Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of John Wright a prisoner at HMP Bullingdon on 15 December 2017

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*

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

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

Mr John Wright was found hanged in his cell at HMP Bullingdon on 15 December 2017, less than eight hours after he had entered prison custody. He was 32 years old. I offer my condolences to Mr Wright's family and friends.

Mr Wright had been under constant watch by police and court staff because he said he wanted to take his life at the earliest opportunity. Although prison staff started suicide and self-harm prevention procedures when Mr Wright arrived at Bullingdon, they reduced the level of observations from constant to twice an hour. In my view, this decision was misjudged and taken far too quickly, without a proper assessment of Mr Wright's risk.

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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **July 2018**

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Summary

Events

1. Mr John Wright was arrested for murder on 12 December 2017. He told police that he planned to take his life at the earliest opportunity. Police placed him under constant watch, which was continued by court staff when he appeared in court on 14 December. He was remanded to custody at HMP Bullingdon. Prior to Mr Wright's arrival at Bullingdon, the manager of the mental health team who had assessed him in police and court custody, contacted a nurse at Bullingdon and told her that he was at very high risk of suicide and he should have an urgent mental health assessment on arrival. The nurse spoke to a colleague but neither recorded this information.

2. When Mr Wright arrived at Bullingdon, he was accompanied by his Person Escort Record (PER, a document that accompanies all prisoners when they move between police stations, courts and prisons), which noted that he was at high risk of suicide and self-harm because he had said he intended to kill himself. Staff started suicide and self-harm prevention procedures (known as ACCT) but they reduced observations from constant watch to twice an hour because they did not consider Mr Wright was in crisis. Healthcare staff completed an initial health screen and identified Mr Wright had symptoms of alcohol withdrawal and very high blood pressure. He was located in the healthcare inpatients unit so his clinical needs could be monitored. No mental health assessment was carried out because the nurse on duty, although he was a mental health nurse, was on general nursing duties that evening.

3. At 11.45pm, a night patrol officer discovered Mr Wright hanged in his cell. Staff attempted to resuscitate him but at 12.58am on 15 December, paramedics declared Mr Wright had died.

Findings

4. The decision of prison staff to reduce the level of observations on Mr Wright to twice per hour was misjudged, given he was already at a very high risk of suicide when he arrived at Bullingdon and that risk had not been properly assessed. We consider staff should have carried out a longer period of observation and a full mental health assessment before making this decision. The nurses who were aware of the information passed to them by the mental health team at the court, did not make anyone else aware so this was not taken into account when the decision to reduce the observations was made.

5. Despite nurses at Bullingdon having been made aware that Mr Wright required an urgent mental health assessment on arrival because of his high risk of suicide, no assessment was carried out. A mental health nurse was on duty that evening and could have carried out the assessment even though he was supposed to be on general nursing duties.

6. Mr Wright was placed in a cell with a medical bed and used an electrical flex from the bed as a ligature. We are concerned that no consideration was given to risk assessing the cell before allocating it to Mr Wright, who was subject to ACCT

procedures and known to be at high risk of suicide. There appeared to be no process for assessing the suitability of cells before allocating them within healthcare.

7. There was a delay in the ambulance entering the prison because of a technical fault with the gate, which had to be opened manually. We accept that staff opened the gate as quickly as they could in the circumstances and that the delay was unlikely to have affected the outcome for Mr Wright. Nevertheless, the prison needs to ensure that ambulances gain access to the prison without delay in future emergencies.

Recommendations

- The Governor and Head of Healthcare should ensure that staff identify and manage prisoners at risk of suicide and self-harm in line with PSI 64/2011 and PSI 07/2015. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners. In particular, reception, healthcare, first night staff and all others who assess risk should:
  - have a clear understanding of their responsibilities and the need to share and record relevant information about risk;
  - consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources;
  - document the information considered when deciding whether or not to open an ACCT, and the level of observations, and who contributed to the decision;
  - carry out ACCT observations at unpredictable intervals.
- The Head of Healthcare should ensure there is provision for completing immediate mental health assessments.
- The Governor and Head of Healthcare should ensure there is a clearly defined process for cell allocation within healthcare, including identifying responsibility for risk assessment.
- The Governor should ensure that prompt emergency vehicle access to the prison is included in contingency planning and that contingency plans are regularly tested.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.

