Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Gray, a prisoner at HMP Bullingdon, on 17 March 2019

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 I oversee can improve their work in the future.

Mr David Gray died on 17 March 2019, after being found hanging in his cell in the healthcare unit at HMP Bullingdon. He was 54 years old. I offer my condolences to Mr Gray's family and friends.

Mr Gray had been recalled to custody on 18 April 2017 after breaching his licence conditions. He had been at Bullingdon since June 2018. He had a historic brain injury and a personality disorder, which made his behaviour unpredictable and violent at times and he often threatened staff and other prisoners. He also had a history of self-harm. He was located in the prison's healthcare unit to offer him support in a quieter environment.

When he made threats to kill himself at Bullingdon, he was sometimes managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT), and sometimes not.

On 16 and 17 March 2019, Mr Gray became angry and agitated. He repeatedly told prison and nursing staff that he intended to hang himself and wrote three notes, which he passed to staff, which said the same. Despite his threats, staff failed to place Mr Gray on an ACCT. They said that it was not necessary because he often made threats of suicide and self-harm and that it was normal behaviour for him.

I am very concerned that no action was taken when Mr Gray made repeated verbal and written threats to take his own life in the two days before his death, particularly given his history of self-harm and complex mental health issues. I consider that some staff had become complacent about Mr Gray's risk to himself and that his complex needs should have been managed under the enhanced ACCT review procedures.

I also share the clinical reviewer's concerns that there was no comprehensive care plan in place to manage Mr Gray's complex mental health needs, and that the care he received at Bullingdon was not equivalent to that which he could have expected to receive in the community.

This is the fifth self-inflicted death we have investigated at Bullingdon since 2016 in which we have found that staff poorly assessed prisoners' risk of suicide and self-harm. Earlier this year I escalated my concerns to the Prison Group Director for South Central, who commissioned a review of the actions taken in response to my previous recommendations. I received a copy of that review in May, but I am escalating my concerns again in light of Mr Gray's death.

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 2021**

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Summary

Events

1. On 8 March 2017, Mr David Gray was released from HMP Portland on conditional licence after serving a six-year sentence for a violent offence. On 17 April 2017, he was recalled to HMP Exeter for breaching his licence conditions.

2. Mr Gray had suffered a brain injury in 2003 and had also been diagnosed with a personality disorder. As a result, his behaviour was unpredictable, and he was prone to violent outbursts. He often threatened staff and other prisoners. He also made frequent threats to harm himself, and in January 2018, he made a serious cut to his arm. He was managed under the Prison Service's suicide and self-harm prevention measures (known as ACCT) on a number of occasions.

3. Mr Gray was transferred to HMP Bullingdon on 18 June 2018 and was located in the prison's healthcare unit, where he remained. He continued to make threats to staff and sometimes bullied other prisoners. He also continued to make threats of self-harm. He was sometimes placed on an ACCT in response and sometimes not.

4. On the night of 13 March 2019, Mr Gray covered his observation panel and told a nurse he was going to hang himself. He later calmed down. He was not placed on an ACCT.

5. On 16 March, Mr Gray threatened to hang himself and later passed a note to staff repeating his threat. He was not placed on an ACCT.

6. On 17 March, healthcare staff challenged Mr Gray about his behaviour towards another prisoner. Mr Gray became angry and threatened to take his own life. He continued to be abusive to staff and passed two notes under his cell door during the day saying that he intended to take his own life. He was not placed on an ACCT.

7. An officer was supposed to complete the evening roll check at 10.00pm, but he failed to do so.

8. At 10.11pm, a nurse went to Mr Gray's cell to complete a routine welfare check. When she looked into his cell via the observation panel, she could see Mr Gray sitting against the back wall. The nurse called to Mr Gray, but he did not respond. She immediately ran to alert an officer so that the cell could be opened. The nurse radioed a code blue medical emergency and an emergency ambulance was called.

9. When staff entered the cell, they saw that Mr Gray had a ligature around his neck. Staff cut the ligature and attempted CPR. Resuscitation continued until paramedics arrived at 10.33pm. Paramedics continued with CPR but at 11.09pm, they confirmed that Mr Gray had died.

Findings

Response to Mr Gray's threats to self-harm at Bullingdon

10. We recognise that Mr Gray's behaviour could be very challenging to manage and that he often made threats to harm himself. However, we are concerned that there appears to have been no consistency in the approach to managing Mr Gray's threats of self-harm at Bullingdon. On some occasions, he was managed and supported under the ACCT procedures, but at other times no ACCT was opened. There appears to have been an

unofficial belief among some nursing and prison staff that Mr Gray's threats of self-harm were simply normal behaviour for him and did not need to be taken seriously or trigger the opening of an ACCT. We have seen no evidence that this was part of an agreed plan to manage Mr Gray.

