Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP Bristol on 22 January 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

This is the investigation report into the death of a man at HMP Bristol on 22 January 2015. He was 55 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care at Bristol. Bristol cooperated fully with the investigation.

The man was serving a life sentence and had been in prison since June 1998. On 29 December 2014, he was transferred to HMP Leyhill, an open prison, as part of his preparation for release. On 8 January 2015, another prisoner alleged that the man had sexually assaulted him and the man was taken to HMP Bristol, a closed prison, while the allegation was investigated.

When he arrived at Bristol, the man was not assessed as a risk of suicide and self-harm and, apart from contact with healthcare staff, there is very little recorded about his two weeks at the prison. He told a nurse he felt isolated and depressed and the nurse referred him to the mental health team, but no one assessed him before he died. He told other prisoners at Bristol that he was considering suicide, but they did not believe him. On the afternoon of 22 January 2015, an officer found the man hanged in his cell.

I am concerned that, when the man was moved from Leyhill and arrived at Bristol, there is little evidence that staff fully considered his risk factors for suicide and self-harm. The man had transferred prisons twice in a short time, which must have been unsettling for him, and I do not consider that staff took into account how the circumstances of his transfer might affect him. While I recognise that he was at Bristol for only a short time, there is a little evidence of active staff support, while he was there. Confusion about next of kin details led to a delay informing the man's family of his death.

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 **September 2015**

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Summary

1. On 23 October 1998, the man was sentenced to life imprisonment for rape. In October 2014, the Parole Board recommended that he should move to an open prison and, on 29 December, he transferred to HMP Leyhill.

2. On 8 January 2015, a prisoner at Leyhill alleged that the man had sexually assaulted him. Prison staff informed the police and the man was transferred to HMP Bristol, a closed prison, that day, while the allegation was investigated.

3. When the man arrived at Bristol, reception staff did not identify him as at risk of suicide and self-harm, despite a number of risk factors including his change in circumstances, prison move and the possibility of further criminal charges. There is no record of any support from a personal officer.

4. On 14 January, the man told the prison doctor that he felt anxious because he had returned to closed prison conditions and was waiting for the outcome of the police investigation. The doctor prescribed medication to help him sleep. Two days later, the man told a nurse he felt isolated and was suffering from depression and anxiety. He asked for help and the nurse referred him to the mental health team, but did not consider he was at risk of suicide. The man told other prisoners that he was anxious about situation; he thought he would never be released from prison and was contemplating suicide. They did not report this to staff.

5. Just before 6.00pm on 22 January, a prisoner told an officer that he was concerned about the man, as he had not seen him for a while. The officer went to check and found the man hanged in his cell. The officer called for help and radioed a medical emergency. Officers and healthcare staff responded quickly, but there was a short delay before the control room called an ambulance. Staff and paramedics were unable to resuscitate the man and, at 6.49pm, paramedics declared his death.

Findings

6. We have found little evidence that reception staff considered the man's risk factors for suicide and self-harm when he arrived at Bristol or that he might be at increased risk because of his situation. There is no evidence of any support from a personal officer while he was at Bristol. After his death, there was a delay informing his family, partly because next of kin details were incorrect.

Recommendations

- The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff:
    i. Identify, consider and document the risk factors for suicide and self-harm of newly-arrived prisoners, including transfer from open conditions;

ii. Complete all sections of the reception and first night risk assessments during the reception process when prisoners arrive;

iii. Have a clear understanding of responsibilities and the need to share all relevant information about risk.

- The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.
- The Governor should ensure that prisoners' next of kin details are checked on reception and recorded on NOMIS and that, where possible, a member of prison staff informs a prisoner's family quickly and in person of their death.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

8. The investigator obtained the man's prison medical records and relevant extracts from his prison record. In February and March 2015, the investigator interviewed staff and prisoners at Bristol and Leyhill.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at Bristol.

10. We notified HM Coroner for Avon of the investigation who provided a copy of the post-mortem report. We have sent the coroner a copy of this report.

