PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Bullingdon on 12 June 2014

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death a man, who was found, hanged in his cell at HMP Bullingdon on 12 June 2014. I offer my condolences to his family and friends.

One of my investigators carried out the investigation. A clinical reviewer was appointed to review the man's clinical care at Bullingdon. The prison co-operated fully with the investigation.

The man was remanded to Bullingdon in August 2013. He had previously tried to kill himself and, when he arrived, prison staff identified that he was at risk of suicide and self-harm. While he was at Bullingdon, staff managed him under suicide and self-harm procedures for four different periods. On 12 June 2014, an officer found he hanged in his cell. He was not being managed as at risk of suicide at the time.

The clinical reviewer considered that the man received some good support for his mental health problems at Bullingdon, and I agree. However, he also identified some gaps in provision which the prison will need to address. I am also satisfied that staff appropriately identified him as at risk of suicide when he arrived at the prison. However, after that, there were a number of deficiencies in the operation of suicide and self-harm prevention procedures which the prison will need to address.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2015**

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SUMMARY

1. In August 2013, the man was remanded to Bullingdon charged with a violent offence against a former partner. He was later sentenced to 12 years imprisonment. This was his first time in prison. He had been diagnosed with dissocial personality and depression and had previously tried to kill himself.

2. When he arrived at Bullingdon in August 2013, staff recognised his risk and began Prison Service suicide and self-harm prevention procedures, known as ACCT. During his time at Bullingdon, staff monitored him under ACCT procedures for four separate periods, but the man said he did not feel well supported. On at least two other occasions, the man gave clear indications that he was at risk of suicide or self-harm, but staff did not begin ACCT procedures.

3. The man took mirtazapine, an antidepressant. A mental health nurse supported him and he had a clinical care plan for his mental health needs. He often complained that he had to take the mirtazapine, which has a sedative effect, in the afternoon, which meant it did not help him sleep. He started a computerised cognitive behavioural therapy (CBT) course, but had to give up as he did not have the computer skills needed to complete the course.

4. The day before his death, the man had an appointment with his solicitor, which he had told friends he was looking forward to. His solicitor cancelled the appointment, but prison staff did not tell him until he arrived at the visits hall. At an early morning roll check the next day, an officer found him hanged in his cell. The officer called an emergency, but was unable to go into the cell immediately as he could not release his emergency cell key from its sealed pouch. The night orderly officer opened the cell shortly afterwards and officers and nurses tried to resuscitate him. Paramedics arrived and continued emergency treatment but, shortly afterwards, pronounced him dead.

5. The man was not being monitored under ACCT procedures at the time he died. However, when he was on an ACCT, prison staff did not always implement the procedures in line with Prison Service guidance and ensure he received appropriate support. His medication arrangements were also not well managed and we are concerned that he was unable to complete a therapy course. After he died, the man's family were given inaccurate information about how he was found. We make five recommendations about these issues.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Bullingdon, inviting anyone with any relevant information to contact her. One member of staff responded.

7. The investigator went to Bullingdon on 19 June 2014, and obtained copies of the man's prison and clinical records. She interviewed staff and prisoners in October and November 2014 and informed the deputy governor of her preliminary findings.

8. NHS England commissioned a clinical reviewer to review the man's clinical review at Bullingdon.

9. We informed HM Coroner for Oxfordshire of the investigation and have sent him a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process and ask them if they had any relevant issues that they would like the investigation to take into account. The man's parents and his partner had a number of questions, set out below. We have covered some other issues in a separate letter:

- Did the man receive appropriate mental health care and treatment?
- How had the man hanged himself?
- When the man was on an ACCT why could he not go to the gym and why was he woken at half hour intervals during the night?
- Were risk assessments comprehensive and appropriate?
- Why was the man not appropriately notified about the cancellation of his solicitor's appointment?
- Why was the man given sedative medicine in the afternoon?
- How many staff were on duty at night when the man died, what were the checking procedures, and when he was checked?
- Was the emergency response appropriate?
- Why were they given inaccurate information by the prison family liaison officer?

11. The man's family received a copy of the draft report. They pointed out a factual inaccuracy. This report has been amended accordingly. The man's family also raised their concern about number of issues that do not impact on the factual accuracy of this report, which we have addressed in separate correspondence.

HMP BULLINGDON

12. HMP Bullingdon is a training and local prison which holds up to 1,114 men and serves the courts of Oxfordshire and Berkshire. Healthcare services are provided by Virgin Healthcare and Oxford Health NHS Trust. Cotswold Medical Ltd provide GP services. There are a minimum of two nurses on duty at all times.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons last inspected Bullingdon in July 2012. Inspectors reported that levels of self-harm were relatively low and staff made efforts to learn from serious incidents. Measures to support prisoners at risk of suicide and self-harm were good but there was a need for more consistency in case management and better attendance at reviews by staff from other disciplines. The inspectorate also found that health services needed improvement and modernisation but mental health services were good. Many prisoners shared cells designed for one and there was insufficient purposeful activity.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the community who help ensure that prisoners are treated fairy and decently. In its most recent report, for 2012-2013, the Board commented that Bullingdon had a good Samaritan support scheme with a rolling training programme for Listeners and a prisoner safer custody assistant had been appointed to provide peer support. (Listeners are prisoners who are trained by the Samaritans to support other prisoners.) The training for staff to act as assessors in the suicide and self-harm prevention procedures was ongoing.

Previous deaths at Bullingdon

15. The man was the fifth prisoner to die at Bullingdon between January 2013 and June 2014, four by suicide. There were no significant similarities between the circumstances of his death and those already investigated.

Assessment, Care in Custody and Teamwork (ACCT)

16. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. The man was remanded to HMP Bullingdon on 19 August 2013, for a serious violent offence against a former partner. He was 38 years old and this was his first time in prison.

