Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Griffiths, a prisoner at HMP Bullingdon, on 20 April 2021

A report by the Prisons and Probation Ombudsman

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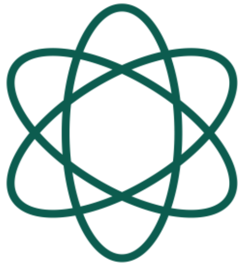
Our vision

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

OGL

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

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

Mr Stephen Griffiths was found hanged in his cell at HMP Bullingdon on 20 April 2021. He was 58 years old. I offer my condolences to his family and friends.

Mr Griffiths was serving a life sentence and had been recalled to prison, just four weeks before his death. Although distressed about his recall, Mr Griffiths appeared to have settled at Bullingdon and mostly kept to himself. Mr Griffiths actively worked with his probation manager on challenging his recall to prison and appeared positive about his situation in the weeks before his death.

The day before his death, Mr Griffiths had some difficult conversations with his partner. Given the information that staff had at the time of his death, I am satisfied that they could not reasonably have prevented his actions.

Although it had no impact on Mr Griffith's death, I am concerned that staff did not record why they did not start suicide and self-harm monitoring procedures when he arrived at Bullingdon.

The clinical reviewer identified deficiencies in the mental health referral system, staff resourcing and the emergency response.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **August 2022**

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Summary

Events

1. On 19 March 2021, Mr Stephen Griffiths, who was serving a life sentence, was recalled to HMP Bullingdon. He was visibly upset that he was recalled. He had several risk factors for suicide and self-harm. During his short time at Bullingdon, Mr Griffiths appeared to settle and appeared to have kept to himself.

2. In the weeks leading to his death, Mr Griffiths had regular contact with his partner in writing and by telephone, and with his probation manager, who had recommended to the Parole Board that he should be re-released. Mr Griffiths spoke to his partner the day before he died, and the call appeared difficult and challenging.

3. At around 5.05am on 20 April, Mr Griffiths was found in his cell, with a ligature around his neck. Officers and paramedics tried unsuccessfully to resuscitate him, and his death was confirmed at 6.10am.

Findings

4. Although Mr Griffiths had several risk factors for suicide and self-harm, we consider that it was reasonable that staff decided not to monitor him under suicide and self-harm prevention procedures, known as ACCT.

5. We note that the calls that Mr Griffiths made to his partner the night before his death appeared to have been difficult and challenging for them both and might have influenced the action he took.

6. We are concerned that staff did not record their consideration not to monitor Mr Griffiths under ACCT procedures when he arrived at Bullingdon.

7. The clinical reviewer concluded that the care that Mr Griffiths received at Bullingdon fell short of the standard which he might have expected to receive in the community. The clinical reviewer was concerned that the mental health team did not assess Mr Griffiths despite his referral and identified deficiencies in the mental health referral process which were impacted by staff shortages.

8. The clinical reviewer also reported that emergency response nurses should be trained to recognise situations in which resuscitation attempts would be futile.

Recommendations

- The Governor of Bullingdon should ensure that first night induction staff record the information considered and their reasoning when they decide not to start ACCT procedures.

- The Head of Healthcare at Bullingdon should ensure that the systems in place for mental health referrals are adequate and that routine assessments are completed within the target timescale of five working days.

- The Healthcare Commissioners and Head of Healthcare should review staffing levels in the mental health team and ensure that the appropriate resources are available to recruit and retain the staff required.
- The Head of Healthcare should ensure that first responder healthcare staff are trained to recognise situations in which CPR would be futile.

The Investigation Process

9. 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.

10. The investigator obtained copies of relevant extracts from Mr Griffiths' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Griffiths' clinical care at the prison.

12. The investigator interviewed eleven members of staff and one prisoner at Bullingdon, some jointly with the clinical reviewer. All the interviews were conducted remotely due to the restrictions imposed as a result of the Covid-19 pandemic.

13. We informed HM Coroner for Oxfordshire of the investigation. He provided us with a copy of the toxicology report. We have sent him a copy of this report.

14. We contacted Mr Griffiths' partner to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why Mr Griffiths was recalled, whether the prison's mental health team assessed and supported him and whether he had access to an in-cell telephone. These concerns are addressed in this report and in the clinical review.