11. The investigator and one of the Ombudsman's family liaison officers visited the man's sister, who had a number of matters for the investigation to consider. We have dealt with some of these issues in separate correspondence. The man's sister wanted to know whether it was usual for prisoners to move from open to closed conditions after allegations are made against them and, if so, whether this usually happened so quickly. She asked whether the police had interviewed the man before he died and wanted details about how the man was found and the emergency response.

12. The man's sister received a copy of the draft report. She raised a number of issues/questions that do not impact on the factual accuracy of this report.

Background Information

HMP Bristol

13. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health and Medco Secure Health Services provide primary healthcare and substance misuse services. Avon and Wiltshire partnership provides mental health services. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty to cover the prison throughout the night.

HM Inspectorate of Prisons

14. At the most recent inspection of HMP Bristol in October 2014, inspectors found that reception and early days' procedures had much improved from the previous inspection, and initial safety screening was good. Although prisoners were positive about the support they received, inspectors found a number of deficiencies in the management of ACCT procedures for prisoners at risk of suicide or self-harm. In their survey of prisoners, inspectors found that 57% said they had not met their personal officer. Of those who had a personal officer, only 25% had met them in the first week. Officers rarely made weekly entries in prisoners' records and they varied in quality, with some limited to comments about wing behaviour of simply reporting no problems.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to July 2014, the IMB said that reduced staffing levels had undermined relationships between prison officers and prisoners. They said that there was no longer an effective personal officer scheme: officers had little opportunity to get to know the prisoners on their wing and prisoners complained that officers were too busy to help them with basic requests and concerns.

Previous deaths at HMP Bristol

16. The man's death was the seventh self-inflicted death that the Ombudsman has investigated at Bristol since 2010. We have previously made recommendations about emergency response procedures.

Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

18. On 23 October 1998, the man was convicted of rape and sentenced to life imprisonment with a minimum term to serve of four years before he could be considered for release. The day after his conviction, prison staff supported him using ACCT suicide and self-harm prevention procedures for four days. This was the only time he had been considered at risk of suicide and self-harm during his time in prison.

19. Over the next 16 years, the man completed several offender behaviour programmes, but the Parole Board never considered his risk to the public was sufficiently reduced to direct his release. After a hearing in October 2014, the Parole Board recommended the man should move to an open prison to help prepare for release.

20. On 29 December 2014, the man transferred from HMP Whatton to Leyhill, an open prison. When he arrived, he said he was pleased to be at Leyhill and raised no problems. Reception staff recorded that the man was polite and respectful and had no thoughts of suicide or self-harm. He told staff that his sister, who lived in London, was his next of kin. The staff recorded this on a contact details form, but did not enter the details on NOMIS (the prison record management system).

8 January 2015

21. At around 4.15pm on 8 January 2015, a prisoner alleged that the man had sexually assaulted him. The Supervising Officer (SO) spoke to the prisoner, who said he wanted to report the incident to the police. The duty governor referred the matter to the police.

22. The duty governor told the investigator that he managed the incident under the prison's violence reduction procedures. His first priority was to support the apparent victim, while the police investigated. Leyhill did not have appropriate accommodation to hold the man separately from the man who had made the allegation against him, so the duty governor asked for a transfer to HMP Bristol. He told the investigator that the member of staff had phoned the duty governor at Bristol, and she had agreed the move. This was recorded in a memo to the Governor of Leyhill on 8 January and said that the duty governor at Bristol had been very helpful. The duty governor said that she did not recall speaking to anyone from Leyhill about the man.

23. Shortly before 6.30pm a custodial manager, took the man to a secure holding cell in the prison reception area. She explained that they were moving him to HMP Bristol because of an allegation against him, and gave him written reasons for the move, which said that the police would be investigating, but did not specify the full details. The custodial manager told the investigator that the man did not appear to be distressed but did not say much. Although the man was transferring to a closed prison, while the investigation was taking place, he remained a category D prisoner (suitable for open conditions).