11. We accept that it may not always have been appropriate to open an ACCT in response to Mr Gray's threats, but we consider that this is a decision that should only have been made after proper consideration and discussion, ideally under the enhanced ACCT review procedures given Mr Gray's complex issues.

12. We are very concerned that when Mr Gray made repeated verbal and written threats to take his own life over two days on 16 and 17 March, officers and nursing staff took no action. We have seen no evidence that they consulted senior staff before deciding not to open an ACCT.

Clinical care

13. The clinical reviewer considered that Mr Gray's medical history strongly indicated he was at risk of harming himself. The clinical reviewer concluded that the care Mr Gray received at Bullingdon was not equivalent to that which he could have expected to receive in the community.

14. We share the clinical reviewer's concern that there was a lack of coordination between the healthcare departments when Mr Gray transferred from Portland to Bullingdon; that he was not referred to the mental health team when he arrived at Bullingdon; and that no comprehensive care plan was put in place to meet Mr Gray's complex needs.

Recommendations

- The Governor and Head of Healthcare should ensure that prison and healthcare staff manage prisoners at risk of suicide or self-harm in line with national guidelines and in particular that they open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

- The Governor should ensure that prisoners with complex needs are generally managed under the enhanced ACCT case review procedures.

- The Governor and Head of Healthcare should ensure there is an effective handover of verbal and written information between day and night staff.

- The Head of Healthcare should ensure that prisoners with complex health or wellbeing needs have comprehensive care plans that are evaluated and updated regularly.

- The Head of Healthcare should ensure that:

    - mental health teams review their referral criteria in line with the Complex Case Pathway requirements; and

    - prisoners with complex needs are allocated a key worker.

- The Head of Healthcare should ensure that patients with complex needs have their SystmOne records reviewed on arrival to gain an understanding of their physical and mental health needs to prevent oversight of treatment.

- The Governor should ensure that all staff know how to conduct a roll check and are aware of the importance of doing so.

- The Prison Group Director for South Central should provide the Ombudsman with an update following the review that was carried out following our previous recommendations, and what further actions will be taken in light of Mr Gray's death.

The Investigation Process

15. 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 one responded.

16. The investigator visited Bullingdon on 22 March 2019. He obtained copies of relevant extracts from Mr Gray's prison and medical records.

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

18. The investigator interviewed six members of staff at Bullingdon in May.

19. We informed HM Coroner for Oxfordshire of the investigation. He gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.

20. We contacted Mr Gray's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Gray's daughter asked:

    - what interventions were being provided for her father in relation to his poor mental health;
    - was he being watched on the day/night of his death; and
    - how was he able to take his own life if he was known to pose a risk to himself?

21. We have sought to answer these questions in this report.

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

23. Mr Gray's family received a copy of the initial report. They did not identify any factual inaccuracies.

24. 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

25. 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. South Staffordshire and Shropshire NHS 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

26. The most recent inspection of Bullingdon was in May 2017. Inspectors reported that Bullingdon was not safe enough. 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.

27. Inspectors found that while new arrivals were asked about thoughts of suicide and self-harm, there was no structured assessment of risk factors. 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. There was an action plan addressing some of recommendations made by PPO following these self-inflicted deaths, and some actions had been implemented. However, some crucial ones had not.

Independent Monitoring Board

28. 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

29. Mr Gray was the fifth prisoner to take his own life at Bullingdon since 2016. In each case, we found that staff poorly assessed the prisoner's risk of suicide and self-harm and as a result no appropriate actions were taken.

Assessment, Care in Custody and Teamwork (ACCT)

30. 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.

31. 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

32. On 21 November 2013, Mr David Gray was remanded to HMP Bristol charged with wounding with intent, actual bodily harm, false imprisonment, having an offensive weapon and driving offences. On 23 May 2014, he was sentenced to six years imprisonment.

33. When Mr Gray was admitted to prison, healthcare staff identified that he had suffered a head injury in 2003, had epilepsy for which he took medication and was a heavy drinker.

34. At a follow up appointment with a prison GP in November 2013, Mr Gray said that he had suffered the head injury in an assault and had had the frontal lobe of his brain removed as a result. He said that he had no concerns about his physical health but that he was worried about anger issues because of his brain injury. Mr Gray was placed on alcohol detoxification medication and was referred to the integrated drug treatment service (IDTS.) The GP recorded that Mr Gray had no history of self-harm and that he had denied any thoughts or intent to harm himself.

