Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shaun Dewey a prisoner at HMP Bristol on 13 April 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

Mr Shaun Dewey was found hanged in his cell at HMP Bristol on 13 April 2018. He was 30 years old. I offer my condolences to his family and friends.

Mr Dewey was on remand charged with murder. It was his first time in prison. In November 2017, he self-harmed after being assaulted by another prisoner, and in January 2018, he was moved to Bristol where it was thought he would be safer. He remained extremely anxious that he and his family were at risk of harm as a result of his offence.

Although he was appropriately monitored under suicide and self-harm prevention procedures (known as ACCT) when he first arrived at Bristol, I am concerned that the ACCT was closed prematurely and that staff gave too much weight to Mr Dewey's assurances that he had no suicidal intentions and insufficient weight to his risk factors and extreme anxiety which remained unchanged.

I am also concerned that staff did not notice that Mr Dewey had not collected his meals or medication and that no one had spoken to him for at least five and a half hours before he was discovered hanged in his cell. This was unacceptable.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

Contents

Summary

Events

1. On 19 September 2017, Mr Shaun Dewey was charged with murder and grievous bodily harm. While in police custody, he told a nurse that he had no future and nothing to live for. On 20 September, he was remanded to prison custody and admitted to HMP Hewell. It was his first time in prison. Staff began Prison Service suicide and self-harm prevention procedures, known as ACCT, and monitored him until 2 October.

2. On 17 October, the security department at Hewell received intelligence reports that Mr Dewey might be at risk of harm in Hewell and that he had been bullied. He was moved to another houseblock.

3. On 13 November, Mr Dewey was assaulted by an unidentified prisoner. Mr Dewey subsequently made deep cuts to his forearms with a razor and told staff that he wanted to kill himself before someone killed him. Staff restarted ACCT procedures due to his low mood and thoughts of self-harm and monitored Mr Dewey until 30 November.

4. On 4 January 2018, Mr Dewey was moved to Bristol for his own safety, and ACCT arrangements resumed that day because of his history of self-harm, anxiety and depression.

5. Mr Dewey asked to see a mental healthcare worker as he felt that he was not coping. The mental health team did not consider that he fitted their criteria and referred him to a GP. She highlighted her concerns to the safer custody and security teams that Mr Dewey was withdrawn, tearful and scared of being attacked by other prisoners.

6. On 1 February, Mr Dewey moved to the Vulnerable Prisoners' Unit (VPU).

7. He did not collect his antidepressants or meals on several occasions and was reluctant to leave his cell. He regularly told staff that he thought he and his family were at risk of harm as a result of his offence and he was particularly anxious about having visits in the visits hall with other prisoners.

8. On 12 February, staff stopped ACCT monitoring as they considered Mr Dewey appeared positive and he assured them that he felt more settled.

9. On 19 February, Mr Dewey had his last visit from his family. He did not arrange any further visits because of his anxieties about them being at risk in the visits hall.

10. From 26 February, Mr Dewey occupied a cell on his own. He only left the cell to collect meals and medication.

11. On 14 March, Mr Dewey's solicitors contacted Bristol to ask for a family visit to be organised for him away from the main visits area. They were concerned that he was frightened, isolated and had acute anxiety. A senior manager assured them that a visit would take place near officers in the visits hall, that Mr Dewey had said that he felt safe at Bristol and was not self-isolating.

12. Just before midday on 13 April, an officer found Mr Dewey hanged in his cell. He had last been seen alive between 5.00 and 6.00am. Staff who worked the day shift did not recall seeing him that morning and it was apparent that he had been dead for some time. Staff tried to resuscitate him until a paramedic recorded that Mr Dewey had died.

Findings

13. Staff appropriately monitored Mr Dewey under ACCT procedures from 4 January to 12 February at Bristol.

14. However, we consider that ACCT monitoring was ended prematurely on 12 February. We are concerned that staff gave too much weight to Mr Dewey's assurances that he did not have suicidal intentions and insufficient weight to his risk factors even though Mr Dewey's risk factors remained unchanged and his anxieties about visits had not been resolved.

15. Mr Dewey lived in the VPU which operated a regime which was virtually identical to other residential units at Bristol. It was left to individual officers to complete additional checks on prisoners' wellbeing. We are concerned that many staff viewed Mr Dewey's self-isolation as a lifestyle choice rather than a cause for concern.

16. There were missed opportunities to discover Mr Dewey sooner on the day he died. We are concerned that staff did not notice that he had not been seen or collected his meals for more than five and a half hours. This was both a safety and a security risk.

17. When Mr Dewey asked for a referral to the mental health team, he was offered GP appointments or group activity instead. He was not told that the mental health team had decided he did not fit their criteria. There were missed opportunities to assess Mr Dewey's mental health and offer him targeted support, especially once the ACCT document had been closed.