24. The custodial manager completed a transfer form for the man. She told the investigator that she did not have any concerns about him. The form suggested that he had poor mental health, but the manager explained that this was an error; she had over-written the man's details on a form referring to someone else and had forgotten to delete this reference. There are no healthcare staff on duty at Leyhill after 4.30pm, so the man did not see a nurse or doctor before he left.

25. The custodial manager said the police arrived at Leyhill shortly afterwards. They interviewed the alleged victim, but did not interview the man before he left for Bristol. Later that evening, the police notified Leyhill that they would not be pursuing the allegation against the man.

HMP Bristol

26. The man arrived at Bristol at 7.35pm. His Person Escort Record (PER, which accompanied him from Leyhill) indicated that his offence was for rape and that there was a current allegation of sexual assault against him. The PER noted that a nurse at Bristol should see him as he had not seen a nurse when he left Leyhill, and that the man had returned to closed conditions pending a police investigation.

27. When prisoners arrive at a prison, staff should identify and record key information and assess the prisoner's risk of harm to themselves and others. After initial reception procedures, the man moved to D Wing, the prison's first night centre where most of the assessment and initial induction process takes place, but the prison was unable to supply us with much documentary evidence of this. The reception custodial manager told the investigator that he could not explain why the induction sheet, which is usually completed in the first night centre and contains details such as the date a prisoner arrived and any concerns, action to be taken and history of self-harm, was not in the man's prison records.

28. An officer interviewed the man in the first night centre. She told the investigator that the man was not very talkative. The officer explained the prison regime to the man and he signed agreements to say that he understood the prison's rules. The officer was aware that he was a life-sentenced prisoner who had been sent to a closed prison because of an allegation of sexual assault. Although he was annoyed that he had been returned to a closed prison, he said he was okay. She completed a cell sharing risk assessment and concluded that, because of the allegation against him, the man was not suitable to share a cell. She had no other concerns about him. There is no record that she considered whether the circumstances of his transfer might make the man at raised risk of suicide and self-harm and she did not open an ACCT.

29. At 9.30pm, a nurse saw the man for a health screen. She reviewed the cell sharing risk assessment and referred to his SystmOne prison medical record. The nurse told the investigator that she knew about the allegation against him. She recorded that the man engaged well and maintained good eye contact during the assessment, which lasted about 15 minutes. The man said that he did not have any current thoughts of suicide or self-harm or identify any concerns. The nurse referred him to the prison doctor to review his medication as he had arrived with co-codamol, for pain relief, and losartan, for high blood pressure.

The nurse told the man that she would arrange for his medication to be re-prescribed the next day, but he said he no longer wanted to take them.

30. The man moved to A Wing, the vulnerable prisoners' wing, because of his offence. An officer introduced himself to the man and allocated him a double cell (A4-3) although he was the only occupant. He made sure he had a flask and a television in the cell. The officer told the investigator that he had no concerns about the man. All new prisoners at Bristol are checked hourly during their first night at the prison. The night patrol officer recorded that there were no concerns about the man that night.

9 January - 13 January 2015

31. The duty governor told the investigator that Avon and Somerset Police contacted Leyhill on 9 January as they had reconsidered and had now decided to investigate the allegation against the man further. On 11 January, the police visited Leyhill and re-interviewed the alleged victim. The duty governor said that he was not aware of the outcome of the investigation or whether the police intended to take any further action.

32. New prisoners are offered a secondary health screen, normally within two days of arrival. The man declined a further health screen at Bristol.

33. On the afternoon of 11 January, the nurse recorded in the man's medical record that she went to see him in his cell as the GP had prescribed his medication but the man had not collected it. The man told her that he no longer wanted to take his medication and signed a disclaimer. He agreed to let the nurse check his blood pressure and the nurse suggested he should have his blood pressure checked again later in the week.

34. On 13 January, the man phoned a member of his family. The prison gave the investigator a brief summary of the call, which they had listened to as part of routine random telephone monitoring. The summary noted that most of the conversation was not in English. When he spoke in English, The man talked about food at Leyhill and mentioned that he had to tell his solicitor the truth.

