Investigation into the circumstances surrounding the death of a man at HMP Bullingdon in March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

This is a report into the circumstances of the death of a man at HMP Bullingdon in late March 2008. Prison staff discovered the man hanging in his cell. He had attached a noose around the cell window when it was open and then closed the window to secure the noose in place. Despite attempts by staff to administer cardio pulmonary resuscitation (CPR), and the attendance of paramedics, he was pronounced dead shortly after 9.30am.

I offer my sincere sympathy and condolences to the man's family and friends for their loss. I must also apologise for the delay in completing this report.

The investigation was carried out on my behalf by two of my investigators. A clinical review of the man's healthcare at HMP Bullingdon was conducted by the Oxfordshire Primary Care Trust (PCT) Clinical Governance Lead on behalf of Oxfordshire Primary Care Trust. I am most grateful to the clinical reviewer for his review.

I would also like to thank the Governor and staff of Bullingdon for their co-operation and assistance. Particular thanks go to the liaison officer for her help throughout the investigation process. I would also like to thank the Lead for sex offender, cognitive and motivational programmes for the Prison Service to whom my investigator also spoke in order to gain a better understanding of the Sex Offender Treatment Programme (SOTP).

The man had arrived at Bullingdon from HMP Leyhill as a category D prisoner to complete some outstanding work on an SOTP which had been identified at his parole hearing as a necessary condition for his release. In total, he had been at HMP Bullingdon for approximately 13 months before his death. Despite having completed the SOTP in approximately eight months, the man was waiting to be assessed at the end of the programme. This meant that he was unable to return to open conditions at Leyhill. As the delay in his transfer continued, so did his frustration. On 12 February 2008, an Assessment, Care in Custody and Teamwork (ACCT) document was opened after the man said he had tried to hang himself because of this frustration.

Six weeks later, on the day before his death, the man received feedback from the prison psychologist in respect of the SOTP work he had undertaken. Soon afterwards, he telephoned his sister and expressed concern about what he had been told.

I make eight recommendations in this report, including five derived from the clinical review (the clinical reviewer makes three additional recommendations). Two of my recommendations are national and directed at the Prison Service (they relate to the management of prisoners transferred temporarily between establishments to complete the SOTP and the support offered to them).

I also note that following the man's death, the hot debrief highlighted areas of concern and that the Governor immediately put in place an action plan to review and rectify the relevant prison procedures. I have been particularly disappointed to learn that the officer who discovered the man had not been issued with an anti-ligature knife, despite a Prison Service-wide instruction to that effect. This resulted in a short delay before the ligature was removed.

SOTP assessments are mainstream, day-to-day business for the assessor. (I mean this in no sense disrespectfully or to suggest that they are conducted other than professionally and sensitively, but as a simple statement of fact.) However, for the prisoner involved such an assessment is a critical (and frequently stressful) event. I will share my report with the Lead for sex offender, cognitive and motivational programmes for the Prison Service so she can consider the learning for Prison Service staff who conduct SOTP assessments and those who commission risk assessments externally.

Given the timing of events, there must remain some doubt as to whether the man intended to take his own life or had hoped to be discovered.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2009**

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SUMMARY

The man was convicted of rape and murder in 1993 and sentenced to life imprisonment. He had progressed through the prison system, and had reached category D status and open conditions at HMP Leyhill. During this time he had undertaken a number of courses, including the Sex Offender Treatment Programme (SOTP), to address his offending behaviour. He had also been released on temporary licence (ROTL) on various occasions.

Following a Parole Board hearing, mid February 2007, the man transferred back to HMP Bullingdon, a category B closed prison, where he occupied a single cell. The Board had decided that he should undertake further intensive work on part of the SOTP that he had not yet completed before consideration could be given to his release. Prior to arriving at Bullingdon, the man also spent a short time at HMP Shepton Mallet.

The man completed the SOTP programme in November 2007 and waited for news of when he would return to open conditions at Leyhill, via Shepton Mallet. (This route was necessary as, following completion of the SOTP, the man had to undergo a penile plethysmograph test (PPG, a measurement of sexual arousal patterns that can indicate whether an individual still has difficulty managing offence-related sexual thoughts). Shepton Mallet has the facilities to conduct this test.)

However, Shepton Mallet could not accept the man back because of population pressures and refurbishment work that was being carried out. This caused a delay in the man’s transfer. He became frustrated and depressed and admitted to staff that he had tried hang himself with shoelaces on the night of 11/12 February 2008. An ACCT document was immediately opened and support was offered to him.

On 14 February, the man was seen by a psychologist who was commissioned by the prison to conduct a routine assessment interview following the completion of his SOTP. This session lasted approximately two hours.

The ACCT document was subsequently closed on 18 February as the man’s mood had improved. No issues were raised at the post closure review of the ACCT held on 27 February.

The man was then seen again by the psychologist on the morning of the day before his death. The purpose of the meeting was for the psychologist to provide feedback on the results of the assessment interview in February. The feedback would then form the basis of a report surrounding his sexual offending called a ‘Structured Assessment of Risk and Need’ (SARN) report. The psychologist explained his findings, detailed the progress the man had made and identified further work that he believed the man still needed to complete. Their meeting had ended just as the prison lunchtime was to begin and the man was escorted back to his cell. Soon afterwards, the man approached an officer on the wing and asked if it was possible to see the psychologist again that afternoon. A telephone call was made to the SOTP unit, but the psychologist had already left the prison.

Later that afternoon, the man telephoned his sister. He said he was frustrated, and believed that the feedback he had received from the psychologist was negative. He thought that this would have a detrimental impact on his return to open prison conditions, and ultimately his release from custody. He said he felt lonely at Bullingdon and had no support there. The conversation ended with the man becoming upset.

The following morning, the man collected his breakfast shortly after 8.45am. An officer on the wing commenced the morning accommodation fabric checks (AFC) at around 9.45am, and saw the man on the wing landing. About 15 minutes later, the same officer arrived to check the man's cell. He went into the cell and found the man hanging from the window. Staff and paramedics attempted to resuscitate him, but sadly they were unsuccessful.

This is the third apparently self-inflicted death to have occurred at Bullingdon since April 2004 when I began investigating all deaths in prison custody. The circumstances of the two earlier deaths have no direct relevance to the death of the man.

My report includes eight recommendations.

THE INVESTIGATION PROCESS

1. My investigator was appointed to lead the investigation into the circumstances of the man's death. He opened the investigation in April 2008 when he visited HMP Bullingdon. He met the Governor, Deputy Governor and representatives from the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). He was shown around the prison by a governor, Head of Residence, who appointed an officer as the liaison point for the investigation. My investigator also spoke with the Clinical Manager.

2. The Oxfordshire Primary Care Trust (PCT) Clinical Governance Lead, was appointed by the PCT to conduct the clinical review. Although the review was delayed, I thank the clinical reviewer for the work he has carried out. The clinical review is annexed to this report.

3. My investigator issued notices inviting staff and prisoners to contact him with any information they felt might be relevant to the investigation. There was no response to these notices. However, my investigator conducted several interviews with staff throughout May and June 2008, accompanied by his colleague, a fellow investigator.

4. One of my Family Liaison Officers spoke and wrote to the man's sister, his next of kin, to invite her involvement in the investigation process. The man's sister was able to provide some valuable insights and raised the issues and concerns listed below. I hope that this report addresses the issues she feels were troubling the man throughout his time in Bullingdon.

