

**Investigation into the circumstances surrounding
the death of a prisoner from HMP Bristol,
who died at Bristol Southmead Hospital
in June 2005**

**Prisons and Probation Ombudsman for
England and Wales**

December 2005

The man, who had been remanded to HMP Bristol in May 2005, was found hanging in his cell just less than two weeks later. This is the report of an investigation into the circumstances surrounding his death.

The loss of any family member is distressing, but especially so whilst they are in custody. I offer my sincere condolences to his partner, children, family and friends.

A member of my office carried out the investigation. I wish to thank the Governor of Bristol for making my investigator welcome, and for arranging the necessary facilities to enable him to carry out his work. I also wish to thank the Principal Officer for his invaluable assistance and support throughout the investigation process.

In the course of the investigation, I asked the Bristol Primary Care Trust to undertake a clinical review of the care and treatment received by the man from HMP Bristol. I am most grateful for their report.

My report makes recommendations for the prison and as well as identifying good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. In May 2005, Bristol Magistrates' Court remanded the man into custody, following his conviction for theft and failing to surrender to custody. The court remanded him for enquiries to be made, and to determine the most suitable method of dealing with the case.
2. Following his reception into prison, a cell sharing risk assessment was carried out. The officer completing the assessment assessed the man as low risk. The officer noted on the form that he said that he had previously been in custody, and monitored under the F2052SH procedure, some three years previously.
3. Because the prison's First Night Centre (FNC) was full, he was allocated to G wing where he shared a cell with another prisoner. However, he was not interviewed under the First Night procedures, as prison staff were not required to carry out these procedures anywhere else in the prison.
4. He had engaged with the Counselling, Assessment, Referral And Throughcare (CARATS) team, and been prescribed a detoxification programme using Subutex. Security information received following his death suggests that he had been under pressure from prisoners to pass his medication to them.
5. On a date in June, he met the CARATS worker, who was sufficiently concerned about him that he asked the Wing Manager to arrange for someone to see him as soon as possible. The Wing Manager said that she would arrange for him to be spoken to and, if necessary, open an Assessment, Care in Custody and Teamwork document (ACCT). The CARATS worker also passed on his concerns to a Registered Mental Nurse, who is based at the prison, and informed him of what the man had said.
6. Less than 90 minutes later at 3.25pm, an officer went to speak to the man, and discovered him hanging from the cell light fitting. The officer summoned assistance and used an anti-ligature knife to cut him down from the light fitting and remove the ligature. The officers checked for signs of life, thought that they detected a weak pulse and breathing, and so began to administer cardio pulmonary resuscitation (CPR) which continued until healthcare staff arrived. Unfortunately, they experienced difficulties with the emergency oxygen equipment which was not working correctly. The defibrillator did not instruct nursing staff to administer an electric shock, but to continue with CPR.
7. The paramedic staff assessed him and also detected a weak pulse. They asked the nursing staff to continue with CPR, while they made preparations to transfer him to hospital. On arrival at the hospital, he was placed on a life support machine. On 5 June, the machine was switched off and he later died.

Investigation Process

8. On 9 June my investigator met the Governor, Deputy Governor, Family Liaison Officer (FLO) and Safer Custody Manager at HMP Bristol and was briefed about the circumstances leading to the man's death. The Governor made available a number of files and records relating to the man which my investigator has been able to examine. He also met with a member of the local Prison Officers' Association (POA), and a member of the prison Independent Monitoring Board (IMB) to brief them about the investigation process.
9. My investigator visited the cell where the man was discovered, and viewed the light fitting used to secure the ligature. He visited the FNC to clarify the procedure for prisoners who cannot be accommodated there on their first night at the prison.
10. A number of staff were identified whom the investigator wished to interview. Arrangements were made for him to return to the establishment on 28 June to continue the investigation.
11. The investigator met the Governor prior to leaving the prison on 9 June to brief her of his initial findings. These included the failure to ensure that all prisoners are interviewed in accordance with the First Night procedures, regardless of where they are located in the prison. The Governor welcomed the feedback and gave instructions to the Safer Custody Manager to ensure that all prisoners were interviewed. The Governor explained that, since taking responsibility for the prison, she had made arrangements for the FNC to be re-located. This should ensure that all prisoners are seen under the First Night procedures, and I welcome the Governor's actions.
12. On 28 June, my investigator returned to the prison and, during the course of the week, interviewed a number of staff who were key to the investigation. He fed back his findings to the Governor or Deputy Governor on a daily basis. On 1 July, he met with the Governor and Deputy Governor to give an overview of his findings and potential recommendations. The Governor decided that a separate investigation was required to clarify the time delay between an officer being instructed to speak to the man and actually carrying out the instruction. The Governor commissioned her own investigation and concluded that no further action was required. Her investigation report does not form part of my own report.
13. My investigator was well received. Staff and prisoners were aware of his attendance at the prison and readily cooperated with the investigation.