35. Two prisoners on A Wing when the man arrived. They told the investigator that it took the man a few days to settle in, but he asked them about the regime and gradually began to speak more openly to them. The man told them that he was depressed as he thought that he might never be released from prison. They said he was concerned about his sexuality and how he would explain his current situation to his sister.

14 January – 21 January 2015

36. On 14 January, the man told the doctor that his urinary function had deteriorated over the past year and he passed small amounts of urine every five minutes, without pain. He said that he felt anxious and was not sleeping properly, because of the police investigation and being sent back to closed conditions. The doctor arranged blood tests and prescribed medication (Kalms) to help him sleep. The doctor told the investigator that he saw no evidence that the man was at risk of suicide or self-harm.

37. On 16 January, the man told a nurse that he felt isolated, depressed and was talking to himself. He asked to see a member of the mental health team. The nurse told the investigator that the man spoke calmly, communicated well and did not appear to be severely depressed. He did not get the impression that the man would harm himself. The nurse referred the man to the mental health team, noting possible symptoms of depression and anxiety.

38. The mental health team met for a triage meeting that afternoon. They agreed to offer the man a routine appointment with a mental health nurse. The nurse said that at the time, the wait for a routine mental health appointment was between one and two weeks.

39. On 16 January, phoned his sister. Most of the call was not in English, but the monitoring officer noted that the man's sister had said that it was "his word against his word".

40. The nurse examined the man on 18 January and recorded his blood pressure (121/83 mmHg, normal blood pressure range is 120/80 -140/90) and pulse (104 bpm, normal resting heart rate for adults ranges from 60 to 100 beats a minute). The man said that he did not intend to take his medication (losartan and co-codamol) as he did not need them anymore, but was happy to take Kalms. The nurse noted that he would ask the doctor to stop the man's prescriptions.

41. A prisoner said he spoke to the man in the exercise yard two or three days before he died. He said the man appeared withdrawn and talked about the incident at Leyhill. He told the prisoner that he was gay and had been tricked by the prisoner who had made the allegation against him. He said that they used to have sex, but something had gone wrong. The prisoner thought that the man had been giving the other prisoner gifts, in return. (Contrary to this account, the prisoner who had made the allegation said he had known the man at Whatton, but had thought he was heterosexual and had never had or discussed sex with him.) The man said he was anxious about what to tell his family about the reasons for his move to Bristol and told the prisoner that he was thinking about suicide. The prisoner told the investigator that, although the man had said that he might take his own life, he did not believe that he had seriously intended to kill himself, as he had heard many prisoners make such remarks.

42. The second prisoner said that around 20 January, the man told him that he was very depressed about his situation. He told the second prisoner about his relationship with the other prisoner at Leyhill and that he had been accused of rape, which he denied. He said he could not see how he could ever get out of prison and was worried about how to tell his family what had happened. He told the second prisoner that he had been thinking about hanging himself. The second prisoner said he tried to encourage him to be less hopeless about his situation and told the investigator that he thought he had persuaded the man not to harm himself, as his mood appeared to improve. The second prisoner and the prisoner did not tell staff that the man had said that he might kill himself.

43. On 21 January, officers moved the man from his cell (which was a double cell) to another cell (A4-009) on the same landing, to free space. Although the new cell was described as a single cell, it had a bunk bed in it.

22 January 2015

44. Around 10.00am on 22 January, the nurse went to see the man in his cell to check his blood pressure. She told the investigator that the doctor had asked nurses to check his blood pressure frequently as he had stopped taking his medication. His blood pressure and pulse were normal. The nurse said he was not very talkative but made good eye contact with her and she had no concerns about him.

45. Between 2.00pm and 3.00pm, the nurse took the man to the wing treatment room for a hepatitis B vaccination then took him back to his cell. The nurse said the man was compliant and polite but again, not very talkative.

46. The evening meal began to be served from around 4.15pm and was followed by an association period, when prisoners are unlocked and able to mix with each other on the wing. The prisoner said that he saw the man leave his cell to collect his meal and then go back to his cell. At around 4.45pm, a third prisoner told the investigator that he left his cell, which was next to the man's, to collect his meal. He noticed the man's door was slightly open, but he did not see him.

