Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Davies, a prisoner at HMP Bristol, on 6 December 2021

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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

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

Mr Ian Davies was found hanged in his cell at HMP Bristol on 6 December 2021. He was 54 years old. I offer my condolences to his family and friends.

Prison staff at Bristol monitored Mr Davies twice under suicide and self-harm prevention procedures (known as ACCT). While there was some good practice, I am concerned that not all conversations were meaningful and that aspects of his care plan were insufficient. I am also concerned that staff missed some conversations and observations and did not always complete the ACCT document.

I am concerned that prison staff did not hold an ACCT review when Mr Davies retuned to Bristol from court on 3 December. I am also concerned that healthcare staff did not see him, even though he was subject to ACCT monitoring and had ongoing mental health difficulties.

I am particularly concerned that staff misinterpreted Mr Davies' risk of suicide and self-harm when they stopped ACCT monitoring on 4 December. Prison and healthcare staff placed too much emphasis on their perceptions of his state of mind, and not enough emphasis on his known risk factors. We have repeatedly said for many years that staff need to avoid making this basic error, and it is very disappointing to see it yet again in Mr Davies' case.

It is also disappointing that we have again identified deficiencies with the management of ACCT procedures at Bristol. The Prison Group Director for Avon and South Dorset will need to address this.

I am concerned that when Mr Davies was found hanged, staff did not immediately enter his cell. Although it did not affect the outcome for Mr Davies, the Governor will need to address this.

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

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

Contents

Summary

Events

1. On 15 October 2021, Mr Ian Davies was remanded to HMP Bristol, charged with possession of an offensive weapon. He presented as agitated and depressed, and staff started suicide and self-harm prevention procedures (known as ACCT). However, they decided not to proceed with ACCT monitoring as Mr Davies said that he did not plan to harm himself.

2. On 22 October, a mental health support worker reviewed Mr Davies' medical record and noted that he had been assessed under the Mental Health Act in May 2021, but staff did not consider that he had a severe mental illness.

3. Over the next three weeks, Mr Davies presented as depressed and became increasingly anxious. Mental health staff reviewed him frequently and prison staff moved him to the vulnerable prisoners' wing after the police spoke to him about an alleged further offence.

4. On 13 November, a nurse started ACCT procedures after Mr Davies presented as depressed and was worried about losing his family's support. Over the next two weeks, Mr Davies frequently reported feeling anxious about a forthcoming court appearance.

5. On 3 December, Mr Davies attended court, but his hearing was adjourned. A mental health nurse reviewed him at court and sent his assessment directly to a prison mental health nurse rather than to the mental health team's generic mailbox. Mr Davies was returned to Bristol later that afternoon but there is no record that prison or healthcare staff reviewed him.

6. On 4 December, staff attended an ACCT case review and recorded that Mr Davies continued to report feelings of guilt, shame and fear but did not report suicidal thoughts. Attendees agreed to stop ACCT monitoring.

7. At 2.11am on 6 December, an operational support grade found Mr Davies hanging from a ligature and radioed a medical emergency code. She remained outside the cell. At 2.13am, two custodial managers arrived and entered the cell. They cut the ligature and laid Mr Davies on the floor. An officer arrived and started cardiopulmonary resuscitation (CPR). At 2.15am, healthcare staff assessed Mr Davies and confirmed that it was inappropriate to continue CPR as he had died.

Findings

Risk management

8. We have raised concerns about ACCT management at Bristol before and urgent action is now required. We found that staff twice stopped ACCT procedures prematurely. While there was some good practice, staff failed to consider Mr Davies' risk factors fully and placed too much emphasis on him denying thoughts of suicide or self-harm.

9. Staff did not always set clear and meaningful caremap actions and should have considered involving Mr Davies' family in the ACCT process. They did not consistently complete the ACCT ongoing record in full or conduct observations and conversations as required.

10. Prison staff failed to arrange an ACCT review when Mr Davies returned from court. We are also concerned that healthcare staff did not review him.

Clinical care

11. The clinical reviewer concluded that the clinical care that Mr Davies received at HMP Bristol was equivalent to that which he could have expected in the community. However, she identified some areas for improvement. Healthcare staff did not review his antidepressants, ensure that all entries in the medical record were saved or promptly respond to requests for welfare crisis visits.