18. When he arrived at Bullingdon, healthcare staff noted from court psychiatric reports that he had been diagnosed with depression and a dissocial personality disorder. Staff at court had noted on his Person Escort Record (which accompanies detained people between police, court and prison and lists risk factors) that he had attempted suicide in October 2011 and that, on 19 July 2013, his partner had found him with a rope with which he had intended to hang himself. The man had sharpened a spoon in his police cell, but officers removed it before he harmed himself with it.

19. At a reception health screen, the man told Nurse Rose A, who had seen the information on the escort record, that he had previously harmed himself by cutting his arms, had taken an overdose and heard voices telling him to "end it all." He said that he had cut a rope to hang himself four weeks earlier. He was seeing the urgent care team in the community but had not been allocated a psychiatric nurse. He reported that he had been prescribed antidepressants but had stopped taking them because of the side effects. The nurse was concerned about the man's risk of suicide and self-harm and opened an ACCT. She told staff that the man should stay in the healthcare unit and be constantly supervised until he was assessed under ACCT procedures.

20. A temporary custodial manager, A, completed the ACCT immediate action plan and agreed with Nurse A's plan. The custodial manager told the man how he could contact his family, use the Samaritans' telephone and the prison Listener scheme. (Listeners are prisoners trained by the Samaritans to support other prisoners in distress.)

21. Officer A completed the ACCT assessment on 20 August, at 10.15am. He recorded that it was the man's first time in prison and noted the following issues:
    - The nature of the man's alleged offence;
    - The man's depressive illness and anger problems;
    - The man's recent suicide attempt;
    - The man's recent behaviour in police custody.

22. The healthcare manager chaired an ACCT case review at 10.25am. The man, Officer A, a healthcare assistant, a mental health nurse, B, the security manager and an officer attended. Despite his identified risk, the panel assessed that he was a low risk of harm to himself, yet set the level of observations at five an hour.

23. The man moved to a different cell in the healthcare unit from the one where he had been constantly supervised and staff gave him a television to help distract him. (A cell sharing risk assessment had indicated that the man was a high risk to other prisoners and should not share a cell.) The panel referred

him to the mental health team for support and agreed a caremap with three actions: for the man to engage with mental health services, engage with staff, and contact his partner and family. They agreed that the next case review should be the next day.

24. On 21 August, Nurse C, completed a clinical careplan with goals and interventions to help the man deal with his depression. These included regular engagement with mental health staff, education about symptoms of depression and how to recognise them, cognitive behavioural education, using physical exercise as a coping mechanism, using a series of practical approaches to problem solving and negative thoughts, and reducing the likelihood of feeling isolated.

25. Later on 21 August, the healthcare manager held another ACCT case review, which Nurse B and the healthcare assistant attended. They assessed that the man's risk was still low and reduced his observations to one an hour. The man said that he had discussed his future with his family and wanted help with depression and would engage with mental health services. He said that he was still thinking about suicide, self-harm and worthlessness but was controlling the voices telling him to harm himself.

26. Later that day, Nurse B saw the man for a secondary health screen and mental health assessment. She noted that he engaged well, gave good eye contact and was talkative with good rapport. However, he seemed low in mood and had rated his mood as 2/3 out of 10. He said that he did not have suicidal thoughts at the time and was more settled than the day before. However, he said that he had problems with his memory, and often felt paranoid and very sensitive. He said that he took things that people said the wrong way and bottled up his feelings before exploding. He said that he was reluctant to ask for help and had a low tolerance of other people. He said that he had two parts, a devil on one shoulder and an angel on the other.

27. The man's GP records, received on 22 August, confirmed that he had been diagnosed with dissocial personality disorder. On 23 August, Dr A, a prison psychiatrist, assessed the man and prescribed mirtazapine (an antidepressant with sedative effects), 15mg, to be given each night for four weeks as a trial. The doctor planned that the man should stay in the healthcare unit until his next ACCT review, he should see him again a week later and that the mental health in-reach team would see him twice weekly.

28. Nurse A chaired the next ACCT case review on 26 August. The man said he was felt more relaxed and did not have suicidal thoughts, but was still hearing voices. The panel assessed him as at low risk of suicide and self-harm and maintained hourly observations. His ACCT caremap remained the same. However, the panel considered that the man might benefit from a move to the prison's Support Monitoring Unit (SMU, where other prisoners act as mentors to support others).

29. The man attended court on 27 August and came back to the healthcare unit. On 28 August, he told Dr B that going to court had upset him and that he was

anxious about moving to the Support Monitoring Unit. The doctor noted that he was unhappy about moving from the healthcare unit to a houseblock, although he was fit to do so.

30. Prisoner A went to assess the man to see whether the Support Monitoring Unit would be suitable for him. The man refused to see him and was hostile to staff for the rest of the day. That afternoon, he told Nurse B that he would not move to the Support Monitoring Unit.

31. On 29 August, Nurse B reviewed the man and they agreed on four actions: he would stay in the healthcare unit for the moment but they would arrange a gradual transition to a houseblock, he would continue to take mirtazapine, he would have a medication review in a week, and the mental health team would continue to support him.

32. On 3 September, healthcare manager held an ACCT case review, which Nurse B and Officer B attended. They discussed a move and the man said that he did not like being in a noisy environment or around a lot of people. He said that he was likely to assault someone if he moved. The panel noted that he could not remain in the healthcare unit indefinitely and arranged another assessment for the Support Monitoring Unit, followed by a gradual move if this was appropriate. They assessed the man's risk of suicide and self-harm as low and kept observations at hourly. No further change was noted at the next ACCT review on 10 September.

33. On 20 September, Dr A saw the man and prescribed an increased dosage of mirtazapine (30mg daily). Later that day, Nurse D and Nurse E held an ACCT case review. The man was angry, abusive and hostile and threatened to hurt someone. They continued to assess him as at low risk of suicide and self-harm and maintained hourly observations. Later that day, the man moved to Houseblock F for an induction to the prison and then moved to Houseblock B on 23 September. Nurse B visited him twice on 23 September and once on 24 September. She noted that he seemed low in mood and arranged for him to collect his medication in the evenings.

