PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in February 2013 at HMP Bristol

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Bristol in February 2013. He was 30 years old. I offer my condolences to his family and friends.

A clinical reviewer reviewed the clinical care the man received at HMP Bristol. The prison cooperated fully with the investigation.

The man was remanded to HMP Gloucester on 24 December 2012 charged with grievous bodily harm against his ex-partner. He was identified as at risk of self-harm and monitored under suicide prevention procedures. On 31 December, he moved to HMP Bristol, where he was very withdrawn. Despite staff attempts to encourage him to engage he did not mix with other prisoners and spent most of his time locked in his cell. In February, at an early morning roll check, he was found hanging in his cell.

The investigation has identified a number of frailties in the management of the man's risk of suicide and self-harm at Bristol. No attempt was made to get his community health records although he said he had been treated in a psychiatric hospital not long before. Factors which would have identified him as an increased risk, such as the nature of the charges he was facing and his history of self-harm were not fully considered. He did not receive an adequate mental health assessment, although the need for one had been identified as an important aspect in his care. The suicide prevention procedures were poorly managed, with little involvement of healthcare staff and a lack of continuity of case management.

Finally, the emergency response when the man was found hanging was particularly poor and indicated an urgent need for training for both prison and healthcare staff, together with a number of procedural improvements.

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 Newcomen CBE
Prisons and Probation Ombudsman **December 2013**

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SUMMARY

1. The man was arrested on 24 December 2012 for allegedly seriously assaulting his ex-partner. When he was in police custody, he said that he was hearing voices and would kill himself, so he was constantly monitored as a risk of suicide.

2. On 26 December, the man appeared at Magistrates' Court charged with wounding with intent to cause grievous bodily harm. He was remanded to HMP Gloucester and reception staff started Prison Service suicide prevention measures (known as ACCT). He said he had self-harmed before and had attempted suicide in prison in 2005. He was referred to the prison's mental health team. He wanted to be considered as a vulnerable prisoner and held separately from the main prison population and, as Gloucester did not have a vulnerable prisoner unit, he transferred to Bristol on 31 December.

3. There is no evidence that his medical record was sent to Bristol or that sufficient efforts were made to get his community GP records, although he said he had spent some time in an acute mental health unit within the previous twelve months. At his initial health screen at Bristol, his history of self-harm, suicide, anxiety and schizophrenia were recorded. The reception nurse referred him to the mental health team and he was still monitored under ACCT procedures. He missed mental health appointments in the prison on 10 and 15 January 2013, apparently because there were no officers to take him to them.

4. On 18 January, the man appeared in court through a video link from the prison. He was told that he could now be charged with attempted murder. Officers noted that he was upset and stressed after the court hearing and, although he said he was not suicidal, his observation level was increased. He was not assessed by a nurse after the hearing.

5. The man rarely left his cell and officers brought his meals to him. At an ACCT review on 22 January, he said he was hearing voices and had suicidal thoughts. The mental health nurse assessed his mental health during the case review and gave him some activities to help keep him occupied in his cell. Based just on this assessment, he was discharged from the acute mental health patient list because he did not have an enduring mental illness. He was referred to a primary care mental health nurse for further assessment. On Friday 1 February, officers asked for an urgent doctor's appointment for him that weekend because they were concerned he was so withdrawn. No appointment was made.

6. At about 5.30am a few days later, the man was found hanging from a bed sheet attached to the top bunk in his cell. A nurse responded to an emergency radio call and started to attempt resuscitation but stopped after several minutes because she was exhausted. No officers helped her. When the paramedics arrived at 5.51am, they found no signs of life and pronounced him dead.

7. We agree with the clinical reviewer’s concerns about the delivery of mental health services and we are concerned about the failure to seek the man’s community health records. Staff did not recognise his risk was heightened because of the circumstances of his offence and suicide prevention procedures were poorly managed. There were a number of serious failings in the emergency response, which need to be addressed as a matter of priority.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on 4 February 2013. The investigator issued notices to staff and prisoners at HMP Bristol to inform them of the investigation and asking anyone who had relevant information to contact him. No one responded.

9. HM Coroner for Avon District was informed of the investigation. The Coroner has been sent a copy of this report to assist with her enquiries.

10. The local Primary Care Trust appointed a clinical reviewer to review the clinical care the man received in custody. On 25 and 26 March, the investigator and clinical reviewer interviewed staff at HMP Bristol.

11. One of the Ombudsman's family liaison officers contacted the man's parents and ex-partner shortly after his death and explained the purpose and scope of the investigation. They asked the investigation to cover the following points:

    - He was severely depressed and was being monitored as a risk of suicide, so how was he able to kill himself?
    - Did the prison know that he took medication for schizophrenia?

12. The family received a copy of the draft report. A solicitor wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP BRISTOL

13. HMP Bristol is a local prison holding more than 600 convicted and remanded adult and young adult male prisoners. At the time of the man's death, the inpatient facility at HMP Bristol was a 20 bed unit managed by Avon and Wiltshire Mental Health Partnership Trust (AWP). AWP staff provided cover from 7.00 in the morning until 11.30 at night alongside physical health nursing input from Bristol Community Health (BCH). BCH staff also provided cover from 11.30 at night until 7.00 in the morning. (The unit is now a residential unit with intensive support interventions provided by mental and physical healthcare providers.)

