Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Justin Still, a prisoner at HMP Bullingdon, on 6 April 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Justin Still died on 6 April 2019, after making a self-inflicted cut to his neck in his cell at HMP Bullingdon. He was 39 years old. I offer my condolences to Mr Still's family and friends.

I am concerned that the reception and first night procedures for Mr Still were unacceptably poor and that staff were unable to provide any justifiable reasons for these failures.

Mr Still arrived at Bullingdon at 4.15pm on 5 April. Information about his past self-harm behaviour and potential risk to himself was contained in documentation handed over to reception staff. Despite this, the information was not seen by all the staff who dealt with Mr Still, and no action was taken by those who did see it. As a result, Mr Still's risk to himself was not appropriately assessed.

Mr Still remained in the reception area for five and a half hours before he was finally taken to a single cell on the first night unit.

Although staff were required to observe Mr Still at least four times during the night because he was a new prisoner, he was only observed once at 10.00pm.

Previous investigations by this office have also identified failures to assess risk at Bullingdon. I escalated my concerns about this to the Prison Group Director for South Central earlier this year. He commissioned a review to identify meaningful actions to address my previous recommendations. As this took place after Mr Still's death, I have not made a further recommendation but I will copy this report to the PGD personally.

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 **October 2020**

Contents

Summary

Events

1. On 5 April 2019, Mr Justin Still was remanded to HMP Bullingdon charged with actual bodily harm.

2. Court staff sent an email to the healthcare team at Bullingdon raising their concerns about Mr Still's wellbeing.

3. Mr Still arrived at Bullingdon at 4.15pm. A member of prison staff spoke to him briefly and checked his warrant and if he had any disabilities, special diets or injuries. The officer also checked the information on the person escort record (PER) form.

4. Mr Still's PER form documented his previous self-harm in 2016 and 2018, and current mental health concerns. The front cover also referred to other documents that were attached to the PER, including the risk assessment, medical assessment and charge sheet. Staff at Bullingdon did not highlight or record the documents.

5. Mr Still was searched and taken to a waiting area at the back of reception to wait to be assessed by a nurse and interviewed by the first night officer. Mr Still remained in the waiting area until 7.30pm, when he was seen by the first night officer.

6. The interview took around 15 minutes and Mr Still was then returned to the waiting area. He remained in reception until 9.05pm. He was then interviewed and assessed by the reception nurse. The nurse recorded that Mr Still said that he did not have any thoughts of suicide or self-harm. The nurse completed the assessment without sight of the relevant documentation that had arrived with Mr Still, because staff could not find it.

7. Mr Still was located in a single cell on the first night unit at around 9.45pm. At 10.00pm, an officer completed a roll check and recorded that Mr Still was sitting on his bed and had raised no concerns.

8. At 5.10am on 6 April, while checking on prisoners subject to suicide and self-harm monitoring (ACCT), an officer noticed the light on in Mr Still's cell. The officer went to check if Mr Still was alright. When the officer looked into the cell via the observation panel, he immediately saw Mr Still lying face down on the cell floor in a very large pool of blood. The officer used his radio to call a medical emergency code. The control room called for an emergency ambulance immediately.

9. A nurse attended immediately and on arrival noted major blood loss from a wound in Mr Still's neck. Mr Still was checked for signs of life but he was cold to the touch and rigor mortis was present, so no resuscitation was attempted.

10. Paramedics arrived at the cell at approximately 5.30am and, at 5.31am, it was confirmed that Mr Still had died.

Findings

Reception and the assessment of risk of suicide and self-harm

11. We are very concerned that staff did not consider all the available information about Mr Still and his risk factors as none of the reception staff and first night staff, including nursing staff, appear to have seen the custody forms, the PER or the email from the court, although all this information was in the prison. As a result, staff relied on Mr Still's presentation and his responses to questions and did not assess his risk of suicide and self-harm adequately.

12. We are also concerned that Mr Still remained in the reception area for nearly five and a half hours.

First night procedures

13. The first night assessment was inadequate and completed without the full information that had arrived with Mr Still from court. The first night officer's checklist was not completed, neither was the nurse's section or the locating officer's section of the first night documents. Staff did not give a reason why these documents were not completed.