15. Mr Griffith's partner received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Bullingdon

16. HMP Bullingdon is a local and resettlement prison, serving the courts of Oxfordshire and Berkshire. It holds approximately 1,100 prisoners. Practice Plus Group provides healthcare services and Cotswold Medicare Ltd provides GP services. There is an inpatient healthcare unit, with 24-hour nursing care.

HM Inspectorate of Prisons

17. HMIP's most recent full inspection of Bullingdon was carried out in July 2019. Inspectors reported that Bullingdon had made significant improvements since their last inspection. However, inspectors reported that they 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. Inspectors also reported that healthcare services at Bullingdon had improved since their last inspection and that they generally provided a good service.

Independent Monitoring Board

18. 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 ending June 2020, the IMB reported that staff who worked in reception and on the prison's induction unit took care to assess all prisoners for potential risks and vulnerabilities and that healthcare staff played an important role in this process

Previous deaths at HMP Bullingdon

19. Mr Griffiths was the fourth prisoner to take his life at Bullingdon since September 2018. In our investigations of two of the previous self-inflicted deaths (in April 2019 and February 2021), we found the circumstances were similar to those of Mr Griffiths' death: staff did not record the information they considered or why they decided not to start ACCT monitoring procedures.

20. There were also seven deaths from natural causes and two drug-related deaths at Bullingdon during this period. There were no significant similarities between these and the circumstances of Mr Griffiths' death.

Assessment, Care in Custody and Teamwork

21. 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. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

Key Events

Background

22. In December 2004, Mr Griffiths was convicted of murdering his ex-partner (after she ended their relationship) and given a life sentence. His tariff, the minimum time he had to spend in prison, was fifteen years, later reduced to twelve years following an appeal. He had tried to take his life before and after their relationship ended.

23. In October 2019, Mr Griffiths was transferred to HMP Springhill, an open prison. He was released from prison during the day to attend a course and to meet his partner.

24. In June 2020, it was noted that Mr Griffiths struggled with the COVID-19 restrictions, which meant he was unable to attend his course or meet his partner. He felt low and told staff that he felt constrained that he was in prison with others involved in drug-taking and other antisocial behaviour. The mental health team offered Mr Griffiths support.

25. In November, the Parole Board confirmed that Mr Griffiths would be released on licence. He was excited to be leaving Springhill.

26. On 4 December, Mr Griffiths was released on licence to an approved premises (AP, formerly known as a probation or bail hostel). Mr Griffiths' licence conditions included a requirement to tell his probation manager about any deterioration in his relationship. Mr Griffiths settled well in the community and he moved into his own accommodation.

27. On 18 March 2021, Mr Griffiths was recalled to prison due to concerns about the repetition of Mr Griffiths' previous risk behaviours as a result of difficulties in the relationship with his partner. His community probation manager noted in his recall paperwork that he might struggle emotionally due to his return to custody, the possible breakdown of his relationship and in light of previous attempts to take his life. She noted that he had previously tried to take his life on three occasions. Mr Griffiths was arrested late that evening and taken into police custody.

28. In the early hours of 19 March, Mr Griffiths spoke to his partner. She said that he was traumatised about being recalled into custody and called the police to make them aware that he had previously tried to take his life.

29. At around 11.45am, the community probation manager, who anticipated that Mr Griffiths would be returned to Bullingdon, contacted the prison's safer custody unit's welfare line to tell them that he would most likely arrive at the prison later that day. No one was available to take her call, so she left a message to outline her concern that Mr Griffiths might harm himself. She left her contact details.

HMP Bullingdon

30. At around midday a safer custody officer checked the safer custody unit's welfare line. She told an officer, who was working in reception, that the community probation manager had left a message outlining her concern that Mr Griffiths might be at risk of harming himself. She said that the officer told her that when Mr

Griffiths had arrived in reception, he would carry out a welfare check and start ACCT monitoring procedures if necessary. (We have been unable to speak with the officer about his contact with Mr Griffiths or any action that he took about this matter, as his employment at Bullingdon had recently been terminated.)

31. At around 2.45pm, Mr Griffiths arrived at Bullingdon. The person escort record (PER, a document that accompanies prisoners between police custody, courts and prisons and which sets out risks) warned that Mr Griffiths had previously tried to kill himself. It noted that he had said that he would not harm himself while in police custody. Mr Griffiths was checked every 30 minutes in police custody and on transfer to Bullingdon.