47. At approximately 5.00pm, the second prisoner went to check on the man, which he said he had routinely done, since becoming aware that the man was depressed. The cell door was shut (prisoners can lock the door by slamming it shut). The second prisoner looked through the observation panel and saw the man lying on the bed watching the television. He said that the man waved at him.

48. After finishing his evening meal, the prisoner left his cell again at about 5.15pm. He said that the man's cell door was shut. Shortly afterwards, he looked through the door observation panel and thought the cell was empty.

49. The second prisoner went back to the man's cell about 5.50pm, just before the end of the association period. He looked through the observation panel but could not see him. The television was on and the man's meal containers appeared to be untouched. He was concerned as he could not think why the man would be out of his cell and went to find an officer.

50. At about 5.55pm, an officer started locking prisoners in their cells for the evening. The officer said that he was on the fourth landing, when the second prisoner and the other prisoner, told him that they were concerned about the man. The prisoner and another prisoner were also present.

51. An officer went to the man's cell with the prisoners. He looked through the door observation panel and could not see the man. A sheet, hanging down from the upper bunk, obscured the view beyond the bed. The officer went into the cell and found the man hanged by a ligature made from sheets and blankets tied to the bed frame. He was not breathing and his face was blue.

52. The officer supported the man's body and tried to loosen the ligature from around his neck. He shouted to the prisoners outside the cell, to raise the alarm and radioed a code blue emergency (which indicates that a prisoner is unconscious or not breathing and should alert the control room to call an ambulance

immediately). The control room recorded the code blue at 5.56pm and the prisoner pressed the general alarm on the wing landing at the same time.

53. The officer was on the landing below when he heard the general alarm and saw two prisoners on the fourth landing beckoning and shouting to him. He ran upstairs and found the officer supporting the man's body and cut the ligature. The officers laid the man on the floor. The officer who was first aid trained, told the investigator that the man was not breathing and his tongue was purple. He immediately started cardiopulmonary resuscitation.

54. Two nurses responded immediately to the code blue and brought an emergency response bag (with a defibrillator, oxygen and other equipment). It took them about a minute to arrive at the cell and set up the emergency equipment. An officer who was also first aid trained, heard the general alarm and the code blue simultaneously and followed the nurses to A Wing. He took over chest compressions from the officer.

55. The nurse noted that the man's body was warm but he was not breathing and he had no pulse. The nurse gave the man oxygen while the other nurse took over chest compressions from the officer. Nurses applied the defibrillator, but this did not find a shockable heart rhythm.

56. The control room operator told the investigator that she alerted staff to the code blue emergency as soon as the officer had called it. However, she had problems calling an ambulance immediately. The telephone in the control room has a pre-programmed button for calling an emergency ambulance. If this is not used, the call diverts to another extension in the control room. The control room operator did not know this and tried several times to phone an ambulance. The duty governor checked whether the control room had called an ambulance and told the control room operator to use the phone in the command suite, next to the control room. The control room operator said she called an ambulance two or three minutes after the code blue. The ambulance service records show that a fast response paramedic arrived at the prison gate at 6.11pm and at the man's cell at 6.17pm. The control room log recorded that an ambulance arrived at 6.16pm.

57. The paramedic crew took over emergency treatment when they arrived. At 6.56pm, they pronounced that the man had died.

Contact with the family.

58. A custodial manager acted as the prison's family liaison officer. The reception manager told the investigator that the man's NOMIS record showed that his mother was his next of kin. However, it was evident that some of the details were not correct and there was no phone number. He found some details for the man's nephew, who lived some distance away. The family liaison officer contacted the local police who agreed to inform the man's nephew that evening. However, the man's nephew was not at home that night and the police did not break the news to him until 8.30am on 23 January.

