy Governor and the prison's death in custody procedures were opened and the appropriate agencies were contacted. The next day, along with the police, prison family liaison officers (FLOs) visited the family at their home

[14] Command suite is a dedicated room used in an emergency to manage the situation.

to offer the prison's condolences. The FLOs gave as much information they had about the circumstances leading up to his discovery and discussed how they could support the family in arranging the funeral. This included the offer of financial assistance towards the funeral.

81. On 31 August, a memorial service for the man was held at the prison at which his family attended. The family also visited his cell and his personal property was later returned to them.

ISSUES

Clinical care

82. The clinical review was conducted by a clinical reviewer. It describes the clinical care received by the man as appropriate to his circumstances and that the care provided in prison was at least as good as that which he would have received in the community. He makes no recommendations.

Mental health history

83. Following his arrival at Bristol, the man had significant contact with the healthcare team both in primary care, mental health and forensic psychiatry. He was fully assessed as having had a history of mental health issues although these assessments found there was no evidence of psychotic illness or depression. The clinical reviewer notes that assessment of his mental health issues happened quickly and effectively.

84. Information was obtained at his reception health screening to suggest the man has been treated in his native country for bi-polar disorder. Healthcare staff took steps to try and obtain further details relating to this in order to fully assess him. Although this was not possible, it was established that he had not taken any medication for at least a period of 18 months.

85. Following issue of the PPO draft report, and further liaison with the police, the investigator was able to establish that the psychiatrist letter (dated 2009) was in fact at the police station. It was not however in or on the man's possession when he was arrested, but was later obtained following a search of his home address. This was therefore considered as evidence and held separately within the police station.

Suicide and self harm procedures

86. Along with the seriousness of the offence the man had alleged to have committed, staff were immediately concerned with his mood on his arrival at prison. He was placed in the healthcare unit and suicide and self harm procedures were rightly opened to monitor him. No significant risk of self harm was found on a number of assessments, which included input into the process from clinicians. As he settled into the prison regime and continued to be monitored, his mood swings varied and included him making reference to wanting to receive the death penalty. Again he was assessed on a number of occasions by senior clinicians where the risk of self harm was appropriately considered. He also received support from his cell mate and family.

87. ACCT procedures are not a fail-safe and while their purpose is to safeguard prisoners, this is not always possible. The investigation has found that staff acted appropriately with regard to the level of risk the man presented at any given time. Moreover, the decisions that were made throughout his time in prison relating to his risk were appropriately made with the benefit of a multidisciplinary team approach.

Emergency response

88. On the morning of the man's death, he gave staff no prior warning or concerns that he intended to harm himself. When he was found hanging in his cell, the response by prison and healthcare staff was immediate and professional. The code system was well used to alert staff to the nature of the emergency. The clinical reviewer describes the resuscitation as handled well. Paramedics were also on site very quickly and their combined efforts allowed him to be transferred to outside hospital for further treatment.

Evidence of good practice

89. The clinical reviewer noted that there was evidence of good practice in comprehensive senior mental health assessments given to the man and the effective communication across the teams caring for him.

CONCLUSION

90. From the time of the man's arrest, concerns about his mental health were noted and later investigated by appropriately trained healthcare staff. Indeed, his healthcare was compared favourably by the clinical reviewer to that which he might have received in the community.

91. Suicide prevention measures were put in place on a number of occasions to support the man, who frequently said he would not harm himself and about whom there was no evidence that he had ever previously harmed himself. He was clearly very unhappy with the situation he found himself and despite having numerous interactions with staff, this investigation has found that his tragic actions were unexpected.