14. The officer on night duty on 5/6 April was required to observe those prisoners who had newly arrived into custody at least four times during the night. The officer checked on Mr Still once at 10.00pm, but did not check on him again until 5.10am.

Clinical care

15. The clinical reviewer concluded that clinical risk management of self-harm by nursing staff Mr Still was not good practice. Staff also did not read the email from court (which outlined his medical history and the concerns about his history of suicide and self-harm) until 6 April, after Mr Still's death.

16. The clinical reviewer concluded that given the information that should have been available to the nurse during the face to face assessment, there was ample evidence that self-harm and suicide prevention measure (known as ACCT) should have been opened.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm.

- The Governor and Head of Healthcare should ensure that when staff decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with suicide and self-harm warning forms, they should clearly record the reasons.

- The Governor should ensure that prisoners are held in reception for the minimum length of time possible.

- The Governor and Head of Healthcare should ensure that information from court L&D teams is made available to staff in reception.
- The Governor and Head of Healthcare should ensure that all staff responsible for assessing the risk posed by newly arrived prisoners are properly trained.
- The Governor should initiate an investigation into the actions of the officer who carried out Mr Still's first night interview on 5 April and the officer who was responsible for the first night checks on the night of 5/6 April 2019, and consider whether disciplinary action is required.

The Investigation Process

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

18. The investigator obtained copies of relevant extracts from Mr Still's prison and medical records.

19. NHS England commissioned an independent clinical reviewer to review Mr Still's clinical care at the prison.

20. The investigator interviewed seven members of staff at Bullingdon 21/23 May. Some interviews were conducted jointly with the clinical reviewer.

21. We informed HM Coroner for Oxfordshire of the investigation. The results of the post-mortem examination and toxicology results have been delayed due to circumstances outside the control of the Coroner. A copy of this report has been made available to the Coroner.

22. We contacted Mr Still's next of kin to explain the investigation and to ask whether there were any matters the family wanted the investigation to consider. Mr Still's family said Mr Still had a long history of self-harm behaviour and had previously attempted suicide. The family asked about his mental state on his arrival at Bullingdon and whether he was placed on any special observations. The family also asked how Mr Still was able to gain possession of a sharp object. We have addressed the family's questions in this report.

23. Aspects of this report have already been disclosed, in line with our established practices.

24. Mr Still's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Still's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Bullingdon

26. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Care UK is the healthcare provider. Cotswold Medicare Ltd provides general practitioner services. Midlands Partnership Foundation Trust provide care for those with severe and enduring mental illness and secondary mental health services. There is 24-hour healthcare and a 21-bed inpatient healthcare unit for prisoners with complex physical, mental health and social care needs.

HM Inspectorate of Prisons

27. The most recent inspection of Bullingdon by HM Inspectorate of Prisons (HMIP) took place in July 2019. Inspectors reported that safety had improved at Bullingdon and there had been a drive to improve the quality of ACCT case management, which included the training of nearly all uniformed staff. Inspectors found that too many ACCT care plans did not focus sufficiently on the issues raised, there was a lack of consistency in ACCT case management and new management quality assurance processes were ineffective.

28. Inspectors were not confident that all reception and first night staff had an adequate understanding of the risk factors that needed to be considered to ensure the safety of newly arrived prisoners. This was of concern because recent investigations by the PPO following three self-inflicted deaths in custody had highlighted weaknesses in identifying risk on arrival. An action plan was in place to address the PPO recommendations following these self-inflicted deaths. Some actions had been implemented but some crucial ones had not.

Independent Monitoring Board

29. 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 2018, published in December 2018, the Board was concerned about the quality of ACCT records and procedures despite 282 staff having been trained in the ACCT process during the reporting year. The Board were also concerned about the level of provision for prisoners with mental health issues.

