

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr James King a prisoner at HMP Bristol on 17 January 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr James King was found hanged in his cell at HMP Bristol on 15 January and died in hospital on 17 January. He was 32 years old. I offer my condolences to Mr King's family and friends.

Mr King and a number of other men had been charged and convicted of very serious sexual offences against children. The case attracted significant media attention. Mr King was bullied and received many threats in prison, but too little was done to investigate these incidents.

Prison staff monitored Mr King as at risk of suicide and self-harm for three separate periods while he was at Bristol, but he had not been identified as needing such support since June 2015. Mr King was serving a very long sentence and it was likely that he was always at long-term risk of suicide. However, there was little at the time of his death to indicate he was at imminent and high risk of suicide, and I consider it would have been difficult for staff at Bristol to have predicted or prevented his actions. The investigation found a need to improve emergency procedures at the prison.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**October 2016**

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# Summary

## Events

1. In October 2014, Mr James King was remanded to prison charged with serious sexual offences against children. The case attracted a lot of media attention. Mr King had lived on the wing for vulnerable prisoners at HMP Bristol since November 2014.
2. Mr King had a history of depression and had attempted suicide in June 2014. Prison staff monitored Mr King using Prison Service suicide and self-harm prevention procedures, known as ACCT, three times at Bristol, the last time in June 2015. A mental health nurse saw Mr King regularly to help him manage his anxiety but did not attend or contribute to any of his ACCT case reviews. After he was sentenced in September 2015, Mr King said he no longer needed mental health support.
3. Between April and December 2015, wing staff submitted 16 separate security reports indicating that Mr King was being bullied and threatened. In line with Bristol's violence reduction policy, these incidents were recorded but not investigated.
4. On 11 September 2015, Mr King was sentenced to 32 years imprisonment. He remained at HMP Bristol but on 13 January 2016, it was agreed that he would move to HMP Rye Hill, a specialist prison for men convicted of sexual offences.
5. At approximately 9.20pm on 15 January, Mr King's cellmate said he found Mr King had hanged himself by a sheet attached to the cell window. His cellmate had nothing to cut the ligature with, so he burned through it with his cigarette lighter and pressed the cell bell to alert staff. Two night patrol officers responded and radioed a medical emergency, but they did not go into the cell. A few minutes later, the night manager arrived, went into the cell, and radioed for a nurse. Nurses tried to resuscitate Mr King. The control room waited to get more information about the incident before calling an ambulance at 9.26pm. Paramedics arrived, stabilised Mr King and took him to hospital. Mr King never recovered and he died in hospital on 17 January.

## Findings

6. The investigation found that prison staff did not investigate several reports of bullying and threats against Mr King. The prison's violence reduction policy did not require such investigations and there was no clear strategy to protect prisoners at risk of intimidation from others on the vulnerable prisoners wing.
7. We do not consider that prison staff could have known that Mr King was at imminent risk of suicide at the time he died. However, we are not satisfied that when Mr King was monitored under ACCT procedures, the process operated effectively to protect him. Few ACCT case reviews were multidisciplinary and there was little to indicate that staff recognised and considered the links between bullying and the risk of suicide.

8. We consider that night staff should have gone into Mr King's cell to administer basic first aid, as soon as they discovered that Mr King had hanged himself. The control room did not call an ambulance as soon as staff called an emergency code, which caused a further delay in the emergency response.

## **Recommendations**

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that the mental health team are invited to attend or contribute to all ACCT case reviews for prisoners under their care and are fully involved in any important decisions about their level of risk. Case reviews should consider the impact of potential bullying on a prisoner's risk to himself.
- The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.
- The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.
- The Governor should ensure that the control room calls an ambulance immediately when an emergency medical code is received and that this is reflected in the protocol with the local ambulance service.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. NHS England commissioned a clinical reviewer to review Mr King's clinical care at the prison.
11. The investigator visited HMP Bristol on 25 January 2016. She obtained copies of relevant extracts from Mr King's prison and medical records.
12. The investigator and an assistant ombudsman interviewed ten members of staff and one prisoner at HMP Bristol on 10 and 24 March. The clinical reviewer joined the investigator for interviews with healthcare staff. The investigator and assistant ombudsman interviewed three prisoners by telephone and video link.
13. We informed HM Coroner for Bristol of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr King's mother to explain the investigation. On 23 February, the family liaison officer and the investigator visited Mr King's mother, who gave them a letter from a family friend asking about the prison's procedure for monitoring prisoners at risk of suicide and why the police had not found Mr King's suicide note when they searched his cell. Mr King's mother received a copy of the initial report. She pointed out some factual inaccuracies. This report has been amended accordingly.