Emergency response

12. The operational support grade who found Mr Davies hanging did not immediately enter the cell. She told us that she forgot that she had a cell key in a secure pouch. Although the delay entering the cell made no difference to the outcome for Mr Davies, this could be critical in future cases.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
    - set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review;
    - encourage family engagement in the ACCT process, where appropriate, to help reduce the risk of suicide and self-harm;
    - consider all relevant factors when assessing a prisoner's risk factors and not rely solely on their behaviour and comments when deciding to stop ACCT monitoring;
    - arrange an ACCT review for the day a prisoner is due to return from court if they are subject to ACCT procedures and a court appearance is identified as a risk factor;
    - conduct ACCT observations and meaningful conversations as directed; and
    - complete all aspects of the ACCT document, including the morning and afternoon summaries and the daily supervisor check in the ongoing record.
- The Prison Group Director for Avon and South Dorset should write to the Ombudsman setting out what action is being taken to improve ACCT procedures at Bristol.
- The Head of Healthcare should ensure that healthcare staff:

- review prisoners' starting antidepressants in line with the Royal College of General Practitioners' guidance;
- record actions and decisions about prisoners' ongoing care in their medical record and check that the entries have saved; and
- conduct welfare crisis visits as soon as possible, ideally on the same day as the request.

- The Head of Healthcare should ensure that prisoners returning to HMP Bristol following a temporary absence are offered a medical review if they meet the criteria set out in PSI 07/2015.
- The Head of Healthcare should ensure that Police Court Liaison and Diversion Service (PCLDS) staff forward mental health assessments and any other pertinent information about a prisoner's risk to the mental health team's central mailbox.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

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

14. The investigator obtained copies of relevant extracts from Mr Davies' prison and medical records.

15. The investigator interviewed 14 members of staff at HMP Bristol between 7 and 16 March 2022.

16. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Davies' clinical care at the prison. The clinical reviewer and investigator jointly interviewed healthcare staff.

17. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Davies' family to explain the investigation and to ask if there were any matters they wanted us to consider. Mr Davies' family wanted to know:

    - when ACCT monitoring started;
    - who decided who should be monitored under ACCT procedures;
    - how often prison staff checked on Mr Davies as part of the ACCT procedures;
    - why Mr Davies was not being monitored under ACCT procedures when he died;
    - what the police told the prison about his mental health issues;
    - whether Mr Davies was assessed by the mental health team; and
    - why his cell had been emptied when they viewed it and not left as it was.

    We have addressed these concerns in this report and by separate correspondence.

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

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

Background Information

HMP Bristol

21. HMP Bristol serves the local courts and holds up to 614 adult men. Healthcare services at Bristol are managed by Inspire Better Health, a partnership of eight health providers led by Bristol Community Health. GP services are subcontracted to Hanham Health Services, and Avon and Wiltshire Partnership provides mental health and substance misuse services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Bristol was in June 2019. Inspectors reported that there was no effective strategy in place to reduce levels of self-harm and that Bristol was failing to keep prisoners safe. Inspectors found that levels of self-harm were higher than at comparable prisons. They noted that the number of prisoners subject to ACCT support was unmanageable and prevented staff from focussing on those at the highest risk. They found that the safer custody team had not effectively coordinated action to address levels of self-harm and to implement the PPO's previous recommendations.

23. Inspectors reported that all prisoners had been allocated a key worker and the quality of their interactions was good but that not enough sessions were taking place for the scheme to be fully effective. They also found that mental health services were good.

24. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification process and informed the Justice Secretary that he had numerous significant concerns about the treatment and conditions of prisoners at Bristol.

25. In September 2020, inspectors returned to Bristol to conduct a short scrutiny visit to investigate the conditions and treatment of prisoners during the COVID-19 pandemic. They found that Bristol had a strong leadership team and had carefully tried to balance the risk of the virus against the impact of a very restricted regime on prisoners' mental wellbeing. Inspectors remained concerned about the high levels of suicide and self-harm.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2021, the IMB reported that although the safer custody department had introduced measures to improve the safety and wellbeing of prisoners and that incidents of self-harm had reduced, Bristol continued to have HMIP's lowest safety rating.