34. A custodial manager, B, held an ACCT review on 26 September, with Nurse F. The record is mainly illegible, but noted that the man was quiet. The nurse did not record a level of risk or note that the caremap was reviewed.

35. The Head of Residence and Safer Custody, chaired the next ACCT review on 4 October, with Supervising Officer (SO) A and Nurse F. The Head of Resident and Safer Custody did not record the man's level of risk or indicate any review of the caremap. The man said that he was happy for the ACCT to be closes as he wanted to go to the gym. The Head of Residence and Safer Custody told the investigator that the man could go to the gym while on an ACCT, but could only use cardiovascular equipment and not weights. (This was because a prisoner had previously killed himself at Bullingdon using a weights bar.) There is no record that the panel discussed the man's previous suicidal thoughts or discussed with him how he now felt. The panel closed

the ACCT and arranged a post-closure review for 11 October. There is no record that this review took place.

36. On 16 October, Dr C increased the man's mirtazapine to 45mg because of his low mood and poor sleep. The man told the doctor that he did not have any thoughts of suicide or self-harm. Nurse B spoke to the man later on Houseblock B. He appeared low in mood, had lost his appetite and some weight. He told the nurse that he was having some suicidal thoughts. The nurse told the investigator that she could not remember if she had considered opening an ACCT at the time.

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37. On 19 October, the man had a visit from his family. His visitors told prison staff that they were concerned that the man was suicidal. SO A spoke to the man who said that he was struggling in prison, had mental health problems, was in a very low mood and was feeling paranoid. He said he was hearing voices which told him to harm himself. The SO opened an ACCT and asked staff to observe him hourly until an ACCT assessment. He assessed the man's risk of suicide and self-harm as low.

38. At an ACCT assessment on 20 October, the man told Officer C that he felt low in mood, was hearing voices in his head and had previously attempted to take his life. He said that he did not want to be on an ACCT as he did not find it helpful.

39. The first case review, which should take place within 24 hours of the ACCT being opened, did not take place until 21 October. Custodial Manager, B, was the only member of staff present but Nurse B contributed by telephone. The man said that he did not think his antidepressant medication was working and he did not believe that the ACCT process was helpful or supportive.

40. Custodial Manager, C, noted that the man should focus on attending the gym and library when possible, and recommended that he should be considered for the CALM programme (a programme to help people manage anger and aggression) at a later date. She assessed the man's risk as low and maintained observations at a minimum of one an hour. An appointment was made for the man to have a medication review with a psychiatrist on 25 October. The actions taken were recorded in the caremap.

41. Later that day, the man told Nurse B that he had a mental health disorder but was not getting any help for it. He said he did not find the ACCT process helpful and referred to having only limited access to the gym. He said that he was given his medication every morning, to take when he needed it, but, if he wanted, he could save it up and overdose on it. (However, there is a low risk of overdose from mirtazapine). The nurse told the investigator that the man often made remarks like this when he was angry, which she considered were deliberately aimed at being unhelpful to write in his notes. The nurse noted that she would check his medication when she visited him. She suggested that he should attend education classes but the man said that he found other prisoners too stressful.

42. On 25 October, Nurse B visited the man in his cell. She noted that he seemed brighter in mood after speaking to a psychiatrist (as part of his defence for his trial). The man asked if his mirtazapine could be increased but the nurse told him that he was already on the highest dose (45mg). He said that was not hearing voices and was not feeling suicidal but he was worried about his partner. The nurse agreed to refer him to a Time for Families programme, for couples affected by imprisonment, which was due to start on 7 November.

43. Custodial Manager, C, chaired the next ACCT review on 28 October, with Nurse B and the acting Head of Safer Prisons. The panel assessed the man's risk as low. Much of the record is illegible, but the man said that the ACCT process was not helping him and again mentioned restrictions on using the gym. The ACCT was closed with a post-closure review set for 5 November. There is no record of the review taking place.

44. On 4 November, the man asked to see Nurse B because he thought that his relationship with his partner had broken down and he had no telephone credit. (They were later reconciled.) He was concerned that, even though his ACCT had been closed, he was still unable to use the gym. The nurse contacted the gym staff to explain that the man was no longer on an ACCT and arranged for houseblock staff to give him some telephone credit.

45. On 15 November, the man told the psychiatrist, Dr A, that he was all right and had no thoughts of suicide. The doctor considered that the man no longer showed signs of depression and noted that he had developed good relationships with three other prisoners, which he considered to be protective factors. The doctor discharged the man from the care of the mental health in-reach team, but said that he could ask the prison doctor or officers to refer him again in the future. He advised that the man should continue to receive mirtazapine.

46. On 22 November, Nurse G assessed the man as suitable to keep medication in his own possession. Dr D agreed that the man should receive his medication weekly. At the time he was prescribed 45mg of mirtazapine, to be taken daily at night.

47. On 25 November, the man told Nurse B that he had taken an overdose of six mirtazapine (45mg) tablets the previous night evening. (He had received seven tablets on 23 November.) He asked the nurse for more mirtazapine, as he did not have any left. The nurse noted that he was low in mood with poor eye contact, but his speech was not slurred and he was not drowsy. He said that he was worried about his eldest son who had Asperger syndrome and might need hospitalisation for a psychotic episode. The man did not want an ACCT to be opened, but the nurse completed one, just before midday.

48. The case manager arranged for the man to move back to the healthcare unit and set hourly observations. (The case manager's name is illegible and the prison has been unable to identify who it was.) The healthcare assistant completed an ACCT assessment that afternoon. The man said that he did not

want to be supported by the ACCT and said that he felt that he was being punished as he would be unable to go to the gym. He said that he had taken the tablets because he wanted to kill himself. He said he had not made plans to kill himself but would take the opportunity if it arose. Because of the overdose, the man now had to take his medication in the afternoon at the medication hatch.