9. The investigator visited Bullingdon on 19 December 2017. She obtained copies of relevant extracts from Mr Wright's prison and medical records. She visited the healthcare unit and spoke to staff who had contact with him.

10. NHS England commissioned a clinical reviewer to review Mr Wright's clinical care at the prison.

11. The investigator interviewed a member of staff on 16 January, and with the clinical reviewer interviewed 12 members of staff at Bullingdon on 19 January. In addition, the investigator interviewed two members of staff via telephone and video link in February and another by telephone in March.

12. We informed HM Coroner for Oxfordshire of the investigation, who gave us the provisional cause of death. We have sent the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers, contacted Mr Wright's family to explain the investigation. Mr Wright's family did not raise any specific issues for the investigation to consider, but wanted to know what information arrived at Bullingdon with Mr Wright from the police and court, whether he was assessed in reception and what measures were in place to monitor him.

14. Mr Wright's family received a copy of the initial report, but did not identify any factual inaccuracies. Mr Wright's family reflected that they did not blame any members of staff, but hoped lessons had been learned.

15. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP Bullingdon

16. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Care UK has been the healthcare provider since 1 April 2016. Cotswold Medicare Ltd provides general practitioner services. South Staffordshire and Shropshire NHS Foundation Trust provide care for those with severe and enduring mental illness and secondary mental health services.

HM Inspectorate of Prisons

17. The report of the most recent inspection of Bullingdon was in May 2017. Inspectors reported that Bullingdon was not safe enough. Assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm was found to be weak and disorganised. Most staff did not have up-to-date ACCT training.

18. Inspectors found while new arrivals were asked about thoughts of suicide and self-harm, there was no structured assessment of risk factors. This was of particular concern because recent investigations by the PPO following three self-inflicted deaths in custody had highlighted weaknesses in identifying risk on arrival. There was an action plan addressing recommendations from the PPO following these self-inflicted deaths, and some had been implemented. However, some crucial ones had not.

19. Inspectors found staffing vacancies in primary healthcare had resulted in the regular use of agency nurses, which caused considerable challenges in promoting a positive culture. Inspectors identified the inpatient unit as a serious area of concern. There was a regular lack of prison staff to unlock prisoners, which meant that, as health services staff did not have their own cell keys, access to prisoners was sometimes delayed.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to 30 June 2017, the Board noted that staff shortages had undermined the effectiveness of much of what the prison had sought to do, including holding prisoners safely. The Board found more improvement was required in the use of ACCTs.

21. The Board noted that Care UK was appointed to provide primary healthcare in April 2016, and that staff recruitment has been a major challenge.

Previous deaths at HMP Bullingdon

22. Mr Wright was the sixth prisoner to take his own life at HMP Bullingdon since 2015. We have previously highlighted weaknesses in assessing prisoners' risks of suicide and self-harm. Since Mr Wright's death, a further prisoner has taken his own life.

Assessment, Care in Custody and Teamwork (ACCT)

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

Key Events

24. Mr John Wright was arrested for murder on 12 December 2017, and taken to Newbury Police Station. He described himself as an alcoholic. A police doctor assessed Mr Wright for signs of alcohol withdrawal and recorded that he suffered from high blood pressure, but had not been prescribed medication. The doctor also recorded that, 'after tonight [Mr Wright] does not want to be here anymore'. Police assessed Mr Wright as at high risk of suicide and self-harm and placed him on constant watch. Later the same day, Mr Wright showed signs of alcohol withdrawal and a doctor prescribed diazepam to help manage his symptoms. Mr Wright told the doctor that he would kill himself when he left custody.

25. While in police custody, the mental health liaison and diversion team (who identify offenders who have mental health, learning disability or substance misuse vulnerabilities) assessed Mr Wright. He told them he wanted to end his life, but being on constant watch prevented him from doing so. Mr Wright said he had previously tried to hang himself, considered jumping into a river in the weeks before his arrest and had stabbed himself in the leg. They noted Mr Wright 'appears at great harm to himself… and intends to end his life'. The liaison and diversion team noted that an urgent referral should be made to the mental health in-reach team if Mr Wright were to be remanded in custody.