# Background Information

## HMP & YOI Bristol

15. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health provides Primary Healthcare and Medco Secure Health Services provide GP services. Avon and Wiltshire partnership provides mental health services and substance misuse 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

16. At the most recent inspection of HMP Bristol in October 2014, inspectors found that there was no effective screening process to allocate vulnerable prisoners and less than a third of those on the vulnerable prisoner unit were there because of the nature of their offence. More vulnerable prisoners than on other wings reported being victimised by other prisoners and the level of violent incidents on the wing was unusually high. Inspectors considered that insufficient was done to make the wing safe. Too few incidents of bullying were investigated and staff did little to challenge bullying behaviour and support victims.
17. 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.

## Independent Monitoring Board

18. 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 June 2015, the IMB said that reduced staffing levels had undermined relationships between prison officers and prisoners. The prison needed to improve systems for monitoring and responding to violence to ensure the safety of all prisoners. The IMB noted that self-harm had increased considerably in the prison since the previous reporting year and that the prison had major lessons to learn from deaths at the prison.

## Previous deaths at HMP & YOI Bristol

19. Mr King's death was the third of four self-inflicted deaths we have investigated at Bristol in 2015 and 2016. We have previously found some deficiencies in management of ACCT case reviews and in emergency procedures, including calling an ambulance immediately and staff going into cells quickly when a prisoner's life is in danger.

## **Assessment, Care in Custody and Teamwork**

20. 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 multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

21. On 23 October 2014, Mr James King was arrested and charged with sexual offences against children. On 24 October, he was remanded to HMP Bedford and transferred to HMP Bristol on 14 November. This was Mr King's second time in prison. He was located in the prisoner's wing for vulnerable prisoners, as he was regarded as at risk from the general prisoner population because of the serious nature of the offences and the associated media coverage.
22. Mr King had a history of depression. In June 2014, he had attempted suicide by cutting his wrists. On 15 November, at an initial health assessment at Bristol, a nurse noted that Mr King had started taking fluoxetine for depression after his suicide attempt, but had then stopped taking it in July. Mr King had been waiting to see the mental health team at Bedford before he had transferred to Bristol, so the nurse referred him for a mental health assessment.
23. On 20 November, an officer found Mr King very distressed. He had a belt by his side, which he had apparently been putting around his neck. She began ACCT monitoring procedures. A Supervising Officer (SO) held the first ACCT case review and completed a caremap. There was no member of healthcare staff present, although a nurse had apparently given some input to him in advance. He recorded that Mr King needed a new cellmate, along with actions to address mental health issues, limited contact with family and friends in the community, and boredom. Staff reviewed the caremap and updated it at case reviews over the next few weeks.
24. On 24 November, a locum GP reviewed Mr King's mental health and prescribed fluoxetine. The GP noted that Mr King scored high on a standard anxiety and depression questionnaire and should have a further assessment to determine if he had bipolar disorder.
25. On 27 November, two nurses assessed Mr King to see if he needed ongoing support from the mental health team. Mr King told them about his suicide attempt in June. One nurse noted that Mr King did not have a severe or enduring mental health illness and his low mood seemed linked to his current circumstances. She referred him for a mental health assessment and to a 'low mood group'.
26. On 2 January 2015, a SO chaired an ACCT case review with a wing officer and Mr King's textile workshop instructor. The review team noted that Mr King's caremap actions had been met, agreed he was no longer at risk of suicide and self-harm, and ended the ACCT monitoring. The next day a nurse decided that Mr King was suitable to keep supplies of medication in his cell, instead of staff giving it to him each day.
27. On 22 January, Mr King and some other prisoners were concerned about the prisoner in the cell near him. They alerted an officer and they found the prisoner had hanged himself. The next day a nurse noted that Mr King was very upset about the prisoner's death and referred him to the mental health team for support.
28. On 26 January, an officer found that Mr King had written a suicide note and began ACCT procedures. A member of staff assessed Mr King and noted that