18. Healthcare staff did not fully explore why Mr Dewey had missed several doses of his antidepressants.

Recommendations

- The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that all staff who assess risk:
    - have a clear understanding of their responsibilities and the need to share all relevant information about risk;
    - consider and record all known risk factors for a prisoner when determining his risk of suicide and self-harm;
    - document the information considered and the reasons for the decisions taken; and

- start ACCT procedures whenever a prisoner has significant risk factors, irrespective of their stated intentions.

- The Governor should ensure that staff record behaviour that is out of character or unusual for a prisoner and that it is discussed at the next shift handover.
- The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of a prisoner's safety and welfare and that there are no matters that need immediate attention.
- The Governor and Head of Healthcare should ensure that when a mental health referral is received, a member of the mental health team assesses the prisoner and where they decide not to accept a prisoner on to their caseload, their reasons are clearly documented.
- The Governor and Head of Healthcare should ensure that staff explore why prisoners have not collected their medication and that alternative measures for them to receive their medication are put in place, where necessary.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one came forward.

20. The investigator visited HMP Bristol four times between April and October 2018. She obtained copies of relevant extracts from Mr Dewey's prison and medical records.

21. NHS England commissioned a clinical reviewer to review Mr Dewey's clinical care at the prison. The investigator interviewed 26 members of staff and one prisoner, 11 of whom were jointly interviewed with the clinical reviewer.

22. We informed HM Coroner for Avon of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology tests. We have sent the Coroner a copy of this report.

23. One of the Ombudsman's family liaison officers contacted Mr Dewey's partner to explain the investigation and to ask if his family had any matters they wanted the investigation to consider. Mr Dewey's family asked why prison staff did not seem to notice that his mental health was deteriorating, why staff did not ensure that he collected his medication, whether his medication was reviewed and why he was moved to HMP Bristol when it had a high level of suicide and violence.

24. Mr Dewey's partner received a copy of the initial report. The solicitor representing her identified two factual inaccuracies and clarifications.

25. The initial report was shown to HM Prison and Probation Service (HMPPS) who pointed out four inaccuracies/clarifications.

Background Information

HMP Bristol

26. HMP Bristol serves the local courts and holds up to 614 adult men over the age of 18 years old. HM Prisons and Probation Service placed it under special measures in 2018 as they considered that it needed additional specialist support to improve performance.

27. Healthcare services at Bristol are managed by Inspire Better Health, a partnership of eight health providers led by Bristol Community Health. GP services are subcontracted to Hanham Health Services, and Avon and Wiltshire Partnership provide mental health and substance misuse services. A number of organisations provide other services, including Prisoner Advice and Care Trust (PACT) who offer support to prisoners to maintain family links.

28. Bristol's Vulnerable Prisoners' Unit (VPU) accommodates up to 126 prisoners who need to be kept separately from other prisoners because they may be at risk from others. This may be due to their age, nature of their offence (particularly sexual offences), vulnerability to bullying, poor coping skills or debt.

HM Inspectorate of Prisons

29. An inspection of HMP Bristol took place in March 2017. Inspectors reported that almost 59% of prisoners said that they had felt unsafe at some point. which was a much higher figure than at similar prisons. They noted that Bristol had struggled with a legacy of underinvestment and chronic staff shortages. This meant that there was no effective personal officer scheme and the regime was limited, with 50% of prisoners locked in their cells during the day. They found that levels of self-harm and violence were very high and support for victims of violence was poor. They noted that there was no clear induction process for the VPU.

30. Inspectors found that many healthcare appointments were lost due to the lack of staff to escort patients to the healthcare centre. They noted that staff were inconsistent in their supervision of medicine administration which provided opportunities for prisoners to be bullied. They found that support for prisoners with lower-level mental health needs was limited.

31. An unannounced inspection took place from 20 May -7 June 2019. HM Chief Inspector invoked the Urgent Notification process on 11 June informing the Secretary of State for Justice that there were numerous significant concerns about the treatment and conditions of prisoners. Inspectors reported that there was no effective strategy to reduce levels of self-harm and that Bristol had failed to keep prisoners safe.

Independent Monitoring Board

32. 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 latest annual report for the year to December 2017, the IMB

reported that poor retention meant that up to 60% of staff were new or had less than two years' experience.

33. The IMB noted that there was no dedicated accommodation for newly arrived prisoners as the First Night Centre had closed which meant that support and induction for prisoners in their early days was inconsistent. They found that there was a poor perception of safety on A Wing (the VPU) due to the varied reasons for prisoners being there, which left some vulnerable to bullying.

Previous deaths at HMP Bristol

34. There have been 13 deaths at Bristol since 2016, seven of which, including Mr Dewey's, have been self-inflicted. Mr Dewey's death was the only self-inflicted death at Bristol in 2018.