HMP Bristol

14. HMP Bristol is an inner city Victorian prison located in the Horfield area of the city. It first opened in 1883. The prison serves the courts in Avon, Somerset and Wiltshire. It has Certified Normal Accommodation of 476 and an operational capacity (maximum crowded capacity) of 606.
15. On 23 August 2004, the Prison Service Standards and Audit Unit audited the prison. The audit report gives overall scores for:
 - Standards Audit, 85%
 - General Standards (Critical Baselines), 75%
 - Security, 79%
16. On 10 January 2005, Her Majesty's Chief Inspector of Prisons (HMCIP) carried out a full announced inspection of the prison. The report's introduction describes Bristol as showing all the signs of its recent unsettled past and inconsistent management. The report described the prison as one which had lost its focus and direction. The report also identifies good practice, including good staff relationships with prisoners.
17. A new Governor has recently taken over and has identified a number of key areas of the prison that require change. A number of these have been commented upon within this report.

Findings

18. On 20 May 2005, Bristol Magistrates' Court remanded him into custody following his conviction for theft and failure to surrender to bail to enable enquiries to be made, and to determine the most suitable method of dealing with the case. He was due to return to court on 8 June for sentencing.
19. Reception Officers and Healthcare staff interview all new prisoners. Part of their task is the completion of the Cell Sharing Risk Assessment (CSRA), including the identification of potentially vulnerable prisoners. The officer who completed the assessment noted that the man said that he had been monitored under the F2052SH procedure (suicide and self-harm monitoring) approximately three years previously, whilst in custody on another sentence.
20. The F2052SH system is used by the Prison Service to monitor those prisoners who have been identified as being at risk of self-harm and is available to any member of staff to open the document. Once opened, a multi-disciplinary team assesses the prisoner's needs and prepares an action plan in partnership with the prisoner. When the prisoner is no longer considered at risk, the form is closed.
21. The Reception Officer and Healthcare assessment recorded that the man was considered as low risk and suitable for multi-cell location. However, neither of the two staff concerned signed the appropriate sections of the document but inserted a cross in place of a signature. Additionally, the "New Receptions" document, which identifies all prison receptions for any given day, asks the officer to complete the form and indicate if the prisoner has previously been inducted or not. An examination of the form for 20 May shows that the document was not completed as required.

The Governor should remind staff of the need to complete documentation accurately, including dating and signing the records.

22. The prison has a FNC, located on A wing, where the detoxification unit is co-located. The FNC should ensure that all new prisoners are interviewed by a FNC officer who assesses their risk of self-harm. The FNC should also ensure that these prisoners are observed at least every two hours, during their first 24 hours in custody. Should the officer be concerned about any other prisoner who has previously been at the prison, they can arrange for them to be observed in the same way as a new prisoner. This level of observation is a local procedure and is good practice.

The level of observation during the first 24 hours for those new to custody, or identified as vulnerable, and located in the FNC, is an example of good practice.

23. The First Night Interview document instructs staff that all new prisoners must complete the first night interview assessment on their arrival on to the FNC. There are no exceptions to this rule. The Policy Statement says the unit has been set up to:

- reassure prisoners received into custody
- provide a safe caring environment
- help them deal with concerns and needs
- promote their ability to cope in custody through the induction process.

24. My investigator found that, due to shortage of space, the man was placed on G wing when he arrived at the prison. G wing is used as an overspill unit for prisoners who cannot be located into the FNC. If G wing becomes full, prisoners are then allocated into one of the remaining wings. Unfortunately, prisoners who are not allocated to the FNC do not receive the usual interview, as there are no alternative arrangements for this to happen.