he was upset about the prisoner's death and the anniversary of his grandmother's death. Later that day, a SO chaired an ACCT case review with a nurse. He recorded in the caremap that Mr King needed to address his boredom and should ask about counselling at his next mental health appointment.

29. On 5 February, a prison GP increased Mr King's dose of antidepressant medication because he said it was no longer helping him. Later that day, he had a second triage assessment with a mental health nurse. He said that he had no thoughts of suicide but that the recent suicide of another prisoner had made him wonder whether his own life was worth living. He wanted to talk to someone about this but the nurse said that the mental health in-reach team did not provide a counselling service. She said he could get help through the prison chaplaincy or talk to Listeners. (Listeners are prisoners trained by the Samaritans to support other prisoners.)
30. Mr King subsequently told one of our investigators, who was investigating the previous death that he had not actually seen the other prisoner hanging, but the incident had brought back memories of when he was a teenager and had found someone who had cut their throat. He said he had asked for counselling but there was none at the prison. A few days later, an ACCT case review noted that all caremap actions had been completed and the staff ended ACCT procedures.
31. On 16 February, a nurse from the mental health team began to see Mr King every fortnight. She told the investigators that the purpose of her sessions with Mr King was to support him and help him manage his anxiety in the time leading up to his sentencing.
32. On 23 February, Mr King admitted that he had been storing his medication, but said that he had thrown it all away because he knew it would not kill him and his friends had talked him out of it. An officer began ACCT monitoring for the third time at Bristol. A SO chaired the first ACCT case review, and assessed Mr King's risk of suicide and self-harm as low. He noted that Mr King would apply to be a Listener and a gay prisoners' representative as actions in his caremap.
33. On 27 February, Mr King was convicted of sixteen sexual offences, but the court would not sentence him, until after the trial of a number of co-defendants finished. He told the nurse from the mental health team that he had no thoughts of suicide or self-harm but was worried about the court case and potential media interest. He wanted to see if he could manage without his medication, but she told him that it was important to take his medication as prescribed. On 25 March, Mr King signed a medical disclaimer stating that he had decided not to take his prescribed medication, against medical advice. Two days later, a prison GP ended Mr King's fluoxetine prescription, at Mr King's request.
34. On 17 April, Mr King told the nurse from the mental health team that other prisoners on his wing had been bullying him after the media started reporting his co-defendants' trial and he did not want to leave his cell. A few days later, a prison GP prescribed Mr King mirtazapine after he told him that he wanted to start taking antidepressants again, as the coverage of the trial was getting him down. The nurse continued to see Mr King every fortnight and gave him self-help materials to help him deal with his anxiety about sentencing and the media

coverage of his case. She discussed further potential therapies that might be useful after he was sentenced.