26. Mr Wright remained in police custody until 14 December, when he was taken to Reading Magistrates' Court. Police noted on the 'Suicide/Self-Harm Warning Alert', that Mr Wright had felt suicidal in the past few weeks and said that he wanted to kill himself. On his Person Escort Record (PER), a document that accompanies all prisoners when they move between police stations, courts and prisons, court staff recorded that Mr Wright had been on constant watch during police custody, and that would continue while he was held in court cells. Court staff recorded that, '[Mr Wright] intends on killing himself when he gets the opportunity'.

27. The mental health liaison and diversion team visited Mr Wright at 10.11am after his court appearance, when he was still under constant watch by court staff. The team lead for the mental health liaison and diversion team, contacted Bullingdon later that day between 3.30pm and 4.15pm, before Mr Wright arrived at the prison, and spoke to Nurse A to inform her that Mr Wright was assessed as being at high risk of suicide. At 4.27pm, she emailed the nurse and attached the assessment completed by the liaison and diversion team. The nurse informed Senior Staff Nurse B by telephone, but Nurse B did not make an entry in Mr Wright's medical record. She told the investigator it was a busy reception and she would have preferred to have received a printed copy of the assessment. Nurse A told the investigator she would typically print off any significant information, but did not know why she did not print off the assessment before going off duty at 5.00pm.

28. Mr Wright was remanded into custody at Bullingdon, and was due to appear at Reading Crown Court the next day. He had not been in prison before. Mr Wright arrived at Bullingdon at 4.15pm. Officer A generated a computerised prison record for Mr Wright at 4.58pm.

29. Supervising Officer (SO) A started Prison Service suicide and self-harm prevention procedures (known as ACCT) at 5.15pm. The SO recorded on the 'concern and keep safe' form, that Mr Wright had arrived from Reading Magistrates' Court charged with murder, was low in mood due to the offence and it was his first time in prison. The SO noted Mr Wright had been on constant watch as he had said that he would try to kill himself at the earliest opportunity.

30. SO A informed the safer custody team that she had opened an ACCT. She discussed the ACCT with the duty governor and Nurse B and they all agreed on half hourly observations until Mr Wright's ACCT assessment could be completed. The SO completed the immediate action plan, noting that Mr Wright was to be located in the healthcare unit because of his physical health and that he would have 24-hour access to Samaritans or Listeners (prisoners trained by Samaritans to support other prisoners).

31. None of the staff who had contact with Mr Wright while he was in reception at Bullingdon considered it necessary to continue constant watch because, in their opinion, he did not present as being in crisis. SO A told the investigator Mr Wright, 'appeared relaxed for someone whose first time it was in prison', and the duty governor said Mr Wright was, 'engaging, he was talking away'. Nurse B told the investigator, 'for me I reduced it [observations] to half hourly… the person in front of me, very smiley, very pleasant… everything was positive in my eyes'. Neither the SO nor the duty governor was made aware of the telephone call that had been made to Nurse A by the mental health liaison and diversion team, details of which had been passed on to Nurse B.

32. SO A completed a cell sharing risk assessment (CSRA) which is designed to assess the risk of violence a prisoner poses. She noted Mr Wright was charged with murder, but there is no other information recorded and he was assessed to be standard risk (although the offence should indicate a mandatory high risk). Nurse B completed the health assessment on the CSRA, and noted Mr Wright was at increased risk because of 'medical/mental health'. The CSRA was not authorised by a manager.

33. Officer B completed Mr Wright's first night reception interview, and noted on Mr Wright's prison record at 5.22pm that he had been placed on an ACCT and had declined a telephone call. This was the last entry in Mr Wright's prison record before he died.

34. At an initial health screen at 5.38pm, Nurse B noted Mr Wright had alcohol related issues and had blood in his urine and stools, so referred him to the substance misuse team and primary mental healthcare team.

35. According to the time on the closed-circuit television (CCTV) in reception, Mr Wright was put into a holding room at 5.54pm. He can be seen reading a newspaper and a prison orderly gave him something to eat at 6.01pm.