35. In June 2014, Mr Gray was transferred to HMP Erlestoke. Not long after his arrival, he began to display violent and confrontational behaviour and was placed on report several times. In October, after he had continuously made threats to both staff and other prisoners, Mr Gray was moved to the segregation unit. He continued to display poor behaviour.

36. In December 2014, he was transferred to HMP Portland. Staff recorded that this transfer would be considered as a fresh start for Mr Gray.

37. Between February 2014 and March 2017, Mr Gray was subject to suicide and self-harm monitoring on eight separate occasions after he made superficial cuts to himself or made verbal threats to harm himself.

38. On 8 March 2017, Mr Gray was released from Portland on conditional licence. On 17 April, he was recalled to HMP Exeter for breaching his licence conditions.

HMP Portland

39. On 15 May 2017, Mr Gray was transferred back to HMP Portland. On his arrival, his negative behaviour continued, and he made threats of violence towards staff.

40. In September, Mr Gray attended a Parole Board hearing to consider his suitability for re-release. During the hearing Mr Gray was confrontational, angry and abusive towards the panel members. It was recorded that some of his threats were ‘veiled’ but others were specific about what he would do if he was released. The Parole Board decided that Mr Gray was not suitable for release and that a further review would take place in 12 months’ time.

41. In January 2018, an ACCT was opened after Mr Gray self-harmed by cutting his arm (needing 34 stitches).

42. In February, Mr Gray was segregated after making threats to staff and carrying a blade. An ACCT was opened in the segregation unit after Mr Gray re-opened his previous self-harm wounds, broke his glasses and swallowed some of the glass, flooded his cell and made threats to staff.

43. Between March and June 2018, seven multi-disciplinary meetings, including healthcare staff, mental health staff, prison staff and probation staff, were held to discuss the best way to manage Mr Gray and plans for his onward progression.

44. His poor behaviour continued and on 5 June, he assaulted another prisoner. He also made cuts to his own head and an ACCT was opened. The following day, he told a member of the Chaplaincy team that he was 'done with it' and was going to kill himself.

45. At a multi-disciplinary meeting on 11 June, staff recorded that Mr Gray's transfer to Bullingdon had been agreed. The meeting considered that a transfer to Bullingdon would be a step forward in a bigger plan for Mr Gray and that the point had been reached where he had to leave Portland. It was now about ensuring that he was given support and decency.

46. On 17 June, Mr Gray covered his observation panel and made a ligature. He later calmed down and handed it to staff and said he had no thoughts of harming himself. On 18 June, Mr Gray was transferred to HMP Bullingdon while still on the ACCT.

HMP Bullingdon

47. When he arrived at Bullingdon, Mr Gray was initially located in the segregation unit while a decision was made about where he should be located because of his poor behaviour.

48. During a reception screen, a nurse noted that Mr Gray was on an ACCT, which had been opened at Portland on 5 June after he deliberately cut his head. Due to his location in the segregation unit, Mr Gray was being observed five times per hour.

49. On 19 June, a residential governor, a Custodial Manager (CM), a worker from the prison's mental health team, a nurse, a Supervising Officer (SO) and a member from the IMB reviewed Mr Gray's ACCT. It was recorded that Mr Gray attended and contributed towards his review. He said that he did not like being in the segregation unit because he had no access to a kettle or television. The CM told Mr Gray that he was only there until a decision was made about how to progress him and to allow staff time to get things in place for him at Bullingdon.

50. The nurse recorded that because Mr Gray had gone straight to the segregation unit from reception, he had not had a secondary health screen or GP review. She also recorded that Mr Gray said that he would go on hunger strike while he was held in the segregation unit, and that nursing staff and segregation unit staff would therefore monitor his food intake. She recorded that Mr Gray appeared to cope well with being in a room with other people during the review. He was in a good humour for most of the discussion, but this was mixed with threats of self-harm, as well as contradictory statements that he did not wish to harm himself.

51. The following day, Mr Gray was moved to the prison's healthcare inpatient unit. A nurse reviewed Mr Gray. She recorded that he was a high risk due to his head injury. In reference to a report that had accompanied Mr Gray from Portland, she recorded that Mr Gray was known to make threats toward staff and that he would often use these to try to dictate a situation. He had also assaulted other prisoners while at Portland.

52. The nurse recorded that Mr Gray had brain damage with frontal lobe and parietal lobe damage that affected his memory. She recorded that he coped poorly in large units and had often made threats of violence and self-harm. She also recorded that Mr Gray was currently on an ACCT and was to be observed five times per hour.

53. Mr Gray settled quickly on the inpatient unit and was described as “well, calm, friendly and jovial”. He engaged well with other prisoners and staff. Following a further ACCT review, the ACCT was closed on 5 July. Mr Gray appeared to be aware of his mental health condition and told staff that if he had any anger outbursts, they should tell him to go back to his cell and not let him out until he had calmed down.