35. On 23 April, an officer saw marks on Mr King's neck. Mr King told him that he was very anxious about threats that other prisoners had shouted from their cells during the night and said that he had tied a ligature around his neck. Later that day, an ACCT case review team assessed his risk of suicide and self-harm as raised. At a further review five days later, they reassessed his risk and reduced it to low. On 15 June, staff decided to end ACCT monitoring because his caremap actions were complete and they did not consider he was at risk of suicide and self-harm. At an ACCT post-closure review, a SO noted that Mr King was still anxious about his sentencing and staff might need to consider ACCT monitoring again nearer the time.
36. Between 12 April and 22 June, staff submitted seven security intelligence reports about Mr King being bullied and threatened by other prisoners in the vulnerable prisoner wing. The reports included incidents where other prisoners had shouted at Mr King's cell door, kicked doors and shouted abuse from their cells, said they were going to make weapons and recruit others to 'do over' Mr King, and threatened to throw hot water over him. There is no evidence that anyone investigated any of these reports.
37. On 19 June, a nurse noted that Mr King had not collected his mirtazapine for over two weeks. He said he did not need it any more and wanted the prescription stopped. The same day, a prison GP ended the prescription.
38. On 11 September, Mr King was sentenced to 32 years imprisonment. An entry in the wing observation book noted that Mr King's sentencing had been covered on television. Staff submitted a security intelligence report noting that other prisoners had kicked their cell doors and shouted abuse at Mr King and the other men who had been convicted. They threatened their safety when their cells were unlocked the next morning. The next day, an intelligence report noted that Mr King had paid off potential attackers on the wing. No one investigated any further.
39. On 16 September, Mr King told the nurse from the mental health team that he was upset about the length of his sentence. Although he had had some suicidal thoughts, he did not have any plans to kill himself. She noted that Mr King talked about which prison he preferred to go to now he had been sentenced, and his future prospects for employment after release. Mr King did not attend any further appointments with her. On 14 October, she went to see him on the wing and he said that he did not need to see her anymore.
40. On 11 October, Mr King made a formal complaint that some other prisoners on the wing had been threatening him and his co-defendants. On 19 October, a custodial manager replied to the complaint and said staff were doing their best to address the antisocial behaviour. He said that they had recently moved some prisoners from the wing and they would move others if there was enough supporting evidence that they were involved in bullying.
41. Between 20 October and 14 December, there were five further security intelligence reports detailing bullying and threats of violence against Mr King.

There is no record that anyone spoke to Mr King about this or that anyone investigated any of these reports.

42. Prisoner A said that he had become friends with Mr King, who sometimes discussed suicide. He said that he had warned Mr King that taking an overdose of paracetamol would be a painful and prolonged way to die. He said that he thought this discussion had deterred Mr King from killing himself. He did not mention anything about this to staff.
43. Mr King had applied to go to HMP Rye Hill, which offered counselling and sex offender rehabilitation programmes. On 13 January 2016, an officer told Mr King that Rye Hill had accepted his application to transfer there. Several staff and prisoners told investigators that Mr King was positive about transferring to Rye Hill, although he was nervous about leaving behind the support network he had built up at Bristol.

## 15 January

44. On the morning of 15 January, Mr King phoned his mother and discussed a video link appointment he was going to have with his lawyers about appealing his sentence. Mr King spoke positively about moving to Rye Hill.
45. Later that morning, Mr King went to a bible study group. Two prisoners who were also at the group that morning, said that Mr King did not seem worried or upset about anything. A prison chaplain led the group and said Mr King had seemed fine. At the end of the meeting, Mr King had asked him to keep in touch, and whether his mother could write to him. He said that he had assumed that Mr King had asked this because he was about to transfer to Rye Hill.
46. Prisoner A told us that he had spoken to Mr King that afternoon, and he was laughing and talking to other prisoners. Around 4.30pm, Mr King's cellmate said he and Mr King had tea in their cell. He said that Mr King then went for a shower and visited some other prisoners on the wing. At approximately 6.00pm, prison staff locked their cell door for the night.
47. Prisoner B said that Mr King had received two letters just before lock-up time that evening. He said Mr King had turned pale when he read one of the letters and then went back into his cell. The cellmate told us that he did not remember Mr King receiving any letters that evening and neither did other prisoners we spoke to. The police and prison staff did not find a letter received on 15 January in Mr King's cell after he died.
48. Around 8.30pm, Mr King's cellmate said he was lying on Mr King's bed watching television, while Mr King was writing at the table. At 9.00pm, the night patrol officer checked the cellmate, who was being monitored under ACCT procedures. At the time, the light was off and the television was on. She said that Mr King and his cellmate were chatting and laughing together. She told the cellmate that she would check him again later that night.
49. The cellmate said that he fell asleep, but woke up when he heard a choking sound. He pulled the curtain back from around the toilet area and saw Mr King hanging from the window by a sheet. He did not have anything to cut the sheet

with, so he used his cigarette lighter to burn through it, but could not remove it from around his neck, as it was very tight. After he had burnt through the ligature, he said Mr King fell and hit his head on the metal sink. At 9.21pm, he pressed the cell bell to call for help.

