Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Rawlins a prisoner at HMP Bristol on 16 July 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 Andrew Rawlins was found hanged in his cell at HMP Bristol on 16 July 2016. He was 26 years old. I offer my condolences to Mr Rawlins' family and friends.

Mr Rawlins had been at Bristol for less than 48 hours. He arrived with well documented risk factors and repeatedly expressed his intention to kill himself. Staff appropriately began Prison Service suicide and self-harm prevention procedures when he arrived. However, there were deficiencies in the implementation of these procedures and staff did not appear to recognise the severity of his risk or address his hearing impairment. Overall, I am not satisfied that Bristol did enough to support this vulnerable man during his early days in 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 **April 2017**

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Summary

Events

1. On 1 July 2016, Mr Andrew Rawlins was remanded to HMP Bristol charged with offences against members of his close family. On 8 July, he was released on conditional bail, but was remanded to Bristol again on 14 July, after breaching his bail.

2. Mr Rawlins was hearing impaired and wore hearing aids and could lip read. He had a history of depression and had had contact with community mental health services. Mr Rawlins had attempted suicide and self-harmed in the past, including as recently as June 2016. He was a regular cannabis user and said that he had suicidal thoughts if he could not smoke it. Before arriving at the prison, he said he would kill himself and he arrived with a suicide and self-harm warning form. Staff began suicide and self-harm monitoring procedures (known as ACCT) as soon as he arrived at the prison. The reception supervising officer noted that staff should check Mr Rawlins once an hour until his risk had been further assessed.

3. A nurse assessed Mr Rawlins in reception and referred him to the mental health team. She realised he was hearing impaired but did not refer him for a disability assessment or discuss his needs with prison staff. A mental health nurse also assessed Mr Rawlins in reception but did not think he had a serious mental illness or that he needed ongoing support from the mental health team. A doctor continued Mr Rawlins' community prescription for antidepressants the next day.

4. On the evening of 14 July, Mr Rawlins flooded his cell, ripped up his sheets and destroyed his television. An operational manager increased the frequency of staff checks to twice an hour, but did not speak to Mr Rawlins or review his ACCT plan. The next day, Mr Rawlins flooded his cell again. An officer referred him to the mental health team, who said that they did not need to assess him again.

5. On 15 July, officers held the first ACCT case review. No one from the healthcare department attended. Mr Rawlins said that he did not understand why he had been remanded to prison again, had been abandoned by his family and had nothing left to live for. He said he had a plan to kill himself, but would not discuss this further. The staff assessed Mr Rawlins as at a raised risk of suicide, but left the frequency of staff checks unchanged at twice an hour. They referred Mr Rawlins for a hearing assessment, a mental health assessment (but did not record that either assessment was urgent) and noted that chaplaincy staff and officers should support Mr Rawlins.

6. That afternoon, Mr Rawlins flooded his cell again and an officer thought he was behaving strangely. She discussed Mr Rawlins with a mental health nurse, but the mental health team did not reassess Mr Rawlins that day.

7. On 16 July, Mr Rawlins refused to come out of his cell. At around 11.20am, an officer checked him and found him hanged from the cell smoke detector with a T-shirt tied around his neck. The officer radioed a medical emergency, and officers and nurses attended and attempted resuscitation. At about 11.35am,

paramedics reached Mr Rawlins' cell and took over the resuscitation attempt. At 11.52am, a doctor pronounced that Mr Rawlins had died.

Findings

8. Mr Rawlins had only been at Bristol for 48 hours when he was found hanged. He had a number of risk factors for suicide and was being monitored under ACCT procedures when he died. However, we are concerned that staff did not consider all of his risk factors when assessing his level of risk and setting the frequency of staff checks. The lack of multidisciplinary attendance at the first ACCT case review meant that Mr Rawlins' risks were not managed holistically.

9. Mr Rawlins' hearing impairment was not properly identified and assessed when he arrived at Bristol. When it was identified, it is not clear that staff considered whether Mr Rawlins needed any immediate support to ensure he could participate fully in prison life.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
    - All known risk factors are considered when determining the level of risk of suicide and self-harm.
    - The level of observations must reflect the risk and should be adjusted when risk changes.
    - Staff hold multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews.

- The Governor and Head of Healthcare should ensure that the needs of prisoners with disabilities are identified on reception and that there is a coordinated and multidisciplinary approach to meeting the needs of those with complex conditions through effective care plans which outline the reasonable adjustments required to allow them to participate fully in prison life.