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of Bristol by HM Inspectorate of Prisons (HMIP) was in January 2010. At that time HMIP concluded that Bristol was a reasonably safe prison but support for prisoners in the early days of custody was regarded as ineffective. Not all prisoners were able to benefit from dedicated first night services, and the induction process was poor. The Inspectorate considered that suicide prevention measures were good, and that ACCT documents were mostly good. All healthcare staff had appropriate training in the use of emergency equipment.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their 2012 annual report, the IMB noted that there were shortcomings in the delivery of ACCT, which they had highlighted before, particularly in relation to attendance at case reviews.

Assessment Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Previous deaths at Bristol

17. In the last two years there have been three self inflicted deaths at Bristol, including that of the man. There are no significant similarities in the circumstances of the deaths.

KEY EVENTS

18. On 24 December 2012, the man was arrested and taken to a police station, where he was charged with wounding with intent to cause grievous bodily harm. His alleged victim was his ex-partner. On 25 December, during an informal mental health assessment in police custody, he said he had a history of psychosis and he was assessed as a standard risk of self-harm. It was recorded that he had no symptoms of mental illness and did not take medication. During the afternoon, he told a doctor that he was hearing voices and would kill himself at the first opportunity. The doctor considered that he was a high risk, and he was placed on constant watch.

19. On 26 December, the man appeared at Magistrates' Court. He told his solicitor that he would kill himself if he was remanded to prison. He was therefore checked every ten minutes while he was at court. He was remanded to HMP Gloucester and scheduled to return to court on 11 January 2013.

HMP Gloucester

20. The man arrived at Gloucester with a suicide and self-harm warning form completed by police. The Person Escort Record[1] (PER) highlighted that he was at risk of self-harm and had possible psychosis. His charge was recorded on Gloucester's remand pro-forma as wounding with intent, but there was no reference to the alleged victim.

21. According to the PER, the man had no medication with him when he arrived. There are no medical records from Gloucester and therefore no evidence that healthcare staff requested his GP community records.

22. The reception officer recorded that the man had previously self-harmed in custody, it was not his first time at Gloucester and he was a heavy drinker. He told the officer that he had last drank alcohol more than a week previously. He said he was thinking about killing himself because he did not want to be in prison. The reception officer assessed that he was at high risk of self-harm, so opened an ACCT document. There is no evidence that they discussed his alleged offence or victim and how this impacted on his risk. The officer recorded that staff should speak to him at least three times a day (in the morning, afternoon and evening) and check him at least five times overnight. He was offered the support of the Samaritans and Listeners. (Listeners are prisoners trained by the Samaritans to support other prisoners in distress.)

23. The man said that he had served a prison sentence for a sexual offence in 2007 and he was worried that there were prisoners who knew about that. He asked to be classed as a vulnerable prisoner and kept separate from the general population. As there was no separate vulnerable prisoner unit at Gloucester, it was agreed that he would be unlocked on his own for his own protection till a suitable place could be found.

[1] PER -This is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer.

24. The man refused to see a doctor on 27 December. During his ACCT assessment that morning, he told an officer that he suffered from psychosis, schizophrenia and depression, all of which were made worse by being in prison. He said that he had not self-harmed recently, but he had jumped in front of a train in 2003, had tried to hang himself when he was in prison in 2005, and had cut his arms. He told the officer that he felt low and did not feel safe on the first night centre. After the assessment, the officer arranged for him to be transferred to HMP Bristol, where there was a vulnerable prisoner unit. While waiting for a space to become available, the officer referred him for a routine mental health assessment and it was agreed that he would continue to be locked in his cell apart from at meal times.

25. The prison's public protection unit contacted local police to check that the man's alleged offence was against a family member. The police confirmed in e-mail correspondence that he had been charged with an offence of domestic violence which was recorded in his P-NOMIS electronic case notes. Despite the increased risk associated with charges of violence against a family member, there is no evidence that this was passed on to the wing or considered as part of the ACCT process.

26. The first ACCT case review was chaired by a Senior Officer (SO) and attended by three officers and the man. He said he was feeling down because he had not slept. He was pleased to learn that he was going to move to Bristol on 31 December, but he was anxious about the other prisoners in the first night centre at Gloucester. The SO assessed that he was at low risk of self-harm and his observation levels were to remain the same. An ACCT caremap was drawn up. This reflected that his vulnerable prisoner application was complete and an appointment with the mental health team had been made. Boredom was identified as an issue. Staff were reminded that although he had requested vulnerable prisoner status, he was to be unlocked separately and offered time out of his cell for showers or to make phone calls.

HMP Bristol

27. On 31 December, the man transferred to HMP Bristol. It was recorded on his Person Escort Record that he had mental health problems and was on an open ACCT. There is no evidence that HMP Bristol received his medical record, or that they contacted HMP Gloucester to chase the missing record.