35. We have made previous recommendations about the management of the ACCT process after three prisoners died within 48 hours of their arrival. The investigation into the apparent self-inflicted death of a prisoner in 2017 found that although he was afraid to leave his cell, staff did not investigate the reasons behind this and did not consider him at risk of suicide or self-harm.

Assessment, Care in Custody and Teamwork

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

Key Events

HMP Hewell

37. On 20 September 2017, Mr Dewey was remanded to HMP Hewell, charged with murder and grievous bodily harm. While in police custody, he had told a nurse that he had no future and nothing to live for. Court staff informed Hewell before his arrival that they had monitored him under suicide and self-harm prevention procedures, and that it was his first time in custody. They wrote in Mr Dewey's Person Escort Record (which accompanies prisoners on all journeys between police stations, courts and prisons to communicate risk factors) that he was at high risk of suicide and self-harm and had a history of depression and anxiety.

38. When Mr Dewey arrived at Hewell, an officer began suicide and self-harm procedures, known as ACCT. Mr Dewey said that he had had suicidal thoughts over the previous few days. A prison manager set the frequency of scheduled observations as hourly.

39. A nurse assessed Mr Dewey's healthcare needs as part of his reception health screen. He noted that Mr Dewey had been prescribed antidepressants by his community GP after his mother's death and that he appeared dejected and tearful. Mr Dewey told him that he did not have fixed plans to end his life and 'would not have the courage to go through with it anyway'. The nurse referred Mr Dewey to the mental health team and GP. A GP prescribed an antidepressant and the mental health team placed him on their waiting list for an assessment.

40. On 21 September, Mr Dewey told an officer who assessed his risk of suicide and self-harm that he had no understanding of prisons and did not know whether he would take his life. He was offered support and the officer raised the frequency of observation to three times an hour. On 23 September, staff at an ACCT case review noted that Mr Dewey appeared more at ease and settled. The frequency of observations was reduced to three conversations a day and hourly observations at night. On 2 October, his case manager concluded that his risk had reduced sufficiently to stop ACCT monitoring. Mr Dewey was employed, was receiving visits and had regular contact with his family.

41. On 10 October, Mr Dewey had a mental health review with a nurse. He recalled that his mood was low when he arrived at Hewell but said that he had 'got over that now'. He said that he occupied himself with a full-time job and though he had insomnia, he did not need a mental health assessment. The nurse observed that his self-care was good, he did not have thoughts of self-harm or suicide and the wing officers said that he had a good rapport with his peers. He was positive during his ACCT post-closure interview on 11 October, and said that he knew how to get help if he needed it. ACCT monitoring was not re-started.

42. On 17 October, Mr Dewey's partner and his solicitor telephoned Hewell to say that they were concerned that he was being threatened. The security department was made aware of the telephone calls. Mr Dewey began isolating himself in his cell and was reluctant to leave it when other prisoners were out of their cells for fear of being threatened because of his alleged offence. He was moved from Houseblock 1 to Houseblock 6.

43. At 5.00am on 14 November, Mr Dewey's cellmate alerted an officer that Mr Dewey had cut himself. The officer called a medical emergency code red (used for incidents of serious injury or bleeding). Mr Dewey had made several deep cuts to both of his forearms. One of the cuts exposed the underlying muscle and ligaments. He was initially treated in the healthcare centre. He told a nurse that he had harmed himself because he was under threat. She referred him to the mental health team and wrote in his clinical record that he appeared scared and vulnerable and his risk of self-harm was severe. Mr Dewey was taken to hospital for further treatment. He returned to Hewell later that morning and moved from the houseblock to the healthcare centre unit known as Lower Medical Unit.

44. Staff began monitoring Mr Dewey under ACCT procedures. Mr Dewey told an officer who carried an out an ACCT assessment while accompanying him to hospital, that he had been feeling worse over the previous weeks. He said that he had been hit several times by an unknown prisoner while walking back from work on 13 November. He said that he cut himself with a razor numerous times because of a build-up of anxiety.

45. At a multidisciplinary case review after the assessment, Mr Dewey said that he was overwhelmed and very anxious. He said that he missed his family desperately and wanted to go home to them. His risk of self-harm was assessed as raised, the frequency of observations by officers was set at four times an hour and a further case review was scheduled for 17 November. Mr Dewey's father had booked a visit for 14 November, but as Mr Dewey did not feel able to go into the visits room, staff arranged for Mr Dewey's father to visit him on the Lower Medical Unit that day.

46. On 15 November, staff held another multidisciplinary case review for Mr Dewey after another prisoner died in custody. Mr Dewey said that he still felt low and although he felt settled in the Lower Medical Unit, he considered himself under threat wherever he was located in Hewell. He said that he would tell staff if he was thinking of harming himself. His level of risk and frequency of observation remained unchanged. On 16 November, his father visited him in the unit but he was told that future visits would have to take place in the visits room.

