Investigation into the circumstances surrounding the death of a man at HMP Bullingdon in May 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of an investigation into the circumstances surrounding the death of a man. He was 62 years old and had been on remand at HMP Bullingdon for around seven months. This was the first time he had been in custody. He was found hanging by his cell mate and an officer at about 4.30pm in May 2010.

I would like to express my condolences and those of my colleagues to his family and I hope my report answers their questions about his care and treatment. I apologise for the delay in publishing my report and for any additional distress that this may have caused.

The investigation was led by my investigator, assisted by an Assistant Ombudsman. An independent clinical review into the man's medical care was undertaken by a clinical reviewer from the local Primary Care Trust (PCT). I am grateful for his clinical review. I am also grateful for the information from the Detective Sergeant of the local police.

I would like to thank the Governor of Bullingdon and his staff for their assistance and contribution to the investigation. I especially thank the liaison officer for her liaison with the investigation team.

Approximately three months before the man was remanded into custody at Bullingdon, he had taken an overdose in an attempt to take his life. He was being treated in the community for anxiety and depression and, although he had a long history of depressive illness, there is a lot of information that his emotional state when he took his life was related specifically to the charges he was facing.

Throughout his time at Bullingdon, I have found that he was assessed, examined and supported by healthcare and mental health trained staff for his high levels of anxiety on numerous occasions. However, it was never thought necessary to put the prison's suicide support and monitoring procedures in place.

As part of my investigation, I consider the assessments made on him and also whether his medication was prescribed appropriately. I make eight recommendations concerning the suicide support procedures and training, record keeping, family liaison and chaplaincy.

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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **July 2011**

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SUMMARY

On 17 December 2009, the man was remanded into custody on charges of a serious nature and was taken to HMP Bullingdon. He was 62 years old and had never been in prison before.

At his first health screen he told staff about a previous overdose but said that he did not feel suicidal at the time of his assessment. Prior to coming into Bullingdon, he had been prescribed various medications for depression and anxiety; in particular he was taking diazepam. He told nursing staff that he had recently lost weight and felt tired but he said that he was otherwise fit and well. He told the nurse that he had no current thoughts of self-harm. Following the health screen the nurse decided that it was not necessary to place him on monitoring under the suicide prevention and self-harm management procedures, but she referred him to the mental health team.

A number of mental heath staff, including a consultant psychiatrist, assessed him. He was diagnosed as suffering from situational depression and anxiety but not from any forensic mental health illnesses, including dementia. As diazepam is an addictive drug and because of its potential misuse in prisons, he was prescribed a reducing dose and it was eventually stopped. However, he was prescribed other anti depressant medication in its place. He also received one to one support from a mental health graduate who had recently started work at the prison, and support from his fellow prisoners.

During his appointments with the mental health graduate, it is recorded that he presented as muddled, nervous and suffering from symptoms of anxiety and depression. He remained adamant that he was not going to harm himself or commit suicide. However, after one session with her on 6 April, he made some disclosures about his offending. He told her that he had been lying in the past and had tried to hang himself on his cell door since coming into custody. She sought advice from her line manager and colleagues and they decided not to place him on the prison's suicide prevention monitoring.

Soon after this his treatment was reviewed and he was discharged from the care of the mental health team. He went to an appointment with a doctor, shortly after being discharged by the mental health team, and complained of increasing anxiety. The doctor prescribed diazepam again, although there is no documentary evidence that explains the doctor's reasons.

He lived in a shared cell on E wing. In May, his cell mate left the cell at 1.30pm to go for a visit. On his return at 4.30pm, he found him hanging by a belt. Attempts by both prison officers and nursing staff to resuscitate him were carried out quickly and proficiently but ultimately were unsuccessful. Treatment was continued by paramedics but, despite their efforts, he was pronounced dead at 5.00pm.

My investigation has concluded that, while it is clear that he received regular intervention from the mental health team, opportunities were missed to support him with the suicide prevention and management of self-harm procedures. I make eight recommendations as a result of my investigation, relating to the suicide prevention and self-harm management procedures and staff training. My recommendations

also concern the prison's personal officer scheme, record keeping, family liaison and chaplaincy.

THE INVESTIGATION PROCESS

1. The man died in May 2010. My investigator opened the investigation by visiting HMP Bullingdon on 20 May. Copies of his prison and medical records were made available and she spoke to his cell mate, who agreed to make a statement. She also spoke to members of the Independent Monitoring Board, who attended the prison immediately after he died.

2. Notices were published to staff and prisoners informing them of my investigation and inviting anyone who had relevant information to contact the investigator. In response to the notices, one prisoner contacted her and she arranged to interview him when she visited the prison. Interviews were conducted on 2 and 3 August by her and an Assistant Ombudsman.

3. She also made contact with the police. She was given access to police reports and statements.

4. A clinical review of the healthcare provided to the man was commissioned by the local Primary Care Trust. (PCT) I am grateful to the clinical reviewer for conducting this review, and his subsequent report. Unfortunately the review was not received until 18 February 2011, some nine months after the man took his life, which has contributed significantly to the delay issuing this report.

5. My Senior Family Liaison Officer spoke to the man's family and explained the role of my office and invited them to be involved in the investigation. The family raised a number of concerns relating to his mental health and prison care, which they asked to be looked at as part of my investigation:

    - The family believe that he was remanded into custody because he was considered to be at risk to himself in the community and had previously taken an overdose. They asked if he had been on suicide watch while at Bullingdon.

    - The family believe that he had been diagnosed with bi-polar disease and asked if he had received treatment for this at Bullingdon.