28. At his initial health screen at Bristol with a nurse, the man said that he was feeling anxious and hearing voices. He said that he had been attacked in prison five days earlier and had a cut to the left side of his chest. (There is no mention of this in his records.) He said he had cut his wrists twelve years earlier and had spent some time in a hospital (an acute mental health unit in Gloucester) in 2012. There is no evidence that the prison contacted the hospital for his records. He said he had seen his GP about his mental health recently, but he could not remember his GP's details. He said he had been

prescribed thyroxine (to treat an underactive thyroid). The nurse referred him to the prison doctor and the mental health team.

29. A nurse dressed the cut on the man's chest later that afternoon when he told her that he had been attacked the day before. The investigator found no record that he had been attacked and no security incident reports were submitted during his stay at Gloucester or Bristol. Despite him being on an open ACCT, there is no evidence that staff considered whether this was an act of self-harm.

January 2013

30. A Senior Officer (SO) chaired an ACCT case review on 1 January, attended by an officer and the man. He said that he was happy at Bristol and felt safe. He said he was still upset about his alleged offence, but now felt calmer and was not as angry. Although the senior officer indicated that the ACCT caremap was reviewed, no new issues were added and no actions were updated that day. It was agreed that his risk of self-harm was low.

31. On 2 January, mental health nurse recorded in the man's medical record that he had been referred to the mental healthcare team and he was to have a mental health triage[2].

32. On 4 January, the unit manager chaired another ACCT review, attended by a SO and an officer. The man said he was settled at the prison, but he was concerned about contacting his ex-partner and not having any money for tobacco. He said he could not remember the night of the alleged offence, so it was hard for him to come to terms with it. After the review, he was given some tobacco as an advance purchase. He said he wanted to be employed as a wing cleaner to keep busy. He was recorded as making good eye contact and said he had no thoughts of self-harm or suicide. As a mental health referral had already been made, the caremap was not updated. It was agreed the ACCT would remain open.

33. Over the next few days, no concerns were recorded about the man. He went out of his cell at association time, talked to other prisoners on his wing and collected his meals.

34. The man was due to attend a mental health triage assessment on 10 January, but there were no officers to escort him from the wing to the healthcare centre so the appointment was rebooked for another day.

35. On 11 January, the man was suffering from vomiting and diarrhoea and was seen by the nurse and doctor on duty. He was too ill to go to court, so his appearance was rearranged.

[2] Health triage is conducted at point of entry to health services and aims to assess and categorise the urgency of health related problems.

36. On 14 January, the man attended an ACCT review with a SO and an officer. A nurse also attended to discuss his mental health. She told the review panel that he was due to have a mental health assessment the next day, on 15 January. He said he was still waiting to get a prison job. The review panel agreed that the ACCT would remain open until after his mental health assessment. His risk of self-harm and suicide was assessed as low. His caremap was updated for staff to check that he had completed his induction (this action was marked as completed on 14 January) and his next ACCT review was scheduled for 18 January.

37. On 15 January, the man's mental health assessment was again cancelled, apparently because there were not enough officers to take him to the healthcare centre. The assessment was rebooked for 22 January.

38. The man's rescheduled appearance at Crown Court took place on 18 January. He appeared via video link because the weather was too bad for travel. He was told that he might now be charged with the more serious offence of attempted murder. He returned to his cell. An officer recorded that he was upset about the possible new charge. His risk was not reassessed after his court appearance. He remained in a low mood during the evening and did not collect his evening meal.

39. The next day, two SOs held an ACCT review in the man's cell because he refused to leave it. One SO recorded that a representative from the mental health team was unable to attend. The SO described him as low in mood because of the possible new charge, and he said he did not want to be around anymore. He said he had no thoughts of self-harm, but just needed to come to terms with the new charge. The SO assessed him as at raised risk of self-harm and increased his observations to at least once every two hours. No new actions were added to the caremap and no actions were updated.

40. The man rarely left his cell over the next few days. On 21 January, an officer recorded that he was feeling very down and he said he could not cope. Officers contacted the mental health team who made an appointment for the next day. The next morning, he refused to leave his cell to attend his mental health assessment, although he said he would see a mental health nurse. He said he did not want to mix with other prisoners. Two SOs conducted an ACCT review in his cell later that morning. A mental health nurse also attended and said he assessed his mental health during the ACCT review.

41. It was recorded that the man spoke softly and made no eye contact throughout the ACCT review. He said he rarely left his cell and that other prisoners he did not know had threatened him, shouting through their cell windows at night. He felt unmotivated. He said he felt worse since the last review and had started to think about suicide, although he had not made any plans. He said he was hearing voices in his head telling him to kill himself. The nurse recorded that his recent change in his charge had triggered a drop in his mood. The review panel reassured him that the nature of his alleged offence would not make him a target for other prisoners. His risk of self-harm was considered to be raised and his ACCT observations and interactions

were increased to hourly. One SO said she would arrange to move him to a lower landing closer to the wing office, as he was on the fourth landing, the highest.

42. The mental health nurse said he would discuss with his colleagues at the next healthcare team meeting whether the man needed medication to help him cope with his low mood. The nurse offered him in-cell activity packs to help to occupy his time. He concluded from the ACCT review that he had no psychotic symptoms and did not have a severe and enduring mental illness. His caremap was updated to reflect that the mental health team would consider prescribing medication, he was to be moved to a lower landing and he was to be given in-cell activity packs to reduce his low mood and anxiety.