59. The reception manager phoned the man's nephew, after the police had visited him. The man's nephew explained that his mother, the man's eldest sister, was in India and that the man's youngest sister, who lived in London, would be likely to act as his next of kin instead. The reception manager phoned her to explain the circumstances of her brother's death and visited her the next day with the deputy governor. In accordance with Prison Service guidance, the prison contributed towards the cost of the man's funeral, which was held on 31 January. HMP Whatton held a memorial service for the man.

Support for prisoners and staff

60. A member of the prison care team spoke to the staff involved in the emergency response and explained what help and aftercare was available to them. The next morning, the Governor, family liaison officer, and the duty governor debriefed the staff involved and offered them support.

61. Staff checked prisoners subject to ACCT suicide and self-harm prevention procedures, in case they had been adversely affected by the man's death. The prisoners we spoke to said that staff had offered support, although one noted that that he was not able to access counselling.

Post-mortem report

62. The post-mortem examination found that the cause of the man's death was compression of the neck as a result of hanging.

Findings

Assessing risk of suicide and self-harm

63. The man had been in prison for over 17 years and had just managed to progress to an open prison, which he hoped would take him a step closer to being released from prison. However, after less than two weeks at Leyhill, he was transferred to closed prison conditions at Bristol and faced a police investigation into an allegation of sexual assault. This would have been a period of great uncertainty and anxiety for the man, which increased his risk of suicide and self-harm. He also told other prisoners at Bristol that he was very worried about how to explain the reasons for the move back to closed conditions to his family.

64. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days at a prison, previous self-harm, change in status, further charges and transfers between prisons. New prisoners must be interviewed in reception so that staff can assess their risk of suicide or self-harm. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including opening an ACCT if necessary. The PSI states that information received should be shared and acted upon appropriately.

65. The duty governor, the Head of Residential Services at Leyhill, told the investigator that, as Leyhill cannot securely lock prisoners in a cell, he decided to transfer the man for his own safety and the safety of other prisoners. The man remained a category D prisoner. We consider that the transfer was appropriate in these circumstances. Although the duty governor at Bristol did not recall speaking to anyone from Leyhill, it is evident that she passed this information on, as reception/first night staff were aware that the man was being transferred to Bristol after a prisoner at Leyhill had made an allegation of sexual assault against him.

66. In April 2014, we published a thematic report about risk factors in self-inflicted deaths. We identified that staff too often focused on their perceptions of a prisoner's behaviour and demeanour and did not place sufficient weight on known risk factors. Officers and the nurse who spoke to the man after he arrived told us that they were not concerned about him. However, there is no record that any of them considered his risk factors, which included the new allegation against him and the nature of his prison transfer, which took place at very short notice and they appeared to have relied almost entirely on how the man appeared.

67. We are concerned that not all of the expected initial documents were completed. The nurse who saw him for an initial health screen said that this was a 'reduced screening' because the man had transferred from another prison, although the escort record had specified that he had not seen a nurse before he left. The nurse said that she knew that he had transferred from Leyhill, but she did not know why and did not ask him.

68. We accept that it would have been difficult for staff at Bristol to have predicted or prevented the man's death. However, we are concerned that staff appeared to rely so heavily on his personal presentation, with little evidence that they took into account the specific risk of his transfer and the likely impact of an indeterminate sentenced prisoner being returned to closed conditions. The effect of such a transfer could have added significantly to the time the man had to spend in prison and he appeared to have recognised this as a possibility. Even if he did not articulate this, being sent to Bristol in such circumstances must have been devastating for him. Ultimately, it is possible that prison staff would have reached the same conclusions about risk if they taken all these factors into account, but we consider that is important to demonstrate that all risk factors have been considered. There is no record that anyone at Bristol took this into account when he arrived or subsequently. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff:

- Identify, consider and document the risk factors for suicide and self-harm of newly-arrived prisoners, including transfer from open conditions;
- Complete all sections of the reception and first night risk assessments during the reception process;
- Have a clear understanding of responsibilities and the need to share all relevant information about risk.