    - The family asked about his medication while in custody and why certain medication had been stopped.

    - The family would like to know where he was living at the time of his death as they are aware that he had moved location ten days before he died.

    - The family have asked why he was allowed to have a belt in his possession when he had previously attempted to take his life.

HMP BULLINGDON

6. HMP Bullingdon is a category C training prison which also holds category B local prisoners. (Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous.) Bullingdon holds convicted and remand adult male prisoners. The prison serves the courts in Oxfordshire, Berkshire and the London area.

7. HMP Bullingdon was opened in 1992 and can currently hold 1,114 prisoners. It is a new 'gallery style' prison which consists of six wings, which are made up of both single and double cell accommodation. Four of the wings have three spurs with the fifth and sixth added in 1998 and 2008 respectively, each having two galleried spurs. E wing, where the man lived, is designated for older prisoners. During 2009 a new building was opened with education facilities and multiskills workshops. This building provides the workplaces for the new houseblock which opened in November 2009, providing another 31 bed places.

8. Since April 2004, when my office began investigating all deaths in custody, there have been seven self inflicted deaths at Bullingdon, including the man's. I note that there have been two previous recommendations, one in 2004 and one in 2010, relating to the personal officer scheme, which is subject to a further recommendation in this report.

Independent Monitoring Board

9. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the prison service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and any areas of concern.

10. The most recent annual report of the Independent Monitoring Board (IMB) is dated August 2008 to July 2009. It says of healthcare:

> "The medical and administrative staff in the Health Care Centre transferred to the local Primary Care Trust on 1 August 2008. Health-related issues were the second biggest cause of complaint to the Board."

11. In respect of safer custody, the report said:

> "Meetings are held monthly and are well attended. The attendance at these meetings is consistent and of a high quality. It is noted that Governors, Listeners and all relevant staff and agencies are present. There is a considerable input from wing staff when monitoring the individual ACCT reports and self harm incidents. There is also continuous effort made to improve quality control particularly on ACCT reviews." [ACCT is explained later in this report.]

Her Majesty's Chief Inspector of Prisons

12. Her Majesty's Chief Inspector of Prisons carried out an announced inspection of HMP Bullingdon in January 2008. The report concluded that, despite considerable change over recent years, overall the prison was performing relatively well. The Chief Inspector said that:

    > "… it was to the prison's credit that it had risen to many of the challenges posed by the complex and diverse demands placed on it. However, there was still more to do but, this should not obscure the progress made, or that progress had been sustained at a time of considerable pressure.
    >
    > "Relationships between staff and prisoners were mixed, and although the interactions that observed were good, personal officer work was underdeveloped. Entries in personal files were mostly about behaviour and displayed little awareness of prisoners' personal and individual circumstances, or their re-settlement objectives. Until recently there had been long gaps in entries in some files …."

Reception

13. When a prisoner arrives into a prison the warrant that accompanies them from court is checked to ensure that the prison has the authority to keep them in custody. All their clothing and property is searched, the prisoner is 'strip' searched, assessed by a member of the health care team, given the opportunity to shower, and convicted prisoners are provided with prison clothing.

14. Prisoners are interviewed, given a unique prison number, which remains with them throughout their sentence, photographed and their personal details recorded. Any money that they have on reception is paid into their prison account and they are issued with a number to allow access to the telephones on the residential units. They are also offered the opportunity in reception to contact someone to tell them that they are in custody. Other items such as tobacco and sweets may also be provided in advance, with the money paid back when a prison account has been set up.

15. **Edgecott Unit**

    Edgecott Unit is a wing at Bullingdon which is specifically provided for disabled and elderly prisoners. There was a community focus where prisoners help each other out. They can also go into the gardens and can be out of their cells to associate for most of the day.

Healthcare

16. There is an inpatient unit with 24 beds where all the cells have toilets inside the cells. This unit is staffed by both discipline (prison staff) and clinical staff from the local Primary Care Trust. The healthcare unit and staff provide a service for prisoners with mental health needs and those with physical illness, who require 24 hour nursing.

17. The healthcare provision is staffed 24 hours a day, with two clinically qualified nurses on duty at night and weekends. Further overnight and weekend cover is made available by local general practitioners who are on call.

18. Medication is administered on a weekly and/or monthly basis to those prisoners who are considered capable to hold it in their own possession. With others who are considered to be at risk, or where the medication is deemed unsuitable to be held in their possession, daily administration is provided. In possession medication refers to medicines that a prisoner has been risk assessed as being allowed to have in his/her possession. This may be an entire week's course of medication which they collect at the start of a week or items such as skin creams or other non oral medication they may be given a longer supply. Certain medications are not allowed to be held 'in possession' for security reasons, and each prisoner must be risk assessed.

Emergency codes

19. Generally the codes used in emergency situations are 'red' and 'blue'. Blue indicates that a person has breathing/respiratory problems and red that the person is bleeding. The codes allow the medical staff to respond with appropriate equipment. At Bullingdon the codes used are 'level one' and 'level two', but these still refer to the same emergencies as those mentioned.

Assessment, Care in Custody and Teamwork (ACCT)

20. The ACCT procedures aim to provide such support as is necessary to ensure the safety of a prisoner who is identified as at risk of suicide or self-harm. All members of staff should have clear responsibilities under the ACCT system, but preventing self-harm or suicide is wider than caring for those identified as at risk. By being supportive to all prisoners, taking into account their very different needs, staff can reduce the levels of distress in their prisons. In turn this will reduce the number of prisoners who may be at risk of self-harm. According to the National Offender Management Service, suicide prevention is the responsibility of all staff.