54. On 24 July, staff opened an ACCT because Mr Gray said that he had thoughts of self-harm during an interview with a specialist brain injury link worker. During an ACCT review on 26 July, Mr Gray joked about the threats that he had made and said that he had no intent to harm himself. Staff decided to close the ACCT.

55. Mr Gray’s general behaviour remained unpredictable. He continued to make threats towards staff and other prisoners and continued to threaten to self-harm. He was managed on an ACCT in August because of his risk to himself. Mention was made of the possibility of referring Mr Gray to a secure psychiatric hospital as it was thought this might be a more appropriate environment for him.

56. Staff told the investigator that although Mr Gray was a vulnerable prisoner due to his self-harming, he was also considered to be a risk to other vulnerable prisoners and was known to bully, steal and act dominantly over others.

57. On 10 October, Mr Gray told a member of the Chaplaincy team that he was depressed and was going to hang himself. The chaplain recorded:

> “I spoke to staff on the wing who mentioned that Mr Gray had a problem with his frontal lobe, which led to him speaking impulsively, but that this was quite in keeping with his behaviour and therefore not out of character. I understand that it has previously been decided that the ACCT process is not the way to deal with his present issues, so I have not taken this further.”

58. At the end of October, a psychologist from the prison’s forensic psychology team (FPT), reviewed Mr Gray. He recorded that the FPT were happy to take Mr Gray onto their caseload. He also recorded that Mr Gray remained in the healthcare unit and had been having some behavioural issues. He said that there appeared to be a lack of consistency in the management of Mr Gray by prison staff. He also said that Mr Gray had both personality disorder traits and frontal lobe disorder and he planned for the FPT to engage with him. He also noted that in his opinion, guidance was needed for all staff working in the prison’s inpatients unit on how best to manage Mr Gray, and that this advice should be provided by the FPT.

59. On 22 October, Mr Gray was placed on the basic regime and an ACCT was opened after he made threats to staff and then made superficial cuts to his head. The ACCT was closed on 7 November.

60. On 25 December, Mr Gray became angry after a disagreement while collecting his lunch. He spent the rest of the day on his own. Staff continued to check on him but the next day Mr Gray said that if they continued to do so he would ‘cut his throat’. Despite these threats of self-harm, staff did not open an ACCT.

61. On 16 January 2019, Mr Gray threatened to assault a member of prison staff. Nursing staff said that he was in ‘a foul mood’. Shortly before 11.00pm, an officer recorded:

> "Mr Gray has told me he will hang himself if he doesn't get some painkillers. He has received his painkillers and poses a low risk; I do not believe an ACCT is required as from working in Inpatients previously I believe this is just a behaviour issue and not an emotional one. Oscar 1 [the Night Orderly Officer] informed."

62. That night, staff recorded that Mr Gray was awake all night, shouting obscenities and throwing items at his cell door. Because of his behaviour, an ACCT was opened. The ACCT was closed later the next day following a team discussion.

63. On 18 January, an officer Mr Gray in his cell with a ligature around his neck. He called for healthcare assistance. When a nurse attended, Mr Gray was sitting on his bed and the officer said that he had helped Mr Gray stand up after he had found him with a ligature around his neck. He had made a superficial cut to his neck. The nurse recorded that apart from a small red mark on the front of his neck, Mr Gray appeared to have no other injuries. Mr Gray did not give a reason for his actions but said that staff had been winding him up. Staff did not open an ACCT.

64. On 19 February, an ACCT was opened after Mr Gray threatened to self-harm and closed on 21 February.

65. On 13 March, a nurse was completing a night shift in the healthcare unit. She checked on Mr Gray at the start of her shift. She recorded that Mr Gray had covered his observation panel with tissue paper. He then removed it and told her that if people continued to check on him, he would 'hang himself'. She told Mr Gray that he would be checked hourly. She told the investigator that Mr Gray continued to be abusive and made threats but settled and began watching television. There were no further issues during the night and no action was taken by staff about the threats Mr Gray had made to hang himself.

66. Over the next couple of days, staff recorded in Mr Gray's medical record that he was bullying other prisoners and was getting them to add items to their canteen orders (orders from the prison shop) for him. Although staff submitted security reports, there is no evidence that they challenged Mr Gray directly about his alleged behaviour.