49. After the assessment, Nurse H held the first ACCT case review, with the healthcare assistant and Nurse B. They did not record the man's risk of suicide and self-harm, but set hourly observations. The man said that he was happy to go back to his houseblock. The panel produced a caremap with one action, for the man to speak to staff if he felt like harming himself. There were no actions for staff. The panel arranged the next review for 29 November. That afternoon, he went back to Houseblock B. Dr D told him that he could not have any further mirtazapine until 28 November, because of the overdose but should resume receiving mirtazapine after that.

50. On 29 November, custodial manager, C, held an ACCT case review with no other staff present. He noted that there was no change in the man's risk level or his caremap actions and reduced observations to two each shift during the day and three during the night. (The ACCT ongoing log indicates that observations remained hourly until 2 December, when they changed to those set by the custodial manager.) The custodial manager set the next review for 2 December.

51. Officer C later noted in the ACCT document that the man had asked for his medication at 8.00pm. An operational support grade, OSG A, later noted that the man had asked for his medication again at 9.50pm, and said that he had been waiting for them since 1.30pm. The OSG telephoned the healthcare unit who said that the man would have to wait until the next day.

52. The next morning, 30 November, The man told his personal officer that he was not happy that he was expected to take his mirtazapine in the afternoon, because it was too early for the sedative benefits to help him sleep at night. The man's personal officer said he should discuss this with the doctor.

53. Over the next two nights, the ACCT ongoing log indicates that the man had complained to night staff that they were waking him when they checked him because they turned the cell light on. This made him feel worse, and he said he wanted to come off the ACCT.

54. On 1 December, Nurse I was giving out medication at 2.46pm. The man took his mirtazapine and put it in his pocket. When the nurse challenged him, the man became verbally abusive. There was no officer near to the medication hatch so the nurse later reported it to houseblock staff who told him they could not do anything about it and that the nurse should put the man on a disciplinary charge.

55. Nurse I emailed the practice manager who agreed that the man should receive and take his medication at the hatch because of his attempt to

conceal it. According to the clinical record, the practice manager said that, if the man did not come to the hatch, he should not be given his medication later. He did not collect his medication for the next three days, even though officers called him for it.

56. On 2 December, custodial manager, D, chaired a case review with two members of healthcare staff present. The man said that he was still having thoughts of suicide. Despite this, the panel assessed that he was a low risk of suicide and self-harm. They advised him to apply to the mental health in-reach team to see a psychiatrist and told him to build up trust with healthcare staff. They added the latter point as a caremap action.

57. At 3.20am on 5 December, the man became angry when an officer turned the light on when he checked him for an ACCT observation. He later smashed the casing for the light bulb and took the bulb out of the light fitting. The next day, staff moved him to a different cell on Houseblock B because the light was no longer working.

58. The head of A and B houseblocks, chaired the next case review on 9 December. Officer D was present but there was no member of healthcare staff there. They did not review the caremap actions and it not clear that the actions were completed. The man said that he was still frustrated about having to take his medication in the afternoon. The head of A and B Houseblocks noted on the review document that being on an ACCT was creating more problems for the man than it solved. The man said that he was still feeling low in mood but, if this carried on, he would ask to speak to a Listener. The head of A and B houseblocks decided to close the ACCT with a post-closure review set for 16 December. This did not happen.

59. On 17 December, the man went to court. When he returned, he went back to Houseblock F without seeing a nurse in reception. Nurse J noted in the man's medical record that a houseblock officer told her that he had come back without a nurse assessing him. She arranged for a nurse to see him the next day, but he did not attend. He did not see a nurse for another three days.

60. A post-closure review, which should have been held on 16 December, took place on 1 January 2014. The man said that he had not felt supported by the ACCT process and the mental health team had not helped him. Some of the form is illegible and it is not clear who held the review.

61. On 14 January, the man allegedly told an escort officer at court that he intended to cut his throat. He later denied this and staff did not open an ACCT. However, he was referred to the mental health in-reach team. A multi-disciplinary team meeting discussed his case on 16 January, but decided he did not meet the criteria for the in-reach team or the primary mental health team. They referred him to the GP. Nurse B added an alert on his medical record that he should be reviewed for risk of suicide and self-harm when he returned from court appearances.

62. On 14 March 2014, the man was sentenced to 12 years imprisonment with four years extended supervision. Nurse H saw him when he came back from court. He was shocked and upset about his sentence and very low in mood. The nurse suggested that he should spend a night in the healthcare unit for extra support, but he refused and went back to Houseblock B. He said that he would not harm himself, and that he had his partner, children and his family to think of. The next day, Nurse K noted that the man was low in mood when he collected his medication and refused to speak to her.

63. On 18 March, Nurse G assessed that the man could be allowed to keep his medication in cell again.

64. Prisoner B, at Bullingdon, told the investigator that he had worked as a safer custody and equality orderly, and as a Listener, for 16 months. He explained that part of his job was to see prisoners on ACCTs and offer them support. He said he had first met the man in November 2013, when he was on an ACCT, but was not often involved with him until after he was sentenced. Prisoner B said that he saw the man every morning for some time after that. He said that the man started "going downhill". He did not shave, his cell was untidy and he would not go to the gym or come out of his cell during association periods. The prisoner said that he had encouraged him to go to the gym and to talk about his personal problems with him. He said he told the man's personal officer, that he was concerned about him. On 25 March, The man's personal officer referred the man to the mental health team. A mental health nurse, Nurse L, became his keyworker on 27 March.