   - The man's sister said that there was a marked change in the man's mood once he had been transferred back to closed prison conditions. He was an outdoor person, and struggled in the physically confined environment at Bullingdon which he found claustrophobic in comparison to other establishments. He had described the prison to her as being noisy and like a school playground. Before this, he had progressed through the prison system to a point where he appeared more positive and had good contacts and a support network. He had been told that he would be at Bullingdon for a much shorter time than it ended up being, and would also be back at Shepton Mallet before Christmas 2007. The man's sister believed that this uncertainty and lack of accurate information had contributed to his depression.

   - When he arrived at Bullingdon, the man stopped his family and friends from visiting as he did not want to subject them to the formality of prison visits. The man's sister had tried to encourage him to let the family visit him as she felt that the lack of visits might be adding to his problems, but the man had refused. He wanted to protect them from the bad memories associated with closed conditions in the past.

   - The man had also told his sister that an element of the rehabilitation programme he was undergoing at Bullingdon had caused him to look at his past and what had caused him to commit his offence. His memories were

extremely troublesome. His sister described the man as tying himself in knots, especially as some of the meetings had apparently lasted some two hours. The man felt this was too long and extremely tiring.

- The man's sister also believed that the man had received mixed messages from the psychology unit. On the one hand he was told everything was okay and that it looked good for the Parole Board. He was then told that he needed to do more work examining his past and in particular to look at the death of his parents. Both of the man's parents had died during his time in prison. It was over three years since his mother died, yet he was encouraged to have bereavement counselling which it was suggested should continue after his release. The man's sister felt that the man was reconciled to his parents' deaths and found them particularly difficult to discuss. He was being put under pressure to reconsider these feelings. The man's sister felt that these sessions had overwhelmed the man and led to his depression. They had impacted on his state of mind, and exerted too much pressure on him. She felt these sessions were the "straw that broke the camel's back".

- The man had told his sister that the level of support from staff available at Shepton Mallet was very different to that at Bullingdon. At Shepton Mallet, the prison was geared up to working with lifers and the man was encouraged to be very open and to discuss his feelings no matter how raw these were. Staff were trained and used to dealing with these kinds of things. At Bullingdon, the man felt staff were not sure how to tackle things and therefore could not talk to him in the same way. He could not inflict on them what he needed to offload. He had kept a journal but was not really able to discuss his thoughts.

BACKGROUND

HMP Bullingdon

5. HMP Bullingdon is a modern prison that can accommodate up to 963 prisoners. There are five wings made up of both single and shared cell accommodation. The majority of prisoners are category C, although some category B prisoners are received from the local courts.

6. Bullingdon has a 24-bed inpatients healthcare facility, with clinical care available at all times. The outpatients facility delivers a daily triage system, referring prisoners to a doctor as necessary. Medication is also dispensed from the facility. A General Practitioner is available for prisoners every weekday and there is an on-call system at weekends and outside normal office hours.

7. In common with other prisons, Bullingdon operates a three tier system of regime (Basic, Standard and Enhanced) as part of the Incentives and Earned Privileges (IEP) programme designed to reward and encourage good behaviour on the part of prisoners.

8. The prison has a range of work, education and training opportunities delivering key and basic skills, and opportunities for a wide variety of vocational qualifications. There are also offending behaviour programmes including the Sex Offender Treatment Programme (SOTP), Enhanced Thinking Skills (ETS) and Short Duration Drug Programme (SDP).

Her Majesty's Chief Inspector of Prisons' report

9. Her Majesty's Chief Inspector of Prisons carried out an announced inspection of Bullingdon in January 2008. She found that the prison had faced considerable change over recent years and had risen to many of the challenges of its diverse role. Overall, it was performing reasonably well.

10. The Chief Inspector noted, however, that education, work and training were insufficient to ensure all prisoners were purposely occupied for most of the day. Sentence planning was inhibited by a backlog of OASys assessments and there was no custody planning for those spending a short time at the prison. (OASys - Offender Assessment System - is a standardised process for the assessment of offenders that has been developed jointly by the National Probation Service and the Prison Service.)

Independent Monitoring Board report

11. Each prison has an Independent Monitoring Board (IMB), the role of which is to ensure that prisoners are treated humanely and that there are appropriate and adequate programmes available to prepare them for their release. The IMB also report any concerns to the Secretary of State, and produce an annual report about the establishment.

12. The most recent IMB report for Bullingdon covers the period from 1 August 2006 to 31 July 2007. It highlighted that, despite the pressures arising from the high population, the positive improvements previously made both to the regime and the treatment of prisoners had continued. Determined efforts had been made to ensure work and education opportunities for prisoners, although the large number of prisoners held meant that there was insufficient work or education for all. (This particularly applied to the sex offender prisoners held on Edgcott Unit, where the man was located.) The IMB also raised concern that the prison should ensure that prisoners transferred from other establishments for the Sex Offender Treatment Programme (SOTP) were suitable for the programme.

Assessment, Care in Custody and Teamwork (ACCT)

13. ACCT has been introduced at all prisons as a documented process to monitor and support prisoners assessed as being at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once an ACCT is opened, the prisoner is observed at intervals determined by their perceived level of risk.

14. Each prisoner is assessed within 24 hours of the ACCT being opened and is then reviewed again at intervals determined by the relevant circumstances. The ACCT guidance says that, to be effective, the review should involve the people who know the person at risk or are involved in their care.

15. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner.

Mental Health In-Reach Team

16. The In-Reach team offers a mental health service for all prisoners who have enduring mental illnesses. They also treat and support prisoners who have mental health problems, offering intervention in crisis situations.

Structured Assessment of Risk and Need - Sexual Offending (SARN)

17. The SARN is the risk report that is written after a sex offender treatment programme of any kind is completed. The SARN is usually completed by someone independent and not involved in the treatment of the individual.

Penile Plethysmograph test (PPG)

18. The PPG is used to measure sexual arousal and can indicate whether an individual still has difficulty managing offence-related sexual interests. A lack of suitably qualified staff to oversee the test has meant that PPGs are currently only available at around ten prisons.

Prisoner categorisation

19. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The initial category can subsequently be raised or lowered as the assessment of risk changes. It is not unusual for prisoners to be moved to a lower category as their release date approaches, and life sentence prisoners would be expected to spend time in an open prison before they could be released on life licence. The security categories are:

    - category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape
    - category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult
    - category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt
    - category D: open conditions, prisoners who can be trusted not to try and escape.

Listeners

20. Like other prisons, Bullingdon has prisoners who support their peers as Listeners. Listeners assist those prisoners who require additional support at any time in their period in custody. They are provided with training from the Samaritans. Confidentiality is a critical feature of the Listeners' role.

Multi-Agency Public Protection Arrangements (MAPPA)

21. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan drawn up for the most serious offenders benefits from the information, skills and resources provided by the individual agencies being co-ordinated through MAPPA.

KEY FINDINGS

Prior to the man's arrival at HMP Bullingdon

22. The man was arrested for rape and murder committed on a night in July 1992. He was convicted and given a life sentence with a 12 year minimum tariff. This was later increased to 14 years on review, meaning that the man could not be released any earlier than July 2006.

23. The man worked his way through the prison system over the years, being held at a number of different establishments. During this time, he also completed a number of rehabilitation programmes to address his offending behaviour and gained enhanced level IEP status.

24. In August 2003, the man was transferred to HMP Leyhill (a category D open prison). This was considered a 'Career Move' following a Parole Board review which identified that the man needed to undertake a booster Sex Offender Training Programme (SOTP) and further work on alcohol relapse prevention. At Leyhill, he was allowed the privilege of being released on temporary licence (ROTL) on a number of occasions for town and weekend home visits whilst he prepared for release.