Previous deaths at HMP Bristol

27. Mr Davies was the fifth prisoner to die at Bristol since December 2021. Of the previous deaths, two were self-inflicted, one was due to natural causes, and one

was drug-related. There has been one further death due to natural causes since Mr Davies' death. Two previous investigations raised issues about the quality of ACCT management.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

29. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

Events between 15 and 27 October

30. On 15 October 2021, Mr Ian Davies was remanded to HMP Bristol, charged with possession of an offensive weapon. His person escort record (a document which accompanies prisoners on all journeys between police stations, courts and prisons to communicate risks) stated that and had threatened to kill himself in police custody. A suicide and self-harm warning raised at court before his arrival indicated that he had made statements about self-harm and seemed depressed.

31. At 4.20pm, a nurse conducted an initial health screen and noted that Mr Davies appeared very agitated and low. Mr Davies reported a history of alcohol and drug misuse, bipolar disorder and post-traumatic stress disorder. She referred him to the mental health team and recorded that he had declined substance misuse intervention.

32. At 5.10pm, prison staff started suicide and self-harm monitoring procedures (known as ACCT). They set Mr Davies' observation requirement at two an hour.

33. A 10.20pm on 16 October, an officer conducted an initial ACCT assessment and listed several concerns, including Mr Davies' mental health difficulties, that his personal relationships had broken down and that he reported feeling low having "lost everything". The ACCT document stated that it was his first time in prison.

34. At 12.00pm, a Supervising Officer (SO) chaired Mr Davies' first ACCT case review which an officer and a mental health nurse attended. He noted that they felt that Mr Davies put on a good act throughout the review and did not report thoughts of suicide or self-harm. The nurse noted that Mr Davies showed signs of emotionally unstable personality disorder and seemed distressed by the breakdown of his personal relationships. However, they stopped ACCT monitoring as Mr Davies said that he did not plan to harm himself.

35. On 19 October, a Custodial Manager (CM) noted that Mr Davies' sister had phoned the prison, concerned about his mental health. She said that he had a split personality disorder and that his GP was assessing him for bipolar disorder. She noted that he 'knew how to work the system' and that she was concerned that he might try to convince people that that he was OK. The CM notified a mental health support worker.

36. On 22 October, the mental health support worker reviewed Mr Davies' medical record. She noted that he was known to Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and had been referred to South Gloucestershire Police Court Liaison and Diversion Service (PCLDS) on two occasions. She also noted that he had been assessed under the Mental Health Act in May 2021 but had not been detained as staff did not consider that he had a severe mental illness.

37. Later that day, the mental health support worker told the CM that she had reviewed Mr Davies' medical record and that after a case discussion at the mental health team meeting, attendees had decided to refer him to the primary care team as there was no evidence that he had a diagnosed mental illness. She then contacted a

mental health nurse prescriber and requested a joint visit for a primary care assessment.

38. On 23 October, a SO saw Mr Davies for an ACCT post-closure interview and recorded that he did not report thoughts of suicide or self-harm. He reminded him that Listeners (prisoners trained by the Samaritans to support other prisoners) were available on all wings.

39. On 25 October, a substance misuse worker reviewed Mr Davies following a referral from the mental health team. He recorded that Mr Davies did not consider that his cannabis use was a problem and declined intervention.

40. On 27 October, the mental health support worker recorded that she and the mental health nurse prescriber tried to assess Mr Davies, but a security issue prevented them from doing so.

Events in November

41. On 1 November, an officer contacted a member of healthcare support staff and raised concerns about Mr Davies' presentation. She was advised that he had an appointment with a non-medical prescriber scheduled for 3 November.

42. That day, the officer made a challenge support intervention plan (CSIP) referral. (CSIP is a national case management model for managing those who are violent or pose a risk of being violent. It can also be used to support victims or potential victims of violence.) She noted that Mr Davies was easily flustered, came across as vulnerable and seemed to have mental health difficulties. The safer custody department subsequently screened the referral and suggested that Mr Davies should be offered peer support and placed under behaviour support monitoring for seven days. (This was a local policy aimed at obtaining more information before progressing a prisoner to the CSIP process.)

43. On 2 November, an officer visited Mr Davies for a keywork session and noted that he reported difficulty adapting to the prison environment. He told Mr Davies that he might feel more settled once he had a prison job and noted that he had completed his employment induction.

44. At 1.56pm on 3 November, a mental health nurse recorded that Mr Davies' sister had contacted the prison, concerned that he had not received a mental health diagnosis and asked for a psychiatrist to review him. He explained that several members of staff had seen Mr Davies and did not consider that he needed a psychiatric assessment.