The Investigation Process

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

11. The investigator visited HMP Bristol on 22 July and obtained copies of relevant extracts from Mr Rawlins' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Rawlins' clinical care at the prison.

13. The investigator interviewed 12 members of staff and a prisoner at Bristol between September and November 2016. He and the clinical reviewer jointly interviewed five members of staff.

14. 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.

15. One of the Ombudsman's family liaison officers contacted Mr Rawlins' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Rawlins' mother asked:

    - What medication Mr Rawlins had received when he arrived at HMP Bristol.
    - How often staff checked Mr Rawlins and whether he was appropriately monitored.
    - Why Mr Rawlins had smashed items in his cell.
    - For details of the emergency response when Mr Rawlins was found hanged.

16. Mr Rawlins' mother received a copy of the initial report. She did not make any comments.

17. The Prison Service also received a copy of the initial report. They pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

HMP Bristol

18. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health provides primary healthcare services and Hanham Health provides GP services. Avon and Wiltshire Mental Health Partnership NHS Trust 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 at night.

HM Inspectorate of Prisons

19. At the most recent inspection of HMP Bristol in October 2014, inspectors found that although prisoners were positive about the support they received, there were a number of deficiencies in the management of ACCT procedures for prisoners at risk of suicide or self-harm. Inspectors reported that reception and early days in custody procedures had improved since the last inspection, and initial safety screening was good.

Independent Monitoring Board

20. 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 the prison needed to improve systems for monitoring and responding to violence to ensure the safety of all prisoners. The IMB noted that incidents of 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

21. Mr Rawlins' death was the fifth self-inflicted death at Bristol since 2015. We have previously found some deficiencies in the identification of risk and management of ACCT procedures.

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 1 July 2016, Mr Andrew Rawlins was remanded to HMP Bristol for damaging property, battery and harassment against members of his close family. Mr Rawlins was hearing impaired and used hearing aids and communicated by lip reading. He had a history of suicide attempts and self-harm, which included taking an overdose of paracetamol in 2013, cutting his left wrist with a knife in 2015 and, in June 2016, tying a T-shirt around his neck in police custody. This was not his first time in prison. When he arrived at Bristol, an officer began Prison Service suicide and self-harm monitoring procedures (known as ACCT) because Mr Rawlins said that he would kill himself if he was not released, or if he was not given tobacco. ACCT monitoring ended on 8 July, when Mr Rawlins was released on conditional bail.

Wednesday 13 July

24. On 13 July, Mr Rawlins breached his bail conditions and was arrested. Mr Rawlins was agitated and aggressive and the nurse at the police station thought he might have mental health problems so referred him to Avon and Wiltshire Mental Health Partnership (AWP) Liaison and Diversion Service for a mental health assessment. During AWP's assessment, Mr Rawlins told a mental health nurse that he used cannabis daily, and that when he was unable to access it he had suicidal thoughts. The nurse concluded that Mr Rawlins did not appear to have a severe or enduring mental illness and did not need input from secondary mental health services or a further assessment under the Mental Health Act 1983.

Thursday 14 July

25. On 14 July, Mr Rawlins was due to appear in court. A police officer completed a suicide and self-harm warning form because Mr Rawlins said that he wanted to kill himself, appeared to be very low in mood and sat on the floor in the corner of his cell, shaking. At court, court escort staff checked him every 10 minutes.

26. Mr Rawlins' case was adjourned until 20 July, and he was remanded to HMP Bristol. When he arrived, an officer began ACCT monitoring in reception, noting the information on the suicide and self-harm warning form and that Mr Rawlins had not engaged with staff since arriving at the prison. A Supervising Officer (SO) recorded that staff should check Mr Rawlins once an hour until the ACCT assessment interview had taken place. The SO told the investigator that he could not remember anything about Mr Rawlins, including what information he had reviewed about him before setting the initial frequency of checks. He said that it was standard practice at Bristol to check prisoners once an hour until the ACCT assessment interview was completed, unless the SO had particular concerns about a prisoner, in which case the checks could be more frequent.

27. A nurse carried out the reception health assessment and noted that Mr Rawlins was angry, agitated and anxious, and did not want to engage. Mr Rawlins told the nurse that the police had stolen his property, including some cannabis, which he said he smoked daily. Mr Rawlins said that he did not know why he had been sent back to prison. The nurse told the investigator that she did not know that Mr

Rawlins had said he had suicidal thoughts if he could not smoke cannabis, and did not refer him to the substance misuse service.