25. In June 2006, the man attended his mandatory parole review hearing which considered his suitability for release. Although the Parole Board agreed that he had met the test for serving the latter part of his sentence in open conditions, his release was considered inappropriate at the time because it was identified that he had not completed an up to date Healthy Sexual Functioning Programme (HSFP), part of the SOTP. To complete the course, the man had to return to closed prison conditions. As a result, the man's parole review was deferred for 12 months. The Parole Board later informed the man that his new parole review date would be October 2007.

26. As a consequence of the Parole Board's decision, the man was transferred to HMP Shepton Mallet in November 2006. This was also considered to be a progressive move where he would continue to participate in the various treatments as directed by the Parole Board.

27. The man remained at Shepton Mallet for around three months before a place became available on the HSFP at Bullingdon. He transferred again to continue with his rehabilitation programme in closed conditions.

The man's transfer to HMP Bullingdon

28. In February 2007, the man was transferred to Bullingdon. He went though the normal prison reception screening process and did not declare any concerns. He admitted to making a deliberate attempt at self harm 14 years earlier, but said he had no current thoughts of harming himself. He said he also suffered from Post Traumatic Stress Disorder (PTSD) and lower back pain. He was examined by the nursing staff who took a blood pressure reading and noted his family medical history. A cell sharing risk assessment was also completed and

he was rated as being a low risk in terms of sharing a cell. The man was offered the use of a telephone to contact family or friends but declined. He was later located onto Edgcott, the vulnerable prisoners (VP) wing, where he received his prison induction.

29. At interview with my investigators, the first officer said that she was a lifer officer and dealt with report writing, compiling dossiers and regularly seeing the life sentence prisoners to motivate and support them. Early March 2007, the first officer spoke to the man who had arrived at Bullingdon with another prisoner (from Leyhill via Shepton Mallet) to do the HSFP. The first officer said that the lifer team were unaware that the man (and the other prisoner) were being transferred to Bullingdon until she saw his name appear on the Prison Service computer system. The man said that he had come to do the HSFP course and, once he had finished it, would return to Shepton Mallet.

30. The first officer said she received no further information about the man from Leyhill. However, she offered the man reassurance that his move back to Leyhill was likely to be sooner rather than later. The man said he was concerned that, if he remained at Bullingdon until his next parole review (October 2007), he would not have been able to have had any further periods of ROTL. This could then have a negative impact for him when he next appeared in front of the Parole Board.

31. Late in March, the man’s solicitors wrote to the Head of Psychology, to request a copy of his Structured Assessment of Risk and Need (SARN) sexual offending report. They were anxious to receive all of the man’s post programme reviews. Leyhill confirmed that they would accept the man back, subject to the content of these reports, and approval from the Pre-release Section of the Ministry of Justice. The solicitors’ letter concluded that the man was “keen to return to Leyhill in good time before his panel in October next”.

32. At interview, the Head of Psychology told my investigators that the role of the psychology team was to deliver the treatment to the man, and that they had no real power to have him transferred. However, she sent an e-mail to Shepton Mallet requesting information as to whether the man could be transferred back to them. She told my investigators that Shepton Mallet said the prison was being refurbished and a transfer was not possible at that time.

33. The first officer told my investigators that she saw the man quite frequently when she was on the wing. The man appeared pleased to be at Bullingdon doing the HSFP because he was progressing through his life sentence plan and towards his release from custody.

34. Early April 2007, staff observed that the man had returned from his SOTP in a tearful manner, having had a bad session. Although this was noted in the staff observation book so staff were aware that they should monitor him, there is nothing noted to suggest that he was offered any specific support.

35. The man's solicitors wrote to the Parole Board on 20 April and requested a deferment of the oral hearing that had been listed for October 2007. This was granted and a new date of October 2008 was scheduled.

36. Throughout April and May 2007, no concerns were raised about the man's well being. He was described by staff as a quiet, respectful individual who had gained employment in one of the workshops.

37. In July, the man experienced problems in the workshop and was moved to work on the wing as a painter. He told staff that he had a lot on his mind and had referred himself to the In-Reach team. A second officer noted the wing history sheet to say that the man appeared "very unsettled" on the wing at that time.

38. Over the next months, the man settled down. While he was described by staff as "quiet and a loner," he maintained contact with his sister and mother in-law by writing letters. In conversation with the second officer, the man said that he was happy and the SOTP counselling sessions were going well. Staff commented that the man was a reliable and hard working prisoner on the wing, who could be left unsupervised to carry out his tasks. It was noted in his wing history sheet that his category D and enhanced status level were well deserved.

39. On 11 July, a trainee forensic psychologist and SOTP Treatment Manager contacted two Community Psychiatric Nurses (CPN), the first nurse (CPN1) and second nurse (CPN2), requesting an urgent In-Reach team assessment for the man. The man had had a SOTP session with the trainee forensic psychologist and SOTP Treatment Manager that day, and she described his behaviour as intimidating and aggressive. The trainee forensic psychologist and SOTP Treatment Manager said that she had found it necessary to end their session prematurely. She felt that the man was anxious and was not coping with the move from an open to closed prison or with the intensive work she was undertaking with him.

40. The man was remorseful after the incident with the trainee forensic psychologist and SOTP Treatment Manager and asked to be referred for further counselling sessions. The referral was immediately acted upon by the prison. The prison counsellor attended Bullingdon on Thursday mornings to see prisoners and she began counselling sessions with the man.

41. The Head of Psychology told my investigators that the man's progress was a "difficult treatment journey". She said the decision was made to suspend the man's SOTP because of the incident that had taken place with the trainee forensic psychologist and SOTP Treatment Manager. The Head of Psychology had reviewed video evidence of the session and felt it was the appropriate thing to do. The trainee forensic psychologist and SOTP Treatment Manager had also told the Head of Psychology that she felt unable to continue working with the man. The Head of Psychology therefore made the decision to continue the man's therapy with a different therapist and appointed another trained facilitator within the department.

42. At the In-Reach referral meeting held late in July 2007, the man's case was assessed following the incident with the trainee forensic psychologist and SOTP Treatment Manager. The meeting concluded that there was "no obvious role for mental health In-Reach, to be passed on to the prison doctor for advice." The prison doctor then assessed the man on 8 August. The doctor did not believe that the man was suffering from any psychiatric disorder but that the problems he was experiencing were "part and parcel of the group dynamic process that when handled properly would be therapeutically beneficial." It was concluded that no further action was required.

43. On 9 August, the prison counsellor concluded her counselling sessions with the man. He had had three in total. She wrote to the therapy facilitator after the man's last session, and provided her with an overview of the sessions. She described the man as very distressed at first but over time he was able to clarify certain issues. He had talked about his disturbed childhood and mentioned the breakdown in communication he had had on the course. This was something he wanted to rectify so he could return to the work he was doing on the SOTP.

44. The man resumed his HSFP with the therapy facilitator mid August 2007. The therapy facilitator introduced herself to him and explained the aims and content of the sessions they would have. She said in interview that the man was very co-operative throughout, and had acknowledged that he needed to focus more to be able to deal with the tasks on the programme.

45. Over the next few months, the other prisoner who had arrived at Bullingdon with the man completed his SOTP programme and was returned to Shepton Mallet.