36. Nurse C, completed an alcohol and drug assessment at 6.04pm, and started an alcohol withdrawal care plan. Nurse B examined Mr Wright again at 6.07pm and noted ACCT procedures had started and Mr Wright would be observed twice an hour and he would be given medication for high blood pressure when he arrived at inpatients.

37. At 6.31pm, a doctor examined Mr Wright and prescribed diazepam for alcohol withdrawal symptoms and medication for high blood pressure (amlodipone). The doctor booked a follow up appointment to review Mr Wright and requested his blood pressure was monitored every four hours. The doctor incorrectly recorded that Mr Wright was on constant watch. He told the investigator that Nurse C had told him this and he would have expected constant watch to have continued until a comprehensive mental health assessment had been completed. The nurse told the investigator that she had overheard that Mr Wright was on constant watch and told the doctor. She said she subsequently became aware that observations had been reduced to twice an hour, but she had no concerns about this as Mr Wright appeared 'really normal' when she spoke to him. Mr Wright was allocated a cell in the healthcare inpatients unit due to his high blood pressure.

38. Mr Wright arrived in the healthcare unit at 6.57pm and was located in cell H114. This was the only available cell in inpatients. It had a medical bed instead of a standard prison bed. At 7.03pm, Nurse D, a mental health nurse, noted in Mr Wright's medical record that he exchanged a greeting with staff when he arrived and that he appeared calm. He also noted that Mr Wright was assessed to be at high risk of suicide as he had expressed suicidal intent while in police custody. The nurse told the investigator 'He [Mr Wright] wasn't showing any signs of you know being depressed or anything like that. He was smiling, very sort of cooperating and he actually shook hands and then the officers took him to his cell'. The nurse noted Mr Wright's blood pressure was to be checked every four hours.

39. There are ACCT entries made at 7.00pm, 7.30pm and 8.00pm, but it is unclear who made them. During that time, Mr Wright was given a cup of water, smoked an e-cigarette and was given medication. Operational support grade (OSG) A started her night shift at 8.45pm and made an entry in Mr Wright's ACCT 'hand over from day staff', but there was no record that she had observed him.

40. At 9.30pm, Nurse E, a mental health nurse, recorded in Mr Wright's medical record that she had given him four specimen bottles for urine samples. He was concerned that he might be unable to provide a sample so she assured him he could provide them anytime. At 10.02pm, the nurse made another entry in Mr Wright's medical record, at the request of Nurse D, who had recorded Mr Wright's blood pressure as 178/116 (high) and pulse 78 beats per minutes (bpm) during his reception assessment. Two minutes later, Nurse E recorded Mr Wright's blood pressure as 188/121 (very high) and pulse 83bpm, and 'I asked him if he had anything worrying him. He [Mr Wright] denied it. I informed him to talk to staff if he needed to'. Nurse E reassured Mr Wright the blood pressure medication would take a little while to work and that she would take another blood pressure reading in the early hours of the morning. Nurse E did not make any entries on Mr Wright's ACCT document.

41. OSG A recorded in Mr Wright's ACCT at 9.00pm, 9.30pm, 10.00pm, 10.15pm, 10.45pm and 11.15pm, that Mr Wright was awake and lying on his bed. When she checked him at 11.45pm, she found him with a ligature around his neck and called a code blue emergency indicating that a prisoner is unconscious or having trouble breathing. The OSG told the investigator that she struggled to open the

sealed pouch and then was surprised to find two keys inside. She said she tried the first key which was incorrect and by the time she had the second key to the lock, officers had arrived.

42. Closed circuit television (CCTV) was situated in the inpatients unit, but when the investigator tried to view the footage the time stamp was incorrect and it was impossible to find the footage because the CCTV system was old and very difficult to navigate. Body Worn Video Cameras (BWVC) were not working so there was no footage to verify timings. An officer from, safer custody, told the investigator that BWVC were not working on the morning of 14 December, were fixed and working by 9.30am, but during the evening another fault occurred. The system was rebooted and working by 6.30am on 15 December. There have been no reported significant issues with the system since.]