65. On 28 March, prisoner B told Officer E that the man had said that he had a razor in his cell and he was feeling low and suicidal. The officer removed the razor. The man said that he felt low in mood, was shocked at his sentence and his antidepressants were not working. The officer opened an ACCT and wrote that he thought that short-term goals and mental health support were a priority. That day, Nurse L agreed to refer the man to the psychology services for help with anger issues. (The nurse, who was not available for interview, completed the referral on 2 April, but did not email it until 22 April. Another nurse chased the referral on 3 June.)

66. SO A completed an immediate action plan, and set hourly observations until someone assessed the man. Officer A assessed the man on 29 March and regarded his risk of suicide and self-harm as low. The man said that he had been expecting only a five year sentence and he was worried about his partner, who had health problems. He said that he had thought about suicide when he was sentenced and that such thoughts were always in his mind. He told the SO that he had considered cutting a vein or hanging himself, and he had nearly done so on 23 March. He said that he was not sleeping well and his mood was low.

67. SO B chaired the first ACCT case review on 29 March. Officer A attended but there was no member of the healthcare team present, which is a mandatory requirement for first case reviews. The SO completed the ACCT caremap, which contained no actions for staff, but four for the man to:

- Speak with staff to relieve stress and anxiety;
- Continue to work with the mental health team and begin cognitive behavioural therapy (CBT) on 6 May 14;
- Speak to his offender manager about a transfer to a therapeutic community at HMP Grendon;
- Collect his medication daily.

68. On 31 March, Nurse J and Nurse B saw the man, who said he would cut his throat with a razor. He was angry and wanted a transfer to HMP Grendon, where he thought he would get more therapeutic involvement. The nurses suggested that he got a job to use his time more constructively. He said that he had no motivation and was worried about his son, who he said had been sectioned to be detained in a psychiatric hospital under the Mental Health Act, and his partner, who had had a kidney transplant. Both the nurses suggested cognitive behavioural therapy (CBT), and ensured that the man was on the waiting list. They planned to review the man in a week.

69. The man's offender supervisor saw him on 2 April. She thought that he would benefit from living in the Support and Monitoring Unit and made another referral. She checked that he had been referred to psychology services and that he was on the waiting list for cognitive behavioural therapy.

70. Later that day, at 2.45pm, prisoner, A, assessed the man as being suitable for the Support and Monitoring Unit. After he left, the man became very upset and locked himself in his cell. According to the ACCT log, he told Officer F that he had nothing left to live for. The officer asked the mental health team to speak to the man as he was worried he might harm himself.

71. Nurse M went to the houseblock. The man said that he was not happy about getting his medication early in the afternoon and wanted to change his antidepressant. He said that he did not think that the doctor listened to him and that he did not want to work with the nurse. The nurse concluded that, although he was in a low mood, the man did not have signs of depression. The man said that he did not feel suicidal, but spoke about feelings of hopelessness. The nurse suggested that the man should move to the healthcare unit as an inpatient for a while. The man refused because he wanted to smoke, which was not allowed in the healthcare unit. The nurse planned to review the man the next day. According to the ACCT ongoing log, healthcare staff gave the man his mirtazapine at 10.50pm (10.00pm in the clinical record).

72. The next day, 3 April, Nurse M saw the man. He was annoyed because he had received his mirtazapine late the night before. He said that he wanted to have his medication in his possession so that he could take it when he wanted. The nurse said that this would be unlikely because of his previous overdose, but suggested that he should ask for another assessment. The man became angry and walked away. The nurse saw him talking with other prisoners, which he said was inconsistent with his low mood a few minutes earlier. That same day, the man was accepted for a place in the Support and

Monitoring Unit, although there was no available cell at the time. The nurse arranged to review the man a week later.

73. SO A held the next review on 5 April with no other members of staff present. He did not record the man's level of risk of suicide and self-harm, and there is no record that he reviewed the caremap actions or considered whether any new ones were needed. The man said he was still in a low mood and worried about his sentence and his partner's health. He said that the ACCT was detrimental to his mental health, and again said that he was concerned that he had to take mirtazapine in the afternoon.

74. On 10 April, the man attended court to face new charges of common assault. He was sentenced to 28 days, to run concurrently with his sentence. Nurse J saw him when he came back from court and gave him his mirtazapine at 7.07pm.

75. SO B held an ACCT review on 12 April. Officer G attended but there were no healthcare staff present. The man said he was depressed and no longer had support as a friend had moved to a different houseblock. The SO assessed him as at raised risk of suicide and self-harm. He maintained hourly observations and noted that he had reviewed the caremap actions. Two of the actions had been completed as cognitive behaviour therapy had been arranged and the man had been assessed for the Support and Monitoring Unit as a precursor to a possible move to Grendon. The other two were ongoing.

76. On 14 April, the man was tearful and in a low mood and told Nurse M that he was anxious and paranoid and could not stand being with people. He said that he had been told previously that he could not receive treatment because he had not been sentenced and that he did not believe that the psychiatrist listened to him. He added that he was going to "end it all" because he felt let down by the mental health services. He nurse suggested that the man move to the healthcare unit for support but he refused. Again this was because he would not be able to smoke there. The nurse noted that the man's mood improved when they spoke.

77. The man told Nurse M that he would not move to the Support and Monitoring Unit because he did not think it was appropriate for another prisoner to be a mentor. He said that he wanted a change of medication because mirtazapine was not working, and wanted treatment for his personality disorder. He said that he would not come out of his cell until he had it.

78. The man was also unhappy that he was still on the waiting list for cognitive behaviour therapy. Nurse N told the investigator that the waiting list was long because she was the only trained member of staff to deliver the therapy. Nurse M noted in his clinical record that the man was not receptive to rational explanations and wanted everything immediately. He had an appointment for cognitive behaviour therapy on 6 May.

79. SO A held an ACCT review on 19 April with just Officer C and the man. Again there was no member of healthcare staff present or anyone from any other discipline. He remained on hourly observations but his risk assessment was reduced to low. It is not clear if the caremap was reviewed. SO A noted that the man was still depressed and wanted to get his medication sorted. The man told the SO that he was appealing against his sentence and had issues with his pre-sentence report.