45. At 2.46pm, the mental health nurse prescriber reviewed Mr Davies and noted that he reported feeling low and anxious. She recorded that he kept thinking about the breakdown of his personal relationships and that he felt abandoned by community mental health services. She prescribed duloxetine (an antidepressant).

46. On 4 November, the mental health nurse prescriber contacted Mr Davies' sister having obtained his consent. She recorded that his sister said that he used cannabis daily, that his behaviour had become more "reckless and impulsive" following a head injury sustained in a motorcycle accident two years earlier and that

he had been discharged from community mental health services for failing to attend appointments.

47. At a mental health meeting on 5 November, staff discussed Mr Davies and concluded that due to his deteriorating mental health, he should be managed under secondary care services. They appointed a mental health key worker and asked for a psychiatric review. There is, however, no record of a care plan.

48. On 7 November, Mr Davies sent a request to the healthcare team, asking to see the mental health team as his "psychological state was bad". Later that day, a mental health support worker reviewed Mr Davies. She recorded that when asked if he was keeping himself safe, he said that he would not try to take his life as his children were his protective factors. He also said that his sleep and appetite had improved since he had started taking medication.

49. On 11 November, the mental health nurse prescriber recorded that she had planned to see Mr Davies, but a consultant psychiatrist saw him instead. There is, however, no record of the psychiatrist's contact in Mr Davies' prison medical record. At interview, he told us that he reviewed Mr Davies and that his anxiety about an upcoming court appearance stood out as particularly concerning.

50. At 9.19am on 12 November, an officer recorded that while unlocking cells, several prisoners told her that there were prisoners on the wing who were willing to seriously hurt Mr Davies. At 1.35pm, a SO recorded that the police had interviewed Mr Davies the previous day about being in a hotel room with a minor and that he had told prisoners what had happened when he returned to the wing. She noted that he was subsequently under threat from prisoners and had barricaded himself in his cell. She made a CSIP referral and contacted a Custodial Manager (CM), who authorised a move to the vulnerable prisoners' unit (D wing).

51. At 3.30pm on 13 November, the mental health key worker reviewed Mr Davies in his cell after his sister contacted the prison, concerned that she had not heard from him. She noted that she had difficulty moving Mr Davies' thoughts from the previous day's events. She noted that he had said that he was worried about losing his family's support as a result of the allegations. He also said that he had not slept due to reliving traumatic events and that it had affected his mood. She told Mr Davies that she would ask a GP to prescribe him sleep medication and start ACCT procedures to keep him safe. At 4.03pm, a prison GP prescribed promethazine (an antihistamine used to treat sleep problems). At 4.20pm, a SO completed an immediate action plan and set Mr Davies' observation requirement at two an hour.

52. At 10.30am on 14 November, an officer conducted an ACCT assessment and recorded that Mr Davies said that he was worried about his safety and confused about why prisoners had "made up stories" about him. He added that Mr Davies was happy to continue engaging with the mental health team and said that he would not end his life as he had family.

53. A short while later, a SO chaired Mr Davies' first ACCT case review, which several members of staff, including another SO, attended. He recorded that Mr Davies was very upset and said that he was a "living nightmare" and just wanted someone to "wake him up". As the review progressed, Mr Davies became really upset and asked to leave the room. The other SO noted that she would arrange for healthcare

staff to conduct a welfare visit the following day. Attendees did not consider that Mr Davies posed a high risk of suicide or self-harm and reduced his observation requirement to one an hour, with three quality conversations during the day and four observations at night. There is, however, no record that they set any care support actions.

54. At 2.36pm, an officer visited Mr Davies to conduct a keywork session. She noted that he did not report any issues about being on D wing but declined to engage in discussion about his family.

55. On 15 November, a SO recorded that at the morning allocation meeting, it was decided that they would postpone Mr Davies' welfare review until the mental health key worker was available the following day. However, there is no record that the review took place.

56. On 17 November, a SO chaired an ACCT case review which the mental health key worker attended. She recorded that Mr Davies was tearful and said that he was worried that staff would move him to a standard wing. She assured him that he would not be moved and encouraged him to engage with other prisoners and to go outside for exercise. Attendees decided to keep his observation requirement at one an hour as his presentation had not improved. The SO added two support actions to the care plan: for staff to address his concern about returning to a standard wing and for a referral to the mental health nurse prescriber to be made.