47. On 17 November, a third case review took place. Mr Dewey said that he missed his family and did not feel confident enough to return to work but he did not have thoughts of self-harm. The frequency of observations was reduced to hourly. The summary of the case review indicates that Mr Dewey asked to be transferred to HMP Bristol, and this request was passed to the relevant department. Mr Dewey's partner maintains that although her fiancé wanted to leave Hewell, he did not ask to move to Bristol.

48. On 19 November, an unidentified officer (whose signature is illegible) checked on Mr Dewey during the afternoon free association period and found him crying in his cell. He said that he missed his wife and child desperately and was overwhelmed by fear of a long sentence if convicted. He was advised to concentrate on one day at a time rather than worrying about the future. After a long conversation, Mr Dewey said that his family were supportive and he asked to borrow some library books, which was arranged.

49. On 23 November, Mr Dewey's risk level was reduced to low at a case review. He was still very anxious but assured the staff present that he was keeping in touch with his family by telephone and letters. He did not want to move from Lower Medical Unit to another unit and asked about his transfer to Bristol. His final case review took place on 30 November as it was agreed that Mr Dewey's risk remained low. An officer discussed with him the possibility of moving to HMP Dovegate, a prison in Staffordshire. He said that he would talk to his family about it. An ACCT post-closure interview was arranged for 7 December but there is no record that it took place.

50. On 1 January 2018, a nurse wrote in Mr Dewey's clinical record that he isolated himself, rarely spoke to anyone and, when asked, he had said that he preferred his own company. She noted that he lay in bed all day with the covers up to his head and often had a headache, which he attributed to stress. She referred him to a GP. On 3 January, a prison GP examined Mr Dewey and spoke to him about ways that he could improve his sleep hygiene after Mr Dewey said that he had a poor sleep pattern.

HMP Bristol

51. On 4 January, Mr Dewey was transferred to HMP Bristol.

52. When he arrived, an officer assessed his needs and checked whether there was any indication that Mr Dewey might be at risk of suicide or self-harm. Mr Dewey said that he had no thoughts of self-harm but had anxiety and would prefer to be in a cell by himself. The officer noted that staff at Hewell had stopped ACCT monitoring in November and that Mr Dewey was facing trial although the date had not been fixed.

53. A nurse assessed his health needs. He declined to give his substance misuse history or be referred to their services but was referred to the smoking cessation clinic. He said that he was not currently taking prescribed medication. This was not in fact the case as he arrived from Hewell with antidepressants.

54. Although Mr Dewey denied thoughts of suicide and self-harm, the nurse and a healthcare assistant (HCA), decided to start ACCT monitoring because of his history of anxiety and depression. The nurse told the investigator and clinical reviewer that Mr Dewey seemed "lost", so the ACCT was a precautionary measure. As the First Night Centre was not operational due to staff shortages, Mr Dewey was taken to a shared cell on D Wing, a standard wing for unconvicted and sentenced prisoners.

55. On 5 January, an officer a trained ACCT assessor, interviewed Mr Dewey. Mr Dewey said that it was his first time in prison and that he was not coping well. He said that he was not sleeping well, was taking medication for depression and anxiety, and missed his partner and child.

56. A case review took place after the assessment. No one from the mental health team attended, though a member of the team apologised afterwards to the Supervising Officer (SO) who chaired the review. Mr Dewey said that he had no intention of harming himself and was not suicidal as his partner and child were too important to him. The SO completed a caremap, a plan of actions to reduce

Mr Dewey's risk, which was assessed as low. He noted that Mr Dewey had not received induction or applied for a job. His next case review was arranged for 9 January.

57. On 7 January, Mr Dewey asked an officer if he could talk to him in private. He said he did not feel safe on D Wing because of his offence. He said that he felt that if others found out why he was in prison, they would punish him. He said that he had not been threatened and was not in debt. He asked about the Vulnerable Prisoners' Unit (VPU). Mr Dewey walked away when the officer told him that it was unlikely that he would be moved to the VPU straight away.

58. A case review took place on 9 January. Mr Dewey appeared worried and anxious. He said that he kept reliving the events which had caused him to be remanded to prison and the abuse that the victim's friends had given him. Staff discussed a possible move to the VPU but no decision was made. Mr Dewey said that he had a visit booked for the next day and he was hoping that it would make him feel better. A SO referred him to the mental health team and said that Mr Dewey was twitchy, anxious and picking a scab on his wrist.

59. On 12 January, Mr Dewey was discussed at the healthcare multidisciplinary team meeting. The entry in his clinical record said that "it doesn't sound as though he needs to be seen" and he was discharged from the mental health team.

60. At the ACCT case review on 13 January, Mr Dewey said that he was not sleeping well or eating much. He agreed to make a GP appointment but feared that he would not get the help he needed. He was pleased that he was receiving visits but found waiting in the holding room with other prisoners difficult.