21. The ACCT procedures have been introduced to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is subject to regular case reviews that direct the frequency of observations and conversations to be carried out, both day and night, determined by their perceived level of risk.

22. Amongst other things the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the multi-disciplinary team involved in an individual's care to decide the most appropriate place to locate them within the prison.

Sex offender treatment programme (SOTP)

23. This is an offending behaviour programme which aims to address behaviour which has elements of sexual offending. To be suitable for the programme, participants must be willing to admit their offences.

24. There are different variations of the programme (Core, Booster, Extended, Rolling and Core Fast Track.) Some prisoners may start with the core programme and then it may be decided that they require a more in-depth program. Other long term prisoners may complete a 'top-up' programme if it has been sometime since they completed their initial course.

Listeners

25. Listeners support prisoners who may be at risk of suicide and or self-harm. They are selected, trained and supported by Samaritans who offer confidential emotional support, 24 hours a day, to fellow prisoners.

26. The Listener scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access a Listener by approaching them in person or asking a member of staff to make arrangements for a Listener to speak to them. During the hours when prisoners are locked in their cells, anyone wishing to speak to a Listener can make a request from the night staff on duty.

Cut-down tools

27. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must be provided with and carry their own personal issue tool when they are on duty.

Personal officer scheme

28. The personal officer scheme is nationally operated but each prison has its own way of delivering the scheme. The guidance on Bullingdon's personal officer scheme says that a minimum of one quality entry should be made in a prisoners wing history file every two weeks. A certain number of prisoners will be allocated to a named officer to whom they can go to for advice or to resolve complaints. The officer completes reports on each prisoner that they are responsible for and ensures that entries are made in wing history files and offers general advice.

29. Difficulties arise in prisons where overcrowding or a high turnover of prisoners is normal as staff may be unfamiliar with the prisoners. It can also be a problem when an allocated officer is off duty and a prisoner does not know who

to approach. The best schemes benefit from a stable population of prisoners, staff who are committed and a group of officers who are designated to care for particular prisoners rather than one named officer.

Chaplaincy

30. The chaplain will normally be a full time position, although in some prisons it may be a part-time position. The chaplaincy provides spiritual care for all those in prison, including members of staff. The team is usually headed by an Anglican Chaplain who will be responsible for the whole team including those representing the Roman Catholic, Jewish, Hindu, Muslim and other recognised faiths.

KEY EVENTS

31. The man was remanded into custody at HMP Bullingdon, on 17 December 2009, for serious offences. He was 62 years old and it was his first time in custody. His family said that he had been expecting to be given bail, but my investigator was told that a remand into custody was requested by the police due to the serious nature of the alleged offences.

32. The escorting supervising officer (ESO) completed a suicide/self harm warning form when he escorted him to Bullingdon. (The self-harm warning form is used by agencies such as police, courts and probation to highlight any concerns about an individual prior to their arrival in custody. Their concerns may be current issues or historic events such as past self-harm.) The ESO wrote,

    "He states that he lost the plot on 6 October 2009, over these charges and tried taking an overdose. States that he has no thoughts of self harming."

    The form was passed to Nurse A at his first health screen when he arrived at Bullingdon.

33. At the health screen he told staff that he had harmed himself in the recent past but did not feel as though he would harm himself now and was not thinking about suicide. As detailed on the warning form, he told nursing staff that he "lost the plot on 6 October", which he explained was due to the allegations against him. He said that he had taken an overdose as he was depressed and suffering from post traumatic syndrome (PTSD). (PTSD is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma.) The nurse recorded on the suicide and self harm warning form that the ACCT procedures were not opened as a result of the information contained on the form. However, he was told about the Listeners scheme and how to access it if he required.

34. The nurse recorded that each day he took:
    - mirtazepine 45mg, used to treat depression
    - baclofen 10mg, a muscle relaxant
    - paracetomol, for back pain
    - diazepam 15mg often used to treat anxiety.

35. It was also recorded that he was a patient of a psychiatrist while in the community. He was described as 'frail' and 'anxious'. He said that he was concerned that he had lost weight and felt generally tired but was otherwise fit and well. The nurse assessed him as suitable for ordinary location in a single or double cell and recorded that he did not need to see a doctor or be placed on ACCT monitoring. However, the nurse made a mental health referral for him and he was moved to Edgecott (E) wing, which is a wing especially for older prisoners. Although he changed cells on this wing, he remained there throughout his time at Bullingdon.

36. On 18 December, he attended court. He was due to have a secondary health screen that day but it did not take place as he was at court. On returning from

court at 6.41pm, he was prescribed 10mg diazepam by the prison doctor because he was very anxious. It is not clear which doctor prescribed this but he had been examined again by Nurse A. The nurse recorded in his medical record, “RIC states fit.” (RIC is an abbreviation used when someone is remanded into custody.) Prison Doctor A prepared prescriptions continuing the medication that he had been taking prior to coming into custody, except for diazepam, as this needed to be verified with the community GP and was likely to be reviewed because of its potential for misuse and its addictive qualities.

37. He attended for the second health screen a day later on 19 December. He told the nurse that he considered his depression to be a disability and had concerns about his weight loss. He continued to say that he was not thinking about suicide or self harm, although he was still very anxious.