50. Officer A said the cellmate later told him that Mr King had asked him to plead guilty to an offence so that he could transfer to Rye Hill with him. He said he had refused to do that. The officer said that the cellmate told him that he had watched Mr King hang himself and waited until he had lost consciousness before ringing the cell bell and trying to remove the ligature. The cellmate denied this and stuck by his original account.
51. The night patrol officer responded to the cell bell, looked through the door observation panel and said the cellmate was shouting, 'He has hung himself!' She asked him to move the curtain so that she could see Mr King. She said that Mr King had blood on his face and made a slight jerking movement. At 9.21pm, she radioed a code blue medical emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing). She said she tried to calm the cellmate down but, because it was a double cell and he was very agitated, she did not feel safe to go into the cell alone. She said that he was shouting and asking what to do, so she asked him to check Mr King's pulse and whether he was breathing.
52. At 9.23pm, the night patrol officer from the next wing arrived and radioed another code blue and a code red (which indicates an emergency when there is a severe loss of blood.) He confirmed with control room staff that they should call an ambulance. He said that he would not go into a cell at night under any circumstances. He said he tried to calm the cellmate down and asked him to check if Mr King was breathing. Control room staff asked both night patrol officers for more information before they called an ambulance, which they did at 9.26pm.
53. Officer A had arrived at Mr King's cell at approximately 9.25pm, closely followed by Officer B, and they went into the cell. Officer B said that he put his hand on Mr King's shoulder and his head moved. He radioed that a nurse was required immediately. The night patrol officer took the cellmate into the Listeners' suite on the wing.
54. Two nurses were working in a nearby wing when they heard the code blue but, as they did not carry keys at night, they had to wait for an officer to take them to Mr King's cell. At approximately 9.29pm, they arrived at Mr King's cell.
55. One nurse said that Mr King was kneeling on the floor, slumped to his right side, and there was swelling on his left eye. Officer A removed the rest of the ligature from Mr King's neck and staff placed him on his back on the floor of the cell. She attached a defibrillator but this did not advise a shock. Mr King was not breathing and his pupils were unresponsive to light, so she gave him oxygen and started resuscitation.
56. At 9.35pm, paramedics arrived and took over emergency treatment. They administered three rounds of adrenalin and established a pulse. At 10.32pm, they took Mr King to hospital.

57. At 11.30pm, the Governor informed Mr King's mother what had happened. After Mr King was taken to hospital, he arranged a taxi to take her to the hospital and for a member of staff to meet her there. Mr King did not recover and died at the hospital at 12.45pm on 17 January.
58. The police found a suicide note on the desk in Mr King's cell. The note said that Mr King did not want to be resuscitated and that everyone would be better off without him. The note also said that he had written a goodbye note in his notebook that explained things further. Police said that they searched for this note in Mr King's cell but were unable to find it. A week later, when the cell had been released by the police, prison staff found the note in a notebook in a cabinet in Mr King's cell.

### **Contact with Mr King's family**

59. A custodial manager acted as the prison's family liaison officer. On 19 January, he visited her at her home to offer condolences and support and make arrangements to return Mr King's property. In line with national instructions, the prison contributed towards the cost of Mr King's funeral.

### **Support for prisoners and staff**

60. After Mr King was taken to hospital, staff took the cellmate to the Brunel Unit in the prison, a unit for prisoners with mental health problems, where staff supported him. The prison posted notices informing other prisoners of Mr King's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr King's death.
61. There was no 'hot' debrief for the staff involved in the emergency response at the time. The staff care team offered support but one member of staff said that they had not received appropriate support.

### **Post-mortem report**

62. A post-mortem examination found that the cause of death was hypoxic ischaemic brain injury and suspension by ligature.