61. On 19 January, Mr Dewey went to the D Wing medication hatch and asked the pharmacy technician whether it would be possible for him to see someone from the mental health team. She replied that a request had already been made for him to see them and they would send him an appointment soon. She told him that healthcare staff were always willing to provide a listening ear in the meantime.

62. On 20 January, Mr Dewey attended an ACCT case review with a SO, and a pharmacy technician, participated by telephone. Mr Dewey said he gave the appearance of being alright in front of other prisoners but he was tearful and anxious when he was alone. He began shaking as he talked about the abuse his family was experiencing and his worries about publicity when his trial started. The pharmacy technician said that he was not collecting all his medication and had asked her if he could see a member of the mental health team as he was not coping. pharmacy technician requested a GP appointment for Mr Dewey and contacted the mental health team about her concerns. An advanced mental health practitioner replied that it would be appropriate for Mr Dewey to see a GP in the first instance as he was already being supported through the ACCT process.

63. On 24 January, Mr Dewey's solicitors wrote to the Governor to ask for him to be transferred to another prison as it had become known in his home community that he was at Bristol. He asked that the information be kept from Mr Dewey. a manager in the Offender Management Unit, replied on 1 February in a telephone

call that Mr Dewey was receiving ongoing support from the safer custody team so it was better for him to remain at Bristol.

64. On 25 January, Mr Dewey told an officer that he was not coping very well and he was not sure how much more he could take. She contacted the healthcare team to request a GP appointment.

65. On 29 January, a prison GP saw Mr Dewey about his withdrawn behaviour. He was tearful and afraid that his victim's family might know people in the prison who could harm him. He asked to be moved to the VPU as he was afraid of leaving his cell. He had not collected his medication on several occasions, even though the time when his medication was dispensed had been changed from morning to the less busier time of late afternoon. Mr Dewey had missed nine doses of his antidepressants over the previous 15 days and for three consecutive days, he had not collected any at all. The prison GP wrote in Mr Dewey's clinical notes that she would reduce the dosage so that he could build it up for seven days before increasing it. She contacted the safer custody team and submitted an intelligence report to the security department about Mr Dewey's concerns.

66. Mr Dewey also attended a case review on 29 January with a SO. There is no evidence to explain why no other staff took part. He told the SO that he was still feeling under threat and isolating himself as a result. He described himself as feeling very low but said that he had no thoughts of suicide or self-harm as his partner and daughter were his focus. The SO wrote in the case review summary that Mr Dewey's anxiety made him appear vulnerable, and that Mr Dewey would move to A Wing, the VPU, when they had an available space.

67. On 30 January, a prison GP wrote in the clinical notes that Mr Dewey should be encouraged to collect his medication and officers should be asked to bring him from his cell to do so.

68. On 1 February, Mr Dewey moved to the VPU. A nurse visited Mr Dewey's cell on 3 February to speak to his cellmate. While she was there, Mr Dewey asked her if he could be referred to the mental health team as he was having increasing difficulty with anxiety. He denied thoughts of self-harm and said that he did not like queuing for his medication. She encouraged him to collect his medication at the end of the treatment session to avoid queuing. The nurse referred him to the mental health team but they did not accept the referral as he did not have a history of mental health concerns. They suggested that the anxiety management group would be a more appropriate intervention.

69. On 5 February, Mr Dewey had another ACCT review. A prison manager and a nurse attended. The nurse wrote in Mr Dewey's clinical notes that his mood was very low, it was not suitable for him to keep his medication in his cell and staff should bring it to him if he did not collect it.

70. On 12 February, Mr Dewey had his eighth ACCT case review, with a temporary case manager, an officer and a nurse. Mr Dewey said that he was apprehensive about using the visits room but his anxiety level had reduced a lot since he moved to A Wing. He asked whether his medication could be reviewed as he still felt anxious, the antidepressant was losing its effectiveness and his mood was getting worse. The nurse said he would request a medication review with a GP.

Mr Dewey said that his cellmate was fine but he had little in common with the other prisoners so was happy to remain in his cell.

71. The temporary case manager told the investigator that it was a very positive review. Mr Dewey was happy to be on A Wing. Mr Dewey said that he found talking to the staff there easier than on D Wing, he communicated well, took an active part in the case review and his body language was good. All the staff present agreed that Mr Dewey's situation appeared more stable, that he sounded positive, and knew who to approach for help if he needed it. They decided to stop ACCT monitoring.

72. On 19 February, Mr Dewey's family visited him. His partner told the investigator that she was concerned that Mr Dewey would not agree to another visit because he was so anxious about the visiting process. She raised it with an officer who tried to speak to him but Mr Dewey was afraid of other prisoners seeing his family talking to staff and asked them to stop. It was the last visit that Mr Dewey had with his family.

73. That day, a SO conducted a post-closure interview with Mr Dewey who said that the issues which had caused him to harm himself were resolved and he would turn to his cellmate or staff for support if he needed it.