46. The first officer said that the man had become frustrated with himself, knowing that he had been close to possibly being released before the incident with the trainee Forensic Psychologist and SOTP Treatment Manager. He had also said he had concerns about having to do the PPG assessment when he returned to Shepton Mallet. Shepton Mallet was apparently the only prison in the vicinity that could conduct this assessment, as Bullingdon did not have the facility. The Head of Psychology said that it was usual to have to undertake the PPG test before and/or after completing the HSFP.

47. The man eventually attended around ten HSFP sessions, each one lasting approximately one hour and 30 minutes. He concluded his HSFP in early November 2007. A post programme review was held late in November attended by the Resettlement Manager, the therapy facilitator (Tutor), the first officer, the man and, by teleconference, the Case Manager.

48. At the review meeting, the man said that the HSFP was the most intensive piece of work he had ever done, and it had changed his beliefs about sexual issues and relationships. He agreed that in the past he had not dealt with his emotional problems and these had ultimately built up throughout his life. He also informed the panel that returning back to closed conditions (at Bullingdon) had been a "massive blow" to him.

49. The review panel acknowledged that the man had worked hard on the programme, was motivated and had produced some good work. The therapy facilitator also agreed that the man now had a better understanding of himself and the issues surrounding his life. She was still concerned that the three counselling sessions the man had completed were not sufficient to deal with the issue of his control over his emotions. Furthermore, the first officer did not feel that the man had done as well as he could on the programme. The first officer believed that he should return to open conditions before his parole hearing and consideration should be given to close supervision on his release.

50. The panel identified that, in order for the man to achieve the objectives of the course, "further exploration of any remaining deep seated, anger and bitterness that might be triggered by frustration/rejection" needed to be done. This work was considered appropriate through individual counselling in open conditions and on release. That said, the panel also noted that a risk report (based on the SOTP he had completed) needed be carried out before the man's Parole Board hearing in October 2008, and which would be key to their decision about his release. The Case Manager said that she felt the man had made a definite step forward and she looked forward to receiving his risk report on which she would base any further reviews.

51. The Head of Psychology said at interview that the man had completed his course in November 2007, and as such there was no particular reason for him to now remain in Bullingdon.

52. At interview with my investigators, the first officer said that the man had felt disillusioned after he completed the HSFP, which he thought had not gone well. He was also worried that he might fail his forthcoming PPG test which he was due to take following completion of the HSFP. The man had been informed he would do the PPG test at Shepton Mallet. The first officer said the arrangement had been made by the psychology department and not the lifer team.

53. The first officer said that she contacted Shepton Mallet to establish whether the man could be transferred out of Bullingdon to another establishment where he could undertake the PPG assessment. However, this proved not to be possible. My investigators contacted the Prison Service's Population Management Section to ask whether any formal transfer requests had been received for the man during his stay at Bullingdon. None was received.

54. On 18 January 2008, the second officer noted in the man's wing history sheet that he remained quiet and continued to work effectively as a wing painter. Having completed the HSFP, he was now awaiting assessments by other staff.

55. In a conversation with the second officer very late in January, the man appeared confused as to why he had not yet been transferred back to Shepton Mallet. The second officer said he hoped to clarify this for the man soon. At this point, the man had been at Bullingdon for almost a year. The following day, the man submitted a complaint asking when he would be transferred back to Shepton Mallet. He received a response to his complaint in writing two days

later which said that Shepton Mallet was being refurbished and it was not possible for him to return there at the present time.

56. At around 9.30am on 12 February 2008, the man spoke with a Senior Officer (SO) when his cell was unlocked. The man admitted to trying to hang himself the previous night with shoelaces. He said that he had attempted to take his life because of frustration at not being transferred out of Bullingdon. He reiterated that he was a category D prisoner and had now completed his HSFP which was the reason he had been transferred to Bullingdon. The man said he was fed up of seeing other prisoners being transferred out before him. He was aware that the first officer had contacted Shepton Mallet about his status, but nothing seemed to have come of this. The man also said that he had put in a healthcare application form three weeks previously, but had not been seen yet.

57. An ACCT document was opened immediately by the first Senior Officer and these issues were recorded as possible trigger points for the man harming himself. The Senior Officer noted that the Head of Psychology should contact the wing prior to issuing the man with his SARN and that he needed support to get through his depression. He made arrangements for the man to work in the gardens for the morning to try and take his mind off things.

58. At interview with my investigators, the Head of Psychology confirmed that the opening of the ACCT document took place after the man's SOTP treatment finished. Her team (psychology) did not routinely or actively get involved in supporting prisoners on ACCT, but she was later made aware of the opening of the ACCT when the man was seen by a psychologist who was commissioned to carry out an assessment.

59. An ACCT assessment interview was carried out around an hour after the man had revealed he had harmed himself. As well as the man, the third officer, a second Senior Officer (Safer Custody Officer), the first officer and a representative of the Mental Health In-reach Team attended. The man told the ACCT review members that he had been feeling depressed recently as it had been the anniversary of his parents' deaths as well as being his son's birthday. Although he was happy to see a doctor, the man said he did not want to take any medication. He disclosed that he had previously been diagnosed with PTSD and a routine referral was made for him to see CPN2.

60. The first officer said she was concerned about the man at the meeting. He was upset, crying, and had said he was depressed about remaining at Bullingdon. He also said he had nothing to live for. The 'Concern and Keep Safe Form' (which contains details of the issues relating to the man's risk of harming himself, and an action plan to address them) was noted by the third officer in the man's ACCT document. He added that the man believed that the rehabilitation programmes he had undertaken, as well as the thought of the forthcoming PPG test, had all had an effect on him.

61. An action plan was put in place to support the man, under which he was to be observed and talked to by staff during the morning, afternoon and evening shifts. During patrol state (when prisoners are locked in their cells), staff were

to check on him hourly (at irregular intervals). The man was also offered the choice of being relocated into a shared cell, but declined. He was also reminded about access to Listeners at any time should he require it. The man said that, although his mood was low, he had no intention of taking his own life.

62. An In-Reach referral meeting was held on 13 February, at which the man's referral was passed onto CPN2. At this time mental health services in the prison were undergoing a reorganisation and CPN2 was taking on a new role. She was to transfer to the forensic team, although would still manage cases such as the man's. It was hoped that this transition would not cause a disruption to the service the In-Reach team offered.

63. The following day (14 February 2008), the man was interviewed by a Chartered Forensic Psychologist who conducted a SARN assessment interview. At interview, the Chartered Forensic Psychologist told my investigators that he was commissioned by the prison as an independent psychologist to report on individuals who had completed SOTPs. In respect of the man, the Chartered Forensic Psychologist said that he had had access to his records prior to meeting him for the first time.

64. He described the man as a prisoner who had spent a large part of his sentence engaging positively in addressing his offending behaviour. The man had completed a number of courses at different prisons including the core programme of the extended SOTP, and was now been required to complete the HSFP.

65. During their interview, they discussed the man's offence, his SOTP progress and other issues. The Chartered Forensic Psychologist concluded that there were no "obvious problems" with the man. He was aware that the man was on an open ACCT but the man said he was okay to continue with their session. The Chartered Forensic Psychologist described the man's mood as "fine". The man himself attributed his recent attempt to harm himself to delays with his transfer from Bullingdon. During their interview, the Chartered Forensic Psychologist said that the man gave the impression that he was to be transferred back to Leyhill.

66. In interview, the Chartered Forensic Psychologist confirmed that the SARN interview with the man covered all aspects of his life and was a very lengthy assessment lasting around two hours. He told the man that, once he had written his assessment up in draft, he would re-visit him in prison and let him know the results.