80. The man did not attend an appointment to see Dr C 23 April. The reason was not recorded. Nurse M saw him that day. He wrote in the clinical record (the entry was made the next day) that he thought the man's mood was lifting, he was looking forward to his first cognitive behaviour therapy session and did not have suicidal thoughts.

81. On 26 April, SO B and Officer G held another ACCT review with no healthcare staff or other disciplines present. The man said that he did not have any thoughts of suicide or self-harm and was starting cognitive behaviour therapy on 6 May. They reviewed the caremap and reduced observations to one each shift when he was unlocked, and hourly at times when he was locked in his cell.

82. On 29 April, the man received a copy of his pre-sentence report. He later complained to the probation trust responsible for the report about it contents. According to letters in his cell, his family were helping him with this.

83. SO A chaired an ACCT review on 3 May, with the man's personal officer no other member of staff present. He described the man's mood as "vastly improved". Prison B was still supporting him and he was looking forward to starting cognitive behaviour therapy. He now had his medication in possession so was able to take the mirtazapine at a time to suit him. He was keen to go to the gym. The panel closed the ACCT. There were no healthcare staff present at the review and it is not clear if the caremap was reviewed or whether the actions had been completed. The man's level of risk was not recorded and there is no record of a post-closure interview.

84. The man attended his first cognitive behaviour therapy session on 6 May, with Nurse N. The session was computer-based and the man was worried about his computer skills. The nurse discussed this with him and they both decided that, because of this, the course was not suitable for him. The nurse gave him some basic computerised cognitive behaviour therapy guided help leaflets, and suggested that Nurse M help him with the guided learning on a face-to-face basis.

85. On 4 June, the man's offender supervisor, saw the man who said he was frustrated that he had to wait for psychology services and wanted to engage with something. She contacted Nurse O, who said that he would chase the psychology application up. The man still wanted a transfer to Grendon, but the man's offender supervisor told him that he would have to complete some offending behaviour work first. She applied for the man to attend the Resolve

course (a thinking and problem-solving course) and encouraged him to consider attending education classes.

86. The man's solicitor had arranged to see him on 11 June at 2.15pm and according to his friends, the man was looking forward to this meeting. He intended to appeal against the length of his sentence, which he thought was longer than it should have been because of the pre-sentence report. Prisoner B told the investigator that he saw the man in the gym in the morning of 11 June, and he looked happier than usual. The man told him that he was looking forward to seeing his solicitor later that day.

87. On 11 June, his solicitor was ill and unable to attend the meeting. The solicitor's office emailed the man using the emailaprisoner.com scheme, but this was not downloaded until 4.21am on 12 June, after the man's death. The solicitor's office also sent a fax to notify them of the cancellation at 10.28am on 11 June. A member of staff clarified with the investigator that this would have been sent to the visits department and the policy was for the visits staff to inform the man's wing staff. They should then have passed the information to the man.

88. The man went for his visit at 2.00pm, and according to another prisoner, prisoner, C, and friend of the man, he returned to the houseblock 10 or 15 minutes later. He told the investigator that when the man got back, he stood on the landing leaning over the rail, looking oblivious to everything. He spoke to him and the man said that he thought staff could have told him about the cancellation earlier.

89. Prisoner C told the investigator that the man had ordered one ounce of tobacco from the prison shop and that he should get it from his cell the next day. The prisoner said that he wondered why he had said this, but the man had then talked about the future. He said that he hoped that his solicitor would realise that he had been wrongly sentenced and would help him appeal.

90. OSG, B, an operational support grade, was the night patrol officer on the man's wing on the night of 11 and 12 June. He did not check the man during the night as he was no longer subject to ACCT monitoring. On 12 June at 5.15am, the OSG checked the man through the cell observation hatch, during a roll count to check that all prisoners were present. The man was hanging by the neck from a cupboard at the far end of the cell, on the left of the window. The OSG could get no response from the man. He then radioed a code blue emergency. (This indicates a prisoner is unconscious or has breathing difficulties.) The control room called an ambulance immediately they received the emergency code call.

91. At night, most prison staff do not carry keys and are locked in the houseblock by the night orderly officer, who has a full set of keys. Staff supervising the houseblocks have a cell key, in a sealed pouch, on their belt, which can be used in an emergency. OSG B radioed the night orderly officer and asked for permission to open the man's cell. He said that he had to ask twice because

his first call was blocked by other radio traffic. The night orderly officer agreed and said he had gone straight to the houseblock when he had heard the code blue call. When he got to the man's cell, the OSG was struggling to break the seal on his emergency key pouch so the night orderly officer opened the cell door with his key. Other officers arrived immediately afterwards.

92. The night orderly officer used his anti-ligature knife to cut the ligature, which was made from a sheet and tied to the cupboard in the cell, and lowered the man to the cell floor. Nurse P and Nurse J had arrived with emergency equipment. Nurse P said that she had thought that the man was dead because he body was cold, his eyes were fixed and his skin was pale and waxy. However, she attempted cardiopulmonary resuscitation. The nurses were unable to find a pulse and connected a defibrillator (a life-saving device that re-starts the heart with an electric shock in some cases of cardiac arrest).

93. The defibrillator did not detect any shockable heart rhythm and the staff continued cardiopulmonary resuscitation. Officer H and OSG B took over and continued the resuscitation attempt until paramedics arrived. The paramedics administered emergency treatment, but, at 6.10am, pronounced the man dead.

94. The manager of the prison's offender management unit, was asked to act as the prison's family liaison officer at a briefing meeting that morning. She and a prison chaplain, the Reverend and OSG C, left the prison at 10.30am to inform the man's family of his death. They arrived at the man's parents' home at 12.00pm, but they were out. The man's partner had gone to Bullingdon for a visit, and an operational manager told her that he had died. The man's partner then informed the man's parents, and they all returned to the man's parents' house, where they met the manager of the prison's offender management unit, who explained what had happened.