74. On 26 February, Mr Dewey's cellmate went to court and did not return to Bristol. Mr Dewey told an officer that he was anxious about sharing a cell with someone new. The officer wrote in his computerised case notes that Mr Dewey was "like a fish out of water" and it had taken him a long time to build a little trust in staff. On 6 March, a medication review was due to take place with a GP but Mr Dewey did not turn up for the appointment.

75. On 14 March, Mr Dewey's solicitors wrote to the Governor of Bristol to say that they were concerned about that Mr Dewey's mental health was deteriorating and that he was becoming isolated due to his fear of using the visits room. They asked whether a monthly visit could be arranged in a more secure environment than the visiting area. The letter was passed to the Acting Head of Operations. asked an officer from the safer custody team to see Mr Dewey.

76. Mr Dewey told the officer that he was not isolating himself but he was fearful of having a visit with prisoners who were not from the VPU present. He asked whether his visit could take place in the legal visits area. The Acting Head of Operations told the officer that this was not possible. The officer explained to Mr Dewey that staff could make some adjustments in the visits hall, such as giving him a corner table to feel safer. The Acting Head of Operations replied to the solicitors on 23 March that VPU prisoners were never placed in waiting areas with other prisoners, that Mr Dewey had said that he felt safe in Bristol and that adjustments could be made such as having a table close to officers. The Acting Head of Operations could not recall how staff handled the matter subsequently.

77. On 15 March, a psychology clinician who runs the anxiety management group, was on her way to see Mr Dewey in his cell on 15 March when an officer saw her on the way and told her that he was self-segregating and isolated. She spoke to Mr Dewey about the group but he said that he would not join it as he did not want to talk in front of other prisoners.

78. On 19 March, an officer noted that she had managed to build up a rapport with Mr Dewey and that he did not interact with other prisoners. She noted that he collected his meals and medication and returned to his cell. She tried to encourage him to come out of his cell more and interact with others. He told her that he had nothing in common with them and felt much better in a cell on his own.

79. On 20 March, Mr Dewey was discharged from the psychology caseload.

80. On 7 April, an officer wrote in Mr Dewey's case notes that she was still trying to encourage him to mix with others but he would not do so. She wrote:

"He has terrible anxiety with regard to his offence and being targeted by a 'hit person', again I have attempted to reassure him but can only do so much. Because of all this he is extremely anxious about having a visit in the main hall with other prisoners, he is afraid for his family and believes they will also be targeted."

She recorded that she had spoken to Custodial Manager (CM), the chaplaincy and Prisoner Advice and Care Trust (PACT, the charity which runs the visitors centre and promotes family links) to see what could be done to facilitate a more private visit as Mr Dewey had not seen his partner or daughter for a while and missed them terribly. She also recorded that Mr Dewey had reassured her that he did not feel like harming himself "as he wouldn't do that to his family".

81. The CM told the investigator that he had arranged with an officer, who was taking the next week off, that when they were both next on duty, they would organise a visit for Mr Dewey in the chapel, with a minimum of fuss. On 9 April, Mr Dewey applied to PACT for assistance with a visit. A PACT worker visited him that day to clarify his concerns.

82. Between 4.14pm and 4.56pm on 9 April, Mr Dewey made three telephone calls to his partner. He told her that his discussion with PACT was helpful as they had said they would try their hardest to arrange a more private visit but that, ultimately, it was up to the prison. Sounding tearful, he said that he had nothing but memories. He said that he did not think he could last long so he needed her to tell their daughter that he was a good person.

83. At 5.21pm, he telephoned his father and said that he had had enough. His father encouraged him to be positive, strong and not to give up. Mr Dewey began to cry and said that his strength had been taken from him and he could not cope. A further GP appointment was due to take place on 10 April but Mr Dewey did not turn up.

84. In a follow-up visit on 11 April, the PACT case worker and the Family Engagement Manager, reassured Mr Dewey that visit arrangements were in hand and they understood that the Acting Head of Operations was organising it. (In fact, the Acting Head of Operations had turned down the request.) On 12 April, Mr Dewey spoke to a Listener (a volunteer prisoner trained by the Samaritans to offer confidential emotional support to peers).

85. A night support officer was on night duty on A Wing from 9 to 15 April. He told the investigator that as the week progressed, Mr Dewey placed an increasing number of playing cards over the observation panel of his cell door to prevent staff observing him. The night support officer, who has worked at Bristol for 31 years and exclusively on A Wing for the last three years, said that while the practice was common among prisoners on the other residential units, he had never seen it on A Wing.

86. The night support officer said that, between approximately 8.00pm and 9.00pm on 12 April, he saw Mr Dewey in bed, watching television with the light off, which was his usual habit.