25. On 20 May, 18 men arrived at the prison, two of whom were new to custody but who were not allocated to the FNC and did not receive the same level of care as those allocated to the FNC. This is a serious flaw in what is otherwise a good system and requires correcting. My investigator raised the matter with the Governor who immediately instructed that all new prisoners should be interviewed under the First Night procedure regardless of where they are located. I welcome this. The Governor informed my investigator that she had already identified difficulties with the FNC, and had drawn up plans to re-locate it in larger premises from October 2005. The Governor's decision is also welcomed. It should eliminate the problem of some prisoners not being interviewed appropriately.

26. My investigator discussed the movement of prisoners through the FNC, and examined why places would not be available. It was evident that there was a backlog of prisoners waiting to be transferred from the detoxification part of the wing to the main prison. Men who should have been in the detoxification part of A wing occupied a number of FNC cells. Managers of wings in other parts of the prison would only allocate cells after assessing the prisoner's suitability. Some managers were also reluctant to re-allocate the cells of men who had gone to court in case they returned later. In a prison where cells are at a premium, and there is little alternative than allocation of new prisoners outside the FNC, it is not justifiable to keep a cell empty in this way. The investigator found that no one person was responsible on a daily basis for ensuring that all cells were fully occupied.

The Governor should consider making an appropriate manager responsible for the daily allocation of prisoners from the FNC and Detoxification Unit, and ensure that other wings are fully occupied.

27. On 23 May, the man was interviewed by a drug worker regarding his drug addiction. He agreed to supply a urine specimen which produced a positive test for cocaine and opiates. He was placed onto the Subutex Care Plan and given a start dose of six milligrams.

28. On 24 May, he signed and agreed to the conditions of Non In-possession Medication. The Detoxification Needs Assessment record shows that the assessor noted:

history depression, treated with dothiepin. States that Subutex makes him have depressed thoughts following administration. Does not appear to be in any form of withdrawals.

29. He also entered into a Detoxification Care Plan which had three goals:
- To stop abusing illegal and or prescribed drugs. To stop abusing alcohol.
 - To develop a normal and regular sleep pattern.
 - To understand risks relating to using drugs and/or alcohol.
30. On 31 May, the Detoxification Care Plan Progress Chart record notes that in relation to the three goals:
- Reports feeling rough and states that he is still withdrawing from heroin, though he is not showing any signs of opiate withdrawal.
 - Reports poor sleep. Therefore Zopiclone.
 - Harm minimisation advice given.
31. The prison has a detoxification unit and also offers the CARATS service which supports prisoners who have a history of drug or alcohol abuse. It can be accessed by the support service or by the prisoner referring themselves.
32. At 2.00pm on 2 June, the CARATS worker at the prison went to carry out an initial assessment on the man. He had been referred to the team because he was on a ten day detoxification programme. The meeting took place in an office in G wing. The worker described him as not engaging from the beginning of the interview. He said that he looked stressed, drew heavily on his cigarette, and was unable to focus. The worker asked him how he was, to which the man replied that he was fed up with the mind game. The worker asked what he meant, and he replied that he had used drugs for 12 years, but had only got ten days on the detoxification programme. He said that the detoxification had come to an end and that he felt unwell.
33. The worker suspected that he was unable to engage in the conversation due to withdrawal from drugs, and asked him if he would prefer to speak to him at the beginning of the following week. He said that this would depend on whether he was there. The worker asked him what he meant by this, and he said that it was the mind game. The worker attempted to talk further to him, but said that he would not speak to him. He noticed that his eyes were red, but was unable to tell if he was frustrated or sad.
34. At approximately 2.05pm, the worker terminated the interview and the man left the room to return to his cell. Because the worker was concerned about him, he immediately informed the Wing Manager of his concerns. He asked that the man be seen as soon as possible, and believed that the Wing Manager understood the urgency of his request. However, when interviewed for this investigation, the worker was clear that his concern was not of a risk of suicide. He believed that the man demonstrated a strong attitude, and was determined to change his drug use.

35. He also passed on his concerns to a detoxification nurse who informed him that it was common for those at the end of detoxification to go down in mood, and then improve again a few days later.
36. He spoke to his own manager, who advised him to return to the wing later to check that the man had been seen as requested. Unfortunately, by the time he returned, he had already been taken to hospital after being found hanging in his cell.
37. My investigator found that the worker went to great lengths to ensure that prison staff and support staff were aware of his concerns for the man.