43. Custodial manager A was the night operational manager. He and other staff were at the gate when he heard the code blue over the radio. Together with Officers C, D, E and F, they ran to the healthcare centre. Officer G, the custodial manager's assistant manager, met them at the healthcare centre. The custodial manager told the investigator it took them around two to three minutes to get to Mr Wright's cell and they arrived at 11.48pm. Nurse F, who was located in the healthcare centre had also responded. The custodial manager used his cell key to open the door, and Officer C entered and cut the ligature (an electrical cable from the medical bed). The custodial manager said they turned and lowered Mr Wright's body to the floor. He described Mr Wright as being very limp and looking pale and believed he was probably dead by the time he was discovered. Nurse F assessed Mr Wright and described him as clammy but not cold and the custodial manager and Nurse E started cardiopulmonary resuscitation (CPR). An automatic external defibrillator was attached to Mr Wright, which indicted he had no shockable rhythm, but staff continued CPR until paramedics arrived.

44. According to the control room records made by OSG B, the code blue was radioed at 11.48pm by Hotel 10 (radio call sign for OSG A) and acknowledged by Oscar 1 (radio call sign for the night manager, the custodial manager) and an ambulance was requested immediately. South Central Ambulance Service records record that they received a request for an emergency ambulance at 11.51pm. Paramedics arrived at Bullingdon at 12.04am, but were delayed at the gate. They arrived at Mr Wright's cell at 12.14am but were unable to resuscitate him. At 12.58am, Mr Wright was pronounced dead. He did not leave a suicide note.

45. Nurse G made a retrospective entry on Mr Wright's medical record at 11.17am, and recorded that she had administered blood pressure medication at 8.00pm the previous night and offered Mr Wright some books.

46. Nurse A made a retrospective entry on Mr Wright's medical record at 11.54am. She noted the court liaison and diversion team had contacted her in the afternoon on 14 December, and said 'he [Mr Wright] was going to complete suicide and that it was a case of not if but when'. She recorded that she verbally handed over this information to Nurse B in reception. She told the investigator that the information was received before Mr Wright had arrived at Bullingdon, and therefore his records had not been started so she could not make an entry on the

electronic medical record. There is no entry from Nurse B on 14 December, about this information and discussion, but she told the investigator she did receive a telephone call from Nurse A.

Contact with Mr Wright's family

47. The prison appointed Officer G as the prison family liaison officer and Officer H as her deputy. Thames Valley Police broke the news of Mr Wright's death to his family on 15 December. Officer G made contact with Mr Wright's family later the same day and visited them at their family home on 18 December. She offered support to Mr Wright's family and told them the prison would contribute towards the cost of the funeral in line with national instructions.

Support for prisoners and staff

48. The duty governor, arrived at Bullingdon around 1.15am. He debriefed the prison and healthcare staff involved in the emergency response and offered his support and that of the staff care team.

49. The prison posted notices informing prisoners of Mr Wright's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Wright's death.

Post-mortem report

50. At the time of issuing this initial report, we have not yet received the final post-mortem and toxicology reports but we are satisfied that Mr Wright died from hanging.

Findings

Assessment of risk of suicide and self-harm

51. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, states that it is a mandatory requirement that staff manage prisoners appropriately when they arrive with an indication that they might be at risk of suicide or self-harm. PSI 07/2015 also states, '*All relevant information available about the prisoner must be noted in the appropriate record, and forwarded to other staff as necessary, both within the establishment and externally. Actions taken in relation to this information must also be recorded and the relevant other agencies and departments informed. Local policies and procedures must make clear the options available to reception, first night and healthcare staff to keep safe and support those identified on reception as being at risk of suicide and self-harm*'.

52. Nurse A took a telephone call from the mental health liaison and diversion team telling her that Mr Wright was under constant watch because he was at high risk of suicide and that he should have an urgent mental health assessment on arrival at the prison. She passed this information on verbally to Nurse B, but neither recorded it. Nurse A was subsequently emailed the mental health assessment completed by the liaison and diversion team, but did not print this off or share it with anyone. As a result, SO A and the duty governor, who were both involved in making the decision to take Mr Wright off constant watch, were not aware of this information. PSI 64/2011 on Safer Custody states: '*The failure to transfer information within and between services is a perennial issue and one that receives significant attention from the PPO in investigation and at inquests'*, which is apparent in this case.