28. Mr Rawlins told the nurse that he was going to kill himself that night and so she referred him for another mental health assessment. She noted that Mr Rawlins was prescribed sertraline, an antidepressant, which a prison GP prescribed the following day (apparently without seeing Mr Rawlins himself). She said that she realised that Mr Rawlins was hearing impaired but did not note this in his medical record or refer him to the disability liaison officer or for a disability assessment because she thought that a GP would review Mr Rawlins and make the necessary referrals. She did not discuss his disability with reception officers.

29. At 5.10pm, a mental health nurse assessed Mr Rawlins' mental health. He had read the AWP Liaison and Diversion Service's assessment, and agreed that Mr Rawlins showed no signs of a severe mental illness and did not need to be referred to the mental health team. He recorded that, during the assessment, Mr Rawlins appeared frustrated about his return to prison, but said he had no thoughts of suicide or self-harm. He told the investigator that Mr Rawlins seemed calm. He thought that Mr Rawlins was at a low risk of suicide and self-harm and wrote in the ACCT that he thought staff could continue to check him once an hour.

30. A custodial manager assessed Mr Rawlins as suitable to share a cell. At 6.50pm, an officer took Mr Rawlins to a standard residential wing. Mr Rawlins did not spend his first night in the prison on the first night centre, as most new prisoners do. The reason was not recorded but staff thought it might have been because the first night centre was full that evening. Although his cell could hold two prisoners, Mr Rawlins did not share a cell while at Bristol. Mr Rawlins asked the officer for a smokers' pack (an advanced supply of tobacco and cigarette papers), but she said that she could not get him one that evening. (Staff told the investigator that Mr Rawlins did not receive a smokers' pack or any tobacco while at Bristol.) She recorded in the ACCT document that Mr Rawlins appeared to be low in mood. At 7.20pm, he told her that if people wanted to come and stare at him and wanted him to kill himself, they should just "give him what he needed to do it".

31. At around 7.40pm, the officer checked Mr Rawlins again, who was ripping up his sheets. He then flooded his cell. At 8.20pm, she recorded that he had ripped apart his television and put it in the flooded sink. Staff turned off the power to his cell as a safety measure. She charged Mr Rawlins with a disciplinary offence for damaging prison property. She also telephoned the custodial manager and asked what she should do. The custodial manager told the investigator that she did not go to Mr Rawlins' cell to speak to him directly and she did not review his ACCT or level of risk, but told the officer to increase the frequency of staff checks to twice an hour. Officers moved Mr Rawlins to another cell on the wing and recorded that he slept well that night and did not raise any further concerns.

Friday 15 July

32. At 8.40am, Mr Rawlins flooded his cell again. Later that morning, a substance misuse worker went to Mr Rawlins' wing to assess him. She told the investigator that, although Mr Rawlins had not been referred to the substance misuse team,

they reviewed all new prisoners' medical records and had identified Mr Rawlins' cannabis use. However, when she arrived an officer advised her that Mr Rawlins had flooded his cell and was aggressive, so she should not see him at that time. She planned to return the following week.

33. The officer knew that a nurse had already reviewed Mr Rawlins' mental health the day before. However, she thought that his behaviour overnight indicated that his mental health had deteriorated. She telephoned the nurse, described Mr Rawlins' recent behaviour and asked the nurse to assess him again. The nurse thought that Mr Rawlins was just frustrated at being in prison and did not think he needed another assessment. The nurse told the officer that based on his and the Liaison and Diversion Service's assessments Mr Rawlins had no severe mental illness and was fit to attend a disciplinary hearing. The nurse told the investigator that, at the time, he did not think that Mr Rawlins' risk of suicide and self-harm had increased overnight because he had not tried to harm himself.

34. At 10.35am, during the ACCT assessment interview and first ACCT case review, Mr Rawlins told staff that he did not know why he had been remanded to prison. He said he had nothing left to live for because his family had abandoned him. Mr Rawlins said that he wanted to die and had a plan to kill himself, which he would not discuss with the staff. Mr Rawlins told them that he smoked cannabis in the community (but did not mention feeling suicidal if he could not smoke it). He said he had self-harmed since the age of 13, and had been involved with community mental health services in the past. A SO said that he recognised that Mr Rawlins had significant risk factors for suicide and self-harm. He told the investigator that he realised that Mr Rawlins was also deaf and could lip read, but thought Mr Rawlins' difficulties communicating might also account for some of his frustration.