38. Nurse B spoke with him on 20 December and he told her that he had not received any medication. She checked his medical records and noticed that he had previously taken an overdose in October. She suggested that he should be given his medication by the nurse each day, rather than monthly, because of the risk of a further overdose. She arranged for him to be escorted to the healthcare centre (HCC) to collect the medication that was available and told him that the remainder would be ready the next day. She also recorded that he had told her that, while in the community he had been prescribed 15mg diazepam daily, but had only been given 10mg since arriving at Bullingdon. She told him that, as per prison policy, a fax would be sent to his community GP for confirmation before it could be prescribed in prison.

39. On 21 December Prison Doctor B changed his ‘in possession’ medication to daily collection, because of his overdose in October.

40. Two community psychiatric nurses (CPN) held a mental health referral meeting on 21 December, in respect of him. The follow up to this meeting was on 19 January, when Nurse C noted that there is no evidence to suggest that he required intervention from the tertiary mental health services. (Tertiary mental health services provide support for patients with forensic mental health problems. For example when they have been diagnosed with a mental illness which has contributed to their offending.)

41. The same day, a graduate from the mental health team spent some time with him on E wing. When interviewed she said that she was on E wing as part of her induction at the prison and had been asked by staff if she would speak with him, as he was “really struggling with the prison regime and feeling anxious”. She said that she and an officer took him into a room and sat and talked to him. She explained that as she was new to the prison she had various levels and types of clinical and strategic supervision. She said that she was managed by a registered mental health nurse and also supported by two team managers. She also obtained clinical supervision from her personal supervisor, who gave group as well as individual support and guidance. She said that she had been on suicide and self harm training and had learned to complete the Assessment, Care in Custody and Teamwork (ACCT) documents.

42. She recorded in his medical notes that he presented as “tearful and muddled, although his body language was relaxed”. She thought that “this could have been a result of his medication”. He told her that he had overdosed in October. She asked him if he had recently thought about self harming and recorded that,

> “… he sat quietly, for a while trying to remember what he had been thinking about the night before. He could not remember what he had been thinking about last night, but he did not feel like harming himself today.”

He also told her that “he was not able to remember the alleged offences and that he felt sure they had not happened”. He was unable to remember the date when he was charged as he said “it was too traumatic”. He told her about the shock when he was charged and talked about feelings of betrayal and his helplessness in regard to the system. He also told her he “wanted to have the opportunity to speak to his alleged victims”. She suggested that he wrote a letter, where he could make his apologies, which would not be sent. She believed this to be a therapeutic approach, which would help him come to terms with his feelings.

43. He talked about his muscle pain and said that he had to force himself to eat. However, she recorded that he struggled to speak about his depression and how that felt. He told her that he used to take diazepam regularly and was waiting for his prescription to be sorted at the prison. She saw him about an hour later when he seemed much brighter and was preparing a sandwich.

44. She told the investigator that when she spoke to him she had not read his medical notes and did not know about his history. Following her conversation, she told the officers that in her opinion he should be referred to the mental health team. The investigator asked her if she knew that he had already been referred by reception staff. She recalled that he had been seen by Nurse C, as it was thought that his problems might have been forensic and linked to his alleged offences. However, she said that the nurse did not think that this was the case and so he had been referred back to the primary care team.

45. Nurse D assessed him for the mental health team on 22 December. He told him that he attempted to commit suicide previously on four separate occasions when he was in the community. He spent some times over the past 40 years receiving mental health treatment in South Africa, Australia and more recently in Bracknell, in the United Kingdom. He again denied that he had any current thoughts of self-harm or suicide but presented to the nurse as “pensive/anxious restricted affect. Intermittent eye contact. Reticent. Has poor appetite, however eats ‘because it is necessary’“. The nurse’s assessment concluded that he was suffering from long standing anxiety and depression for 40 years and that he was currently in a situation where his anxiety was extremely high because of his imprisonment. The plan was for mental health graduate to offer ongoing support and monitoring and for him to have voluntary support from the chaplaincy team and the Listeners.

46. Nursing staff received confirmation on 22 December that he had been prescribed diazepam, 15mg daily, by his community GP. The confirmation said that no formal mental illness had been identified but he was suffering from situational depression. Prison Doctor B prescribed a reducing dosage of diazepam of 15mg for five days, then 10mg for five days then 5mg for five days then to stop, as per the prison's policy. The prison healthcare staff do not generally prescribe diazepam because it comes from a group of drugs called benzodiazepines, which are highly addictive and are open to misuse by prisoners.

47. His personal officer, Officer A, introduced himself on 29 December. He recorded in his wing history file that he had "settled into the regime well, although he was quiet". The officer saw him and made three more entries in his wing history file, but was then not in the prison again for six weeks. On each entry the officer commented that he was a quiet prisoner who rarely came to the attention of staff and was polite. On 24 January, Officer B made an entry into his wing history file, which said that,

> "He has taken some time to settle into the regime but I am now happy he knows the support networks available to him. Polite and respectful at all times, towards staff and his peers. He needs to gain employment. Keeps a clean cell and his personal hygiene is acceptable."

48. In Officer A's absence, Officer B was his shadow personal officer. (A shadow personal officer works as a back up when the main personal officer is not available.) The officer only made one entry in his wing history file before he changed jobs and moved off the wing. (No further entries were made in the file in the nine weeks from 14 March and 16 May when he took his life. After the officer moved from the wing, there is no evidence to suggest that he was allocated another personal officer.)

49. Officer B told my investigator that in his interaction with him, he found him to be a "very troubled individual". The officer believed that he had been subject to ACCT monitoring, but the investigator has found that this was not the case. He said that, as he was not his main personal officer, he did not sit down to talk at length with him, but he had been told by other prisoners that he was "struggling to cope" with prison life and the charges for which he had been remanded.