# Findings

## Assessment and management of risk of suicide and self-harm

63. Mr King had a number of factors that put him at heightened risk of suicide and self-harm. Staff identified him as at raised risk and managed him under ACCT procedures three times at Bristol. The last time was in June 2015, and no one had considered he was at particular risk in the seven months before his death.
64. Mr King had been convicted of very serious and heinous offences, which had attracted a lot of adverse media attention and abuse from other prisoners. He had been sentenced to a very long prison sentence. He had a history of depression and had previously attempted suicide. It is likely that Mr King was always at long-term risk of suicide, but there was little to indicate that he was at imminent and high risk of suicide at the time of his death. Although we have some concerns that prison staff did not properly consider the links between risk of suicide and self-harm and bullying and threats (see below) we do not consider that staff could have predicted or prevented his actions on 15 January.
65. The management of ACCT procedures during the periods when staff monitored Mr King as at risk of suicide was generally appropriate. However, we were concerned that few of the ACCT case reviews were multidisciplinary. Although mental health was an ongoing issue and Mr King had regular contact with the mental health in-reach team, a member of the mental health team did not attend ACCT case reviews. The nurse, who had Mr King on her caseload, told us that she did not attend any of his ACCT case reviews. A SO said that mental health staff did not usually attend ACCT case reviews, unless the prisoner has a serious mental illness.
66. Prison Service Instruction 64/2011 states that ACCT case reviews must be multidisciplinary where possible. Multidisciplinary case reviews increase the effectiveness of ACCT procedures by ensuring that a range of views are taken into account in assessing a prisoner's risk of suicide. Where there are ongoing health issues, particularly relating to mental health, we would expect consistent healthcare attendance at reviews, from the person most involved in the prisoner's ongoing care. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that the mental health team are invited to attend or contribute to all ACCT case reviews for prisoners under their care and are fully involved in any important decisions about their level of risk. Case reviews should consider the impact of potential bullying on a prisoner's risk to himself.**

## Safety of prisoners

67. Between April and December 2015, prison staff submitted 16 separate security intelligence reports about Mr King being the victim of bullying and intimidation on the wing. There is no record that anyone investigated these allegations further or took any formal action to support Mr King or prevent him being victimised by other prisoners. Although there was evidence of officers taking individual

initiatives to protect him, there was no evidence of any investigation to identify and challenge the perpetrators.

68. Bristol's local policy 'Violence Reduction and Safer Custody' states that the safer custody department will investigate ongoing concerns of bullying to ensure victims are appropriately safeguarded and actions are being taken against perpetrators. The policy states that the prison is 'working towards a position where all incidents of violence are investigated', and that incidents of antisocial behaviour will not be further investigated unless a trend is identified through analysis of security intelligence reports at monthly safer custody and violence reduction meetings. There is no evidence that any of the security intelligence reports related to Mr King were discussed at the safer custody and violence reduction meetings, although there were concerns over a number of months.
69. We would expect that, where possible, the prison should investigate all incidents of violence and antisocial behaviour. There is no record of any investigations into the information that Mr King was being bullied and threatened during his time at Bristol. At the 2014 inspection, the HM Inspectorate of Prisons found that few incidents of bullying were investigated and that the safer custody department only investigated violent and bullying incidents where the victim was hospitalised.
70. A custodial manager in the safer custody team when Mr King was at Bristol told us that safer custody staff were not able to act on reports of bullying or threats unless they or wing staff had heard or seen the threatening or bullying behaviour. He said that during the time Mr King lived in the wing for vulnerable prisoners, some prisoners had been punished for anti-social behaviour through the incentives and earned privileges (IEP) scheme, which is used to encourage responsible behaviour, or were moved off the wing. However, these actions had not been in direct response to complaints or reports from Mr King or his co-defendants. Some prisoners were moved off the wing because of reports of anti-social behaviour received from other parts of the prison. During the consultation period, the prison said that the movement of these prisoners and these actions were in direct response to reports of anti-social behaviour from a variety of sources, including Mr King's complaint.
71. The PPO has published a range of publications identifying the links between bullying and suicide, but we are concerned that prison staff do not seem to have recognised or considered that the assaults, bullying and intimidation Mr King experienced might have increased his risk of suicide or self-harm. In a review of self-inflicted deaths, published in June 2011, we found evidence of bullying and intimidation in 20 per cent of the cases we reviewed. In a follow-up report of October 2011, 'Violence reduction, bullying and safety', we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that individuals who have been the victim of bullying are potentially at greater risk of suicide and self-harm. We repeated similar messages in our review of all self-inflicted deaths in prisons in 2013/14 and pointed to the need for all reports or suspicions that a prisoner is being threatened or bullied to be recorded and thoroughly investigated and for the potential impact on the victim's risk of suicide to be considered.