Events of 16 March

67. Just after midnight on 16 March, an officer who was working the night shift on the healthcare unit went to answer Mr Gray's cell bell. When he arrived, he asked Mr Gray what was wrong. He recorded that Mr Gray was in a "really bad mood" because the nurse was putting his cell light on to complete her checks. Mr Gray told him that the next time he got woken up "the fucking rope's coming out". The officer said that he left the cell, but Mr Gray pressed his cell bell again. When he went back, Mr Gray slid a note under the door, which said, "Next time a nurse or yous wake me up again the fuckin ropes cumming back out or is that what the nurse wants. Not a good thing 2 get me angry Jock."

68. There is no evidence that staff took any action after Mr Gray made threats to harm himself. The note that he wrote was placed in the wing observations book, but there is no evidence that his remarks were passed onto day staff when they attended for duty and no one opened an ACCT.

Events of 17 March

69. On 17 March, Mr Gray was recorded as having a settled morning. A healthcare assistant (HCA) recorded that she went to another prisoner's cell at lunch time to check that he was taking food because there were concerns about his diet. Mr Gray walked into the cell and took a piece of chicken from the prisoner's plate. She told the investigator that she challenged Mr Gray and said, "He [the other prisoner] wanted that". Mr Gray said, "Well he didn't fucking eat it" and walked off. She told the investigator that she then returned to the office.

70. A nurse told the investigator that she was passing through the inpatients unit. She saw Mr Gray leave another prisoner's cell with two pieces of chicken and she challenged him. The HCA said that while she was in the office, she heard shouting. When she came out, she saw that Mr Gray was getting very angry. Mr Gray said, "I did not take the fucking chicken. You are pissing me off. That fucking nurse is taking on the wrong person." The HCA said that Mr Gray then turned to her and said, "You fucking grassed on me, you fucking bitch". Mr Gray then returned to his cell.

71. Two officers were on duty in the healthcare unit. Officer A said that it was the first time he had worked on the healthcare wing and he had no prior knowledge of Mr Gray. Officer B said that he had been called over by the nurse because she believed that Mr Gray had taken food from another prisoner and had challenged him about it. Both officers said that Mr Gray became angry and went back to his cell, throwing his lunch in the bin as he went.

72. Officer B told the investigator that he and Officer A went to check on Mr Gray. When they arrived at his cell, he had covered up his observation panel. They looked through the gap in the side of the door and saw Mr Gray sitting on his bed. He said that Mr Gray kept telling them to 'fuck off'.

73. Officer A recorded what had happened in Mr Gray's wing record and wrote that when he asked Mr Gray to remove the blockage from the observation panel, Mr Gray said that it was staying up so they could not see him killing himself. He also recorded that when he talked to the nurses about Mr Gray's behaviour, they told him that there was no need to open an ACCT because these types of outbursts were common for Mr Gray and that he just needed some time to calm down due to his medical problems.

74. Officer B told the investigator that he and Officer A told the nurses what Mr Gray had said and that they had been told that an ACCT was not needed. However, the nurse and HCA both said that they 'definitely did not' give the officers such advice.

75. Over the lunchtime period, Mr Gray posted a note under his cell door saying that he intended to take his own life. Officer C (who was on lunch cover on the unit) showed the note to the HCA. The HCA said that she went to check on Mr Gray. She opened the hatch on his door and asked him if he was 'all right'. Mr Gray started swearing at her and calling her names.

76. The HCA said that she shut the hatch and told Officer C that Mr Gray was fine. She also said that because the officer did not know Mr Gray, she told her about his frontal lobe injury and how he could be angry one minute and fine the next. She said that Mr Gray had passed notes previously and would later calm down and apologise for his outburst. Staff did not take any further action in the light of Mr Gray's threats.

77. When Officer A returned from his lunch, Officer C told him about the note that Mr Gray had written. He said that throughout the afternoon he attempted to observe Mr Gray through the observation panel and Mr Gray swore at him most of the time. He said that he considered this to be a positive response from Mr Gray and therefore had no concerns.

78. Officer A told the investigator that on one occasion when he checked on Mr Gray, the observation panel was blocked, and Mr Gray did not respond. When he opened the hatch, Mr Gray swore at him and threw an item at the door. He said that for the most part, Mr Gray was quiet during the afternoon, but he did press his cell bell a few times. When he answered, Mr Gray swore at him.

79. In the early evening, Mr Gray passed another note under his cell door, again making threats to harm himself. Officer A said that he went to check on Mr Gray again, but again, Mr Gray swore at him. He said that he returned to complete a further check after Mr Gray had pressed his cell bell. When he arrived at Mr Gray's cell, Mr Gray had removed the blockage from the observation panel and told him, "Once I finish my coffee, you will watch me do it".

80. Officer A said that Mr Gray's tone of voice still sounded agitated, but while talking to him about why he wanted to 'do it', Mr Gray calmed down and told him about his brain injury. Mr Gray then became aggressive again and swore at him. There is no evidence that the officer or other staff took any action following Mr Gray's comments.