95. The man's parents did not consider that they had been given accurate information about the position the man had been found in. The manager of the prison's offender management unit told the investigator that she had not been given accurate briefing about the circumstances which had led her to give his parents incorrect information. She continued to liaise with the man's family and offered a financial contribution towards the funeral, in line with national guidance. The man's family told us that they had found her supportive and wanted to note that the man's personal officer had been a good support to him.

96. Staff informed prisoners on Houseblock B about the man's death and those on ACCTs were reviewed in case they had been affected. The man's friends told the investigator that they were well supported by wing staff. Managers held separate debriefs for clinical staff and officers who had been involved in the emergency response and offered support.

ISSUES

Management of risk of suicide and self-harm

97. The man arrived at Bullingdon with an escort record setting out factors that increased his risk of suicide and self-harm. He had been remanded to prison for a violent offence against a former partner, had a history of mental health problems and had made a recent suicide attempt. This was his first time in prison. We are satisfied that reception staff rightly identified that he was at heightened risk of suicide and self-harm and correctly began ACCT procedures. While he was at Bullingdon, staff opened four separate ACCT documents for periods from 9 August 2013 to 4 October 2013, from 19 October 2013 to 26 October 2013, from 25 November 2013 to 9 December 2013 and from 28 March 2014 to 3 May 2014.

98. However, we do not consider that staff at Bullingdon always managed ACCT procedures in line with national instructions. We list our concerns below and then discuss some in more depth:

- The man's assessed level of risk did not always reflect his circumstances, presentation and risk factors at the time;
- The level of observations was not always adjusted in response to the man's level of risk of suicide and self-harm;
- Caremaps were of poor quality, did not always address the man's identified issues and too often put the onus on him to engage with service providers;
- ACCTs were closed on 4 October and 3 May without reference to the caremap;
- A first case review was held outside the specified timescale on 21 October;
- There was no healthcare worker at the first case review of 29 March 2014, a mandatory requirement of PSI 64/2011;
- There was little consistency in case management and the reviews were not always multi-disciplinary;
- One post-closure review was late and there is no evidence that three others took place at all;
- All four ACCTs were closed without healthcare staff being present, despite the man's involvement with mental health services;
- Many ACCT case reviews and ongoing record entries were illegible;
- Staff did not always open ACCTs when the man's risk of suicide and self-harm had increased.

99. Nurse A recognised the man's level of risk when he arrived and opened an ACCT. Other staff opened ACCTs three more times. However, there were at least two other occasions when we consider staff should have opened an ACCT in response to increased risk. On 16 October 2013, the man told Nurse B that he was low because of his likely sentence and that he was having suicidal thoughts. On 14 March 2014, when the man was sentenced,

he told Nurse H that he was shocked at the length of the sentence and was very low in mood. Staff did not open an ACCT on either occasion.

100. It is a mandatory requirement for healthcare staff to be present at the first ACCT case review. This did not happen at the review on 29 March 2014, and at the first review on 21 October 2013, Nurse B contributed by telephone and not in person. ACCT reviews are expected to be multi-disciplinary, yet there were many where this was not the case and some where there was only one member of staff present. Most ACCT case reviews had no representation from healthcare staff, although the man's main issues were about medication and mental health. Despite this, all four ACCTs were closed without healthcare staff present. Without appropriate multi-disciplinary input, it is difficult to be satisfied that the man's issues were fully addressed at ACCT reviews.

101. Continuity of ACCT case managers is important to provide consistency of approach and to ensure identified issues are addressed and resolved over time. During the period the first ACCT was open, five different managers chaired seven case reviews. For the second and third ACCTs, there were six different managers for each of six reviews. The fourth was better with two managers for six reviews. However, in total there were 13 different managers for 19 ACCT reviews. This cannot enable effective case management.

102. Too frequently, the man was the sole person responsible for caremap actions. For his first ACCT, the actions were for him to engage with his family, mental health services and staff, with no staff responsibility. Others had similar actions for him to achieve alone. Some of the most pressing issues, such as his reaction to his sentence and the timing of his medication, were not addressed in caremap actions at all. At some reviews, there is little evidence that the caremap actions were considered and it is not apparent the caremap actions had been completed when ACCTs were closed.

103. We are concerned that one of the caremap actions, that the man should attend the gym, was difficult to fulfil. This was because of an apparent blanket ban on prisoners on ACCTs using weights because of a previous death when a prisoner used a weights bar to kill himself. While we understand Bullingdon's desire to limit the options for suicide and self-harm, it seems unlikely this would be a risk for many prisoners and might increase the risk for some by removing an opportunity to relieve stress.

104. On 28 March, the man said that he was suicidal and he handed a razor to staff. Despite this, the next day, staff assessed the man's level of risk of suicide and self-harm as low. We do not consider that this accurately reflected the man's state of mind. At other times, including the first case review on 25 November 2013, case managers did not record the level of risk. On 12 April 2014, he was correctly assessed as being at raised risk of self-harm, yet this did not lead to any increased support and his level of observations remained the same as when his risk was assessed as low.

105. Post-closure reviews are mandatory but, in three of the four ACCTs, there was no evidence that a review was done. In the other one, the review was two weeks after the scheduled date. Post-closure reports are designed to ensure that the prisoner's risk of suicide and self-harm has not increased, after ACCT support has ended, and is an important part of the continuing assessment and support process.