32. A Reception Supervising Officer (SO) completed Bullingdon's early days in custody booklet. He noted that Mr Griffiths had historic suicide and self-harm warnings but no mental health or substance misuse issues, that he had been recalled to prison and that his original offence was murder. Mr Griffiths denied having any thoughts of suicide or self-harm.

33. The SO emailed a prison offender manager to talk to Mr Griffiths about his recall to prison.

34. An officer completed Mr Griffiths' first night prison interview. He noted that Mr Griffiths was polite but was not very talkative. He noted that Mr Griffiths had last tried to take his life around 20 years earlier. Mr Griffiths denied thoughts of suicide and self-harm. (The officer did not record what risk factors he had considered and why he had decided not to start ACCT monitoring.)

35. There is no evidence to suggest that Mr Griffiths was provided with a first night phone call to contact family or friends. (The prison told us that a telephone PIN phone account was issued to him on 19 March, along with £2.00 credit, but they were unable to provide any evidence of this. A number was first added to Mr Griffiths' PIN phone account on 22 March. His first credit was added on 25 March, with further credits on 26 March and 1 April. PIN phone records show that Mr Griffiths made his first phone call on 10 April.)

36. A nurse completed a first night reception health screen. Mr Griffiths told her that he had been recalled to prison and might now remain in custody until the end of his life sentence. She noted that at times, he held his head in his hands, was shocked, did not understand why he had been recalled and had asked to speak with the prison offender manager, whom he had known previously from Bullingdon. She noted that he had previously had depression and had tried to take his life at around the time of his original offence.

37. Mr Griffiths declined mental health support and told the nurse that he did not need help and was okay. The nurse told Mr Griffiths how to access support, which he again declined, and she noted that he had previously been a Listener in prison and that his partner was very supportive. She said she was reassured by what Mr Griffiths had told her, that he had "good insight", was focussed on the future and was adamant that he had no thoughts of suicide or self-harm. She considered that Mr Griffiths did not need to be monitored under ACCT procedures. She referred him to the prison GP and the mental health team for an assessment, with the intention that they would be aware of his recall.

38. On 20 March, a Church of England chaplain spoke to Mr Griffiths by in-cell telephone. Mr Griffiths said that he was “absolutely devastated” that he was recalled to prison. He told her that he had recently “rowed” with his partner, which might have led to his recall. She prayed with him and arranged for him to be sent some reading material. She told the investigator that he was polite and reflective. She described him as a “closed person” and said that he expressed no thoughts of self-harm.

39. The prison offender manager spoke to Mr Griffiths about his recall. She gave him his recall paperwork, which set out the reasons for his recall. She told him that there would be a Parole Board review and that until he was allocated an offender manager in the prison, he should continue to keep in contact with his community offender manager. She said that Mr Griffiths told her that he was fine and understood what was happening.

40. A prison GP reviewed Mr Griffiths, noted that he appeared well but had asked for sleeping tablets. The GP re-prescribed blood pressure medication and a sedating antihistamine.

41. At a secondary health screen, an agency mental health nurse noted that Mr Griffiths had been depressed during the preceding two weeks and had felt troubled by repeated thoughts and recent life-changing events. She told the investigator that she had no concerns about Mr Griffith’s mental state, did not consider that he needed to be referred to the mental health team or ACCT monitoring. The nurse said that if she had had concerns, she would have noted it in his medical record. On 22 March, Mr Griffiths declined psychosocial support.

42. On 23 March, Mr Griffiths was told that he could make an appeal to the Parole Board to challenge his recall to prison. He confirmed that he would do so on 26 March. The Parole Board also asked the community probation manager to make representations and asked her for a clear recommendation about whether she would support Mr Griffiths’ re-release.

43. On 25 March, the community probation manager spoke to Mr Griffiths by video link about the reason for his recall. She noted that Mr Griffiths was “teary” and apologetic and felt that he had let people down. He told her that he had spoken to his partner while in police custody and knew that she had shared information about their relationship with probation staff. Mr Griffiths denied thoughts of suicide or self-harm.

44. On 26 March, Mr Griffiths was introduced to his new prison offender manager. She told him she would catch up with him in the second week in April after a period of leave.

45. In a general application to the healthcare team, Mr Griffiths said that his sleep medication had not been effective and asked for stronger tablets. On 31 March, it was noted that Mr Griffiths’ request for sleeping tablets had been received. In an undated response, he was told that the healthcare team would consider his request.