Previous deaths at HMP Bullingdon

30. Mr Still was the fifth prisoner to take his own life at HMP Bullingdon since 2017.

31. In our investigations into previous self-inflicted deaths at Bullingdon in July 2016, December 2017 and January 2018, we found that staff poorly assessed the prisoner's risk of suicide and self-harm and as a result no appropriate actions were taken. We made recommendations to address this and the prison said they would issue notices to remind staff of their responsibilities and provide further training.

32. Following a further self-inflicted death in April 2018, where we found similar problems, we concluded that more sustained and effective action was required

from the prison to address our earlier concerns. As a result, we made a recommendation to the Prison Group Director (PGD) for the South-Central Group requesting that he provide an account of what had been done to ensure that meaningful action was being taken to address our recommendations.

33. The PGD responded in June 2019, saying that a review of the previous investigation reports had been conducted to identify areas of concern and a plan of work to address these had been produced.

Assessment, Care in Custody and Teamwork (ACCT)

34. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

35. On 5 April, Mr Justin Still appeared at Reading Magistrates Court, charged with actual bodily harm. He was remanded to Bullingdon until 7 May 2019.

36. Prior to appearing in court, Mr Still had been held in police custody on 4 April. A medical report and a risk assessment report was completed. The medical report recorded that Mr Still was asthmatic and needed inhalers to treat his condition. He also had anti-depressant medication. It was recorded on the person escort form (PER), completed while in police custody, that Mr Still was currently under the care of Berkshire Traumatic Service for depression and had been on anti-psychotic medication for the past six months. Mr Still said that he had previously self-harmed, most recently in December 2018, by taking an overdose, and had also attempted suicide when he was remanded to prison in 2016. All this information was recorded and was made available to escort staff and prison staff after Mr Still left police custody.

37. It was also recorded that the Liaison and Diversion (L&D) Team needed to assess Mr Still when he appeared in court because of his extensive mental health history.

38. L&D services aim to identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system. The intention is to reduce the likelihood that they will reach a crisis point and to ensure the right support can be put in place from the start. The L&D team assessed Mr Still while he was at court. They sent an email to the healthcare team at Bullingdon and raised their concerns about Mr Still's well-being.

39. Mr Still arrived at HMP Bullingdon reception at 4.15pm. A supervising officer (SO) spoke briefly to him. The SO told the investigator that he does not usually work in reception but on 5 April, he had been due to go out on an escort, which had been cancelled, and offered to help in reception instead. The SO said that he stamped the back of Mr Still's warrant, checked whether he had any disabilities, special diets or injuries and checked the information on the PER.

40. The PER form accompanies all prisoners being escorted between, police, courts and prisons. The form details any contacts that the prisoner has had during the escort, incidents and background information, including risks. Mr Still's PER form recorded his previous self-harm in 2016 and 2018, and current mental health concerns. The front cover also referenced other documents that were attached including, the risk assessment, medical assessment and charge sheet. The SO told the investigator that he did not see these documents and that they were not in the documents that were made available to him.

41. Mr Still was searched and taken to a waiting area at the back of reception. Mr Still waited there to be assessed by a nurse and interviewed by the first night officer.

42. CCTV shows that Mr Still was taken to the waiting area at around 4.30pm and remained there until 7.30pm. He was then collected and taken for an interview by an officer, who was acting as the first night officer. The officer was required to

complete a first night interview with Mr Still and complete the first section of the cell sharing risk assessment (CSRA.) The CSRA asks several questions which are designed to identify whether a prisoner might pose a risk to another prisoner if placed in a shared cell. Once he had completed the documentation, the officer escorted Mr Still back to the waiting area.

43. Mr Still attempted to call his mother on five occasions, but each time the calls went to an answer machine. Mr Still left a message and said that he might not have another opportunity to call that evening. Mr Still's next of kin said that she had only received a single call from him.

44. Mr Still remained in the waiting room until 9.05pm. He was then collected and taken to be assessed by a nurse from the prison's healthcare unit. The nurse told the investigator that when she had arrived for her night shift, she was told that there were still people waiting to be seen in reception. She had then gone to help. The nurse said that both she and her colleague apologised to Mr Still that he had been forgotten.