Clinical care

69. The clinical reviewer, concluded that the man's clinical care was comparable to that he could have expected in the community and there was no nothing to indicate his death could have been expected. However, the clinical reviewer was concerned that there was little documented evidence that anyone asked the man how he was coping with his sudden move back to closed conditions, even after he asked for a mental health assessment on 16 January.

The man's contact with staff

70. There were no entries in the man's prison NOMIS record after he arrived at Bristol to show any meaningful contact with officers. He did not have any allocated activity and spent most of his time locked in his cell on the wing with little to do. Staff we interviewed seemed to know little about the man, other than that he was quiet and polite.

71. We are concerned at the apparent lack of staff interaction with the man Bristol's personal officer policy states that personal officers should introduce themselves as soon as possible to the prisoners they are responsible for and make at least one constructive and relevant written observation each week in their prison record. Personal officers are expected to get to know prisoners, support them and help them with any problems. There is no record of anyone introducing

themselves to the man as his personal officer at Bristol and no other record of positive staff interaction.

72. The lack of staff interaction meant wing staff had no insight into the man's concerns and had little awareness of his apparent withdrawal. There is little evidence that wing staff were aware of the man's situation. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.

Emergency response

73. Prison Service Instruction 3/2013 (issued February 2013) requires that governors must have a medical emergency response code protocol, which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensure that staff take the correct equipment to the incident and that there are no delays in calling an ambulance.

74. An officer responded quickly when he found the man hanged in his cell. He radioed an emergency code blue, which the control room operator, the control room operator, broadcast over the radio network at 5.56pm. Officers and healthcare staff responded quickly. However, the control room operator did not know that the telephone had a pre-programmed button for the emergency services, which caused a delay of about two minutes in calling an ambulance. Although the one-touch dial facility is useful in an emergency, staff need to be aware of it. The duty governor told the investigator that the button was now clearly marked on the control room telephones to ensure that staff know how to use the system. We are satisfied that this matter has now been addressed.

Contact with the man's next of kin

75. Prison Rule 22 requires prisons to inform the next of kin as soon as possible if a prisoner dies. PSI 64/2011 instructs that, wherever possible, this must be done in person by a family liaison officer and another member of staff.

76. The man gave next of kin details when he arrived at Leyhill, but staff did not update his NOMIS record. There is no record that staff checked and updated his records when he arrived at Bristol. Ultimately, this led to a delay of almost a day before the man's sister was fully informed about her brother's death.

77. After the initial delay, the prison asked the police to contact the man's nephew, who lived a two-hour drive away. Given the delay that had already occurred, this was a reasonable decision. However, the man's nephew was not at home, and the police did not inform him until the following morning. This should have allowed a member of prison staff to travel to see him to break the news, in line with the national instruction. We make the following recommendation:

The Governor should ensure that prisoners' next of kin details are checked on reception and recorded on NOMIS and that, where possible, a member

of prison staff informs a prisoner's family quickly and in person of their death.

Action plan

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible	Progress (To be updated after 6 months
1	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff: Identify, consider and document the risk factors for suicide and self-harm of newly-arrived prisoners, including transfer from open conditions; Complete all sections of the reception and first night risk assessments during the reception process when prisoners arrive; Have a clear understanding of responsibilities and the need to share all relevant information about risk.	Accepted	All prisoners received into custody at HMP Bristol are screened by a Registered Nurse. As part of the initial reception/ transfer screening process, prisoners are asked about previous self-harming/ suicide attempts, previous time on/ support through the ACCT process and how they are feeling etc. Any concerns identified by the Nurse would lead to an ACCT being opened (self-harm/ suicide risk) and/ or a referral to Mental Health (dependent on specific concern/ presentation). There is a Duty Mental Health Worker on site from 07.00 to 20.00 hours, 7 days a week. The duty worker will triage the referral for level of urgency through undertaking an assessment and based on information available at the time. An 'Identified Risk' form has recently been introduced for	Clinical Services Manager (Bristol Community Health) - complete Team Manager Mental Health (Avon and Wiltshire Partnership Trust) - complete Head of Operations, Head of	