13 April

87. At about 5.00am on 13 April, the night support officer began counting A Wing prisoners. Mr Dewey had placed so many cards over the observation panel that there was a gap of only about one-eighth of an inch so the night support officer found it impossible to see him. He called out to Mr Dewey a couple of times and tapped on the door. He said Mr Dewey jumped out of bed, knocked the cards off the panel and got back into bed. He did not speak. The night support officer did not note the playing cards as an unusual occurrence as he assumed that Mr Dewey had learnt the practice from being on another wing. He took it that Mr Dewey was unhappy about being woken up and was satisfied that he had obtained a response. He continued the roll count without incident.

88. From 7.15am, an officer had been assigned A2 landing, where Mr Dewey was located. However, he arrived late due to heavy traffic. Two officers, who usually worked on D Wing, were asked to assist A Wing staff before escorting prisoners to healthcare clinics at 9.00am. When they arrived on A Wing between 7.30am and 7.45am, the SO briefed staff and then asked the two officers to cover A2 landing and supervise the collection of medication at the hatch. Neither had worked on A Wing before.

89. Each officer was responsible for half of the landing. An officer unlocked the cells which included Mr Dewey's cell. He told the investigator that he pushed each door half open and said good morning but he was not looking for a response, did not go into any of the cells and could not say if he saw any of the prisoners, including Mr Dewey, as he did not know them. He then assisted at the medication hatch, and made sure that prisoners swallowed their medication. An officer covered the breakfast servery on A1 landing. At about 8.30am, an officer offered to lock up the A2 prisoners while another officer waited for him in the healthcare centre.

90. An officer took over A2 landing at about 9.00am and all the prisoners who were not at work or doing a designated activity were locked in their cells while the landings were cleaned. The officer told the investigator that he thought he did some Accommodation Fabric Checks (AFCs), and made sure that walls, windows, light switches and the cell fabric were intact and functioning. All the prisoners were unlocked at about 11.00am and lunch was served from about 11.15am. Prisoners usually collect their meals and the servery orderly ticks their names. No one flagged up that Mr Dewey had not collected his lunch. At about

11.40am, prisoners were locked in their cells to be counted for the noon roll check.

91. The officer began counting prisoners on A2 landing. He looked into Mr Dewey's cell but could not see him. When he went into the cell, he could not see the back wall because towels and bedsheets were draped from the bottom of the upper bunk bed and a blanket was draped across the window. He moved closer and saw Mr Dewey half-standing with a ligature around his neck which was tied to the bed. At 11.45am, he radioed a medical emergency code blue (indicating a prisoner has breathing difficulties or is not breathing). He did not receive an immediate reply so radioed again and, the second time, an alarm sounded on his radio. An ambulance was called at 11.46am. An officer responded and held Mr Dewey up while the other officer cut the ligature which was thick and made from torn strips of bed sheet which were tied tightly around his neck.

92. An officer arrived and moved some furniture to create more room. She began chest compressions but a paramedic who worked at Bristol, advised that resuscitation efforts should not continue as there were clear signs that Mr Dewey could not be revived. He was very cold and stiff and the paramedic noted that his condition was incompatible with life. The paramedic pronounced him dead at 11.48am. There were a number of letters from family members on him and around the cell but there was no suicide note.

Contact with Mr Dewey's family

93. At 3.00pm on 13 April, the prison family liaison officer (FLO) and the Deputy Governor, broke the news of Mr Dewey's death to his father, grandparents and partner's mother. The prison offered to contribute to the cost of Mr Dewey's funeral, in line with national instructions, however Mr Dewey's partner declined the offer.

Support for prisoners and staff

94. After Mr Dewey's death, a senior manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

96. The post-mortem report concluded that Mr Dewey died from compression of the neck caused by suspension by a ligature.

Findings

Assessment of risk of suicide

97. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, being charged with a violent offence, early days in custody and the first time in prison. All these risk factors applied to Mr Dewey.

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

99. 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.

100. Staff correctly began ACCT procedures as soon as Mr Dewey arrived at Hewell and at Bristol. Regular case reviews took place until 12 February and the staff present at that review were unanimous that he appeared to have turned a corner.

101. We consider that this was an error of judgement. Although a temporary case manager described the review on 12 February as "positive" and Mr Dewey said that he was happy in the VPU and his anxiety levels had reduced a lot, he was still anxious about using the visits hall and said that he felt that his antidepressant medication was becoming less effective and his mood was deteriorating. No support mechanisms were put in place for these issues.

102. We consider that staff should have recognised that Mr Dewey's risk remained raised even though he had not physically harmed himself for several months. He was facing trial for murder, the most serious of crimes, was in prison for the first time, his mood was low, he was finding it difficult to cope and he was socially isolated.

103. It is clear from Mr Dewey's case notes that he continued to be extremely anxious about having visits in the visits hall. Although contact with his family was very important to him, his anxiety was so great that he chose not to have visits for the two months before he died. We consider that the ACCT should have remained in place until this key issue had been resolved.