45. The nurse recorded that Mr Still told her that he was asthmatic and used inhalers. She also recorded that Mr Still said that he had mental health issues. She made a routine referral to the mental health team. She recorded that Mr Still said that he did not have any thoughts or intentions of self-harm, and that he had previously taken an overdose in the community in 2016. She recorded that she had no concerns about Mr Still's presentation and that he did not appear worried.

46. The nurse asked her colleague to get Mr Still's PER form from the reception area. Her colleague returned without the PER and told her that the staff were unable to find it. They continued to register Mr Still without the PER form.

47. Once Mr Still had finished with the nurse he was returned to the waiting area. At around 9.45pm, he was taken to the first night unit. Mr Still was placed in a single cell and he raised no concerns.

48. The officer on night duty on the first night unit was expected to complete at least four observations on all newly arrived prisoners during their first night. He was also required to check on prisoners subject to ACCT monitoring. He completed a roll check at 10.00pm and recorded that he had seen Mr Still sitting on his bed. He did not complete any further checks on Mr Still.

49. The investigator asked the officer whether there was a reason that he had not completed the required checks. He said that he 'just totally forgot'. The investigator asked the officer whether it was just Mr Still's checks that were not completed, or whether he had failed to complete checks on the other newly arrived prisoners. The officer said that he had only completed two checks. He said that he had walked round the unit and looked in on all the prisoners, but he had not completed the paperwork, which he knew he should have done.

50. At 5.10am on 6 April, the officer was checking on prisoner's subject to ACCT monitoring and noticed that Mr Still's cell light was on. The officer said that he thought this was strange and went to check whether Mr Still was alright. The officer looked into the cell via the observation panel and immediately saw Mr Still lying face down on the cell floor in a very large pool of blood. The officer used

his radio to call a code red medical emergency. The control room immediately called an ambulance.

51. A nurse attended immediately. On arrival, she noted major blood loss from a wound in Mr Still's neck. She updated the medical code to code blue (meaning a prisoner is not breathing) so the control room could update the emergency services. Mr Still was checked for signs of life but it was recorded that he was cold to the touch and rigor mortis was present, so no resuscitation was attempted.

52. Paramedics arrived at the cell at approximately 5.30am, and at 5.31am, it was confirmed that Mr Still had died.

Contact with Mr Still's family

53. Mr Still's next of kin was his mother. Due to the distance to the family home from the prison, Bullingdon sought assistance from colleagues at closer prisons. A member of staff from the South Central Group Safety Team visited Mr Still's mother at the family's home at 4.05pm on 6 April. She informed her of his death and offered her condolences. She informed Mr Still's next of kin of the support available and that a family liaison officer would be appointed by Bullingdon.

54. In the days that followed, Bullingdon appointed a family liaison officer. She maintained contact with Mr Still's next of kin and, in line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

55. A manager held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising and for managers to offer support. The staff care team also offered support.

56. The prison posted notices informing staff and prisoners of Mr Still'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 Still's death.

Post-mortem report

57. At the time of issuing this report, no post-mortem or toxicology reports have been made available due to delays outside the Coroner's control.

Findings

Reception and the assessment of risk of suicide and self-harm

58. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists several risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse, and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

59. When Mr Still arrived at Bullingdon he had some risk factors for suicide and self-harm, including previous self-harm, mental illness and being charged with a violent offence. A SO told the investigator that he only completed the initial part of the reception process. The SO accepted that previous acts of self-harm were noted on Mr Still's PER. He also said that other than recording 'cut wrists in 2016', the form did not specify that this had occurred when Mr Still had been remanded in custody. The SO accepted that he should have made further enquires with Mr Still about this.

60. The SO told the investigator that he had not had sight of the documentation completed in police custody. He said that if he had seen this, he would have opened an ACCT document.

61. The 'reception SO check sheet' used as part of the reception process says, 'you are responsible for receiving the prisoner and all his documentation into custody'. There are also five tick boxes on the form, relating to mental health, self-harm, alcohol/substance misuse, vulnerability and first time in custody. The form says that if any one of these boxes is ticked, then the prisoner must be processed as a 'priority'. As Mr Still had a history of self-harm, he should have been assessed as a priority.