43. The man refused to leave his cell for the next two days despite encouragement from officers. Officers had been taking his meals to him in his cell but, to encourage him to come out of his cell, the senior officer decided that this should no longer be done. On 24 January, he came out of his cell in the evening but he did not collect any food. Officers recorded that they were happy with this small improvement.

44. On 25 January, the man's mental health was discussed at the weekly healthcare meeting. The meeting was chaired by a nurse (acting team leader of the mental health team) and it was recorded that he was discharged from the mental health service. The nurse explained to the investigator that the term discharge was misleading. In fact, he had been referred to the primary[3] mental health team, rather than the secondary mental health team who deal with more acute mental health conditions. A mental health nurse was asked to assess him to determine what mental health support he needed and if he would benefit from medication.

45. Two SOs conducted an ACCT review later that day. A mental health nurse spoke to the senior officers before the meeting and explained that the man had been discharged from the mental health team's care as his low mood was regarded as a reaction to his charge of attempted murder, rather than clinical depression. He engaged more at the case review, but said that his mood had not changed and he still refused to leave his cell. One SO agreed that officers would take his meals to him again, which he was reported to be happy about.

46. The man said that he felt unsafe and asked to be transferred. He was told that he was likely to remain at Bristol until his case had been dealt with at court, which he appeared to understand. He agreed to leave his cell when prisoners on the enhanced level of the incentives and earned privileges scheme were at association. His interactions and observations were to remain the same. No new actions were added to his caremap.

[3] Primary mental health services treat less acute conditions, such as situational depression, anxiety, and insomnia. Secondary mental health services treat severe and enduring mental illness, for example psychosis or clinical depression.

47. The man remained reluctant to leave his cell and mix with other prisoners. He left his cell to have a shower and, once, to have his hair cut. Officers recorded that he seemed quite happy, and he would say that he was “fine”.

48. On Friday 1 February, a SO chaired an ACCT review attended by an officer, a nurse and the man. He was still not coming out of his cell and his mood was low. He stared at the floor and nodded in response to questions about his medication history. Although he said he did not want to speak to his family, after some encouragement, he agreed to write to them and was given a pen and some paper. The officers encouraged him to think positively about his outstanding court case. The officers were concerned about his demeanour, so a SO asked for a doctor’s appointment that weekend. The nurse booked him an appointment for the weekend after in error. She recorded in his ACCT that he was due to have a primary care mental health assessment.

49. The ACCT review panel agreed that the man could stay on the fourth floor rather than move closer to the office, and he agreed to leave his cell to collect his evening meal. He was assessed as low risk. His ACCT observations and interactions were reduced to six per day: two in the morning, two in the afternoon and two in the evening. He was to be observed every two hours observations during the night. It is not clear why the review considered he was at low risk and decided to reduce the level of observations.

50. That evening, the man had his evening meal brought to him. He left his cell to collect hot water and visited other prisoners’ cells to get cigarette papers. At around 7.00pm, an officer recorded that he was watching television, and said he was not good. He refused the services of a Listener, so the officer told him to press his cell bell if he needed anything. He did not press his cell bell that night.

51. There were no concerns recorded about the man the day before the incident. An officer told the investigator that she spoke to him in the evening. She thought he had become paranoid and thought other prisoners were talking about him. With encouragement, he collected his evening meal. There were no other recorded concerns during the night and he did not press his cell bell. At 8.50pm, he was watching television and, at 11.00pm, he was lying in his bed.

Events of the incident

52. An Operational Support Grade (OSG) recorded that he checked the man at 12.55am, 3.00am and 5.05am on 4 February, and that he was asleep in his bed each time. He started the morning roll check at around 5.20am to check that all prisoners where present, when he looked through the observation panel on the man’s cell door, he noticed that he was sitting on the floor with his knees up. He knocked on the cell door and called his name to get his attention but there was no response. As the cell was dark he shone his torch. He saw a bed sheet tied around the man’s neck. He said he immediately

radioed a code blue emergency[4] alarm (recorded at 5.29am on the incident log) and waited for assistance.

53. The SO who was in charge of the operation of the prison during the night radioed an officer, who was his assistant, to collect the nurse from the healthcare centre and went straight to the man's cell. A nurse and a healthcare assistant (HCA) were in the healthcare unit when they heard the emergency call over their radio. The HCA said while they waited to be collected, she gave the nurse the emergency bag containing oxygen and an ambubag. She said she had intended to carry the other emergency bag with medication and a defibrillator[5] to the emergency. The officer arrived quickly, so the nurse had not had enough time to get the keys for the wing medication cupboard. The OSG offered to get them and the officer said he would return to the unit to collect her once he had taken the nurse to the emergency. She told the investigator that no one came back to the wing to collect her and she remained locked in the healthcare centre for the duration of the emergency response.

54. The SO arrived at the cell within two minutes of the code blue being called and looked through the observation panel. He saw the man hanging by a bed sheet attached to the top bunk. The SO tried to open the door, but it was barricaded with furniture from the inside. The OSG helped him push the door. They were joined by another officer. The SO managed to push a small cupboard out of the way and they went into the cell. The officer and nurse arrived at the cell door just as they had gone in.