35. A SO completed the first case review document. No one from the healthcare department attended, contrary to national instructions. The SO noted that Mr Rawlins was very agitated and confused and that he had plans to kill himself, but would not reveal them. The review assessed Mr Rawlins' risk of suicide and self-harm as raised (from options of low, raised and high), and left the frequency of staff checks unchanged at twice an hour. The SO wrote three actions in the ACCT caremap: he referred Mr Rawlins to the healthcare department for a hearing assessment; asked chaplaincy and the wing staff to support Mr Rawlins with activities and interactions and referred him to the mental health team for an assessment. The SO rang the mental health team that day to make the referral. He told the investigator that he understood that someone from the mental health team would assess Mr Rawlins again within the next two days.

36. At 4.00pm, an officer went to speak to Mr Rawlins in his cell to offer him some support, because he had flooded his cell again. When she arrived, Mr Rawlins was outside his cell, wearing only a t-shirt. Mr Rawlins told her that somebody had stolen his tobacco and cannabis and that his family had lied to him. The officer wrote in the ACCT document that Mr Rawlins behaved strangely, that his answers did not relate to her questions and he was shaking. She gave him a meal, and brought him dry trousers and a book to read. She told the investigator that she was very concerned about Mr Rawlins' mental health because he appeared not to accept that he was in prison, and was incoherent. She did not think that Mr Rawlins was at a high risk of suicide or self-harm because he did

not mention any thoughts of self-harm and did not appear to be low in mood. She told the investigator that she discussed Mr Rawlins with a member of the mental health team and expected someone would assess him. The member of the mental health team told her that he was going to speak to a nurse, but did not record that Mr Rawlins needed another mental health assessment.

37. At 6.20pm, the officer brought Mr Rawlins blankets and found that he had blocked the observation panel in his cell door. She asked him to unblock the panel and he swore at her. By 7.10pm, he had removed the obstruction from the observation panel, but continued to swear at staff who checked him. Officers recorded that he slept well that night.

Saturday 16 July

38. At 9.15am, Mr Rawlins refused to attend his disciplinary hearing and asked an officer to lock him in his cell.

39. At around 9.50am, an officer recorded that Mr Rawlins was standing close to his cell window. At 10.15am, he recorded that Mr Rawlins was on his bed and at 10.47am, that Mr Rawlins was using the toilet.

40. At around 11.20am, the officer checked Mr Rawlins again and saw him hanging by a ligature made from his t-shirt, which he had tied to the smoke detector. The officer shouted for help and another officer who was very close by responded. The two officers went into the cell and a third officer supported Mr Rawlins' weight while an officer cut the ligature. The officers placed Mr Rawlins on the floor and checked for signs of life. According to the prison log, at 11.22am, the first officer radioed a code blue emergency (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties) and staff in the control room called an ambulance a minute later. A SO started cardiopulmonary resuscitation. Two nurses arrived at the cell shortly after and continued with the resuscitation attempt.

41. At 11.31am, paramedics arrived at the prison. They reached Mr Rawlins' cell four minutes later and took over the resuscitation attempt. At 11.52am, a prison GP pronounced that Mr Rawlins had died.

Contact with Mr Rawlins' family

42. The duty governor appointed an officer as the family liaison officer. Mr Rawlins had not given contact details for his next of kin when he had arrived at the prison or during the ACCT process. The officer and the duty governor checked Mr Rawlins' prison records and found two telephone numbers but no names or addresses, so they asked police officers, who were in the prison at the time, to find Mr Rawlins' family and deliver the news as soon as they could.

43. At 6.20pm, the police phoned the officer and told her that they had broken the news to Mr Rawlins' mother. It is regrettable that the prison was not able to deliver the news in person, but we appreciate that the prison wanted Mr Rawlins' family informed without delay. At 7.05pm, the officer phoned Mr Rawlins' mother, and spoke to a friend of the family. She visited Mr Rawlins' mother and other family members on 18 July, offered her support and answered their questions.

Mr Rawlins funeral was held on 29 July. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

44. After Mr Rawlins death, a unit manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

45. The prison posted notices informing other prisoners of Mr Rawlins death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rawlins death.

Post-mortem report

46. A post-mortem examination concluded that Mr Rawlins died of ligature suspension. The toxicology examination found cannabis in Mr Rawlins' blood and urine when he died, but could not confirm how recently Mr Rawlins had last used cannabis.

Findings

Management of Mr Rawlins' risk of suicide and self-harm

47. Mr Rawlins had been at Bristol for less than 48 hours when he was found hanged in his cell. Five days earlier, he had been released on bail from Bristol after spending a week at the prison. On both occasions, Mr Rawlins expressed suicidal thoughts and was monitored under suicide and self-harm prevention procedures (ACCT), including at the time of his death.

48. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists some of the risk factors and triggers which increase a prisoners' risk of suicide and self-harm, including previous self-harm and suicide attempts, a history of mental health problems, including depression, early days in prison, substance misuse, a disability (such as a hearing impairment) and family and relationship instability. These factors all applied to Mr Rawlins. After Mr Rawlins arrived at Bristol on 14 July, he behaved erratically and flooded his cell three times, appeared almost naked outside his cell and, at times, appeared confused. Officers were concerned about his mental health but two mental health assessments concluded that he did not have a severe and enduring mental illness, or indeed any particular symptoms of mental illness. The clinical reviewer concluded that the mental health assessment and support Mr Rawlins received during this period of imprisonment was appropriate and equivalent to what he might have expected to receive in the community.

49. An officer appropriately began ACCT monitoring as soon as Mr Rawlins arrived at the prison on 14 July. A SO set the initial frequency of staff checks at once an hour. However, he could not remember what information about Mr Rawlins he had read before setting the frequency of checks and said that it was standard practice at Bristol to check prisoners once an hour before their ACCT assessment interview, unless there were great concerns about the prisoner, in which case the checks could be more frequent. We consider checks of once an hour to be low for someone with Mr Rawlins' risk factors, history and presentation and found no evidence that the SO fully assessed Mr Rawlins' risk before setting the initial frequency of staff checks. Later that day, a custodial manager increased the frequency of checks to twice an hour, after Mr Rawlins flooded and smashed items in his cell. She did not speak to Mr Rawlins herself that evening, but did not think that his disruptive behaviour indicated that his risk of suicide had increased.

50. At the first and only ACCT case review on 15 July, staff assessed Mr Rawlins as at a raised risk of suicide and self-harm and left the frequency of staff checks unchanged at two an hour, despite Mr Rawlins telling them that he had a plan to kill himself. We are concerned that staff's assessment of Mr Rawlins' level of risk did not place sufficient weight on his known risk factors and his clear statements of intent.

51. No one from the healthcare department attended Mr Rawlins' first ACCT case review, which is a mandatory requirement of PSI 64/2011. None of the staff interviewed knew that it is mandatory for a healthcare representative to attend the first case review. A SO said that he did not invite anyone from the healthcare

department because he did not know about Mr Rawlins' mental health issues and hearing impairment at the time. A multidisciplinary case review might have helped staff to consider Mr Rawlins' risk more holistically and could have improved planning about his ongoing care.

52. We are concerned that these failings in the identification and assessment of Mr Rawlins' risk meant that he did not receive sufficient support in his early days at Bristol. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **All known risk factors are considered when determining the level of risk of suicide and self-harm.**
- **The level of observations must reflect the risk and should be adjusted when risk changes.**
- **Staff hold multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews.**

Identifying and managing Mr Rawlins' hearing impairment

53. PSI 07/2015, early days in custody, stipulates that during the reception process, healthcare staff must assess a prisoner's disability and ensure that any follow up action is taken. The PSI acknowledges that the early days in prison are particularly difficult for prisoners and stresses the importance of staff identifying any disabilities and offering immediate support. PSI 32/2011, covering equality issues, requires prisons to make reasonable adjustments to enable prisoners with disabilities to take full part in the normal life of the establishment.

54. On 1 July, when Mr Rawlins was first remanded to Bristol, staff identified that he was deaf and used hearing aids. However, when he returned on 14 July, a nurse failed to record that he was hearing impaired, did not refer him for a disability assessment and did not share the information with reception officers. At the first ACCT review on 15 July, the SO did note that he would refer Mr Rawlins to the healthcare department for a hearing assessment, but did not record whether this was urgent.

55. All of the officers that we spoke to said that they had realised Mr Rawlins was hearing impaired when they interacted with him. Most said that Mr Rawlins seemed able to lip read and communicate well, as long as he could see the face of the person speaking to him. However, an officer thought that one of the reasons for Mr Rawlins' frustration might be his communication difficulties.

56. The clinical reviewer found that the failure to ensure that Mr Rawlins' disability was properly assessed and addressed when he returned to Bristol meant that the care he received at the prison was not equivalent to what he might have expected to receive in the community. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the needs of prisoners with disabilities are identified on reception and that there is a coordinated and multidisciplinary approach to meeting the needs of those with complex conditions through effective care plans which outline the reasonable adjustments required to allow them to participate fully in prison life.

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