The CARATS worker should be commended for the level of care that he gave to the man.

38. At approximately 2.10pm, The Wing Manager returned to the third landing and met an officer. She asked the officer to speak to the man, assess his mood and, if necessary, open an ACCT form. She was satisfied that the officer understood her request and that he would deal with it. She returned to her own duties.
39. ACCT forms are being introduced across the Prison Service to replace the F2052SH system, and have been in place at Bristol since 1 May 2005. My investigator has established that both the Wing Manager and officer have participated in the ACCT training.
40. At approximately 2.15pm, an officer was supervising haircuts on G wing. In interview, he recalled that the man was having his hair cut. He said that he and the man had a normal conversation and at no stage was he concerned for his safety. Once he had had his hair cut, at approximately 2.40pm, the officer locked him into his cell.
41. My investigator interviewed the prison contracted hairdresser and he recalled that he began to cut the men's hair at approximately 2.10pm. He said that the man was the first one to have his hair cut. (The officer's account does not concur with this, as he said that the man had his hair cut at approximately 2.30pm and was preceded by other prisoners.) The hairdresser said that the man was given a crew cut which took about five to ten minutes to complete. He recalled that he said that he wanted his hair to be tidy for his court hearing. He had known him from previous periods in custody, and said that at no stage did he give him any cause for concern.
42. At approximately 3.15pm, the Wing Manager asked an officer if he had spoken to him. He said that he had not done so as he had been busy. She asked him to speak to him straight away, and then returned to her office.
43. At approximately 3.25pm, the officer opened the observation flap of cell G1:17. He wanted to check where he was before he opened the door. He saw him suspended by a ligature from the cell light fitting and shouted for assistance as he opened the cell door. Another officer, who had been in an adjacent cell, responded. So did two other officers, who were on another landing.

44. One of the officers was carrying an anti-ligature knife (known as a 'Fish Knife') which he got out and used to cut the ligature from around the man's neck. Fish knives are shaped like a fish, and contain a concealed blade in the mouth section which is designed to allow the user to get underneath the ligature. The action of pushing the knife forward cuts the ligature away from the body.
45. He and the other officers laid him on to his back on the floor of the cell and began to check for signs of life. A further officer joined them in the cell and, whilst checking the man, he thought that he detected a weak pulse. One of the officers also thought that he detected air coming from the man's mouth. At that point, Healthcare staff arrived and took over caring for him.
46. The Wing Manager heard an officer shouting for assistance, realised that a Code Blue message had been called and went to the cell. (Code Blue is the local procedure which alerts medical staff that assistance is required for a prisoner who is having difficulty breathing. It ensures that medical staff take the correct equipment for the medical emergency.) The Wing Manager arrived on the ground floor landing, which is known at the prison as the One's landing. She saw him lying on his back on the floor of his cell with officers attending to him. She could see an officer removing a ligature from around the man's neck. She said that the officers were not performing CPR, and were removing the ligature and checking for signs of life
47. At approximately 3.28pm the prison's Mental Health Service Manager and a nurse were interviewing a prisoner in G wing. They heard the Code Blue radio message and responded quickly. Each wing has Grab Bags containing oxygen and a defibrillator for use in an emergency. They took the bags with them to the cell and, as they arrived, they met another nurse.
48. One of the officers informed the Healthcare staff that he thought that the man was still breathing. The Mental Health Service Manager said that one of the nurses was unable to obtain a pulse, and the other was unable to detect any sign of breathing. Whilst the nurses looked for signs of life, she opened the grab bags to set up the resuscitation equipment. However, the tube to the oxygen cylinder was disconnected and, when she attempted to connect it, she found that the tube was too large for the cylinder. She created a seal by squeezing the tube against the oxygen outlet pipe with her fingers. This proved to be successful as the Ambu Bag filled with oxygen. A further nurse joined the Healthcare staff and also assisted with CPR.
49. At 3.30pm, the Mental Health Service Manager requested an ambulance, and asked for a doctor to attend. One was on duty in the prison and responded to the request and instructed the Healthcare staff to continue with CPR. The defibrillator, which had been attached to the man's chest, did not instruct the staff to administer an electric shock and so CPR continued until the arrival of the paramedics.