62. The first night officer told the investigator that he had not actually read the PER form or any of the attached documents. The officer collected Mr Still for the interview at 7.30pm, three hours after he had arrived at the prison. The investigator asked him whether he thought that three hours was appropriate for a priority assessment, to which he replied 'no.'

63. A nurse completed the initial health screen with Mr Still at 9.05pm as a favour to her colleagues, because he was still waiting to be seen when she arrived for duty. The nurse did not have all the information available to her about Mr Still because her colleague could not find it. She therefore completed the assessment without sight of important and relevant information which had arrived with Mr Still. It is a requirement for medical staff completing the health screen to have sight of the PER form and any other information in order to appropriately complete the assessment and determine potential risk.

64. The healthcare manager at Bullingdon, told the investigator that her team have ongoing conversations with the L&D teams from court, who can send reports and can telephone to do hand overs if they have concerns about someone that they might have seen in court. She said that this is to highlight concerns to the reception nurse who would see the prisoner when they arrive. She said that this information is also sometimes written on the PER, but the healthcare team would normally receive a separate report.

65. The L&D team emailed a report to the healthcare team at Bullingdon at 3.00pm on 5 April, outlining Mr Still's mental health history and the concerns about his history of suicide and self-harm. The healthcare manager told the investigator that the email went into a generic healthcare mailbox and was missed because the mailbox was not routinely monitored. The report from the L&D team was not picked up by a member of the healthcare team until 6 April, after Mr Still's death.

66. We are concerned that, although various pieces of valuable information were available to both healthcare staff and prison staff about Mr Still and his risk factors, staff did not read these. Instead staff said that they were reassured by Mr Still's presentation and his responses to questions.

67. There is no evidence that the staff balanced Mr Still's risk factors against his presentation. None of the reception staff or first night staff, including nursing staff, appear to have seen the custody forms, PER or L&D email, despite all the information being in the prison. The staff who dealt with Mr Still did not have the full information to assess his risk of suicide and self-harm and did not ask Mr Still in-depth questions about the issues that were raised, such as his previous self-harm.

68. However, irrespective of the court report and the other information from police custody, we consider there was a case for staff to have opened an ACCT when Mr Still arrived at the prison, based solely on the risk factors recorded and mentioned by him. We accept that staff used their judgement based on their experience and skills but there is no record why they discounted his risk factors in favour of his presentation.

69. Prison Service Instruction (PSI) 07/2015, *Early Days in Custody*, sets out mandatory reception procedures and requires reception staff to examine the PER that must accompany each new prisoner, and any other available documentation to identify any immediate needs and risks already recorded. As no one in reception either saw or read the custody report, L&D report or the PER, we do not consider that the prison complied with this instruction. We make the following recommendation:

The Governor and Head of Healthcare should ensure that reception staff examine all available documentation about a prisoner and consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm.

The Governor and Head of Healthcare should ensure that when staff decide not to begin ACCT procedures for prisoners with significant risk factors, or who arrive with suicide and self-harm warning forms, they should clearly record the reasons.

First night procedures

70. Prison Service policy on first night procedures is set out in PSI 07/2015. The PSI says that 'the first night in custody, when family and community links are broken and the future is uncertain, is one of the most stressful times for prisoners' and that many self-inflicted deaths and self-harm incidents occur within the first 24 hours, the first week, and the first month, particularly among younger prisoners. For these reasons, prisoners need to be kept safe and supported during their first night in prison and their immediate needs met.

71. The PSI says that newly arrived prisoners should be held in reception for the minimum length of time possible, and must not be held in holding rooms for any longer than is necessary, while waiting to complete the procedures, before moving to their first night location. Mr Still was held in reception at Bullingdon for five and a half hours in total and we do not consider that this was acceptable.

72. The PSI also says that all prisoners must be risk assessed for potential harm to themselves, to others and from others, and that to do this the PER and any other available documentation must be examined and the prisoner interviewed.