			all received prisoners who have had a change in circumstance, and where reception staff have concerns about their increased risk, for example following recall to prison, new conviction, appeal rejection and prison transfer. A new record is completed each day, and this identifies those prisoners who staff have concerns about risk of suicide and/or self-harm, and records that staff have updated the NOMIS case notes and raised their concerns with the First Night Centre, Mental Health team, the Orderly Officer (if deemed necessary) etc. The completed form is returned to the Safer Custody Department for their information. All reception staff are trained to open an ACCT where they have concerns about a prisoner's risk of suicide and/or self-harm. It is intended that prisoner peer orderlies will be trained who in the future can visit those prisoners with identified concerns during their first week to offer further support. First Night Induction	Safety & Equalities – complete January 2016 Head of Safety & Equalities	

			staff use NOMIS to check for any previous ACCTS and alerts. Staff also check records that arrives with the prisoner, including the Prisoner Escort Record and Warning/ Alert Forms, for any risk related information. A case note entry will be entered on NOMIS, in order that any risk related information is shared. All new prisoners and transfers are placed on hourly observations as part of the first night process, recorded in the 'First Night Book'). The staff undertaking these checks are required to enter a case note on NOMIS with a brief summary of the prisoner's first night in custody. A weekly NOMIS dashboard (Management Information System enabling monitoring of metrics) meeting commenced in June 2015. The purpose of these meetings is to ensure all appropriate information, including regular case notes is recorded on NOMIS. Evidence to date shows that there has been a gradual increase in the number of case note entries.		

2	The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.	Accepted	All managers will be asked to remind their staff of the importance of building good relationships with prisoners and interacting with them regularly, and recording any meaningful contact. All managers will be reminded in their bilat meetings that case notes are a performance measure A weekly NOMIS dashboard (Management Information System enabling monitoring of metrics) meeting commenced in June 2015. The purpose of these meetings is to ensure all appropriate information, including regular case notes is recorded on NOMIS. Evidence to date shows that there has been a gradual increase in the number of case note entries.	Heads of Function Target date for completion: 30th September 2015 Business Hub Manager, Head of Departments Target date for completion: 31st October 2015	
3	The Governor should ensure that prisoners' next of kin details are checked on reception and recorded on NOMIS and that, where possible, a member of prison staff informs a prisoner's family quickly and in person of their death.		Prisoners' next of kin details are checked on reception and recorded on NOMIS. The Head of Operations undertakes a regular check to ensure this is completed. A weekly NOMIS dashboard (Management Information System enabling monitoring of metrics) meeting commenced in June	Head of Operations – complete Business Hub Manager, Head of Departments Target date	

			2015. The purpose of these meetings is to ensure all appropriate information, including next of kin details is recorded on NOMIS. There is early evidence that there has been a significant improvement in the recording of this information.	for completion: 31st October 2015	
			All duty Governors have been reminded of the need to remain in contact with the Police after they have agreed to inform the next of kin, and that where the police attempts are unsuccessful, the prison should dispatch a prison Family Liaison Officer (or request the assistance of a Family Liaison Officer from another prison), in a further attempt to inform the next of kin as soon as possible. The establishment contingency plan for the death of a prisoner states the next of kin should be notified as soon as possible, ideally by a visit from the Family Liaison Officer and one other (e.g. Chaplain), and that if the distance is too great then the visit should be made by the Governor of a nearer prison or the Police with the Family Liaison Officer making a follow-up	Duty Governor/ Silver (person managing the incident) - complete	

			visit. practice. A Notice to staff has been published 30th July 2015 to all staff making them aware of this, that the local safety strategy mandates the actions required to ensure accurate recording of next of kin. The responsibility for contacting the next of kin will remain with the Governor. This is essential in order to ensure that the next of kin is informed face to face, wherever possible. Family Liaison Officers will continue to be supervised and supported by an Operational Manager to ensure that bereaved families are managed sensitively and reasonable needs are met.		

Prisons & Probation Ombudsman
Independent Investigations

No	Recommendation	Accepted / Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1					

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