67. An ACCT case review was conducted at 11.00am on mid February. Three members of staff (a third Senior Officer, the third officer and a fourth officer) attended with the man. The man said he was feeling much better and working in the garden was going well. He had talked to his sister on the telephone, which had helped him a great deal, and he no longer wished to harm himself. He was aware of the support networks that were available to him. As the man's mood appeared much better, the ACCT document was closed.

68. On 21 February, the man was assessed by a second prison doctor. The doctor noted that he had been depressed on and off for the last year. He had completed the HSFP which made him think about himself and his disturbed childhood. His sleep pattern was good, as was his appetite, but his concentration and memory were poor. She commented on his diagnosis of PTSD and attributed this to events in his childhood. Following her interview with the man, the second doctor discussed the situation with the CPN2 who informed her that she was due to see him at some point soon.

69. The first officer said she came into contact with the man twice in the period after the man's ACCT document was closed. On both occasions, he appeared a little bit more upbeat. She told the man that Shepton Mallet had no space to take him back, but they were trying to do a "swap, a one for one" with one of their prisoners, as soon as possible.

70. In accordance with the ACCT procedures, an ACCT post closure review meeting was held on 27 February. The third officer noted that the man appeared more settled than he had been previously. He was working part-time in the farms and garden and was also a wing cleaner. His mood had improved and he had had contact with his former mother-in-law and sister by telephone and letter. The ACCT therefore remained closed.

71. On 4 March, The second officer made a note in the man's wing history sheet. It said that the man was a category D prisoner on enhanced IEP and still awaiting a transfer out to Shepton Mallet. He was described as having had a mixed past month where his mood was often low, although his work in the garden and farms appeared to be helping him. The second officer wrote that it was very frustrating for the man to be in this position.

72. It was noted in the man's medical records that CPN2 planned to see him on 5, 17 and 18 March. However, due to other patients' needs, the appointments had to be postponed. She was unaware that the man's ACCT document had been closed.

73. A member of the Independent Monitoring Board visited the lifer team on Arncott unit on 6 March for a general update on prisoners. The first officer brought the man's case to his attention. She explained that the man had come to Bullingdon to undergo the intensive SOTP. He had completed this and was now waiting for a move back to Shepton Mallet. The first officer told the member of the Independent Monitoring Board that the man was distressed by the delay and admitted to wanting to harm himself whilst on Edgcott unit. The member of the Independent Monitoring Board later raised the first officer's concern with a governor.

74. My investigators found e-mail correspondence that showed that the governor immediately followed up the first officer's concern. The correspondence detailed Bullingdon's frustration at not being able to transfer the man back to Shepton Mallet and made reference to him harming himself. Earlier correspondence had also been received from Shepton Mallet (dated 12 February) which stated that they were unable to take the man as they had

reached their maximum population capacity. Shepton Mallet said they hoped they would be in a position to do a ‘one for one swap’ with Bullingdon very soon.

75. At interview with my investigators, the first prisoner (a fellow prisoner) said that he was aware of the man’s frustration at not being returned to open prison conditions. In a conversation on 26 March, the man had told him that he had a meeting two days later that he hoped would provide closure for him. The first prisoner said that he later found out that the meeting the man attended did not go as well as he had hoped.

Events on The day before the man’s death

76. The Chartered Forensic Psychologist had arranged to speak to the man to feedback about his assessment on the day before the man’s death. He saw the man that morning at about 10.30am and proceeded to provide feedback for approximately one hour.

77. The Chartered Forensic Psychologist told my investigators that, as part of the process, he had interviewed other prison staff who knew the man quite well. He found that the man had been in prison for a “long time, was fairly stable, kept himself to himself, and was considered a model prisoner and easy to manage”. The Chartered Forensic Psychologist therefore did not envisage any particular difficulties with delivering the man’s feedback, as he was someone who had completed a number of programmes in custody already.

78. He was also aware of the incident that had resulted in the man’s SOTP being postponed for a while and they discussed this. He spoke to the man about his risk levels, and the circumstances where his risk level might be elevated and those in which he could maintain a lower level of risk. They then discussed the Chartered Forensic Psychologist’s recommendations which covered the issues that had been raised in his assessment and the possible ways the man should address them.

79. The Chartered Forensic Psychologist’s feedback amounted to nine recommendations and included some further work which he believed the man should do. This included a booster SOTP programme, which was normally completed within 12 months of a prisoner’s release. In his opinion, the man was a very experienced lifer who knew that things did not move quickly in the prison environment.

80. The man talked about his past relationships and also that he suffered from PTSD, something the Chartered Forensic Psychologist was unable to comment on as he had not seen any records relating to this diagnosis. The man also had a query about past PPG assessments he had done. He was unclear whether the assessments conducted showed a decline in deviant fantasies or evidence of a profile of deviant fantasies. Unfortunately, the Chartered Forensic Psychologist was unable to locate any of the results in the man’s records to confirm this.

81. The man gave the Chartered Forensic Psychologist the impression that he was not shy about raising concerns or expressing whether he was happy or not. The man's belief was that he would leave Bullingdon once he had completed the SOTP and return to a category C or D establishment. The Chartered Forensic Psychologist said that it was not uncommon, in his experience, for some offenders to do further SOTP work in the community following release. The Chartered Forensic Psychologist said that he would only recommend the work the man needed to complete and it would be for the Prison Service to decide when and where this would be done.

82. The man also told the Chartered Forensic Psychologist that he was to return to Shepton Mallet to complete the PPG test. He gave no indication that the test was causing any anxiety, nor did he allude to not receiving adequate support from prison staff.

83. The Chartered Forensic Psychologist told my investigators that the man seemed fairly positive when he delivered his SARN assessment feedback. The man had been open about a number of the issues regarding his previous relationships and his behaviour. Some issues he agreed with and some he did not. The man also talked about his outburst with Trainee forensic psychologist and SOTP Treatment Manager during the SOTP and wanted to make amends for his behaviour. He said that he was looking forward to moving to Leyhill, where he had previously enjoyed ROTL.

84. The Chartered Forensic Psychologist said that throughout the meeting the man raised no particular issues that were causing him concern. When the meeting ended, the Chartered Forensic Psychologist assured the man that he would receive the typed report the following week.

85. The Head of Psychology told my investigators that the man's SARN assessment showed he had made good progress in understanding his offending, and had acknowledged many of the risk factors that he needed to manage if he was to reduce the risk of re-offending in the future. She described the report as "positive", along with the fact that it recommended the further work which was to be undertaken in the community and managed by the Probation Service.

86. In interview, the fourth Senior Officer said that she would facilitate the movement of prisoners to and from various programmes they attended within the prison. When the man had his assessment with The Chartered Forensic Psychologist, she escorted him to and from the meeting. The man gave no indication to her that he had any concerns before or after he had met with the Chartered Forensic Psychologist.

87. A fifth officer told my investigator that in the six months he had worked on Edgcott wing the man had not caused staff any great concern. He was aware that the man was participating on a SOTP, and staff with knowledge of this would generally offer support if needed. However, staff tended not to talk to prisoners in detail about their SOTP because they themselves would not necessarily know the full extent of what occurred in their sessions. In general,

wing staff were not informed what types of SOTP sessions prisoners were having.