46. On 1 April, Mr Griffiths’ partner responded by email to a letter that he had written to her in which he said that the last thing he wanted was for their relationship to end.

She talked of the difficulties that they faced going forward and asked whether their relationship could continue.

47. On 4 April, Mr Griffiths told a nurse at a healthcare triage clinic that he still struggled to sleep. The nurse noted that he appeared anxious about sharing a cell and had spoken to officers about doing so. (Mr Griffiths never subsequently shared a cell with another prisoner.) The nurse told Mr Griffiths that he should keep himself busy by exercising or by other distractions and that officers would monitor him. He referred Mr Griffiths to the prison GP to review his sleep and to the mental health team for an assessment. The prison pharmacist later prescribed a further course of a mild sedative to help him sleep.

48. Mr Griffiths' partner emailed him to ask why he had not called her the previous Thursday. She thought it might be an issue with his PIN Phone account but also questioned if he had decided to end their relationship.

49. On 6 April, Mr Griffiths' referral to the mental health team was discussed at a mental health team triage meeting. They noted that his anxiety had not improved. The mental health team wrote to Mr Griffiths to let him know that he had been added to their waiting list for assessment and that they aimed to see him within seven working days but that this might take longer. They advised him to speak to staff, Listeners or the prison chaplaincy in the meantime if he needed support. (Mr Griffiths was never assessed by a mental health practitioner before his death.)

50. That day, Mr Griffiths' partner emailed him and told him that she was happy to give their relationship a second but last chance. She also talked about him not having "credit", likely referring to his PIN phone account.

51. On 7 April, Mr Griffiths telephoned his community probation manager and told her that he was willing to be re-released to an AP. She noted that Mr Griffiths had talked about his improved mental health and that the probation team's involvement was a protective factor. Mr Griffiths spoke about re-building his relationship with his partner and completing community programmes if he was re-released.

52. That day, prison staff told Mr Griffiths that £25 credit had been made to his PIN phone account the previous week.

53. On 9 April, the community probation manager spoke to Mr Griffiths by video link. He confirmed that he had been in contact with his solicitor. They discussed possible additional licence conditions and his relationship with his partner. He told her that his recall had been "scary" and a "wake up call". She later noted in his recall paperwork that Mr Griffiths had presented as remorseful and disappointed with himself. She noted that Mr Griffiths did not appear resentful towards his partner for sharing information with probation staff and did not try to blame her for his abusive behaviours.

54. On 11 April, the prison chaplain spoke to Mr Griffiths by telephone, as he was struggling to cope with his recall. She said that Mr Griffiths was rational and calm and asked her to send him a Bible correspondence course.

55. On 12 April, Mr Griffiths talked to the prison chaplain for around one and a half hours about his recall to prison, his relationship and future. She noted that he

struggled to explain why he had not disclosed his abusive behaviours and understood the need for him to be released to an AP.

56. On 13 April, the community probation manager spoke to his prison offender manager to update her about Mr Griffiths' recall to prison and possible recommendations if he was re-released. The prison offender manager said that she had not yet met Mr Griffiths and confirmed that his records contained no reports since his return to custody but that he had sought chaplaincy support.

57. On 14 April, Mr Griffiths told his community probation manager that he did not have a copy of his solicitor's representations but had discussed them. Mr Griffiths said he had also sought chaplaincy support which he had found useful, but he had not been in contact with any other prison support services. Mr Griffiths denied thoughts of suicide or self-harm and she agreed to speak with him two days later. During the day, she submitted a referral for Mr Griffiths to reside at an Oxford AP should he be re-released.

58. Mr Griffiths' partner emailed him to say that she had not been talkative during their recent telephone calls but that she loved him.

59. On 16 April, the community probation manager told Mr Griffiths that she had recommended that he should be re-released with the same licence conditions and risk management plan as he had before but that he needed an AP place to be confirmed before he could be re-released. She noted that Mr Griffiths was relieved but was worried about timescales and the possibility that his case might be referred to the Parole Board for a full hearing. She told Mr Griffiths that she had spoken to his prison offender manager about the benefit of him completing work about relationships and noted that he was positive about this.

60. On the afternoon of 18 April, Mr Griffiths spoke to his partner about family and told her that he was "terrified" to talk about their relationship. His partner did not comment.