50. At 3.37pm, the paramedics arrived and told Healthcare staff to continue with CPR. One of the paramedics detected a weak pulse, and set up an intravenous line.
51. At 3.50pm, he was moved from the wing to the ambulance. At 3.59pm, he left the prison to be taken to the Accident and Emergency Department of Southmead Hospital. He was accompanied by two officers and the Mental Health Service Manager.
52. Any prisoner required to remain in hospital, who has not been released from custody on temporary licence, is escorted and monitored by prison officers under the 'Bedwatch' procedures. This usually means that two officers remain at the bedside and record any significant changes or events. Subject to a risk assessment process, the Governor decides whether the prisoner should be handcuffed and the number of officers required to stay with the prisoner. In the man's case, he was not handcuffed at any stage during the time he was in hospital and he was accompanied by a single officer.
53. An examination of the Bedwatch Records shows that appropriate records were made and prison managers were kept informed. However, there is only one entry for a member of the prison management team visiting the hospital during the time the man was in hospital.

The Governor should remind managers of the need to visit a prisoner on bedwatch at least once every 24 hours and to record their observations and comments in the Bedwatch Report.

54. The prison has a system where prisoners can make a written application to either the Healthcare Department or CARATS team. Their applications are placed in a sealed post box which is opened on a daily basis. The Clinical Review comments that on 3 June, the day after the man was taken to hospital, an application from him was found in the post box dated the previous day. He had written that he needed to see someone from either the detoxification or mental health teams, as he wanted to sort himself out and not cause himself stress or harm. By the time he made his application, the box had already been emptied on 2 June, and so it was not opened again until the next day. The time that it was emptied is unclear, but after emptying the applications were processed and his was logged. This explains why his application was not found until 3 June.
55. On 6 June, the Detective Sergeant in charge of the police investigation telephoned the prison to request that any video recording evidence be secured. He spoke to a senior manager who assured him that the videotape was secure. However the tape handed to the police was not the correct one, and it showed a different incident on a different day. My investigator has been informed that the videotape for G wing on 2 June has not been secured, and has probably been taped over. This means that potentially important information is not available to either the police or my own investigator.

The Governor should ensure that systems are in place to secure potential scene of crime information and a clear chain of custody is maintained.

56. On 7 June, two prison officers were asked to remove the man's property from his cell, and prepare it for re-occupation. During the clearance, they found a note written by him on the top of a cabinet which had been overlooked by the police when they examined the cell. The note was not addressed to a specific individual. It explained the reasons for his actions, which he said were due to sleepless nights, constant head games and healthcare matters.
57. My investigator discussed the failure of the emergency equipment with the Mental Health Service Manager to find out the system for ensuring that it was kept in good working order. She said that the responsibility for the bags was not hers, but that of another department. She was aware that the bags are sealed, the equipment is checked every day, and a record of the check is kept. She had also carried out her own enquiry regarding the equipment failure and was able to produce a record of the check. The check sheet shows that, on 1 June, an unidentified member of staff noted that the oxygen tank was full and ticked a box to say that the bag was intact. There was no record that the equipment had been tested and was working satisfactorily. The record also shows that on 29 May the oxygen tank was empty. The investigator asked the Mental Health Service Manager to explain the equivalent arrangements in an external hospital, and she said that equipment would be tested daily to ensure that it was in good working order.
58. Whilst the equipment failure may not have had an effect on the outcome of the man's actions, it is possible that vital time might be lost in another incident. My investigator brought the matter to the attention of the Governor who arranged to meet the Mental Health Service Manager to ensure that, with immediate effect, systems were put into place to deal with the failure. I welcome the action by the Governor and the Mental Health Service Manager.
59. In her statement dated 2 June, the Wing Manager describes her conversation with the CARATS worker and said that he expressed concerns over the man being low in mood. She informed the worker that she would instruct an officer to have a chat with him and if necessary open an ACCT booklet. She said that she instructed an officer in those terms. The Wing Manager also explained that, at 3.15pm, she asked him if he had seen the man. He had replied that he had not yet had the chance, because he was answering cell bells, but would go and see him shortly. The final entry in the Wing Manager's statement is that, about ten minutes later, she heard the officer shout for staff assistance as he had discovered him with what appeared to be a ligature around his neck.
60. When he was interviewed for this investigation, the officer confirmed that he was the Patrol Officer on G wing during the afternoon of 2 June. The Patrol Officer is required to answer cell call bells activated by prisoners locked in their cells who require assistance (cell bells are intended for emergency use only although, in practice, they are used for non-emergency purposes too). Initially, the officer said that at approximately 3.00pm he had been supervising a telephone call on landing four and noticed the man walking towards the hairdresser on landing one. Following the telephone call, he said he returned to landing three at approximately 3.15pm, and that it was then that the Wing Manager asked him to

have a chat with the man. He said that this was the first time that the request was made.