72. Several officers told investigators that staff did not follow the correct referral procedures for allocating to the wing for vulnerable prisoners, and prisoners were moved there without the required risk assessment in their local policy for vulnerable prisoners. An officer told us that she had tried to address safety problems on the wing by moving the most vulnerable prisoners, including Mr King, to the level four landing. She said that this made prisoners feel safer because it was rare for other prisoners to come on the landing when she was there. Prisoners on the level four landing said that the vulnerable prisoner wing was no safer than any other wing in the prison and we noted that inspectors found that poor allocation processes for the wing for vulnerable prisoners meant that the mix of prisoners was such that levels of victimisation and violence were higher than elsewhere in the prison. We have no evidence that the mix of prisoners on the wing was responsible for the intimidation of Mr King, but the Inspectorate made a recommendation about this, which the prison will need to address. We make the following recommendation:

**The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.**

### Entering cells in an emergency

73. Bristol's local instruction 'Nights – Opening Cells' says that where there is, or appears to be, immediate danger to life, cells may be unlocked by one member of staff. Preservation of life must take precedence over security concerns, but night staff should not take action that they feel would put themselves or others in unnecessary danger. Staff should undertake a dynamic risk assessment in deciding whether to open a cell or wait for assistance.
74. The night patrol officer said that when she arrived at Mr King's cell she decided not to go in because she thought she was not safe, as it was a double cell and the cellmate was so upset. Another night patrol officer told us that, like other night staff, he had a cell key in a sealed pouch for use in an emergency, but he could see no circumstances when he would unlock a cell and go into a cell on his own at night. While it is appropriate for staff to make an individual risk assessment taking into account their safety, we consider that in these particular circumstances, as there were two staff present, as soon as they understood the situation was life-threatening, they should have unlocked and gone into the cell to administer basic life support.
75. In a previous investigation into a death at Bristol in 2013, we were concerned that staff did not appear to be aware they should consider going into a cell at night in a life threatening situation, subject to an individual risk assessment. The Governor issued additional staff guidance at the time. Night staff will often be the first to attend an emergency response and any delay may be crucial in saving a prisoner's life. We make the following recommendation:

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

### Emergency response

76. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, contains mandatory instructions that prisons should have a protocol with guidance to staff about efficiently communicating the nature of a medical emergency, ensuring that there are no delays in calling an ambulance. It states that an ambulance must be called as soon as a medical emergency is called over the radio network without waiting for further information. The PSI makes it clear that an ambulance can be cancelled if it is later assessed that it is not required.
77. Bristol's protocol with South West Ambulance Services indicates that the prison needs to gather and provide information to the ambulance service so that there is an appropriate priority of response. We are concerned that the protocol with the ambulance service conflicts with the Prison Service Instruction that requires an ambulance to be called immediately. This issue was raised with Bristol in 2013, and the Governor said that they had issued a notice to staff in line with the instruction, with particular attention to control room staff, about when to call an ambulance. In line with the national instruction, we consider that, in a life-threatening situation, an ambulance should be called immediately and further information passed to the ambulance service once it is available.
78. The code blue was radioed at 9.20pm and ambulance records indicate that a call was received from the prison at 9.26pm. This significant delay of six minutes was apparently caused by gathering information to pass to the ambulance service. Such a delay would not happen in the community and should not happen in prisons. In an emergency, even a short delay can have a significant impact on a person's chance of survival and this is particularly concerning as, although Mr King did not recover, paramedics were able to establish a pulse. We cannot know whether earlier emergency intervention would have affected the outcome for Mr King. We make the following recommendation:

**The Governor should ensure that the control room calls an ambulance immediately an emergency medical code is received and that this is reflected in the protocol with the local ambulance service.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations