Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Callum Smith a prisoner at HMP Bristol on 2 March 2016

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*

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 Callum Smith was found hanged in his cell at HMP Bristol on 2 March 2016. He was 27 years old. I offer my condolences to his family and friends.

Although a number of significant indications of concern were present, Mr Smith was not identified as at risk of suicide or self-harm during his six days in Bristol. The investigation found frailties in reception and first night procedures that meant his risk factors were not properly assessed when he first arrived. Staff subsequently failed to identify his risk subsequently, even after he threatened to kill or harm himself and even after he cut himself the evening before he died. I have raised similar concerns about the assessment of risk in previous investigations at Bristol and reiterate the need for them to be addressed.

I also echo concerns raised by HM Inspectorate of Prisons and the Independent Monitoring Board about the need to more effectively safeguard the victims of bullying and investigate bullying. This is another matter I have raised with Bristol before.

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 **January 2017**

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Summary

Events

1. On 26 February 2016, Mr Callum Smith was remanded to HMP Bristol charged with an offence against a family member. He had been in prison before. Mr Smith had a history of self-harm and substance misuse and reported mental health problems. His urine tested positive for opiates, although he had no symptoms of withdrawal. Taking into account his presentation, the nurse assessed that Mr Smith was not at risk of suicide or self-harm. There is no record that any officer in reception spoke Mr Smith or assessed his risk of suicide or self-harm.

2. On his first night in the detoxification unit, 26 February, Mr Smith told prisoner representatives that he was worried for his safety and that prisoners were taking his belongings. They reported his concerns to the safer custody department who spoke to him six days later, but did not investigate his concerns or put support measures in place for Mr Smith as a victim of bullying.

3. On 29 February, Mr Smith became very upset during a substance misuse assessment and the substance misuse worker arranged for an urgent mental health assessment. Mr Smith told her that he wanted to kill himself, but she did not record this and no one started Prison Service suicide prevention measures, known as ACCT. The mental health nurse did not speak to officers or the substance misuse worker before her assessment, but reviewed Mr Smith's records and spoke to him. She concluded that he did not need urgent mental health treatment, but his ongoing mental health care should be discussed at a mental health team meeting four days later.

4. On 1 March, Mr Smith threatened to cut himself with a razor blade, and later, cut his arm. No one considered Mr Smith's risk of suicide or self-harm on either occasion.

5. At 12.30pm on 2 March, an officer responded to Mr Smith's cell bell at 12.30pm and he was lying on his bed. At about 3.10pm, a prisoner told an officer that he was worried about Mr Smith. Officers found Mr Smith hanging from a sheet attached to a fan in the toilet and radioed an emergency call at 3.14pm. The control room waited to get more information about the incident before calling an ambulance at 3.18pm. Staff and paramedics tried to resuscitate Mr Smith, but were unsuccessful. He was pronounced dead at 3.45pm.

Findings

6. We are concerned that reception and first night procedures did not effectively follow Prison Service policy in identifying or assessing Mr Smith's risk of suicide or self-harm when he first arrived at Bristol. The nurse in reception relied too heavily on Mr Smith's presentation and did not take into account the underlying risk factors which were present when she concluded that he was not at risk of suicide or self-harm. There were at least three occasions when staff should have begun ACCT procedures, during his six days at the prison. These concerns

about the identification of risk at Bristol have been the subject of findings in previous reports and we repeat them.

7. The clinical reviewer considered that Mr Smith's substance misuse needs were appropriately managed, but that the mental health nurse should have spoken to others about Mr Smith's behaviour, before assessing his mental health.

8. We found that 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 produce clear 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 all others who assess risk:

  - Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm;
  - Review a prisoner's risk when they self-harm or express thoughts of suicide and begin ACCT monitoring when indicated.

- The Head of Healthcare should ensure that healthcare staff complete mental health assessments accurately taking into account all the available information.

- 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 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.

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 Smith's clinical care at the prison.

11. The investigator visited Bristol on 8 March 2016. She obtained copies of relevant extracts from Mr Smith's prison and medical records, and interviewed one officer.

12. The investigator and clinical reviewer interviewed eight staff and two prisoners at Bristol on 14 and 15 April. She interviewed two more staff by video link on 6 May.

13. We informed HM Coroner for Bristol of the investigation. We have sent the Coroner a copy of this report.

14. One of the Ombudsman's family liaison officers wrote to Mr Smith's family but raised no issues. We have sent them a copy of this report.

Background Information

HMP Bristol

15. 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

16. At the most recent inspection of HMP Bristol in October 2014, inspectors found that reception and early days in custody procedures had improved from their previous inspection, and initial safety screening was good. Services for prisoners with drug and alcohol needs had improved since the previous inspection in 2013.

17. Inspectors also found that levels of violence had risen sharply since 2013 and were considerably higher than in 2013. Few incidents of bullying were investigated and the safer custody department only investigated violent and bullying incidents where the victim was hospitalised.

18. 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

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent report for the year to July 2015, the IMB said that they were concerned with prisoners' increased use of New Psychoactive Substances (NPS) and their unpredictable effects. 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.

20. The IMB also 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. The IMB expressed concern about the systems for monitoring and responding to violence in the prison, and the need to ensure the safety of prisoners, in particular those at risk of bullying or intimidation.

Previous deaths at HMP Bristol

21. Mr Smith's death is fourth self-inflicted death we have investigated at Bristol in 2015 and 2016. We have previously found deficiencies in the identification of a prisoner's risk of suicide and self-harm, as well as the management of bullying and the emergency response.

Assessment, Care in Custody and Teamwork

22. 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

23. On 26 February 2016, Mr Callum Smith was remanded for threatening to burn a family member's house down. He had been in prison before and was most recently released from HMP Hewell in February 2015.

24. Mr Smith's accompanying person escort record (PER – a document which accompanies prisoners when they move between police custody, court and prison) recorded that he had banged his head in police custody, was aggressive on arrest and had previously self-harmed. The officer wrote in the risk section of the PER that Mr Smith said he had been diagnosed with depression years ago and court staff assessed that he should not share a cell because of his mental health issues. After the initial report had been issued, Bristol advised the investigator that an officer had completed Mr Smith's reception process and another carried out the first night interview.

25. At his initial health screen, Mr Smith told a nurse that he took mirtazapine (an antidepressant) for depression, although he had not been prescribed it. He said he thought he might have a bipolar disorder and asked her to refer him to the mental health team, which she did. Mr Smith told her that he had no thoughts of suicide or self-harm at that time, but had cut his arm during a previous time in custody. She noted that Mr Smith had withdrawal symptoms and his urine tested positive for opiates, so she referred him to the drug services team. She said that she thought Mr Smith was chatty during the health screen. Based on his presentation, she did not assess that Mr Smith was at risk of suicide or self-harm, so did not start Prison Service suicide prevention measures, known as ACCT.

26. A healthcare assistant noted that Mr Smith was anxious, jittery and confused in the detoxification unit that evening. She recorded that she thought he might have been using subutex illicitly. A prison GP then examined Mr Smith and noted that he did not show any signs of withdrawal, but thought he might still be under the influence of drugs. The GP asked staff to assess Mr Smith for withdrawal symptoms using the clinical opiate withdrawal scale (COWS).

27. At about midday the next day, a healthcare assistant checked Mr Smith and recorded that he scored three on the COWS scale, which indicated he was experiencing mild withdrawal.

28. A drug support worker saw Mr Smith an hour later. When she tried to explain her role and assess his substance misuse needs, she noted that Mr Smith was disorientated and did not understand their conversation. Mr Smith said he was trying to manage his own detoxification, but he could not remember what he had taken. She said that Mr Smith became distressed and ripped up a confidentiality consent form. He said that he did not know who she was and that she was putting him under too much pressure. She calmed Mr Smith down and explained her role again, but he remained confused and asked to return to his cell, which he did. After their meeting, she referred Mr Smith for a mental health assessment and asked a prison GP to see him to consider prescribing him some detoxification medication to relieve some of his distress.

29. Less than half an hour later, a prison GP could not find Mr Smith in his cell in the detoxification unit to examine him, so reviewed his medical records and spoke to

the healthcare assistant who had assessed Mr Smith that morning. The GP noted Mr Smith had a history of opiate misuse and had reported hearing voices in his head in the past. The GP recorded that staff suspected Mr Smith might have recently taken illicit drugs. He asked nurses to continue to observe Mr Smith and, if his symptoms worsened, suggested that the mental health team review him. The healthcare assistant checked Mr Smith's drug withdrawal symptoms at 5.38pm. Mr Smith's score remained three on the COWS scale, which meant he still only had mild withdrawal symptoms.

30. On 28 February, a mental health nurse recorded that he had received Mr Smith's mental health referral and would book a triage appointment as soon as possible.

31. A healthcare assistant assessed Mr Smith's opiate withdrawal that afternoon and assessed that his withdrawal symptoms remained mild (still three on the COWS scale). Mr Smith said that although he felt physically better than when he arrived at the prison, he still felt paranoid.

32. When a healthcare assistant checked Mr Smith at about 9.30am on 29 February, his COWS score remained three, indicating he was still experiencing mild withdrawal. Shortly afterwards, a nurse noticed that Mr Smith was acting suspiciously and refused an energy drink he had been prescribed because he was underweight. She telephoned the mental health team with her concerns and they agreed to assess him.

33. A prisoner mentor visited Mr Smith that evening, as he does with all new prisoners. He described Mr Smith as agitated and suspicious. Mr Smith was reluctant to talk, so he asked the prisoner safer custody representative to speak to him. Mr Smith told the representative that he was being bullied and some of his belongings had been stolen. The representative said he explained to Mr Smith how to keep things safe and encouraged him to speak to officers if he was being bullied. He thought Mr Smith was too nervous and agitated to take in their conversation. He said he was aware of the ACCT process, but he did not consider that Mr Smith was at risk of suicide or self-harm. He recorded their conversation in a report for the safer custody department.

34. Mr Smith asked a substance misuse worker for a substance misuse assessment when she passed him on the unit. She recorded that Mr Smith was paranoid and unstable during their conversation. He told her that he could not cope without methadone. She discussed Mr Smith with a nurse and then contacted a mental health nurse to ask for someone to assess Mr Smith's mental health urgently. She told the investigator she thought Mr Smith was frightened and appeared to be talking to someone who was not there. She remembered that Mr Smith told her that he would hit his head against a wall until he died, although she did not record this. She said she considered that Mr Smith was at risk of suicide and self-harm, but she did not start ACCT monitoring because she had contacted the mental health team. She said she assumed that the mental health team or officers would begin ACCT procedures.

35. While they were waiting for the mental health nurse, an officer stayed with Mr Smith and told the investigator that Mr Smith was incoherent. The clinical nurse manager was also nearby and remembered that Mr Smith was shouting that other prisoners were annoying him, but he did not make much sense.

36. The duty mental health nurse reviewed Mr Smith's records and saw Mr Smith on the wing less than five minutes after the substance misuse worker spoke to the nurse. She recorded that Mr Smith was sitting on the landing floor with his arms over his head and would not look or speak to her. She took him to a private office, with the clinical nurse manager and the officer. Mr Smith told her that he did not want to speak to anyone. She asked Mr Smith when he had last taken an illicit substance. Mr Smith said he had last smoked a so called "legal high" about a week earlier. She had noted that he tested positive for opiates on arrival, but he had only had mild withdrawal symptoms over the previous three days. She concluded that Mr Smith was a little paranoid, but he did not need urgent mental health treatment. She agreed with the clinical nurse manager that she would monitor his mental health that week and discuss his ongoing care at the multidisciplinary meeting on Friday, four days later. She asked officers to contact her if there were any concerns in the meantime.

37. Mr Smith said he was having trouble with his phone account and wanted some tobacco. An officer agreed to sort this out for him. The clinical nurse manager said that he discussed whether to start ACCT monitoring with the officer and mental health nurse, but thought that he was not at risk of suicide or self-harm and just wanted to speak to his mother and to have some tobacco, which was being arranged. (There is no record that Mr Smith's phone account was set up and he did not make any phone calls in his six days in prison.)

38. At about 3.00pm, a healthcare assistant noted that Mr Smith was still mildly withdrawing, but his COWS score had reduced to two.

39. Shortly afterwards, an officer was escorting Mr Smith to his cell. A prisoner was standing at a cell door and Mr Smith hit him. Prisoners said Mr Smith hit the prisoner with a flask, but another officer said he did not have a weapon. The officer restrained Mr Smith and took him back to his cell. Mr Smith told another officer that he thought the prisoner was going to attack him. This officer had seen the assault and assured him that he was not going to be attacked, but recorded that Mr Smith was confused and placed him on report. The escorting officer telephoned the mental health team and asked whether they could admit Mr Smith to the Brunel Unit, a unit for prisoners with complex mental health needs. The other officer said that the mental health team said Mr Smith was not suitable because he just wanted medication. Neither officers considered that Mr Smith was at risk of suicide or self-harm.

40. On 1 March, the prisoner safety custody representative told an officer from the safer custody department that Mr Smith told him he was being bullied the previous day (29 February). He said Mr Smith had told him that prisoners had taken things from his cell. The officer noted this conversation in Mr Smith's case history but no action was taken.

41. At about 7.00pm, a nurse examined Mr Smith in his cell because he had cut his right arm. She dressed the wounds and planned to review him again in a couple of days. She recorded her treatment in Mr Smith's medical record (which indicates that she was asked to see Mr Smith by "an unknown staff member"), but there is no record of his self-harm in his prison record. No one started ACCT

monitoring or contacted the mental health team and there is no indication that Nurse Steinhausen considered opening an ACCT.

Wednesday 2 March 2016

42. On the morning of 2 March, Officer A recorded that Mr Smith seemed very confused. He discussed his concerns with Officer B, who took Mr Smith to the medication hatch on the wing to collect his energy drink. Mr Smith refused it and asked why he had to go back into his cell. Officer B described Mr Smith as paranoid.

43. On his way back to his cell, Officer A said that Mr Smith became emotional and threatened to cut himself with a razor blade. He said he wanted a shower, a telephone call and some tobacco. Officers took the razor blade from him, arranged a shower and a telephone call, but did not give him tobacco. Officer A told the investigator that he did not take Mr Smith's threat to cut himself seriously and did not consider that he was at risk of self-harm. No one started ACCT monitoring.

44. When the substance misuse worker tried to complete Mr Smith's substance misuse assessment that morning, she was told that he was in his cell and could not be assessed. During a substance misuse meeting, she raised her concerns about Mr Smith's mental health and she was told that all prisoners in the detoxification unit are seen by a member of the mental health team every Wednesday, as a matter of routine. After the meeting, a member of the substance misuse team told a nurse that they were still concerned about Mr Smith's behaviour and asked her to see him again, which she agreed to do.

45. Mr Smith rang his cell bell three times that morning. Officer B went to Mr Smith's cell each time, and each time Mr Smith went to his toilet and shouted that he did not want to speak to anyone. At 12.30pm, Mr Smith pressed his cell bell and asked Officer B for a toilet roll. When the officer returned with it, Mr Smith was lying on his bed and stared at the officer blankly. Mr Smith remained locked in his cell over lunch.

46. At 3.10pm, a friend of Mr Smith's tried to say goodbye to Mr Smith, as he was leaving the unit for the afternoon. He called out to him through his cell door, but Mr Smith did not respond. He thought this was unusual, so he called Officer B. When the officer went to Mr Smith's cell and got no response, he called Officer C to go into the cell with him. He told the investigator that he did not feel safe going into Mr Smith's cell by himself, because of Mr Smith's earlier behaviour.

47. The two officers went into the cell and found Mr Smith hanging with a torn strip of a sheet attached to a fan above the toilet around his neck. Officer C radioed a code blue at 3.14pm. Officer B used his anti-ligature knife to cut the ligature and lowered Mr Smith to the floor. Officer C said Mr Smith was not breathing and looked very pale, so the officers started resuscitation. They continued until healthcare staff arrived in the cell.

48. The clinical nurse manager arrived at Mr Smith's cell quickly because he was nearby and he and Officer C took it in turns to deliver chest compressions. Other

healthcare staff arrived, applied a defibrillator, which advised to continue resuscitation, which they did.

49. An officer was working in the control room. He heard the emergency code blue call but did not telephone an ambulance immediately. He explained that the South West Ambulance Service will not send an ambulance without a prisoner's date of birth and details of their condition. After speaking to someone on the unit for Mr Smith's details, he requested an ambulance at 3.18pm.

50. The first paramedics arrived at 3.27pm. More paramedics arrived three minutes later. The paramedics and healthcare staff continued to try to resuscitate Mr Smith, but a GP pronounced him dead at 3.45pm.

51. A prisoner wrote to prison staff after Mr Smith had died to inform them that Mr Smith had smoked a new psychoactive substance the day he died, although none was detected in the post-mortem examinations.

Contact with Mr Smith's next of kin

52. At 6.00pm, a Supervising Officer (SO) and the Governor visited Mr Smith's parents on 2 March and informed them that he had died and offered condolences and support. The prison contributed to the cost of Mr Smith's funeral, in line with national instructions.

Support for prisoners and staff

53. On the evening of 2 March, an operational manager debriefed the staff involved in the emergency response. She offered her support and that of the care team.

54. The prison posted notices informing other prisoners of Mr Smith'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 Smith's death.

Post-mortem report

55. The post-mortem examination found that Mr Smith's cause of death was hanging. A toxicology report found no evidence that Mr Smith had no drugs or alcohol in his bloodstream when he died, although the toxicologist could not rule out that Mr Smith might have taken something which had not been detected.

Findings

Managing Mr Smith's risk

56. Mr Smith had been charged with an offence against a family member. When he first arrived at the prison, he said he had mental health problems, a history of substance misuse and his PER noted that he had a history of self-harm. Mr Smith tested positive for opiates. A nurse said that she did not think that Mr Smith was at risk of suicide or self-harm. She told the investigator that Mr Smith was chatty and told her that he had no thoughts of suicide or self-harm at the time. She did not assess that Mr Smith was at risk of suicide or self-harm.

57. Prison Service Instruction (PSI) 64/2011 Safer Custody and PSI 07/2015 Early Days in Custody both list a number of risk factors and potential triggers for suicide. These include those charged with an offence against a family member, those dependent on drugs and with a history of self-harm and attempted suicide. The NHS document 'Clinical Management of Drug Dependence in the Adult Prison Setting' also highlights the heightened risk of suicidal risk among opiate dependant prisoners. All of these factors applied to Mr Smith, yet there is little evidence that staff recognised or considered them.

58. PSI 7/2015 requires that the PER and any other available documentation must be examined in reception to assess the risk of self-harm or harm to other prisoners, or harm from other prisoners. There is no evidence that any officer in reception saw or read Mr Smith's PER or considered the detailed information about his risk. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time a member of staff sees them, and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

59. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often staff place too much weight on their perception of a prisoner and do not consider all the relevant information. We reinforced this in a recent learning lessons bulletin in February 2016, about early days in custody.

60. On 29 February, Mr Smith told the substance misuse worker that he wanted to kill himself. She did not record what he said and thought that the duty mental health worker or officers would start ACCT procedures. No one did. The day before he died, on 1 March, Mr Smith cut himself. A nurse treated his wounds, but nobody opened an ACCT. The morning he died, 2 March, Mr Smith threatened to cut himself with a razor blade, but officers did not take his threats seriously, so did not start ACCT monitoring. PSI 64/2011 Safer Custody requires that "any member of staff who receives information … which may indicate a risk of suicide or self-harm must open an ACCT".

61. We consider that staff should have begun ACCT procedures on each of these occasions. We have recommended improvements to the identification and management of risk at Bristol twice before and make the following recommendation:

The Governor and Head of Healthcare should produce clear 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 all others who assess risk:

- **Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm;**
- **Review a prisoner's risk when they self-harm or express thoughts of suicide and begin ACCT monitoring when indicated.**

Clinical care

62. The clinical reviewer considered that Mr Smith's substance misuse needs were managed appropriately. Mr Smith could not give a reliable history of his substance misuse, healthcare staff monitored him regularly, and recorded that his withdrawal symptoms remained mild. The clinical reviewer agreed that it would not have been appropriate to prescribe a prisoner an opiate detoxification programme in these circumstances.

63. A nurse referred Mr Smith for a mental health assessment after his initial health screen on 26 February. The emergency mental health nurse saw Mr Smith on 29 February in response to an urgent request from the substance misuse worker. She reviewed Mr Smith's medical records quickly before she went to see him on the wing, but she did not speak to officers about his behaviour and she did not discuss the substance misuse worker's concerns with her directly. She concluded that Mr Smith did not need urgent mental health treatment.

64. The clinical reviewer was concerned that the mental health nurse did not speak to officers or the substance misuse worker to understand why Mr Smith's behaviour had led to an urgent mental health assessment. He concluded that this meant that her assessment was not fully informed. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff complete mental health assessments accurately taking into account all the available information.

Bullying

65. Mr Smith told the safer custody representative, nurses and officers that he was being bullied and prisoners had taken his belongings. Nobody investigated his allegations or sought to put additional victim support measures in place.

66. HMP Bristol has a Violence Reduction and Safer Custody policy, published in October 2015, which states what action would be taken if a prisoner is victimised or bullied. Paragraph 1.6 says "Residential staff will undertake a fact finding investigation into all allegations of bullying or intimidation and unexplained injuries. The outcome of this process will determine what action will be taken". Paragraph 1.9 says, "Investigations will be carried out by the Safer Custody department into ongoing concerns of bullying to ensure victims are appropriately safe guarded and actions are being taken against perpetrators". We would expect that, where possible, the prison should investigate all incidents of violence

and antisocial behaviour. At the 2014 inspection, 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.

67. We are concerned that prison staff do not seem to have recognised or considered that Mr Smith's experience might have increased his risk of suicide or self-harm.

68. The PPO has published a range of publications identifying the links between bullying and suicide. 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.

69. In our most recent investigation into the death of a prisoner at Bristol in January, we raised similar concerns about the investigation and management of bullying and intimidation. We repeat that 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.

Emergency response

70. 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.

71. 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 he 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.

72. A code blue was radioed at 3.14pm but the officer in the control room did not call an ambulance until 3.18pm. This potentially material delay of four 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. Again, this is an issue that we have raised with Bristol before, most recently following a death in January 2016. We repeat that 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.

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Independent Investigations

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