61. A SO spoke briefly to Mr Griffiths when he collected his evening meal, asked how he was doing and if he was okay. She said that Mr Griffiths was "quite elated" and said to her, "It's all looking great. My relationships on track and probation are going to recommend my re-release." The SO said that Mr Griffiths seemed positive about the future and that as she knew him well, she would have identified any concerns about him.

62. At around 7.00pm, Mr Griffiths spoke again to his partner about his possible re-release. He told her that he had spoken to a SO about his recall, that he "was not great". They talked about family and domestic issues. Mr Griffiths' partner told him that they needed to talk. Mr Griffiths asked if he should worry. His partner said that they needed to move forward, and they agreed to speak the next day.

63. At 1.00pm on 19 April, Mr Griffiths spoke to his partner. They talked about him contacting his solicitor and about his partner's work. They agreed to speak later that day.

64. Mr Griffiths spoke to his community probation manager at 3.30pm about his representations. She told him that an AP place had not yet been agreed but that she would let his partner know if one was confirmed by the end of the week.

65. In her police statement, the community probation manager said that she and Mr Griffiths arranged to speak again on 23 April, after which he would be able to let his solicitor know whether an AP place had been found so it could be included in his representations. She said that Mr Griffiths gave her no indication that he felt low, that he was struggling or that he was at risk of suicide or self-harm. She said that Mr Griffiths appeared positive about building his relationship with his partner.

66. Mr Griffiths spoke to his partner at 7.00pm for around 15 minutes. He told her that the community probation manager could not recommend his re-release until an AP place had been found and that the Parole Board would not recommend his release until this had happened. Mr Griffiths spoke most during the call and his partner said very little. He told his partner that he was exhausted and asked her what she wanted to speak about. She said that she did not know. The call ended with a long pause. Mr Griffiths asked his partner how she felt and if she was okay. She replied that she was okay but did not appear to engage in conversation. Mr Griffiths asked if “they were okay” and his partner replied, “I don’t know”. He told his partner “I am going to go now”, she said “okay”, and he said he would speak to her the following day.

67. Mr Griffiths spoke to his partner again at 7.36pm for around three minutes. He asked her if she could find the post code for an AP, which she agreed to do. He said he had just woken up and was feeling a bit down and apologised for being miserable. The call ended with Mr Griffiths and his partner agreeing that they would speak the next day.

68. A wing officer described Mr Griffiths as polite and respectful and said that he kept to himself. She said that due to the limited COVID-19 regime, Mr Griffiths did not mix much with other prisoners.

69. Another officer said that he would sometimes unlock Mr Griffiths for his meals, to carry out roll checks and had occasionally answered his cell bell. The officer said that Mr Griffiths did not interact with other prisoners, kept to himself and he knew very little about him. He said that Mr Griffiths gave no indication that he was at risk of suicide or self-harm.

70. At around 8.45pm, an Operational Support Grade (OSG) arrived for her nightshift and received a handover from colleagues. At around 10.00pm, she completed her evening roll check. She said that Mr Griffiths raised no concerns. This was the last time that Mr Griffiths was seen alive.

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71. At around 5.05am, the OSG checked on Mr Griffiths as part of the morning roll check. She could not see him and felt there was something wrong as there was no mattress on the top bunk and a lot of “clutter” on the floor. She shone her torch into the cell, knocked on the door and called out to get a response from Mr Griffiths but there was none. She turned the cell light on and saw Mr Griffiths in a small gap behind the shower curtain, with what appeared to be prison sheets tied around his

neck. At 5.06am, she called a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties).

72. Because her view of Mr Griffiths was obstructed by the shower curtain, she considered that she may be at risk if she entered the cell on her own and so she waited for assistance from her colleagues. A nurse telephoned the OSG for further information and the OSG told her that Mr Griffiths was hanging.

73. A Custodial Manager (CM) and four officers responded immediately to the code blue and collected the nurse from the healthcare unit, which was en route. The nurse was waiting with the emergency response bag and defibrillator.

74. When the officers arrived on the wing, the OSG told them that she could not see Mr Griffiths or get a response from him.

75. The CM said that the cell was dark when he arrived. He unlocked the cell door and went in with Officer A. The CM pulled back the toilet's privacy curtain and found Mr Griffiths in a standing position, between the bed and cell toilet, with a ligature tied around his neck. (He had tied the ligature to a chair which was wedged into the bars of the top bunk of the bed.)