88. The fifth officer recalled that the man had an interview with the psychologist from the SOTP unit on the Friday morning. Later in the afternoon, the man spoke to the fifth officer and said he had some outstanding issues that he needed to discuss with the psychologist. The fifth officer telephoned the SOTP unit and was told that the psychologist had already left the prison. They agreed to arrange an appointment for the man the following week. The information was relayed to the man who appeared to respond positively. The fifth officer said that the man appeared to be fine and he reminded him of the services of the Samaritans telephone line and Listeners. When the fifth officer finished his duty later that day, he did not report any concerns about the man.

89. The Chartered Forensic Psychologist confirmed to my investigators that he left the prison early in the afternoon after a session with another prisoner. He was unaware that the man wanted to see him again and nobody contacted him that day to tell him. The Head of Psychology confirmed that her department had received a telephone call from staff on the man's wing to this effect.

90. Later that day, the man telephoned his sister. The content of this conversation was not known to the Prison Service at the time. He told her he had seen the Chartered Forensic Psychologist earlier that day and that a draft of the SARN report had been completed and fed back to him. The report was to be typed up the following week when the man would receive it and have the opportunity to read and respond. He also said that the meeting with the Chartered Forensic Psychologist was cut short because the lunchtime period had approached and he had to be returned to his cell. When this occurred, the man felt that they had not fully concluded their discussions.

91. The man said that one of the issues raised in their meeting was that there appeared to be no actual report of him ever being assessed as suffering from PTSD. The Chartered Forensic Psychologist had said the man might need to see a psychiatrist to talk about this issue. The Chartered Forensic Psychologist had also told him that a risk assessment would need to be carried out as part of the Multi Agency Public Protection Arrangements (MAPPA) process and that the man would have to participate on an anger management course.

92. The man told his sister that he felt as if the goal posts were being moved in respect of him completing his rehabilitation work. Their conversation continued in a negative manner with the man telling her, "I'm like dangling in mid air," and "I've given my all and I can't give any more." He said he had made further disclosures about his past behaviour in the SOTP sessions that he had not previously taken responsibility for. These in turn had brought to light other issues during his assessment. The man felt as if he had "dug a hole" for himself and that this had "set him back".

93. During the telephone call, the man's sister said that she felt he was "winding himself up" and should just wait until the following week when he would receive the SARN report. She offered to visit him but he declined. The man said that

he felt lonely and had no one talk to about what he was going through. He referred to the wing staff at Bullingdon and said that they were not trained to deal with individuals on SOTP unlike those in previous establishments he had been in. He was starting to lose faith with the things staff were telling him. He was on a wing that had very limited facilities and, as someone who liked to keep busy, he found this frustrating. The man said he would "grit his teeth" and just wait for the outcome.

94. The man also said that he had spoken with his solicitor who felt that he should not have been transferred back to closed prison conditions. The telephone call to his sister ended with the man saying that he had to go because he was in the middle of the wing and had started to get upset. My investigator found no record of any concerns raised about the man for the remainder of the evening.

Events on the morning of the day the man died

95. The fifth officer started duty at 7.30am the next morning. He completed a roll count and at that time the man was asleep in bed. Other staff soon arrived and the wing was unlocked for breakfast at around 8.30am. For the remainder of the morning until lunch time (11.45am -12.20pm), cells were unlocked and prisoners had a period of association. The fifth officer said he began his accommodation fabric checks (AFC) (a daily check on the locks, bolts and bars in each cell) which all prisoners were familiar with.

96. The fifth officer said he observed the man on the landings talking to other prisoners. The man then went to collect his breakfast pack and return to his cell. The fifth officer described him as a "very compliant prisoner" who generally seemed fine.

97. At about 8.45am, whilst checking the cell opposite the man's, the fifth officer saw the man on the landing. He continued checking the cells on the other side of the landing until a prisoner asked him for help to complete a form. The request took around five minutes and delayed the AFC checks. The fifth officer resumed the AFC checks and went to six more cells before getting to the man's cell, each cell taking about two minutes to be checked.

98. When the fifth officer arrived at the man's cell, the door was not fully closed. It was around 15 minutes since he had last seen the man. He entered and immediately saw the man hanging by a ligature that had been hooked over the window hinge. The fifth officer said that his first instinct was to use a fish knife (a tool designed to cut through ligatures) to release the ligature so that cardio pulmonary resuscitation (CPR) could be carried out. However, as he had not been issued with a fish knife, he shut the cell door immediately and left to summon help and assistance from other staff. While heading to the central office to do so, he used his radio to call a "Code 1" emergency (alerting all staff to a life threatening situation) which was picked up by the Communications Office and transmitted throughout the prison on the radio network.

99. At interview with my investigating officers, the fifth Senior Officer said she was working in the central wing office when the fifth officer came running in and

shouted, “the man is dead.” The sixth officer told my investigators that he was outside the office when he heard the fifth officer shout this. Immediately afterwards, the emergency message ‘Level 1 Edgcott’ was broadcast over the radio network. The fifth Senior Officer and the sixth officer immediately followed the fifth officer to the man’s cell. When the fifth Senior Officer arrived at the cell and entered, she saw the man hanging from the bed sheet from the window. The fifth officer supported the man’s body whilst the sixth officer used his fish knife to cut the ligature. The man was then laid on the floor. The fifth officer, who was first aid trained, said in interview that the man showed no signs of life.

100. The fifth Senior Officer said that as the officers ran into the cell, they had forgotten to “shoot the bolt” so that the cell door would not lock behind them. They were aware that other prisoners were milling around on association and unfortunately the door did shut. The fifth Senior Officer began to bang on the cell door to alert other staff responding to the alarm to their whereabouts as they approached the cell. They also pressed the cell bell.

101. In the meantime, the fifth and the sixth officers tried to make as much space in the cell as possible to assess the man. Although he had not had any CPR refresher training in some time, the sixth officer immediately checked the man for signs of life. He found no pulse or signs of breathing and so commenced cardio pulmonary resuscitation (CPR) at the rate of 1:30 (one breath to every 30 compressions). The cell door was very quickly opened by the seventh officer, Healthcare Officer (HCO) and the first nursing sister entered the cell. The first Principal Officer was the orderly officer (codenamed Oscar 1, and in charge of the prison) and he also arrived at the man’s cell. The fifth and the sixth officers then left the cell. The seventh officer escorted all prisoners who were on the landings back to their cells.

102. The Health Care Officer and the first nursing sister were in Dalton Unit when they heard the level one emergency call over their radio at around 9.03am. As they were very close to Edgcott Unit, they immediately shut the hatch in the treatment room, picked up all the emergency equipment (such as oxygen, air masks, a defibrillator and intravenous fluids) and ran through to Edgcott. At interview with my investigators, the Health Care Officer said they arrived at the man’s cell within two minutes and were briefed about the situation as soon as they arrived.

103. The first nursing sister went into the cell first. The man was still fully clothed, lying on the floor with his head facing the door. The first nursing sister told my investigators that she could see ligature marks around the man’s neck and he “looked dead”. She immediately inserted an airway into his mouth. The Health Care Officer placed the defibrillator pads on the man’s chest and waited for its instruction. The defibrillator machine indicated that there was no cardiac activity and CPR should be continued. The Health Care Officer continued with CPR using the ambu-bag to pass air into the man’s lungs. The first nursing sister carried out chest compressions. The fifth Senior Officer assisted them by holding the man’s head.

104. The first nurse soon arrived at the man's cell. At interview with my investigators, the first nurse said that she was assigned as the first response nurse for the prison and responded to the emergency call. When she arrived at the man's cell, she took over from the first nursing sister and carried out chest compressions. The first nursing sister asked for the prison doctor to be called. The prison doctor arrived within two minutes and injected adrenaline into the man's arm.

105. The Principal Officer waited outside the cell directing staff as necessary to conduct various duties and ensuring all prisoners were locked in their cells. He spoke to the fifth and sixth officers as they left the cell, offering them support.

106. Despite CPR and adrenaline being administered, the man still showed no signs of life. The defibrillator machine also showed that there was no heart activity. Healthcare staff continued with CPR, which the fifth Senior Officer said lasted for around 20 minutes. The ambulance paramedics arrived at approximately 9.30 am. CPR was continued until the man was formally pronounced dead at 9.45 am.

After the man's death

107. The prison's death in custody contingency plan was activated immediately and the necessary agencies, including the police and the IMB, were notified. The duty care team was available for the staff who had found and attempted to resuscitate the man. All prisoners who were being monitored on ACCT plans were reviewed. Arrangements were made for the man's body to be removed from the prison.

108. When the man had arrived at Bullingdon, his next of kin had been recorded as his parents. It was soon discovered that their details were out of date as his parents had died some time ago. The man's sister was then contacted. Because she lived in Doncaster, some considerable distance from Bullingdon, police local to her were contacted and asked to break the news of the man's death. A governor, the Head of Prisoner Community (Head of Residence), later telephoned the man's sister. So too did a chaplain, who offered pastoral support and contact numbers.

109. At 11.30am, the first governor and head of residence chaired a hot debrief meeting (a meeting held immediately after an emergency has occurred with those individuals involved) and a number of issues were raised. One was regarding psychologists' interviews and SOTP meetings being conducted a Friday. It was thought that, as there were fewer SOTP staff available over the weekend, if a prisoner subsequently needed extra support or specific SOTP information they would generally have to wait until the following Monday.

110. The hot debrief also identified that staff had responded quickly to the emergency alarm. The seventh officer raised her concern that she felt that there had been few members of staff available on the landing to return prisoners to their cells. The eighth officer said that the batteries in the radios on Blackthorn Unit had not been recharged and so staff were unaware that there

was an alarm. A second Principal Officer, who was located on Spur 2 of Edgcott Unit, said the staff there were also unaware that an alarm had been raised as none of them had a radio. The Governor raised action points for both of these issues to be addressed immediately. The Governor also reiterated that a mandatory decision was already in force that all staff were to carry fish knives and he would re-issue a notice to staff to this effect immediately.

111. The day after the man's death, the chaplain, again telephoned the man's sister to offer further support and assistance in respect of arranging the man's funeral. The governing Governor also wrote a letter of condolence to the man's family. The man's sister subsequently agreed that the chaplain should conduct the man's funeral service. Over the next couple of weeks, the chaplain met with the man's family to discuss and arrange his funeral. The funeral was held on 17 April and was attended by the prison governor. The prison offered to contribute to the costs.

112. A memorial service was conducted in the prison which was well attended by staff and prisoners. The chaplain later wrote to the man's family to say that a donation from prisoners had been made to the Shannon Trust. (The Shannon Trust runs the award-winning peer mentoring Toe to Toe programme which encourages and supports prisoners who can read to give one-to-one tuition to those who have literacy problems.)

Post Mortem

113. The post mortem report concluded that the cause of the man's death was hanging and he was not under the influence of alcohol or any other substance.

ISSUES RAISED IN THE INVESTIGATION

Clinical care

114. The clinical review was undertaken by the Governance Lead Oxfordshire PCT, and is annexed to this report. The clinical reviewer reviewed the man's medical records, had access to transcripts of interviews with Bullingdon staff, and viewed other documentation. The clinical reviewer has made eight recommendations that will be shared with the PCT for their action. I have referred to five of these recommendations which seem to me the most pertinent.

115. The clinical reviewer comments that the standard and completeness of the man's clinical records was "just adequate". Staff failed to update the man's summary sheet with details of an attempt of self strangulation in 1994, or his admission of wanting to harm himself that had resulted in the opening of the ACCT document in February 2008. The clinical reviewer also comments on the lack of detailed information given on a referral document completed by trainee forensic psychologist and SOTP Treatment Manager.

116. Whilst it is unlikely that more detailed and complete records would have prevented the man from harming himself, the importance of good record keeping cannot be overstated.

The Head of Healthcare should ensure the standard of clinical record keeping on EMIS (prison medical computer records) is improved and every attempt is made to ensure medical records are both summarised on admission, and kept up to date subsequently. If other contracted services fail to meet the required standards of documentation, action must be taken by the contracted service.

117. Upon arrival at Bullingdon, the man underwent the First Reception Health Screen. This is an opportunity for staff to identify all health concerns that might need attention while the prisoner is in their care. During the screening, the man's blood pressure was recorded as slightly raised. This was not followed up, even though it was recorded that his father had suffered from ischaemic heart disease. Again, I share the clinical reviewer's concerns and agree with the recommendation made.

The Healthcare Manager must ensure that if the healthcare screening examination finds an abnormal result it should be followed up subsequently. The Healthcare Manager needs to ensure staff are suitably trained, and audits are in place to ensure this happens.

118. The man had also told staff that he had made an application for a healthcare appointment three weeks prior to the opening of his ACCT document. My investigator found no record of this. I made a similar recommendation following the death of a prisoner at Bullingdon in December 2004, and so I am disappointed that this issue has been raised again.

The Healthcare Manager needs to ensure a clear process exists, and is documented, for the management of healthcare applications, and that this process is communicated to staff and prisoners.

Opening and closing of the ACCT

119. I agree with the clinical reviewer's findings that the ACCT was managed with diligence, care and compassion, and its closure after six days appears to have been appropriate. The post closure review confirms this. However, CPN2 appears not to have been informed that the ACCT had been closed although the information might have affected the prioritisation of her case load.

The Governor should remind staff that, when an ACCT is closed, information should be passed to all staff who have a role in the management of the patient.

The man's contact with Mental Health In-Reach team

120. The man's mental state was of concern and he was referred to the In-Reach team. It is very evident that CPN2 intended to assess the man but, due to the reorganisation of the mental health service within the prison, this did not happen.

121. The clinical reviewer highlights his concern that, during this transitional period, three clinical posts were unfilled and so the service might not have been properly managed. This resulted in an inadequate mental health service being available to the man at the critical time leading up to his death.

122. It is impossible to say whether higher staffing levels might have prevented the man's death, especially given that those with whom he did have contact did not assess his situation as being critical. It remains a possibility, however, that some risk assessment, or other intervention, during the days leading up to his death might have made a difference.

The Head of Healthcare should ensure that, should there be a need for any further reorganisation of its services, a clear transition plan, with adequate or enhanced staffing, needs to be in place to ensure as much continuity of care as possible.

The man's completion of SOTP programme and his failure to transfer from Bullingdon

123. It is evident from my investigation that the man had worked hard and progressed through the prison system to a point where he believed his release from prison would come in October 2008. He expected his transfer from Leyhill to Bullingdon to be short term. Indeed the man had told his family that he expected to back at Leyhill by Christmas 2007.

124. At his stage of his sentence, the man might not have expected the SOTP to have been so intensive. The course certainly raised deep rooted issues with

him, and ultimately affected his progress. The closed prison surroundings no doubt added to this. Nonetheless, he completed the SOTP in November 2007, nearly five months prior to taking his life.

125. It is not clear whether the man had to remain in Bullingdon in order to have the SARN assessment which did not take place until February 2008.