50. On 12 January 2010, he told Nurse E that he was not coping well. He was concerned that his diazepam had been stopped and said that his condition had worsened since it had stopped.

51. He attended an appointment with Prison Doctor C on 14 January when he asked if he could resume taking diazepam in the short term. The doctor arranged for him to have an appointment with Prison Doctor B on 19 January. He attended this appointment and the doctor noted that he did not want to re-start taking diazepam, although he was still anxious. Instead the doctor prescribed propranolol, which is used to treat high blood pressure and anxiety.

(The doctor was not interviewed as part of my investigation as the investigator was told that he was no longer employed at the prison.)

52. On 15 January, he approached Nurse D in E wing. He told him that he felt he needed mental health team support as he was suffering from higher levels of anxiety and confusion. He said that this had started since he had stopped taking the diazepam and his main concern was the lack of this medication. He was tearful and agitated and the nurse reminded him of the support which was available. He also reminded him that he had an appointment on 19 January where he could discuss his medication. His medical record shows that he told the doctor that he did not want to resume the diazepam but felt low and anxious.

53. The mental health graduate saw him on a number of occasions. She noted that he continued to be anxious and often forgot what he was about to say with lots of gaps between speaking. On 4 February, he told her that he had thought about suicide some time ago and had looked around his cell for ligature points but could not find any. However, he said that he no longer felt suicidal and took away information leaflets on yoga and doing crosswords and puzzles to distract himself.

54. At another of their sessions, he told her that he was worried about his mental health, as his father had suffered from dementia. He was subsequently referred to a consultant psychiatrist who examined him on 18 February. The doctor concluded that there was no evidence of psychosis or dementia and that he was suffering from moderate to severe depression with anxiety. The plan was to continue with current mental health input and consider appropriate ongoing support from the Listeners and the chaplaincy team.

55. On 1 March, he had another session with the mental health graduate. She noted that he was less muddled and much more coherent. He told her about practical issues that he needed to sort out, such as cancelling his life insurance policy. He also had a new cell with a cellmate who was a Listener and very supportive to him. He appeared at Crown Court on 2 March and was due to appear again on 12 July.

56. Prison Doctor C changed his prescription form propranolol to citalopram, a different anti depressant, on 11 March because he said that he was still experiencing high levels of anxiety and panic attacks. The doctor commented in the medical notes that he had no thought disorders and gave no indication of harming himself.

57. On 23 March, he saw the mental health graduate again. She noted that he made good eye contact and reported feeling well. He told her that he felt his anxiety had deteriorated over the last ten days since he started taking the citalopram, although he remained concerned about his weight loss. She booked an appointment for him to see the doctor because of his worries about losing weight.

58. Prison Doctor C examined him two days later on 25 March about his weight loss. He had lost 2kg in weight since coming into prison. The doctor recorded that he made good eye contact, his speech was normal and he was in regular contact with the mental health team. The doctor made a note that his weight should be checked on monthly basis by a healthcare assistant or nurse. However no further intervention was considered with regard to his weight loss and no physical symptoms were identified.

59. He was examined by Prison Doctor D on 1 April when he again complained about high levels of anxiety. The doctor restarted his prescription for diazepam to be taken daily. No other information is recorded in his medical notes about this examination and it is not clear why the doctor resumed the diazepam prescription, given that he had been through a reduction programme. (My investigator was unable to ask him about his decision as he had left the prison. The clinical reviewer makes comments about his entries and record keeping and this is discussed in the issues section of this report.)

60. On the same day that he was assessed by the doctor, he spoke to Nurse E. He told the nurse that he had received copies of his charges from his solicitor and did not agree with some of them. The nurse advised him to speak to his solicitor about it. He also spoke to the mental health graduate in the healthcare centre (HCC) and asked to see her on the wing. She recorded that he was "unshaven, grinding his teeth and was tearful". He told her that he had deteriorated in the last few days and was finding things "totally impossible". He was pleased to have restarted taking diazepam but was frightened of having to withdraw from it again in the future.

61. He restarted his diazepam on 2 April and it was prescribed for seven days. He was told that he would have to go to the HCC to collect his medication each morning and night time as he was not allowed to have the tablets in his possession due to the earlier risk assessment. He said he was not happy about having to go to the HCC for the medication because he felt that it would be too stressful.

62. He had another appointment with the mental health graduate on 6 April. She thought that he appeared calmer but he told her that he had felt suicidal a few weeks ago, and had attempted to hang himself on the back of his cell door. He believed that this had resulted in him becoming "unconscious for a while". He denied feeling like harming himself or taking his life and said he did not feel too depressed. He apologised about not having told her about his attempt to self-harm previously. He also told her that he had lied about his past offending and spoke graphically to her about this.

63. She was asked by the investigator whether she had considered stopping the interview when he began talking about his offending. She said that she could have done so, but did not as she felt that it was therapeutic for him to discuss it at that time. Given the nature of what he disclosed, she was also asked whether she considered opening the ACCT procedures. She said that she did not think this was appropriate because he said that he had no current thoughts of suicide. Her view of what he told her and the need for the ACCT procedures

was that he spoke about “historic” matters and that ACCT was for “current” issues.

64. Following her conversation with him, she discussed his disclosures with her colleagues and her line manager. She told the investigator that they agreed that there was no need for the ACCT procedures to be initiated. In addition to discussing with her colleagues, she passed on the information he had disclosed to the security department at Bullingdon.

65. In view of what he had said to her, it was decided that his treatment and support should be reviewed. She said that some concern was raised by the forensic team about whether their relationship was “healthy”. She also told the investigator about another concern that had been raised which was that as she had been seeing him for a while, it was questioned whether he might benefit from support from a trained counsellor.

66. On 8 April, she told him that she had passed the information about his disclosures to the security department. She said that he told her that he understood that she would have had to do this and did not think that she had broken his trust. He also told her that he had met his solicitor after making the disclosures and his solicitor had told him not to take them any further. She told him to continue with his plan to disclose his offences to the police so that he could start to deal with his feelings of guilt and shame. He would get help from the sex offender treatment programme. She told him that she would review their progress at the next meeting. She felt she had become more of a counsellor to him, which was not an area in which she had experience.

67. Prison Doctor D prescribed further diazepam on 8 April, for his continuing “anxiety state”. There is no mention in the record of his symptoms at this time and it is not clear whether he attended an appointment with the doctor before the prescription was written. (In his clinical review the reviewer comments that “Prison Doctor D’s record keeping is unacceptable. He is on the performers list of a PCT, another PCT are pursuing the matter with a further PCT who need to be confident he is practising medicine and keeping records in his current post to acceptable standards”.)

68. On 13 April, the mental health graduate had a planned review meeting with him. She told him that she was discharging him from her caseload as she did not want to develop a “counter productive, dependent relationship” and her intervention was only meant to be short term. She thought that he accepted this, saying that he had found the support helpful but asking what he could do if he deteriorated again. She told him that he could contact the mental health team if necessary but another member of the team might respond. She encouraged him to use the Listener service and referred him to the chaplaincy team.

69. He spoke to Nurse D on 16 April and asked if he could again be given diazepam before his court case. It is not clear from the records when the last prescription of diazepam ended. The nurse recorded that there was no indication of self-harm or suicidal thoughts and advised him to speak to the GP

about another prescription for diazepam. He had an appointment with Prison Doctor D on 29 April. The doctor made the following entry in the medical notes, “Problem – Anxiety state NOS, agitation little to done.” He attended another appointment with the doctor on 13 May and was again prescribed diazepam, 10mg, once daily.

16 May

70. The man’s cellmate was asked if he had noticed anything different about him on 16 May. He said that “he was depressed and everything”. The cellmate said that he seemed uninterested in anything and hardly spoke to him. The Sunday regime in the prison is that prisoners go to social visits in the afternoon and the cellmate had a visit booked for that day. He told the investigator that he asked him “do you think they (officers) will come to check” and “do you think they will leave my door open.” He said that he just thought they were “silly” questions and told him “you know what will happen on a Sunday”. He left him in the cell at about 1.30pm to go to his visit and returned at around 4.30pm.

71. Officer C escorted the cellmate back to the wing after his visit and opened his cell door. The cellmate said that he walked a couple of steps into the doorway and then saw him at the back of the cell looking in towards the door. He said that he did not see a ligature but it was clear to him that he had hung himself. It took him a moment to realise what had happened and he said “oh no”. He looked and saw that he was hanging from a ligature from the back window of the cell. The officer immediately moved the cellmate out of the cell and called a level 1 emergency code over the radio.

72. Officer D was nearby and ran to assist the officer. On going into the cell, they noticed that the man had used a leather belt as a ligature and wedged the end into the window. (His family have asked why he had a belt in his possession. Prisoners are allowed belts in their possession unless they are subject to ACCT monitoring and have been considered as ‘high risk’. The only other restriction on belts in prison is in relation to the size and shape of the buckles which may result in an item being prohibited.)

73. Officer D supported the body whilst Officer C cut the belt using his cut down tool and removed the ligature from his neck. He was laid on the floor and the officers tried to find a pulse in his neck or wrist. They were unable to find a pulse and immediately started cardio pulmonary resuscitation (CPR). Officer C performed two sets of 15 chest compressions followed by two breaths. Officer D told my investigator that he had last done first aid training five years ago and these were the instructions at the time. Although the guidelines have since changed to 30 compressions to two breaths, the clinical reviewer states that this would not have altered the outcome for the man.

74. Healthcare staff arrived a few minutes after the officers started CPR and they brought emergency equipment. They attached a defibrillator to him which signalled that there was no heartbeat and they should continue CPR. Nursing staff administered CPR at a ratio of 30 compressions to two breaths. A nurse asked the staff to call an ambulance, and this was done by a governor.

Paramedics arrived around 30 minutes later, CPR having continued throughout by two nurses. The paramedics continued to administer treatment before pronouncing at 5.00pm that he had died.

Events following the man's death

75. The staff who were not directly involved in the resuscitation attempt supported the man's cellmate and moved him into a cell where there was a Listener. He told my investigator that he was well cared for by staff and prisoners alike but continued to have nightmares. Staff also reviewed the prisoners on the wing who were at risk of self harm or suicide and on ACCT monitoring.

76. A hot debrief was held where the staff had the opportunity to discuss their concerns and feelings. They were also offered care from the duty care team. Those staff directly involved were given the opportunity to go home if they wished.

77. There was a delay moving the man's body because a chaplain could not be contacted until 7.00pm. A minister from the Salvation Army attended and said prayers before his body was moved. There was a further delay in contacting his family. The prison explained that they were initially concerned that his next of kin might have been the victims of his alleged offence and so staff needed to assess the emotional impact which the news of his death might have. Eventually contact was made by telephone and the family liaison officer did not keep a log of the events. However, I understand that the family accepted a visit to the wing where he had lived and were given financial assistance for his funeral arrangements.

ISSUES

Prescribing diazepam

78. When the man went into Bullingdon he was taking diazepam, which had been prescribed in the community to treat his anxiety. He was put on a reducing dosage and eventually it was stopped altogether. However, Prison Doctor D restarted this medication although he recorded little about his assessment of him or the symptoms that led to him making his decision. The last time when he was prescribed diazepam was on 13 May, three days before he took his life, when he was examined by the doctor. However my investigator was unable to interview the doctor who left the prison before the interviews took place.

79. The clinical reviewer commented on the issue of diazepam in his review that,

> "It is difficult to say if the decision to stop his diazepam was correct, although I note that he was taking it when he committed suicide. Diazepam is not an anti depressant so would not have helped with his depression, although it would have helped relieve some of his anxiety. The consultant psychiatrist did not suggest restarting the diazepam which I am sure he would have if he had felt it was appropriate."

He further writes that,

> "the benzodiazepines (of which diazepam is one) are a group of drugs which GPs are discouraged from using because they do not help depression, are addictive and also have a strong potential for misuse."

80. The clinical reviewer does not make a formal recommendation about the prescription for diazepam. However, when any medication is prescribed, it should follow an assessment and a concise written record should be made. This would ensure that anyone called to assess the patient in the future is fully aware of the reasons for the medication being prescribed. On this point he makes the following recommendation which I endorse but have slightly recast:

    The Head of Healthcare must ensure that both nursing staff and doctors record all their assessments with patients to inform all future assessments by healthcare staff. All records must be in line with the General Medical and Nursing and Midwifery Council Guidelines.

81. He also makes a recommendation to two PCTs in respect of Prison Doctor D's record keeping and I draw their attention to his concerns.

Mental health and consideration of using ACCT support

82. While there are policies and guidance about how ACCT should be managed in prisons, the system relies on staff acting on any concerns about an individual and using all the relevant information. It is not enough to assume that when a prisoner says that they have no current thoughts of self-harm, that they would not still benefit from the added support and monitoring provided by the ACCT procedures, if managed correctly.

83. When the man arrived at Bullingdon he told staff that he had taken an overdose only two months earlier. He also told staff that he had been treated by the community mental health team and had made at least four previous suicide attempts. He disclosed that he had previously been admitted in 1976 to a psychiatric hospital in South Africa, although no records about any diagnosis were traced.

84. A mental health assessment was completed and he was offered support from the primary care mental health in reach team. A consultant psychiatrist also assessed him to ascertain whether he was suffering from dementia. The result of this examination was that there was no indication that he was suffering from any psychotic illness and that his treatment should remain in the form of primary care intervention from the mental health in reach team.

85. Being remanded into custody and the early period of custody is a time when a prisoner should particularly be considered as to whether they are a 'high risk' of suicide and self-harm. These views are detailed in the Prison Services guidance on suicide and self-harm, Prison Service Order (PSO) 2700. The guidance also says that those charged with violent offences particularly against a family member are also of increased risk. I believe that a man of his age, who had not been in prison before and who was charged with serious offences should have been given particular attention.

86. Withdrawal from drugs or alcohol is also considered to place a person at an increased risk of suicide and self-harm. He was not a user of illicit drugs, but was on a reduction programme for diazepam, which is known to be addictive, only for it to be restarted. He is also recorded as mentioning that prescribing diazepam was something that he considered to be an issue for him.

87. He had ongoing contact with healthcare staff regarding his depression and anxiety. He also had a great deal of contact with a mental health graduate working at the prison. Nevertheless I believe that there were a number of occasions when it was appropriate for the ACCT support procedures to be put in place.

88. First of all, the information disclosed by him at reception together with the nature of the alleged offence and that it was his first time in custody should, I believe, have been enough for staff to open an ACCT document on the first occasion. Next, the disclosure to the mental health graduate of an attempted "suicide" in prison should also have resulted in the ACCT procedures being

opened. It is simply not correct to think that ACCT support was unnecessary because the events had happened previously.

The Governor and Head of Healthcare should ensure that sufficient ACCT training is given to staff and those with direct contact with prisoners. Staff should not base the decision to open an ACCT solely on the self-disclosure of a prisoner, especially when there are factors (as listed in PSO 2700) which demonstrate a raised risk of self-harm and suicide. All staff should be made aware of this and reminded of PSO 2700 in its entirety.

Personal officer scheme

89. The guidance on Bullingdon's personal officer scheme says that a minimum of one quality entry should be made in a prisoner's wing history file every two weeks. I would also expect any significant events to be recorded both in the file and the unit observation book. During the man's time at Bullingdon there were only five entries in his history file, four from his personal officer and one from his shadow personal officer. Each entry gave very little information about his emotional wellbeing. This may be because he chose not to discuss his frame of mind with wing staff. However, he was regularly in contact with healthcare and mental health staff. Information was passed from the mental health graduate to wing staff, especially when he disclosed some of his alleged offences on 8 April. The absence of information in the observation book and his history file prevents important information being shared and provides no evidence that staff knew about significant events.

90. He was without a personal officer from 8 April, while Officer A was away from the prison, and was not given another personal officer before his death. I make two recommendations in this respect, one repeated from my report of February 2010 about completing records and the other relating to ensuring that all prisoners have a dedicated personal officer.

The Governor and Head of Healthcare should remind all staff of the importance of completing wing history sheets and observation books, noting their interactions with prisoners, especially when that information relates to issues of risk of self-harm, whether historic or current.

The Governor should satisfy himself that the personal officer scheme is operating effectively and in accordance with the local protocol. When officers are on long term leave or have changed jobs, another personal officer should be allocated to prisoners.

Family liaison and chaplaincy

91. When he died, the chaplain was on holiday and could not be contacted. It took four and half hours to contact an appropriately qualified religious person to attend and provide spiritual involvement.

92. At the time, there was only one trained family liaison officer at the prison and this further delayed the process of contacting the family. Although PSO 2700 requires prison's to visit the family to tell them of a death, on this occasion, contact was made by the police. The Governor explained that this was because of the distance that the family lived from the prison and because there was some concern that the listed next of kin might have been a victim of his alleged offending.

The Governor should review the procedures for contacting a member of the chaplaincy team outside normal working hours.

The Governor should consider whether having one trained family liaison officer is sufficient to meet the needs of Bullingdon.

The Governor must ensure that all actions of the appointed family liaison officer following a death in custody are in line with PSO 2710 (Follow up to a death in custody).

Diagnoses of bi-polar disorder

93. The man's family said that they believed that he had been diagnosed with bi-polar disorder and was not given the appropriate medication while he was in prison. My investigator made enquiries with healthcare staff, the police and the clinical reviewer. At no time did he tell staff that he had been diagnosed with bi-polar disorder. Staff at Bullingdon correctly asked for his community mental health records and they contained no indication of this diagnosis. The clinical reviewer has also addressed this concern and says:

> "While he was in prison he talked about his anxiety and depression but there is no evidence he mentioned a diagnoses of Bipolar disorder. The prison GP's, nurses, psychiatrist and psychologist who saw him never raised it as a possibility. Looking at the records, while he may have been diagnosed with Bipolar disorder earlier, I do not think it would have been the correct diagnosis for his symptoms while he was at Bullingdon …"

CONCLUSION

94. The man was 62 when he was remanded into custody for serious offences. It was his first time in custody and he was in a high level of anxiety throughout his time there. He had taken an overdose in October 2009, which he had said was related to the charges he faced. There are a number of issues including the alleged charges, previous and more recent suicide attempts and the fact that this was his first time in prison, which would have made him more vulnerable to the risk of self harm or suicide, and should have been acted upon.

95. He was interviewed by a number of doctors and various mental health specialists. Although he told one member of staff that he had attempted suicide whilst he was in prison, no one thought that he was an imminent risk to himself. They considered that previous attempts were 'historical' and, I believe, were too quick to accept that he said he had no current thoughts, without considering all the risk factors. Having spoken to staff and taken the comments made by the clinical reviewer into account, it is my view that there were a series of missed opportunities when an ACCT should have been opened. As well, and as I found in February 2010, the personal officer scheme was deficient which may account for more opportunities when opening an ACCT should have been considered.

96. This is a sorry tale of a man variously described as anxious, tearful, muddled and frail. It will be of no comfort to his family that he is also described as polite and rarely coming to the attention of staff. I am sorry that they have had to wait so long for my report and that my conclusions will offer little reassurance.

Family feedback to draft report

The family have asked for a letter to be attached to the report. The family concur with the recommendations made in this report and reiterate the importance of the prison making the changes recommended.

RECOMMENDATIONS

1. The Head of Healthcare must ensure that both nursing staff and doctors record all their assessments with patients to inform all future assessments by healthcare staff. All records must be in line with the General Medical and Nursing and Midwifery Council Guidelines.

   Accepted – This has been discussed with the Partnership Board and the PCT has assured the Governor that all record keeping is in line with guidelines. Ongoing checks will be carried out by the Healthcare senior management team.

2. The Governor and Head of Healthcare should ensure that sufficient ACCT training is given to staff and those with direct contact with prisoners. Staff should not base the decision to open an ACCT solely on the self-disclosure of a prisoner, especially when there are factors (as listed in PSO 2700) which demonstrate a raised risk of self-harm and suicide. All staff should be made aware of this and reminded of PSO 2700 in its entirety.

   Accepted – ACCT Training has been offered to the healthcare team and will be given a high priority in the training schedule.

3. The Governor and Head of Healthcare should ensure that staff do not base the decision to open an ACCT solely on the self-disclosure of a prisoner, especially when there are a number of factors (explicitly listed in PSO 2700) which evidence a raised risk of self-harm and suicide. All staff should be made aware of this and reminded of PSO 2700 in its entirety.

   Accepted – To be included in the ACCT training and on all induction training for healthcare staff.

4. The Governor and Head of Healthcare should remind all staff of the importance of completing wing history sheets and observation books, noting their interactions with prisoners, especially when that information relates to issues of risk of self-harm, whether historic or current.

   Accepted – The importance of recording quality entries on C NOMIS and observation books has been accepted as a concern. Notices will be published to all staff as a reminder.

5. The Governor should satisfy himself that the personal officer scheme is operating effectively and in accordance with the local protocol. When officers are on long term leave or have changed jobs another personal officer should be allocated to prisoners.

   Accepted – A full review of the personal officer scheme is currently under review with an expected completion date of June 2011.

6. The Governor should review the procedures for contacting a member of the chaplaincy team outside normal working hours.

   Accepted – The procedure to contact Chaplains when they are outside the establishment was reviewed and implemented on 17 May 2010.

7. The Governor should consider whether having one trained family liaison officer is sufficient to meet the needs of Bullingdon.

   Accepted – Action is being taken to identify staff and arrange training.

8. The Governor must ensure that all actions of the appointed family liaison officer following a death in custody is in line with PSO 2710 (Follow up to a death in custody).

   Accepted – This recommendation will be put in place on completion of the training.