76. The CM and officer supported Mr Griffiths, while another officer cut the ligature from around his neck. They lowered him to the floor. The CM checked Mr Griffiths for signs of life but there were none, and the officers started cardiopulmonary resuscitation (CPR). The nurse was also unable to find any signs of life. She later noted that rigor mortis and hypostasis (the accumulation of blood in the lower parts of the body) were present. Both the nurse and an officer said that they believed Mr Griffiths was already dead.

77. The nurse attached a defibrillator and gave Mr Griffiths oxygen while officers continued with chest compressions. The defibrillator advised that there was no shockable rhythm. At around 5.17am, the nurse asked the officers to stop CPR as she believed that Mr Griffiths had died. The CM questioned the decision to stop CPR and suggested that they should continue their resuscitation attempts until paramedics arrived. The nurse agreed.

78. The CM updated the control room and the ambulance service. (The control room log noted that an ambulance was called at 5.07am and arrived at Bullingdon at around 5.25am.)

79. At around 5.35am, paramedics arrived at Mr Griffiths' cell and unsuccessfully continued resuscitation efforts. They pronounced at 6.10am that Mr Griffiths had died.

Contact with Mr Griffiths' family

80. At around 10.45am, the appointed family liaison officer broke the news of Mr Griffiths' death to his partner. Bullingdon contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

81. A prison governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

82. The prison posted notices informing other prisoners of Mr Griffiths' death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Griffiths' death.

Post-mortem report

83. The post-mortem report into Mr Griffiths' death had not been completed at the time of our report. However, the post-mortem toxicology results found no substances in Mr Griffiths' body.

Findings

Assessment of Mr Griffith' risk

84. Prison Service Instruction (PSI) 64/2011 on safer custody requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures. Mr Griffiths was not subject to ACCT monitoring at Bullingdon. He arrived with a number of risk factors: he had murdered his ex-partner, he was serving a life sentence, he had been recalled to prison and it was possible that his recall would affect his relationship with his current partner.

85. Mr Griffiths' PER, completed in police custody, noted his risk of suicide and self-harm due to his recall and history of attempted suicide. It also noted that he had said that he would not hurt himself in custody. A SO, a nurse and an officer told the investigator that they had considered Mr Griffiths' risk factors, but they did not consider that he needed to be monitored under ACCT procedures.

86. Mr Griffiths received support from the prison's chaplaincy and significant input from his community probation manager. He had frequent, in-depth conversations with her about the review of his recall and she had recommended to the Parole Board that he should be re-released to an AP, which pleased Mr Griffiths.

87. With the benefit of hindsight, it is easy to conclude that Mr Griffiths should have been monitored under ACCT procedures when he arrived at Bullingdon and we note the clinical reviewer's surprise that he was not monitored given his history of attempted suicide, his recall and observed distress. However, on balance, we conclude that the three members of staff who saw Mr Griffiths on his arrival at Bullingdon considered his risk factors reasonably and appropriately, given the information that they had access to at the time and that they were unaware of the community probation manager's concerns about him.

88. We note that the community probation manager, concerned about Mr Griffiths' vulnerability, had contacted Bullingdon's safer custody team about her concerns. The message was received and passed to an officer, who said he would check on Mr Griffiths. However, because we were unable to interview the officer, we are unable to ascertain what action he took, there is no evidence that the concerns raised by the probation manager were not passed to his colleagues who subsequently assessed Mr Griffiths risk when he arrived at the prison.

89. ACCT monitoring is used to monitor people who are in a period of crisis. Although Mr Griffiths was clearly upset and frustrated about his recall to prison, we do not consider that he appeared sufficiently in a state of crisis during his time at Bullingdon to alert staff to start ACCT monitoring. However, we acknowledge that if Mr Griffiths had been monitored under ACCT procedures, the mental health team would have become involved in his care which might have prevented Mr Griffiths from taking his life. We also note that Mr Griffiths' telephone conversations with his partner in the days before his death may have played on his mind and contributed to his decision to take his life.

90. It is difficult to determine what effect the COVID-19 restrictions might have had on Mr Griffiths but being locked in his cell alone for long periods might have affected his wellbeing and mental health. In normal times, staff would also have had more interaction with him and, as a consequence, might have become aware of any issues that he had and whether they increased his risk of suicide or self-harm. However, we cannot know whether Mr Griffiths would have shared his anxieties with staff, and we are satisfied that there was little to indicate to staff that Mr Griffiths was at immediate risk of suicide or self-harm at the time of his death.