53. Mr Wright was under constant watch during his time in police and court custody because he had said he intended to take his own life at the earliest opportunity. PSI 64/2011 states: '*Constant supervision must only be used at a time of acute crisis and for the shortest time possible'.* SO A told the investigator that Mr Wright did not appear to be in crisis and he appeared relaxed. Nurse B and the duty governor said he was engaging well. They all agreed twice hourly observations were appropriate.

54. The doctor and Nurse A both told the investigator they would not have reduced observations from constant, until there had been a longer period of assessment, yet neither contributed to the decision-making process.

55. We consider that the decision to take Mr Wright off constant watch was premature and failed to take into account all the available information about his level of risk. In addition to the information provided by the police and court service, indicators of risk (which are set out in Prison Service policy) included the offence with which Mr Wright was charged (murder), the fact that this was his first time in prison, the fact that he was experiencing withdrawal from alcohol and the fact that he was also experiencing physical ill-health.

56. We also consider that, against this cumulative evidence of risk, too much reliance was placed on Mr Wright's presentation. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered

as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

57. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that reception assessments often place too much weight on staff's perception of the prisoner and they do not consider all relevant information. We reinforced these messages in a learning lessons bulletin, issued in February 2016, about early days and weeks in custody.

58. We also identified some deficiencies with the ACCT procedures. SO A should have recorded the reasons for the collective decision to reduce the level of observations from constant to twice an hour on the ACCT document but did not do so. The SO said it was routine practice at Bullingdon for the immediate action plan to be completed by an SO and not the orderly officer or duty governor. CM A and a member of the Safer Custody, also said this had been routine practice at Bullingdon for some time, and told the investigator that if a prisoner was to be located in the inpatient unit they would have expected the duty governor or orderly officer to have been consulted. SO A did discuss Mr Wright's location with duty governor, but there is no evidence the immediate action plan she completed was reviewed or authorised by a senior manager.

59. Mr Wright should have been observed every half an hour, but he was not checked for 45 minutes between 8pm and 8.45pm. Recorded observations at times lacked detail and were regular and predictable. Neither Nurse E nor Nurse D made entries on the ACCT document; Nurse E said it 'slipped in my mind' and Nurse D said it was because his contact with Mr Wright was 'clinical'.

60. In summary, we consider that the decision of Bullingdon staff to take Mr Wright off constant watch was misjudged. Mr Wright should have been subject to a period of observation and a mental health assessment before any decision to reduce the level of observations was taken. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff identify and manage prisoners at risk of suicide and self-harm in line with PSI 64/2011 and PSI 07/2015. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners. In particular, reception, healthcare, first night staff and all others who assess risk should:

- **have a clear understanding of their responsibilities and the need to share and record relevant information about risk;**
- **consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from Person Escort Record forms (PER) and other sources;**
- **document the information considered when deciding whether to open an ACCT, and the level of observations, and who contributed to the decision;**
- **carry out ACCT observations at unpredictable intervals.**

Clinical care

61. The clinical reviewer concluded the care provided in respect to Mr Wright's physical health, including withdrawal from alcohol, was reasonable and appropriate.

Mental health referral process

62. Nurse A said there was no protocol for assessing a prisoner's mental health when they first arrived at Bullingdon and no "crisis response" mental health provision to provide immediate assessment. The nurse said an urgent assessment would typically be completed within 48hrs. The Head of Healthcare, told the investigator that the mental health team was very stretched, especially given the scale and size of Bullingdon. He said there was no contractual requirement, but there was a need for a rapid response mental health service. Nurse D, a mental health nurse, was on duty when Mr Wright arrived in healthcare, but said he was not required to complete an assessment as he was designated to work as a general nurse during his shift.