81. Officer A said that when he checked Mr Gray for the final time before finishing his shift, Mr Gray was sitting in his cell watching television. He said that Mr Gray came to the door to speak to him and appeared calmer. He said that he spoke to Mr Gray about his previous self-harm and Mr Gray said that he had not cut himself for eight months. He said that during the conversation, Mr Gray said that he had a blade and that this was 'for anyone that attempted to give him medication'. He said that Mr Gray's attitude changed while he was talking with him and he started swearing at him again.

82. There is no evidence that Officer A recorded that Mr Gray had said that he had a bladed article, that he passed this information on to the night staff or that Mr Gray was searched for a bladed article.

83. Two nurses were on duty in the evening. Nurse A was designated as second response nurse and was located on F wing, the first night unit. Nurse B was first responder and was in the prison's inpatients unit.

84. Officer D was in the inpatient's unit to support Nurse B. The officer was supposed to conduct the evening roll check and account for all prisoners on the unit at 10.00pm (at the start of his shift) but he failed to do so.

85. When the two nurses and the officer started their shift, they were given a hand-over from the day staff about significant events that had occurred and the prisoners who needed to be monitored. The officer was not available for interview, but the investigator asked both nurses whether they were told about any issues with Mr Gray, particularly about the threats he had made or the letters he had passed to staff during the day. Both nurses said that they were not told about any issues with Mr Gray.

86. At 10.11pm, Nurse B went to do a routine check on Mr Gray. She said that when she looked through the observation panel, she expected to see Mr Gray in bed watching

television as normal, but instead the cell was in darkness. She turned on the cell light and Mr Gray was not lying in bed as she expected. She initially thought that he might be using the toilet, so she called out to him but got no response. She then looked around the cell and noticed Mr Gray was sitting against the far wall of the cell, fully dressed. She called out to him again but got no response.

87. Nurse B did not have a cell key, so she ran to the office to alert Officer D (who had a cell key in a sealed pouch in case of emergencies) that she needed access to Mr Gray's cell. As she returned to the cell with the officer, she used her radio to call a code blue medical emergency. The control room called an emergency ambulance.

88. Nurse B said that as soon as she entered the cell, it became apparent that Mr Gray had a ligature around his neck, which was attached to the window. She said that the ligature was cut by Officer D and Mr Gray was laid down on his back. She checked for signs of life but found none. Nurse A responded and collected the emergency medical bag from the treatment room along with a defibrillator. She helped Nurse B and prison staff try to resuscitate Mr Gray.

89. A first responder paramedic arrived at the prison at 10.33pm, followed by a second vehicle at 10.41pm. Efforts to resuscitate Mr Gray continued but he did not respond. At 11.09pm, paramedics confirmed that Mr Gray had died.

Contact with Mr Gray's family

90. Mr Gray named his daughter as his next of kin. The prison informed her of her father's death and offered their condolences and support. In line with Prison Service guidance, the prison contributed to the cost of the funeral.

Support for prisoners and staff

91. A debrief for staff involved in the emergency response was completed by a senior manager to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

92. The prison posted notices informing staff and prisoners of Mr Gray'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 Gray's death.

Post-mortem report

93. A post-mortem examination gave Mr Gray's cause of death as suspension (hanging).

94. Toxicology results showed that Mr Gray was not under the influence of alcohol or any illicit drugs at the time of his death.

Findings

Response to Mr Gray's threats to self-harm at Bullingdon

95. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the Prison Service's framework for delivering safer custody procedures. The PSI says that all staff should be alert to the increased risk of self-harm or suicide posed by prisoners, and should act appropriately to address any concerns, including opening an ACCT if necessary.

96. Mr Gray's head injury and personality disorder meant that his behaviour was challenging. He could be calm, friendly and jovial at times, but he could also be violent, threatening, unpredictable and impulsive. He often made threats to harm himself and had cut himself badly at Portland in January 2018 and self-harmed less seriously in February and June. An ACCT was opened on each occasion and he was on an ACCT when he transferred to Bullingdon on 18 June.

97. At Bullingdon, however, there was a lack of consistency in the way staff responded to Mr Gray's threats to self-harm or kill himself. ACCTs were opened in July (twice), August and October 2018 and in January and February 2019 when he disclosed thoughts of self-harm or threatened to kill himself. However, no ACCT was opened on other occasions in October (when he said he was depressed and planned to kill himself) and December 2018 (when he threatened to cut his throat) or in January 2019 (when he was found with a ligature round his neck and made a superficial cut to his neck).