55. The officers supported the man's body while an officer cut the bed sheet with his prison issue cut down tool[6]. He was placed on the floor. The OSG said he was warm. The SO and an officer checked for signs of life, but found none. The OSG left the cell to continue the roll check. The SO also left the cell and at 5.33am requested an ambulance. He then went to the wing office.

56. As the officers left the cell, the nurse went in and checked the man, but found no signs of life. She started cardiopulmonary resuscitation (CPR) by doing chest compressions. She asked an officer to help her by using the ambubag[7] to give him rescue breaths, but he refused. He said he could not help because he was not first aid trained and did not know how to use the ambubag. The nurse said she continued chest compressions by herself for about seven to ten minutes but then became too exhausted to continue. An officer said that he thought that the nurse had carried out around 20-30 chest compressions, before she said that nothing more could be done for him. None of the officers offered to help the nurse.

[4] Emergency codes are used to summon staff to deal with a particular situation. A Code Red indicates a blood related injury and a Code Blue is used to indicate a life threatening incident or if a prisoner is unconscious.

[5] A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest.

[6] Cut down tools are knives that are specifically designed for safely cutting ligatures and are carried by all officers and healthcare staff who are in contact with prisoners.

[7] Ambu-bag is used to supplement oxygen supply to the patient.

57. After five or ten minutes, the SO went back to the man's cell and gave an officer his keys to escort the paramedics when they arrived. The SO said that he was surprised that resuscitation had stopped and asked the nurse for an explanation. He said that she told him that the man was dead and there was nothing more she could do.

58. At that point, 5.43am, a paramedic arrived at the cell. They assessed the man, but found no signs of life. The paramedic pronounced him dead at 5.51am.

59. After the man's death, the paramedic completed an incident report. In it he said that the nurse told him that she had attempted chest compressions for a couple of minutes and stopped because the man had no pulse and his eyes were dilated. The paramedic said he had asked the nurse where the defibrillator was, but the nurse said that she was not competent to use it and it had been a long time since she had done so.

60. The police found a note in the man's cell after his death, in which he said that he loved his family and indicated that he intended to take his life.

Support for prisoners

61. The Governor posted notices in the prison to let prisoners know of the man's death and services of support that were available to them. All prisoners subject to ACCT monitoring were reviewed in case they had been adversely affected by his death.

Support for staff

62. An operational manager held a hot debrief to offer support to the staff who had been involved in the emergency response. The staff were asked how they were feeling and were offered the support of the staff care team if they felt they needed it. Although she had played a central role in the emergency response, the nurse told the investigator that she had not been invited.

Family liaison

63. The prison family liaison officer and a SO visited the man's parents at their home that morning to break the news of his death. Later that morning, they went to see the man's ex-partner and told her what had happened. The family liaison officer maintained regular contact with the family to assist in making the funeral arrangements. The prison offered financial assistance towards funeral costs in line with Prison Service guidance. The funeral was held on 22 February.

Post-mortem report

64. The post-mortem report confirmed that the man had died from hanging.

ISSUES

Transfer of documentation

65. The man transferred from Gloucester to Bristol on 31 December. There is no evidence that his medical record was transferred with him. (HMP Gloucester closed in March 2013.)

66. Prison Service Order (PSO) 3050 - Continuity of Healthcare for Prisoners sets out that it is the sending establishment's responsibility to ensure that a prisoner transfers with their medical records and any medical needs are effectively communicated with the receiving establishment. Prison Service Instruction (PSI) 64/2011 – Safer Custody requires that all documentation transfers with a prisoner to ensure that any existing care and support is maintained in the receiving establishment. Although it was Gloucester's responsibility to ensure that the documents were transferred with the man, Bristol should have followed up the missing records with the sending prison as a matter of priority.

67. It is important that prisoners' records transfer with them. When they do not arrive the receiving prison should chase them up. We make the following recommendation:

    The Governor and the Head of Healthcare should ensure that reception staff request any missing documentation from the sending prison for all newly transferred prisoners.

Community medical records

68. There is no evidence that the man's GP records were requested when he arrived at Gloucester. He told a nurse at Bristol that he could not recall his community GP's details, but that he had seen the doctor not long before because of mental health problems and had also been prescribed medication for an underactive thyroid. He also told the nurse in reception that he had been treated at a hospital, an acute mental health unit, in 2012. There is no record that the prison contacted the hospital, or tried to obtain his GP details, such as through the hospital, his family or other means. This meant his community medical records were never retrieved.

69. PSO 3050 requires that efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he or she has recently been in contact with to inform his clinical care in custody. The clinical reviewer considers that the prison should have contacted the local primary care support agency, who could have provided the man's GP contact details. We make the following recommendation:

    The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare.

Missed mental health appointments

70. The man was apparently referred for a mental health assessment when he first arrived at Gloucester on 24 December, but he transferred to Bristol before it took place. A nurse referred him for a preliminary mental health assessment when he arrived at Bristol on 31 December. An assessment was scheduled for 10 January and then 15 January. He missed both appointments apparently because there were insufficient staff to take him to the healthcare centre. A further assessment was arranged for 22 January but he would not attend. Mental health staff told the investigator that Bristol has no formal timescale for mental health assessments to be completed after referral.