63. The head of healthcare said that in his opinion, regardless of what the designated role is, a nurse should always use their skills and not to do so would be poor quality nursing. (Nurse D has since been suspended from duty for reasons unconnected to this particular case.) He explained that since Mr Wright's death, he has made a business case to healthcare commissioners for a mental health nurse to be available between 1 and 9 pm, and a mental health response model for those prisoners who need urgent and immediate assessments. Although Bullingdon have taken steps to address this gap in mental health provision with healthcare commissioners, this has not yet resulted in a formal agreement. Therefore, we make the following recommendation:

The Head of Healthcare should ensure there is provision for completing immediate mental health assessments.

Bed allocation - inpatients

64. Mr Wright was allocated a cell that had a medical bed. It was the only cell available in the inpatients unit and there was no clinical reason for this. Mr Wright used the electrical flex on his bed as a ligature. We are concerned that the cell was not risk assessed before Mr Wright was allocated it. During interviews, it was clear that there was confusion and a lack of understanding about how a cell is allocated in inpatients and who is responsible for any risk assessment.

65. The head of healthcare told the investigator that decisions should be clinically led depending on the prisoner's healthcare needs, but that in practice are often based on what and how many cells are available. He said there are ongoing discussions to improve the process. We make the following recommendation:

The Governor and Head of Healthcare should ensure there is a clearly defined process for cell allocation within healthcare, including identifying responsibility for risk assessment.

Emergency response

Entering Mr Wright's cell

66. PSI 24/2011 - *Management and Security of Nights,* gives national guidance for entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and a cell must be opened with a minimum number of staff (according to local risk guidelines) present. However, the PSI goes on to say, that the preservation of life must take precedence over this. Where there is or appears to be threat to life, staff may open and enter cells on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.

67. OSG A correctly radioed a code blue medical emergency. Officers do not carry cell keys on their key chains at night, but have a key in a sealed pouch for use in an emergency. The OSG said the seal was difficult to break, Nurse E also struggled to open the pouch when asked to assist, and when they did there were two keys inside the pouch. She said she had not known there would be two keys, and had never been briefed that the sealed pouch also contained a key to the constant watch cell.

68. The officer from safer custody, told the investigator that since Mr Wright's death, only one key is held in a pouch and different seals were used and had been replaced on all key pouches. As Bullingdon have already made changes to the sealed pouches, we do not make a recommendation.

Ambulance delay

69. OSG B recorded in the communications log that a code blue was called at 11.48pm and an ambulance requested at the same time. However, ambulance service records show the ambulance was requested at 11.51pm, six minutes after Mr Wright was first discovered. He said he did not record the time when OSG A first radioed a code blue at around 11.45pm, as he was at the gate (with custodial manager and the other staff) and returned to the Control Room immediately. OSG B said he did not use a telephone in the gate to request the ambulance as the only telephone you could dial 999 directly from was in the Control Room. He was adamant that there was no delay in requesting an ambulance. During his interview, he checked the time on the prison computer, which links to the radios, and found it was inaccurate by around five minutes. While there is a slight discrepancy in the timings, we accept his explanation.

70. PSI 03/2013 also contains mandatory instructions that prison staff should prevent unnecessary delay in escorting ambulances and paramedics to the patient. The ambulance service recorded that they were delayed entering the prison and it took ten minutes to reach Mr Wright. Paramedics recorded that there was a mechanical fault with the gate and prison staff had requested that one of the paramedics stayed with the ambulance, leaving one paramedic alone for around five minutes. The clinical reviewer concluded that despite the delays, resuscitation is unlikely to have been successful.

71. The custodial manager, the night orderly officer, said he had been aware there were difficulties earlier on that day with the gate, but it was opened as soon as

reasonably possible and cranked open by hand. OSG B said he had no prior knowledge that the electronic gate was not working or faulty and it was only when he went to put the system into manual override to open, that it didn't work. He said he accessed two key pouches; one to use a key in the computer to override the night state, but had to use a second key to gain access to the crank to manually open the gate. OSG said Officer G assisted him in cranking open the gate, but did not recall how long this took.

72. The custodial manager said that he requested one of the paramedics stay with the ambulance, as he realised the ambulance would be required to enter the prison, and that one paramedic went to the healthcare unit to avoid any additional delays. We make the following recommendation:

The Governor should ensure that prompt emergency vehicle access to the prison is included in contingency planning and that contingency plans are regularly tested.

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