98. In the days before Mr Gray hanged himself in March 2019, he made frequent threats to kill himself:

- 13 March – he covered his observation panel and made threats to hang himself
- 16 March – he threatened to hang himself in the early hours and later passed a note under his door threatening to hang himself
- 17 March – he covered his observation panel and said he was going to kill himself and later passed two notes under his door (at lunchtime and in the early evening) saying he was going to kill himself; he later uncovered his observation panel and said he was going to kill himself and had a blade in his cell, before he was found hanged just after 10.00pm.

We are extremely concerned that an ACCT was not opened on any of these occasions.

99. We recognise that a prisoner like Mr Gray, who poses a threat to others as well as to himself and makes frequent threats to self-harm, is very difficult to manage. However, we are concerned both by the inconsistency of Bullingdon's approach and by the fact that there appears to have been an understanding among at least some staff that Mr Gray's threats to kill himself were normal behaviour for him and did not therefore need to be taken seriously or trigger the opening of an ACCT.

100. The understanding that the ACCT process need not be used for Mr Gray dated back to at least October 2018, when a member of the Chaplaincy team recorded that he had been told by staff that it had "previously been decided that the ACCT process is not the way to deal with [Mr Gray's] present issues". In January 2019, an officer recorded that, from his previous experience of working in the inpatients unit, he did not think an ACCT was

required as Mr Gray's threat to hang himself was "just a behaviour issue and not an emotional one". Then on 17 March, the day Mr Gray hanged himself, Officer A recorded that when he talked to the nursing staff on duty (a nurse and HCA) about Mr Gray's threat to kill himself, they told him that there was no need to open an ACCT because these types of outbursts were common for Mr Gray and that he just needed some time to calm down due to his medical problems. Officer B said the same thing at interview, and Officer C also decided to take no action on Mr Gray's note threatening to kill himself after the HCA told her that this was normal behaviour for Mr Gray.

101. The nurse and HCA deny telling the officers that it was not necessary to open an ACCT. However, it seems unlikely that Officer A and Officer C would have reached this conclusion by themselves, as they had no previous knowledge of Mr Gray. We consider on the balance of probabilities that they did say something along these lines.

102. Whether such advice was or was not given by nursing staff, an ACCT can - and should - be opened by any member of staff who has concerns about the well-being of a prisoner. The officers did not need the permission of nursing staff to open an ACCT document and should have done so in view of Mr Gray's threats and behaviour.

103. We are very concerned that this understanding that the ACCT process need not be used for Mr Gray appears to have been informal and unofficial. Certainly, neither we nor the clinical reviewer saw evidence of a formal agreement or decision to this effect. If this is what had been agreed, it should have been formally passed on to all staff who worked on the unit and came into contact with Mr Gray. As it was, prison officers who did not know Mr Gray seem to have taken their cue from nursing staff without any formal direction.

104. We accept that it may not always be necessary to open an ACCT in response to every threat of self-harm made by a prisoner, but we consider that this should only be decided after discussion and that the reasons should be properly recorded.

105. We are also concerned that the decisions not to open an ACCT in response to Mr Gray's threats and actions were taken on each occasion by junior staff – officers and nurses – with no evidence that they consulted anyone more senior. We do not consider that an officer was qualified to decide by himself, for example, that an ACCT was not needed because it is "just a behaviour issue and not an emotional one", particularly in the case of a prisoner with such complex issues as Mr Gray.

106. Indeed, one of the worrying aspects of this case is that we have seen no evidence that senior healthcare or prison staff were sufficiently involved in the management of Mr Gray during his time at Bullingdon. We consider that Mr Gray's complex problems and challenging behaviour merited an enhanced ACCT review process, involving multi-disciplinary staff and led by a Band 5 Custodial Manager as a minimum.

107. The idea that Mr Gray's threats of self-harm need not be taken seriously led to a worrying degree of complacency on 16 and 17 March. Over the two days, Mr Gray repeatedly said he was going to kill himself, passed three notes to staff saying he was going to kill himself, blocked his observation panel, said he had a blade in his cell, and remained agitated and angry throughout. Mr Gray had self-harmed in the past and his behaviour was known to be volatile and impulsive as a result of his brain injury. While it may possibly have been reasonable not to open an ACCT (after discussion) after the first incident, we consider it was simply unacceptable that nursing staff and officers failed to open an ACCT when Mr Gray remained very agitated and continued to make threats to kill himself over a two-day period.

108. In addition, there is no evidence that they handed any concerns about Mr Gray's repeated threats and disturbed behaviour over to the night staff. If they had done, at the very least he might have been monitored more closely.