61. My investigator informed the officer that his account did not concur with that of the Wing Manager. He then changed his account and said that the request from the Wing Manager had been made earlier at approximately 3.00pm. He confirmed that he had been asked to speak to the man prior to facilitating the telephone call, and that the conversation at 3.15pm was when the Wing Manager checked whether he had spoken to him as requested. He said that he was asked to have a chat with him, and that he was not asked to do anything else such as assess his mood and consider opening an ACCT.
62. Following the interview with the officer, my investigator then interviewed the hairdresser and the officer who supervised the haircuts. The evidence from them is that the man had his hair cut between 2.15pm and 2.30pm, and that he was locked back into his cell at approximately 2.40pm.
63. My investigator examined the computer printout for the telephone calls made by the prisoner escorted by an officer. The printout confirmed that he made one call on 2 June, at 2.15pm, and that it lasted for four minutes 21 seconds. The call was not made at 3.00pm, as stated by the officer.
64. My investigator re-interviewed the officer, and he confirmed that he was asked to speak to the man prior to facilitating the telephone call for the other prisoner. When shown the computer printout, confirming the time of the telephone call at 2.15pm, he agreed that the request to speak to him was made before he facilitated the call. He was asked whether he had forgotten to carry out the instructions, and he said that he had not forgotten but had been busy.
65. My investigator also examined the cell call computer printout which showed a large number of calls, none of which were made by the man. The examination showed that between 1.38pm and 3.50pm, a number of cell bells were activated which were not responded to for several minutes, and on one occasion the bell was activated for 40 minutes before an officer checked the prisoner. Nine of the cell call bells took over ten minutes for an officer to action. This is not acceptable.
66. The cell call record identifies that four of the cell calls were made after 2.00pm from prisoners located on landing one. This means that if the officer answered cell calls in the afternoon, he was on the same landing as the man, knew that he had been asked to speak to him, but had not carried out the instructions. The officer said that he could not remember whether he dealt with landing one or not.
67. He was shown the cell call printout and he commented that he could recognise the prisoner from each cell. He identified a number of prisoners, all on landing two (Landing 6 on the printout), who he described as persistent cell call users. He said that he always knew what these men wanted, without visiting the cell. It is not acceptable that, of the 14 cell calls activated on landing two between 1.58pm and 3.32pm, it took more than ten minutes to respond to seven of them, three took more than 20 minutes, and another more than 30 minutes.

Additionally, one call, activated on landing two at 1.46pm, was not responded to until 2.26pm, some 40 minutes after the original activation. These are worrying and unacceptable time delays.

The Governor should remind all staff of their responsibility to answer cell call bells promptly.

68. My investigator raised these matters with the Governor who commissioned her own investigation to determine whether the officer failed to follow the instructions from the Wing Manager, and also to examine why cell call alarms were not answered promptly. On 15 August, the Governor wrote to my investigator to inform him that she had not identified that disciplinary action was required, but had made recommendations which were followed up in an Action Plan. I welcome the Governor's swift response.

69. When he arrived at the prison, the man was allocated to G wing where he shared a cell. My investigator met his cellmate who said that at no time did he say anything about killing or harming himself. He did recall that, approximately seven to ten days prior to being discovered hanging in the cell, he asked night staff if he could see a Listener but no one arrived to speak to him.

70. Listeners are prisoners who have been selected and trained by the Samaritans and are able to offer 24 hour support to prisoners who feel vulnerable, suicidal or at risk of self-harm. Although meetings are confidential, when a prisoner has asked to see a Listener the request should be recorded in the Wing Observation Book and Night Occurrence Log. Neither of these records contains a request from him to speak to a Listener. My investigator has been unable to identify the officer whom the cellmate said the man had spoken to.