106. The man frequently told staff that he did not want to be managed under ACCT procedures as he did not think that they helped him, including being woken at night for checks. There is a need to ensure that ACCT operates supportively and sensitively with a clear aim of reducing risk. It is important that efforts are made to operate the process effectively, in line with Prison Service guidance and instructions, to provide the best possible support. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that:

- **Healthcare staff attend all first case reviews and are involved in subsequent reviews as necessary ;**
- **There are multidisciplinary case reviews attended by all relevant people involved in a prisoner's care, with continuity of case manager where possible and which record all relevant information and action taken;**
- **Risk assessments are consistent with the risks posed by the prisoner and levels of observations are adjusted as the perceived risk changes;**
- **ACCT caremap actions are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated at each case review;**
- **ACCT monitoring continues until the risk posed by the prisoner has reduced and all caremap actions have been completed.**
- **Post-closure reviews are completed**

Clinical care

107. The clinical reviewer has covered the man's clinical care in detail in his review and the Governor and Head of Healthcare will need to ensure that the recommendations of the review, not all of which are repeated in this report, are addressed. Overall, and with the exception of the provision of cognitive behavioural therapy, the clinical reviewer found that the man's clinical care was comparable to that he could have expected in the community.

108. The clinical reviewer found that the man was appropriately referred to the mental health in-reach team when he arrived at Bullingdon, and that his care from that team was generally good. Healthcare staff obtained the man's community GP records and one of the GPs at Bullingdon spoke to his community GP to ensure continuity of care. He considered that the mental

health in–reach team appropriately discharged the man from their care as his condition improved.

109. The clinical reviewer found that there were several occasions when the man should have been offered further support by mental health services, including after he had taken an overdose on 25 November 2013 and, in January 2014, when he returned from court. He also found that staff, including a GP, were unsure about the different roles of the mental health in-reach and primary care mental health teams. He has made a recommendation about the mechanism for the delivery of mental health services in his clinical review.

110. The clinical reviewer noted that the arrangements for administration of medication at night were unsatisfactory. This led to the man receiving medication at inappropriate times. This was clearly an issue for the man as, when he was not allowed to keep his medication in possession, he had to take mirtazapine (which has a sedative effect) earlier than he should have done. Nurses said the man was often taken to the healthcare unit in the evening to receive his medication, but this was sometimes difficult because of a lack of staff to escort him.

111. The clinical reviewer also found that in-possession risk assessments were not completed properly. On 22 November 2013, a doctor changed the man's prescription to in-possession without seeing him. Two days later, he took an overdose. On 19 March 2014, a pharmacist changed the prescription back to in-possession, but did not take the man's overdose or very recent comments about his sentence into account. On 21 May, Dr B prescribed the man's medication weekly in possession. She told the clinical reviewer prisoners were disadvantaged by having to take supervised medication as it was then more difficult for them to access activities and jobs. She agreed that she could have arranged for the man to receive his medication daily in-possession, which would have meant he could have taken it in the evening at his preferred time. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff completing medication in-possession risk assessments use all relevant information and that prisoners who are not allowed to keep medication receive it at the appropriate time.

112. The man was keen to take a course in cognitive behavioural therapy, which would have helped his chance of moving eventually to a therapeutic community at Grendon. However, the course was computer-based, which was not suitable for the man. The clinical reviewer considered that cognitive behavioural therapy should be available on a face-to-face basis, as it is in the community. We agree and make the following recommendation:

The Head of Healthcare should ensure that all prisoners have access to talking therapies such as cognitive behaviour therapy, in line with provision in the community.

Emergency response

113. When the night patrol officer, OSG B, found the man hanging, he correctly called a code blue emergency and control room staff called an ambulance immediately. The OSG asked for permission to go into the man's cell, but then could not open the sealed key pouch. He said at interview that he tugged at the cable tie but was unable to open the pouch to release the key. The night orderly officer arrived with keys almost immediately and went into the cell, so there was little delay in assisting the man. We are satisfied that there was a swift and appropriate emergency response but, sadly, it was too late to save him. While the difficulty opening the sealed pouch did not affect the outcome for the man, in other circumstances, this might have led to a significant delay in emergency help. We make the following recommendation:

The Governor should ensure that staff carrying sealed key pouches at night know how to open them in an emergency.

Informing the man's family

114. The man's family told us that the family liaison officer, did not give them accurate information about the position the man was in when he was found. The family liaison officer told us that this was because she had been incorrectly briefed when she was preparing for the visit. She had relied on what she was told and at the time she left the prison, there were no written statements available.

115. Prison Service Instruction (PSI) 64/2011 informs staff how to conduct family liaison after a death in custody. The PSI states that "It is vital that accurate information about the prisoner's death is given to the next of kin. Inaccurate information given at this stage can cause unnecessary distress and suspicion and can undermine the prison's ability to build a relationship with the family." The man's family said that the family liaison officer was supportive to them, but it is clearly important that families of prisoners who have died in custody receive the correct information about their family member from the outset. We make the following recommendation:

The Governor should ensure that family liaison officers are given the correct information about the circumstances of the death of a prisoner before informing families.

RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that:

    - Healthcare staff attend all first case reviews and are involved in subsequent reviews as necessary ;
    - There are multidisciplinary case reviews attended by all relevant people involved in a prisoner's care, with continuity of case manager where possible and which record all relevant information and action taken;
    - Risk assessments are consistent with the risks posed by the prisoner and levels of observations are adjusted as the perceived risk changes;
    - ACCT caremap actions are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated at each case review;
    - ACCT monitoring continues until the risk posed by the prisoner has reduced and all caremap actions have been completed.
    - Post-closure reviews are completed

2. The Governor and Head of Healthcare should ensure that staff completing medication in-possession risk assessments use all relevant information and that prisoners who are not allowed to keep medication receive it at the appropriate time.

3. The Head of Healthcare should ensure that all prisoners have access to talking therapies such as cognitive behaviour therapy, in line with provision in the community.

4. The Governor should ensure that staff carrying sealed key pouches at night know how to open them in an emergency.

5. The Governor should ensure that family liaison officers are given the correct information about the circumstances of the death of a prisoner before informing families.