73. An officer was the first night officer and was required to complete the first night interview and documentation with Mr Still.

74. The first question on the form completed by the officer asks whether the prisoner has a previous or current conviction for life-threatening assault or murder/manslaughter of another prisoner or if they have assisted a prisoner to commit suicide. The officer recorded that Mr Still had. The officer also recorded that Mr Still was at heightened risk and had previous adjudication history (indicating that Mr Still had previously broken prison rules while in prison custody.) The officer also recorded that Mr Still had no history of self-harm, either in custody or in the community, and that the length of his sentence was a cause for concern.

75. The investigator asked the officer why he had recorded these answers on the form and where the information had been obtained. The investigator was unable to find any information that supports what the officer recorded. The officer told the investigator that Mr Still must have provided the answers and that he did not recall the PER form highlighting any previous self-harm issues. The officer also told the investigator that he had not actually read the PER form or any of the attached information. The officer said that his assessment with Mr Still took him around 10 – 15 minutes.

76. If the information recorded by the officer had been correct, Mr Still should have automatically been recorded as a high risk of potential harm to other prisoners on the cell sharing risk assessment. He was not, he was recorded as standard risk. The officer was unable to explain why this was the case.

77. The officer did not complete the first night officer's checklist, and the nurse's section or the locating officer's section of the first night documents were not completed either. No reason was provided as to why these documents were not completed.

78. The PSI also says that Governors must put arrangements in place to monitor prisoners' safety and wellbeing throughout their first night. Under Bullingdon's local policy, Mr Still should have been checked four times during his first night.

79. The officer who was responsible for carrying out these checks only checked on Mr Still once, at 10.00pm, before he went to his cell again at approximately 5.10am. He could provide no explanation for this, other than saying that he forgot. This was not acceptable.

80. We are concerned that the first night procedures were not conducted appropriately for Mr Still. In particular, he was left in reception for an unacceptably long time; his risk was not properly assessed; key documents were not available; and he was not checked as he should have been during the night. We make the following recommendations:

The Governor should ensure that prisoners are held in reception for the minimum length of time possible.

The Governor and Head of Healthcare should ensure that information from court L&D teams is made available to staff in reception.

The Governor and Head of Healthcare should ensure that all staff responsible for assessing the risk posed by newly arrived prisoners are properly trained.

The Governor should initiate an investigation into the actions of the officer who carried out Mr Still's first night interview on 5 April and the officer who was responsible for the first night checks on the night of 5/6 April 2019, and consider whether disciplinary action is required.

Access to razors

81. Mr Still used a razor blade taken from a disposable razor to make the fatal cut to his neck. The officers told the investigator that new prisoners are not issued with razors as part of the first night procedures and that razors are not included in the induction pack provided to them.

82. The investigator confirmed that the pack provided to new prisoners does not contain razors. The investigator also reviewed CCTV footage from the period that Mr Still was held in the reception area and at no point was he provided with a razor or can he be seen acquiring a razor or razor blade.

83. We cannot therefore say how Mr Still came to be in possession of a razor blade. It is possible that he had it hidden on his body when he entered prison or that he obtained it from another prisoner while waiting in the holding room in reception.

Clinical care

84. The clinical reviewer concluded that clinical risk management of self-harm by nursing staff who dealt with Mr Still was not good practice. The clinical reviewer considers that given the information that should have been available to the nurse during the face to face assessment, there was ample evidence that an ACCT should have been opened.

85. As a result, the clinical reviewer has made a number of recommendations about healthcare provision and management, which we do not include in this report but which the Head of Healthcare will wish to address.

Previous PPO recommendations and prison actions

86. We have identified a failure to assess the risk of suicide and self-harm effectively in a number of previous investigations into self-inflicted deaths at Bullingdon. In June 2019, the Prison Group Director assured us that he and the Governor were taking action to implement previous PPO recommendations on this issue. As this was after Mr Still's death, we assume that meaningful steps have since been taken and we expect to see a significantly improved performance in future. We therefore make no further recommendations.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141