71. In January 2005, HMCIP carried out a full announced inspection of HMP Bristol. Her report commented that the safer custody strategy was out of date, and prisoners had difficulty accessing Listeners especially at night. The Safer Custody Manager is responsible for Listeners and, since taking over responsibility, has been told by a number of them that some staff do not pass on requests to see them. He is examining the service and will be implementing his own action plan to ensure the Listener Scheme operates correctly, and staff are aware of their responsibilities.

The Governor should ensure that the Listener Scheme operates correctly, maximising prisoner access to this service. This should include staff making appropriate recordings of requests in Wing Observation Books and the Night Occurrence Book, and a system for Listeners to access those prisoners requesting their support in a timely manner.

72. His cellmate also said that some prisoners were bullying the man for his medication, and he had told him to speak to officers as they are approachable. He told him that he would sort it out himself. The prison's Security Department only became aware of allegations of bullying after he died, and they have identified a number of prisoners who might have been responsible.

73. In the afternoon of 2 June, the man's cellmate attended the prison's education department. As he was leaving the cell, the man said to him that he would not be there when he returned. This was the last conversation that he had with him. He thought that he meant that he was moving to another cell.
74. I offer the family of the deceased person the opportunity to raise any concerns about the care and treatment the prisoner received whilst in custody. They are contacted by one of my FLOs who works closely with the investigator. On 24 June, the FLO contacted the man's partner. She said that, on 30 May, he had written to her and referred to getting off drugs, getting their children back and making future plans. She said that she was contacted after he was found hanging, and informed that he had been taken to hospital without information about the circumstances. The incident log simply shows that contact was made with his next of kin at 4.35pm.
75. His partner also said that the prison had returned his property, neatly folded and in a bag and that the Governor had contributed towards the cost of the funeral. She and his brother were offered a chance to view his cell, but they declined. She and his family have no concerns about the care he received and have only one question which is to know what happened. I hope that this report will help them to understand the events leading up to his death.
76. On 14 June, he was cremated at Bristol Crematorium. The Governor and the Prison Chaplain attended the service. The following week, a memorial service was held in the prison, which was attended by his partner and brother. I commend the actions of the Governor and Chaplain in the aftermath of the man's death.

The actions of the Governor and Chaplain in the aftermath of the man's death have reflected very well on themselves, their prison and their Service.

77. Following the discovery of the man hanging in his cell, I am satisfied that his care and treatment were appropriate, and he was treated with dignity throughout. However, I agree with the Governor that further investigation was required into why a delay of over one hour occurred following the concern raised by the Mental Health Service Manager.
78. This is not the first occasion on which I have had to report a prisoner using the in cell light fitting as a ligature point. The Governor should consider the feasibility of sealing the edge of the light fitting with a suitable compound to prevent a ligature being passed through. The Prison Service may also wish to consider if like advice can be given to other Governors.

The Prison Service should consider the sealing of the edges of in cell light fittings to reduce the number of ligature points.

Recommendations for the Prison Service

Policy

1. The Prison Service should consider the sealing of the edges of in cell light fittings to reduce the number of ligature points.

Operational

1. The Governor should remind staff of the need to complete documentation accurately, including dating and signing the records.
2. The Governor should consider making an appropriate manager responsible for the daily allocation of prisoners from the FNC and Detoxification Unit, and ensure that other wings are fully occupied.
3. The Governor should remind managers of the need to visit a prisoner on bedwatch at least once every 24 hours, and to record their observations and comments in the Bedwatch Report.
4. The Governor should ensure that systems are in place to secure potential scene of crime information, and a clear chain of custody is maintained.
5. The Governor should remind all staff of their responsibility to answer cell call bells promptly.
6. The Governor should ensure that the Listener scheme operates correctly, maximising prisoner access to this service. This should include staff making appropriate recordings of requests in Wing Observation Books and the Night Occurrence Book and a system for Listeners to access those prisoners requesting their support in a timely manner.

Good Practice

1. The level of observation during the first 24 hours for those new to custody, or identified as vulnerable and located in the FNC, is good practice.
2. The CARATS worker should be commended for the level of care that he gave to the man.
3. The actions of the Governor and Chaplain in the aftermath of the man's death have reflected very well on themselves, their prison and their Service.