71. The man's mental health had been identified as linked to his risk of self-harm, and the assessment was one of the support measures recorded on his caremap. A prisoner's wellbeing should not be compromised because of poor staffing arrangements. If there were insufficient officers to take him to his appointment elsewhere in the prison then consideration should have been given to the assessment taking place on the wing to avoid further delay. The clinical reviewer considers that the urgency of his assessment should have been reviewed each time it was cancelled. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that mental health assessments are cancelled only as a last resort and rebooked with appropriate priority.

Mental health assessment

72. The man refused to go to his mental health assessment on 22 January. This was at a time when he rarely left his cell. The nurse did not go to see him in his cell, although he indicated he would be willing to see him. A mental health nurse made an informal assessment of his mental health as part of an ACCT case review which the nurse described as a mental health assessment. He was uncommunicative during the case review, but the nurse concluded that his low mood was a response to the possible seriousness of the charge he was facing and that he did not have a serious mental illness. The clinical reviewer notes that a mental health assessment should be conducted in private to ensure that there is a protective environment for the patient to discuss all of his issues.

73. We do not consider that an appropriate mental health assessment was carried out in a suitable confidential environment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that appropriate mental health assessments are carried out.

Discharge from mental health

74. At a healthcare meeting on 25 January, it was agreed that the man could be discharged from the mental health team because he did not have a serious mental illness. In fact, he was discharged only from secondary mental health services and it was intended that an experienced primary care mental healthcare nurse would review him and assess what support he needed and whether he would benefit from taking medication to support his mental health. This assessment was referred to as a medication review.

75. The clinical reviewer is concerned that the terms 'discharge' and 'medication review' did not adequately reflect the situation and the further mental health support that was apparently planned for the man. Officers were told that he had been discharged from mental health team. They told the investigator that this was understood to mean he no longer needed support for his mental health. It is also possible that he did not understand what mental health support was available for him. We share the clinical reviewer's concerns and make the following recommendation:

    The Head of Healthcare should ensure that prisoners with mental health problems are appropriately supported and have effective care plans which are clearly communicated to the prisoner and to officers and other staff involved in their care.

Assessment of risk and ACCT procedures

76. Prison Service Instruction (PSI) 64/2011 – Safer Custody lists a number of risk factors for suicide, including a history of deliberate self-harm, mental illness, relationship instability and early days in custody. The PSI also recognises that prisoners charged with a violent offence against a family member are at particular risk of suicide. The man had all of these risk factors. Triggers can include further charges, court appearance and transfer between prisons. Although an ACCT was opened as soon as he arrived in custody, these risk factors were not effectively reflected in his initial ACCT document, or his caremap. Despite the risk factors, he was sometimes assessed as a low risk of suicide.

77. When the man first arrived at Bristol, he told a nurse in reception that he had been assaulted at Gloucester and had a cut across his chest. He later repeated this to the nurse who dressed the wound, but his account was slightly different. There was no entry in his prison record to indicate that he had been assaulted or involved in a fight. He was on an open ACCT when he gave these differing and unsubstantiated accounts of the injury. There is no evidence that anyone considered whether the injury was caused by self-harm.

78. ACCT case reviews lacked continuity of case management and very few were multi-disciplinary. The man's first three ACCT reviews at Bristol were chaired by three different case managers. None of the officers who attended the first case review attended the second case review. PSI 64/2011 requires that ACCT case reviews are held by a multidisciplinary team and states that "the

ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments/services".

79. There were five actions on the man's caremap: his vulnerability because of his past offence, his mental health (repeated), boredom, review location of his cell and for staff to ensure that he completed his induction. Officers at Bristol only updated the caremap three times, recording that a mental health appointment had been arranged, mental health were to consider prescribing his medication and provide him with in-cell activity. A caremap is an ongoing record of support measures to reduce a prisoner's risk of suicide or self-harm. There is little evidence from his caremap that officers understood or tackled the root cause of his risk, his alleged offence and possible length of sentence.

80. Even though mental health was mentioned on the limited caremap, no healthcare staff contributed to the man's caremap for the first month he was in custody. When officers assessed that his risk had increased because his charge might change, no one informed the healthcare team and he was not assessed after his video link court appearance.

81. We make the following recommendation:

The Governor should ensure that ACCT assessments and reviews take account of and document all known risk factors, that caremaps address the cause of the prisoner's distress, that realistic goals are set that meet identified needs and that these are reviewed and fully updated at consistently chaired, multi-disciplinary ACCT reviews.

Emergency response

<u>Entering the cell</u>

82. As soon as the OSG saw bed sheets tied around the man's neck, he radioed a code blue, used for life-threatening emergencies. He was the sole occupant of the cell, but the OSG still waited for assistance before going into the cell, despite having a cell key in a sealed pouch for use in such an emergency. He said he did not enter the cell because of fears for his safety. While it is appropriate for staff to make an individual risk assessment taking into account their safety we consider that in these particular circumstances, and as soon as he understood the situation was life-threatening, he should have entered the cell. We make the following recommendation.