104. After Mr Dewey's cellmate left the prison on 26 February, Mr Dewey remained in a cell on his own. We are concerned that, although staff were aware that Mr Dewey was staying in his cell, often sitting in the cell in darkness, and only coming out to collect his meals and medication and make telephone calls, they did not take sufficient account of this in assessing his risk of suicide and self-harm. Rather than seeing this as a sign of distress or an indication of something

amiss, it was interpreted by many staff as a lifestyle choice and therefore unremarkable.

105. Mr Dewey repeatedly denied that he had thoughts of self-harm, saying that he would not want to cause his family pain. We are concerned that staff placed too much reliance on this and did not give sufficient attention to the fact that Mr Dewey's risk factors for suicide and self-harm remained unchanged and unresolved. So, although Mr Dewey assured an officer on 7 April that he had no suicidal intentions, two days later on 9 April he expressed feelings of hopelessness in his telephone calls to his family. Although staff were not aware of the content of these calls, they emphasise the dangers of relying on what prisoners say to staff, without taking their risk factors into account.

106. We make the following recommendation:

The Governor and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that all staff who assess risk:

- **have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **consider and record all known risk factors for a prisoner when determining his risk of suicide and self-harm;**
- **document the information considered and the reasons for the decisions taken; and**
- **start ACCT procedures whenever a prisoner has significant risk factors, irrespective of their stated intentions.**

107. We are also concerned that the night support officer did not record the sudden appearance of playing cards covering Mr Dewey's door observation panel in the last few days of his life, and their gradual nightly build-up. This was out of the ordinary for Mr Dewey and we consider that it should, therefore, have been noted in the wing observation book and brought to the attention of staff. We make the following recommendation:

The Governor should ensure that staff record behaviour that is out of character or unusual for a prisoner and that it is discussed at the next shift handover.

Family contact

108. An officer documented what was normal or unusual for Mr Dewey and tried to seek help when she had concerns that he was not coping. She made a particular effort to get to know Mr Dewey even though he was resistant at first.

109. Attempts by Mr Dewey's solicitor to arrange a family visit in a more private environment were not successful. The Acting Head of Operations at the time, tasked an officer who did not know Mr Dewey, to speak to him. He decided on

the basis of the officer's feedback that Mr Dewey was not isolating himself and that a private visit could not be facilitated, even though Mr Dewey's case notes contradicted the officer's conclusions.

110. The Acting Head of Operations was not personally involved in seeking a solution and though Mr Dewey died less than a month after dealing with the matter, his name did not register with him when the investigator raised it with him and he re-read the letter he had written to the solicitors. We do not criticise him for this as we recognise that this was just one of the very many issues he would have been dealing with in his role as Head of Operations. However, it illustrates why Mr Dewey's concerns about visits would have been better addressed and resolved as part of the ACCT process by staff who knew him.

Cell checks

111. Mr Dewey was last seen alive between 5.00am and 6.00am. His body was only discovered at about 11.45am when staff were doing a lunchtime roll check. Rigor mortis was present, indicating that Mr Dewey had been dead for some time before he was discovered.

112. There were missed opportunities to check on Mr Dewey's wellbeing that morning. An officer should have spoken to him when unlocking his cell for the first time after the night shift; when he did not collect breakfast or his medication; when cells were locked after breakfast; when cells were unlocked for an association period and collection of lunch; and when he did not collect his lunch. We are concerned that no member of staff spoke to Mr Dewey or noticed that he was not collecting his meals for more than five and a half hours. This was particularly unacceptable given the concerns that should have existed about Mr Dewey's social isolation. We make the following recommendation:

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of a prisoner's safety and welfare and that there are no issues that need immediate attention.

Clinical care

113. The clinical reviewer concluded that the mental health care offered to Mr Dewey did not match the provision that could be expected in the community for someone with enduring depression after a serious and deliberate attempt of self-harm.

114. Mr Dewey was isolating himself, persistently believed that he and his family were under threat, said that he felt anxious and without hope, said that his antidepressant medication was not working and repeatedly asked for mental health intervention. In addition, his solicitor repeatedly raised concerns about his wellbeing. The prison does not appear to have sought healthcare input in considering the concerns raised, failed to explore why he was not collecting his medication and failed to put in place more effective measures to ensure that he consistently took his medication.

115. Bristol's Standard Operating Procedure on the management of missed doses of medication had been in place since October 2017. This required a repeated pattern of missed doses to be investigated but it was not consistently followed. We recommend that:

The Governor and Head of Healthcare should ensure that when a mental health referral is received, a member of the mental health team assesses the prisoner and where a prisoner is not accepted on to their caseload, their reasons are clearly documented.

The Governor and Head of Healthcare should ensure that staff explore why prisoners have not collected their medication and that alternative measures for prisoners to receive their medication are put in place, where necessary.

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