91. We note that an officer did not record his consideration of Mr Griffiths' risk factors and the reasoning behind not opening ACCT procedures in the appropriate forms, an issue which we have raised in our reports into the deaths of two previous prisoners at Bullingdon. We therefore make the following recommendation:

The Governor of Bullingdon should ensure that first night induction staff record the information considered and their reasoning when they decide not to start ACCT procedures.

Mr Griffiths' access to the telephone

92. Mr Griffiths' next of kin asked whether he had access to a telephone in the first few weeks at Bullingdon. The investigator could not establish why Mr Griffiths appeared to have made no calls, despite his telephone account showing that he had credit. It is possible that he had used an incorrect PIN access number or simply chosen not to make any calls. However, we know that Mr Griffiths used the telephone in his last couple of weeks at Bullingdon.

Clinical care

93. The clinical reviewer considered that the care that Mr Griffiths received fell short of the standard which he might have expected to have received in the community. The Head of Healthcare will need to address the clinical reviewer's recommendation that all healthcare staff, including agency staff, receive ACCT training.

Mental health referrals

94. The clinical reviewer reported on the breakdown of the mental health referral process at Bullingdon and that there was no system in place for tracking the progress of referrals. The clinical reviewer said that there had been an unacceptable delay of 17 days between Mr Griffiths' first referral to mental health services and him being discussed at a triage meeting.

95. The clinical reviewer noted that the nurse's second mental health referral might have indicated that his need for intervention had become urgent. The clinical reviewer noted that mental health triage meetings were supposed to take place weekly but that there were no such meetings between 19 March and 6 April. The clinical reviewer noted that during this time, urgent referrals took priority over routine ones. Although the mental health team aimed to see routine referrals within five working days and urgent ones within 48 hours, many assessments were

repeatedly delayed due to staff shortages and the need to complete urgent work, including assessing prisoners subject to ACCT procedures.

96. The Head of Healthcare acknowledged that at the time that Mr Griffiths was at Bullingdon, the healthcare team was struggling due to staff shortages, with only two permanent mental health practitioners, supplemented by three agency nurses. The Head of Healthcare also said that there was no primary mental health lead although a permanent member of staff was performing the role.

97. The clinical reviewer reported that as a consequence, Mr Griffiths was never fully assessed by a mental health practitioner at Bullingdon which might have enabled him to receive support and intervention which in turn might have resulted in a different outcome.

98. The Head of Healthcare told us that issues raised by the clinical reviewer were being resolved and that since Mr Griffiths' death, new members of staff had been appointed, the mental health referral system had been revised and a list of mental health referrals were regularly reviewed to prevent delays in assessments. We welcome the action taken but would like more detail about the changes that have and will be implemented to address these issues. We therefore make the following recommendations:

The Head of Healthcare at Bullingdon should ensure that the systems in place for mental health referrals are adequate and that routine assessments are completed within the target timescale of five working days.

The Healthcare Commissioners and Head of Healthcare should review staffing levels in the mental health team and ensure that the appropriate resources are available to recruit and retain the staff required.

Emergency response – resuscitation

99. The clinical reviewer noted that when Mr Griffiths was found, no time was lost in summoning assistance but that the accounts of his attempted resuscitation painted a picture of confusion. The clinical reviewer noted that when the nurse checked on Mr Griffiths for signs of life, she found none and described his legs as discoloured and noted that his temperature was only 28 degrees. She considered that he was already dead. After a short time, she told the officers to stop CPR, which they did for a short while, until the CM questioned whether they should continue with resuscitation attempts until the paramedics arrived.

100. The nurse said that during an emergency response, decisions were often made collectively and that it sometimes helped to listen to other opinions. She said that the prison officers present had persuaded her to continue to try to resuscitate Mr Griffiths. Following their arrival, paramedics led resuscitation attempts until they assessed that he had died.

101. Despite paramedics continuing resuscitation efforts, the clinical reviewer concluded that as the nurse assessed that Mr Griffiths appeared to be already dead when he was discovered, resuscitation should not have been attempted. We therefore make the following recommendation:

The Head of Healthcare should ensure that first responder healthcare staff are trained to recognise situations in which CPR would be futile.

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