The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

Resuscitation and emergency equipment

83. An officer collected the nurse from the healthcare centre, who brought some emergency equipment. The healthcare assistant told the investigator that the officer said he would go back to collect her and the additional emergency equipment, including a defibrillator, because she was not ready to leave the healthcare centre immediately. The officer did not return to bring her to the wing and she remained locked in the healthcare centre throughout the emergency response. There was another defibrillator in the wing office, but no one took that to the cell.

84. The SO left the man's cell as soon as the nurse arrived and went to the wing office. The OSG left the cell to continue the roll check. An officer refused to help the nurse with resuscitation and another officer did not offer to assist as his first aid training was out of date and the OSG had never received any first aid training.

85. The nurse started working at the prison in October 2012, employed by Bristol Community Health (BCH). She had not yet had her prison induction, and had not been told what the emergency codes were. The officers suggested that she did not manage the incident adequately and did not give clear directions to enable them to help her. She told the investigator that she continued resuscitation for around seven to ten minutes, when she stopped because she was exhausted and believed the man was dead. The clinical reviewer considers that the nurse did not manage resuscitation adequately.

86. We are concerned that the entire incident was badly managed and the SO should have taken charge when he arrived at the cell. Even though they were not trained or up to date with their first aid training, the OSG, the two officers and the senior officer could have tried to assist resuscitation under the nurse's guidance. The clinical reviewer notes that a nurse should be able to direct an untrained person to carry out effective cardiac massage. All medical emergency equipment should have been taken to the cell immediately to improve the chances of resuscitation and the officer should have returned to the healthcare centre to bring the healthcare assistant to help. While the incident clearly identifies that the nurse has training needs which need to be addressed, we do not consider that the prison staff involved operated an appropriately by leaving the nurse unsupported throughout the resuscitation efforts. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that there are clearly understood procedures for managing emergency incidents at night. There should be sufficient first aid trained staff on duty at all times who are competent to provide an effective emergency response using all necessary emergency equipment. Officers and healthcare staff should work together to help resuscitate unresponsive prisoners.

Resuscitation policy

87. The man's body was reported to be warm when he was found, and the OSG indicated that he was apparently asleep in his bed less than half-an-hour earlier. (We have been unable to verify this account from other sources as there is no CCTV coverage on the landing to confirm the OSG's account of the timing of his last ACCT check.) By her own account, the nurse stopped resuscitation after seven to ten minutes when she became exhausted. The investigator asked the Head of Healthcare if BCH had a current resuscitation policy, but was given only a draft policy which was not clear about the duration of resuscitation efforts. Usually it would be expected that resuscitation attempts should continue until qualified help in the form of either a doctor or paramedic arrives and the clinical reviewer considers that resuscitation should have continued until the paramedic arrived. However, we note that in this case the nurse was left alone to carry out CPR without relief and could therefore well have been too tired to continue. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that staff have clear guidance that in an emergency incident, unless there are clear signs of death, resuscitation attempts should continue until paramedics arrive.

Ambulance

88. The control room log records that the emergency code blue was called at 5.29am, but an ambulance was not requested until four minutes afterwards.

89. Bristol's own local guidance (18/2013 issued 24 January 2013) requires an ambulance to be called when a code blue is called. PSI 3/2013 – Medical Codes in an Emergency, which came into effect at the end of February after the man's death, also now makes it clear that an ambulance should be requested automatically when a code blue is called. Even a short delay in such circumstances can have a significant impact on a person's chance of survival. An ambulance should have been called as soon as he was found hanging. We make the following recommendation:

The Governor and Head of Healthcare should ensure that an ambulance is called immediately in an emergency and automatically when an emergency code is called.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should ensure that reception staff request any missing documentation from the sending prison for all newly transferred prisoners.

2. The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare.

3. The Governor and the Head of Healthcare should ensure that mental health assessments are cancelled only as a last resort and rebooked with appropriate priority.

4. The Governor and Head of Healthcare should ensure that appropriate mental health assessments are carried out.

5. The Head of Healthcare should ensure that prisoners with mental health problems are appropriately supported and have effective care plans which are clearly communicated to the prisoner and to officers and other staff involved in their care.

6. The Governor should ensure that ACCT assessments and reviews take account of and document all known risk factors, that caremaps address the cause of the prisoner's distress, that realistic goals are set that meet identified needs and that these are reviewed and fully updated at consistently chaired, multi-disciplinary ACCT reviews.

7. The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

8. The Governor and Head of Healthcare should ensure that there are clearly understood procedures for managing emergency incidents at night. There should be sufficient first aid trained staff on duty at all times who are competent to provide an effective emergency response using all necessary emergency equipment. Officers and healthcare staff should work together to help resuscitate unresponsive prisoners.

9. The Governor and the Head of Healthcare should ensure that staff have clear guidance that in an emergency incident, unless there are clear signs of death, resuscitation attempts should continue until paramedics arrive.

10. The Governor and Head of Healthcare should ensure that an ambulance is called immediately in an emergency and automatically when an emergency code is called.