109. The investigator found that rather than accepting that an ACCT should have been opened, staff appeared more interested during interviews in distancing themselves from any accountability for not doing so. Whether Mr Gray was in the habit of making threats to harm himself or not, an ACCT should have been opened on 17 March and it was the responsibility of any member of staff in contact with him to do so.

110. Although not directly related to Mr Gray's death, we are also very concerned that there is no evidence that Officer A recorded or took any action in response to Mr Gray's claim that he had a blade in his cell on 17 March, even though Mr Gray was known to be a risk to staff and other prisoners and was making threats to kill himself.

111. We make the following recommendations:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines and that they open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

The Governor should ensure that prisoners with complex needs are generally managed under the enhanced ACCT case review procedures.

The Governor and Head of Healthcare should ensure there is an effective handover of verbal and written information between day and night staff.

112. In our investigations into three self-inflicted deaths at HMP Bullingdon in 2016-2017, 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 Bullingdon said that it would issue notices to remind staff of their responsibilities and provide further training.

113. Following a further self-inflicted death in April 2018 where many of the same issues arose, we considered that more sustained and effective action was needed from the prison to address our concerns. As a result, we made a recommendation to the Prison Group Director for South Central that he provide the Ombudsman with an account of what had been done to ensure that meaningful action had been taken to address our recommendations.

We were told in response that a review of the previous investigation reports had been commissioned to identify areas of concern and commonality and a plan of work to address these would be produced. We were also told that a review of previous recommendations had already taken place and following this further review, a report would be shared with us, which would be completed in May 2019. We received a copy of the report from the Prison Group Director in June 2019, but we want to know what further actions have been taken in light of Mr Gray's death. We recommend:

The Prison Group Director for South Central should provide the Ombudsman with an update following the review that was carried out following our previous recommendations, and what further actions will be taken in light of Mr Gray's death.

Clinical care

114. The clinical reviewer considers there was a clear medical history that strongly indicated Mr Gray was at risk of harming himself.

115. The clinical reviewer concluded that the care Mr Gray received at Bullingdon was not equivalent to the care he could have expected to receive in the community.

116. We also share the clinical reviewer's concerns about the apparent lack of co-ordination when Mr Gray was transferred from Portland to Bullingdon. When Mr Gray arrived at Bullingdon, we would have expected him to be seen by the mental health team, given his diagnosis of a head injury and personality disorder, and the fact that he had been engaging with the mental health team at Portland. The clinical reviewer considers that this should have happened, but also found that the assessment process that preceded Mr Gray's transfer to Bullingdon gave no indication that further assessment by the mental health team at Bullingdon should occur.

117. Mr Gray remained in the inpatient unit at Bullingdon for nearly eight months with limited evidence of specialist input. The clinical reviewer concluded that there was, at best, limited strategic and local oversight of Mr Gray's needs and future care. There was no comprehensive care plan in place to manage Mr Gray's complex needs, and he should have been referred to the mental health team on arrival at Bullingdon. Guidance on managing someone with Mr Gray's type of head injury was available to nursing staff, had they chosen to access this, but there is no evidence to suggest that this was the case.

118. The clinical reviewer found that the were shortfalls in the management and care by healthcare staff in a number of areas including the management of care plans, mental health referral criteria, prisoners with complex needs and key worker allocation, and that prisoners with complex needs should have their SystmOne records reviewed on arrival at prison. We make the following recommendations:

    The Head of Healthcare should ensure that prisoners with complex health or wellbeing needs have comprehensive care plans that are evaluated and updated regularly.

    The Head of Healthcare should ensure mental health teams review their referral criteria in line with the Complex Case Pathway requirements and prisoners with complex needs should be allocated a key worker.

    The Head of Healthcare should ensure that patients with complex needs have their SystmOne records reviewed on arrival to gain an understanding of their physical and mental health needs to prevent oversight of treatment.

119. The clinical reviewer has made several other recommendations which we do not repeat in this report but which the Head of Healthcare will wish to address.

Information shared during investigation

120. The Governor of Bullingdon told the investigator that Officer D, who was on long-term sick leave at the time of our interviews, had admitted that he had failed to complete the 10.00pm roll check when he arrived for duty in the healthcare unit on 17 March. As a result, the Governor had commissioned an internal disciplinary investigation. This found that the officer had not been shown the correct way to carry out a roll check when he started work at Bullingdon following his prison officer training. The Governor told us that

he is confident that the officer is now able to carry out a roll check correctly and fully accepts that he did not conduct a full and proper roll check on17 March. At a disciplinary hearing on 19 June, it was decided that no further action would be taken against him.

121. We therefore make no recommendations about Officer D. We do, however, recommend:

The Governor should ensure that all staff know how to conduct a roll check and are aware of the importance of doing so.

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