126. Shepton Mallet confirmed that they were not in a position to accept the man back into their custody. However, the actual management of this process is a little clouded. My investigators found little documentation showing that attempts had been made to arrange a transfer for the man to a different prison. Whether this would have been possible or not is not known. However, it is disappointing that the management of the transfer process appears to have been so hit-and-miss and undocumented. The man's expectation was clearly that his stay in Bullingdon would be temporary. This expectation became difficult to manage because staff themselves they were not fully briefed on the man's situation when he arrived, and were unable to provide any definite information to him on a regular basis.

The Prison Service should ensure that the process of moving to a more secure prison to complete short treatment programmes is properly managed and that all parties are kept up to date on progress. Agreement for the return should be made before the initial transfer.

Delivery of SOTP and feedback

127. One of the issues raised by staff concerned psychologists' interviews and SOTP meetings being conducted on a Friday, a day set by the psychology unit. It was felt by wing staff that that there were fewer SOTP staff available over the weekend period and, if a prisoner subsequently needed extra support or information, they generally had to wait until the following Monday.

128. A similar situation applied to the appointment between the Chartered Forensic Psychologist, as an externally commissioned psychologist, and the man. The Chartered Forensic Psychologist was only in the prison for a limited time and was not available for any follow up communication with the man or to speak with the Head of Psychology.

129. When using external psychologists, it would be useful if their findings were shared with the prison psychology unit after the initial assessment and before they are fed back to the prisoner. Although this may have occurred, there is no record of the information being passed on. Given that the Chartered Forensic Psychologist made a number of recommendations in respect of further work the man should complete, it might have prompted staff to ensure that further support was made available to him after he had received this information from the Chartered Forensic Psychologist. In turn, this might have assisted in reducing his fears.

130. Following the man's death, I am pleased to record that the Head of Psychology has now agreed that SOTP meetings will no longer be delivered on Fridays.

This will mean that there will be a greater number of staff available for support of prisoners undergoing any SOTP activity.

131. With the benefit of hindsight, there are some indicators that additional support would have been helpful for the man. It was known he found the SOTP course difficult, an ACCT document had been closed only recently, and he was frustrated with the delay of his transfer. My investigator found nothing documented on the man's files to indicate that a risk assessment had been undertaken to assess the possible impact that returning to a closed prison could have on him. There was also nothing describing what arrangements were in place for offering support outside of his SOTP group and individual sessions. I think this should form part of the delivery process of such programmes.

The Prison Service should consider the level of additional special support available to prisoners both during and after completion of SOTP.

Basic life support training

132. The man was an experienced prisoner and aware that staff carry out daily AFCs. He observed the officer carrying out AFCs on his landing only 15 minutes before he was discovered in his cell. Whether the man's intention was to be discovered before any serious harm could occur will never be known. However, the clinical reviewer highlights that it is important that all staff have relevant and up to date first aid and CPR training and I reiterate this. I note that the sixth officer commenced CPR at the rate of 1:30 (one breath to every 30 compressions). I intend no personal criticism of the sixth officer but the current guidelines advise that the appropriate ratio is two breaths to every 30 compressions.

The Governor should remind staff of the current guidelines on CPR and assess the levels of first aid and CPR training.

Staff response to the emergency alarm

133. The hot debrief identified that staff had responded quickly to the emergency alarm. The seventh officer raised her concern that she felt that there were insufficient staff available on the landing to assist in returning prisoners to their cells. The eighth officer said that the batteries in the radios on Blackthorn Unit had not been recharged and so staff there were unaware that there was an alarm. The second Principal Officer, who was located on Spur 2 of Edgcott Unit, said the staff were also unaware that an alarm had been raised as none of them had a radio. The Governor issued action points for both of these issues to be addressed immediately. I reiterate their importance.

The use of fish knives

134. Following the issue of Prison Service Instruction 32/2006, it became mandatory with effect from 20 November 2006 for uniformed staff in closed and semi-open establishments to be provided with and carry on duty their own personal issue fish knife. It is disappointing to say the least that this had not been fully

implemented at Bullingdon at the time of the man's death. However, I am pleased to note that, following the hot debrief, the Governor immediately determined to re-issue a notice to staff to this effect.

Next of kin details

135. The man's parents were recorded as his next of kin when he arrived at Bullingdon. His parents had in fact died by this time, which suggests that it was very unlikely that these details were checked on his arrival. It is imperative that next of kin details are kept up to date to avoid unnecessary delays in informing relatives when a death occurs.

136. In a number of my investigations I have found that next of kin information was inaccurate, and I have recommended establishments introduce a process for reviewing the details. I am pleased to note that the Governor has already listed this as an action point following the hot debrief held after the man's death.

CONCLUSION

137. The man had worked hard to attain category D status. It was unfortunate, albeit appropriate, that it was identified that he needed to carry out further rehabilitation work to address his offending behaviour by completing a course that was only available in closed conditions. His transfer to Bullingdon was clearly going to be demanding, and this was evidenced by his outburst during an SOTP session and his attempt to harm himself.

138. I believe it would have been appropriate had the man received more personalised support during this process. However, what was also fundamental to the man's plight was his uncertainty as to when he would leave Bullingdon and return to Leyhill. Unfortunately, staff were unable to lessen his anxiety as they themselves appeared unable to influence his transfer.

139. It is necessarily uncertain whether the man intended to take his own life. He had seen an officer on the landing and, given his knowledge of prison AFC checks, would have expected that officer to arrive at his cell, approximately ten minutes later. Unfortunately, the officer was delayed by around five minutes. There was a further short delay because the officer in question had not been issued with a cut-down tool, despite a Service-wide instruction to that effect.

140. The SOTP and other offending behaviour programmes are an important way in which the Prison Service delivers on its responsibility to reduce reoffending and protect the public. However, this report can be read in part as an essay in how these programmes are received by prisoners themselves – especially, perhaps, when they are long into their sentence.

RECOMMENDATIONS

1. The Head of Healthcare should ensure the standard of clinical record keeping on EMIS (prison medical computer records) is improved and every attempt is made to ensure medical records are both summarised on admission, and kept up to date subsequently. If other contracted services fail to meet the required standards of documentation, action must be taken by the contracted service.

   The Prison Service have accepted this recommendation.

2. The Healthcare Manager must ensure that if the healthcare screening examination finds an abnormal result it should be followed up subsequently. The Healthcare Manager needs to ensure staff are suitably trained, and audits are in place to ensure this happens.

   The Prison Service have partially accepted this recommendation.

3. The Healthcare Manager needs to ensure a clear process exists and is documented for the management of healthcare applications and that this process is communicated to staff and prisoners.

   The Prison Service have accepted this recommendation.

4. The Governor should remind staff that, when an ACCT is closed, information should be passed to all staff who have a role in the management of the patient.

   The Prison Service have accepted this recommendation.

5. The Head of Healthcare should ensure that, should there be a need for any further reorganisation of its services, a clear transition plan, with adequate or enhanced staffing, needs to be in place to ensure as much continuity of care as possible.

   The Prison Service have accepted this recommendation.

6. The Prison Service should ensure that the process of moving to a more secure prison to complete short treatment programmes is properly managed and that all parties are kept up to date on progress. Agreement for the return should be made before the initial transfer.

   The Prison Service will respond to this recommendation in due course.

7. The Prison Service should consider the level of additional special support available to prisoners both during and after completion of SOTP.

   The Prison Service will respond to this recommendation in due course.

8. The Governor should remind staff of the current guidelines on CPR and assess the levels of first aid and CPR training.

   The Prison Service have accepted this recommendation.