ACTION PLAN: The Man - HMP Bristol

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor and the CSM for BCH should ensure that reception staff request any missing documentation from the sending prison for all newly transferred prisoners.	Accepted	Health - This would normally be sourced via System 1 if applicable. Follow up and tasking to source (electronic messaging system) missing items now in place. Prison – We will ensure all known missing paperwork is requested for newly transferred prisoners.	Completed Completed	
2	The CSM for BCH should ensure that community GP records and other relevant records are routinely requested to ensure continuity of healthcare.	Accepted.	This is routine for healthcare patients either at reception or on the wings, and a separate check is now made at secondary health screenings to ensure this takes place.	Completed	

3	The Governor and the CSM for AWP should ensure that mental health assessments are cancelled only as a last resort and rebooked with appropriate priority.	Accepted.	All new referrals are directed to the duty worker. A duty worker is available from 7am until 8.30pm, 7 days / week. The duty worker reviews the reason for the referral and screens the client against AWPs database to include information about past / current mental health difficulties. If the person is currently open to a community Mental Health team, the duty worker liaises with the Care co-ordinator for a handover, corroborates medication, reviews risks to self / others – the case is then placed straight for allocation at our Friday allocation meeting. If the person is not currently open to a mental health team but the needs outlined on the referral appear urgent, the duty worker liaises with the referrer and will offer a same day assessment if they consider this to be clinically indicated.	Completed	
4	The Governor and CSM for AWP should		All assessments be they routine or duty, are discussed in the multi	Completed	

	ensure that appropriate mental health assessments are carried out.	Accepted	disciplinary SPEM (single point of entry meeting) every Friday often attended by the Team's Consultant Psychiatrist. Decisions to allocate people for further assessment, to take them onto caseload or to discharge them, are taken in this forum by the whole team.		
5	The CSM for AWP should ensure that prisoners with mental health problems are appropriately supported and have effective care plans which are clearly communicated to the prisoner and to officers and other staff involved in their care.	Accepted	We ask all clients to give us consent to share information – we then sign the consent if given, to state whether or not the consent is capacitated. If capacitated consent is given then we regularly discuss our care plans with service users and those involved in their care (Prison Officers, Offender Managers, Governors, Substance Misuse Workers etc). If assessment indicates a service user needs to come onto caseload then they are issued with a formal, written care plan, Service users then sign and are given a copy their care plan. Any risk issues identified in their AWP risk assessment are included in the care plan with a clear outcome re how we / the service user plan to	Completed	

			mitigate that risk. Service users are at liberty to share their care plan with who ever they wish. AWP has clear policies and procedures for the management of risk. Further the team is represented at the Prison's safer custody strategy meetings, CSRA forums and interdepartmental risk management forums where we consider more strategic responses to various risk issues.		
6	The Governor should ensure that ACCT assessments and reviews take account of and document all known risk factors, that caremaps address the cause of the prisoner's distress, that realistic goals are set that meet identified needs and that these are reviewed and fully	Accepted	As an interim measure whilst all staff continue to be trained in ACCTs the "caring for people at risk in prison" ACCT approach guide will be reissued to all staff. Safer Custody department will also carry out audit checks on open, closed and post closure stages to ensure compliance with PSI64/2011	Currently being sourced from Norwich.	

	updated at consistently chaired, multi-disciplinary ACCT reviews.				
7	The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.	Accepted	Our local LSS policy states “Staff have a duty of care to the prisoners and to themselves and to other staff. The **Preservation of Life** must take precedence over the security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger” We are going to provide a guide for staff of what potentially is a risk to them and when they should they shouldn’t enter a cell. We are fully conscious that staff make a dynamic risk assessment at the time	October 2013	
8	The Governor and CSM for BCH should	Accepted.	Health - There are clear procedures for managing emergency incidents	Completed and ongoing	

	ensure that there are clearly understood procedures for managing emergency incidents at night. There should be sufficient first aid trained staff on duty at all times who are competent to provide an effective emergency response using all necessary emergency equipment. Officers and healthcare staff should work together to help resuscitate unresponsive prisoners.		at night in place. BCH have launched an updated and comprehensive induction programme to ensure that all staff are aware of procedures, equipment (including location) and expectations during an emergency. All prison staff are aware of the need to assist and be directed by the health care staff in the event of an emergency situation. This has been reinforced by a notice to staff making them aware of the importance of joint Prison and Healthcare staff working together in emergency situations.	.	
9	The Governor and the CSM for BCH should ensure that staff have clear guidance that in an emergency incident, unless there	Accepted	The Head of Healthcare and the Governor will draft clear guidelines for staff about the circumstances in which resuscitation is not appropriate. This will be reiterated to staff via notice to staff and	Completed	

	are clear signs of death, resuscitation attempts should continue until paramedics arrive.		emphasised through Safer Custody Meetings.		
10	The Governor and CSM for BCH should ensure that an ambulance is called immediately in an emergency and automatically when an emergency code is called.	Accepted	Health - Although previously in the procedure for attending emergencies within the prison, a new element stressing the need to work closely with Officers, ensuring that critical actions have been completed has now been included in the new induction programme. Prison - A notice to staff was issued in line with PSI 03/3013 covering when to call for an ambulance in an emergency situation. This notice to staff has been re issued with particular attention to control room staff that generally make the phone call to the emergency services.	Completed Completed	