57. On 22 November, a SO chaired an ACCT case review which the mental health key worker attended. He noted that Mr Davies felt low and cried when he asked how he felt. He also recorded that it was difficult to engage him from that point onwards as he kept saying that he was struggling and did not know how people got through it. Mr Davies told the mental health key worker that he had thoughts of suicide and self-harm but would not be able to do anything about it. The SO added that they did not achieve anything constructive and decided that his observation requirement should remain unchanged. One support action was added to the care plan: for staff to give Mr Davies an anxiety and low mood booklet.

58. On 25 November, the psychiatrist reviewed Mr Davies and recorded that he felt worthless and appeared anxious about a forthcoming court appearance. He increased his duloxetine and referred him to a social prescriber for additional support. (Social prescribing supports patients to engage in meaningful activity.)

59. On 26 November, a SO chaired an ACCT case review and recorded that mental health staff contributed. She noted that Mr Davies said that he was worried about his court appearance and how it would affect his family. Mr Davies failed to respond when she asked if he had thoughts of self-harm or suicide and she assessed that he posed a high risk of suicide or serious self-harm.

60. On 29 November, a pharmacy technician referred Mr Davies to the mental health team after he presented as 'incredibly anxious' about his court appearance when collecting his medication. He recorded that Mr Davies said that "he needed to plead guilty as he could not do this anymore". A SO reviewed the referral and recorded that she would arrange for the mental health key worker to see him the next day.

61. On 30 November, an officer conducted a welfare check after Mr Davies' family contacted the safer custody team, concerned that they had not heard from him. Mr Davies said that he had left a message for his sister but had not called anyone else as he did not know what to say to them. Later that day, the mental health key worker reviewed Mr Davies with a social prescriber, and he told them that he had read the prosecution statement and felt that he would die in prison. The key worker recorded that Mr Davies was distressed and that she went through some breathing exercises with him.

Events between 1 and 4 December

62. On 1 December, Officer A saw Mr Davies for a welfare check after his daughter contacted the safer custody team, concerned that she had not heard from him. She noted that Mr Davies was in his cell, watching TV, and said that he did not want to return her call as he has nothing to say.

63. At 11.45am on 2 December, a SO chaired an ACCT case review which Officer A and another officer attended. There is no record that healthcare staff attended or contributed to the review. The SO noted that Mr Davies refused to leave his cell but said that he talked to his sister every now and again. He also said that he wanted to take a pill and end it all as there was no way out after court. The SO also recorded that Mr Davies needed to be reviewed after his court appearance and set the next review date for 4 December.

64. At 5.35pm, a pharmacy technician sent an electronic task to the mental health team, stating that Mr Davies was shaking at the medication hatch and appeared extremely worried about his upcoming court appearance. She noted that Mr Davies said that he was desperate for some sleep and asked the mental health team if there was something they could do to help. At 5.49pm, a prison GP prescribed promethazine and asked the mental health team to review him that evening or the next day. However, there is no record that a member of the mental health team reviewed him.

65. At 8.39am on 3 December, a nurse reviewed Mr Davies before he left for court and assessed him as fit to attend. At court, a PCLDS mental health nurse assessed Mr Davies and noted that he had a history of anxiety. Mr Davies said that he felt "very low" and that while that was common for him, he had felt worse since being sent to prison. The nurse reviewed Mr Davies' community mental health record and liaised with the prison's mental health team. He concluded that while Mr Davies did not display any evidence of severe mental illness, he would benefit from help to regulate his strong emotions. He sent a copy of his assessment directly to a mental health nurse rather than the mental health team's generic mailbox.

66. At 3.43pm, a nurse recorded that she had spoken to Mr Davies' sister and confirmed that he had been to court. His sister asked if his duloxetine could be prescribed for him to take later in the day as she felt it was affecting his sleep. The nurse liaised with a colleague, who told her that he would have to continue taking his medication in the morning.

67. At 5.10pm, Mr Davies returned to Bristol. (The PER shows that his case was adjourned pending a psychiatric assessment and that he was remanded in custody

until 2 February 2022). However, there is no record that a member of prison or healthcare staff reviewed him in reception.

68. At 9.05pm, an Operational Support Grade (OSG) noted that during the evening roll check, Mr Davies told him that he had wasted his life, that his court proceedings had been adjourned and that he did not want to be in prison. He added that he tried to comfort Mr Davies and asked if he would like to talk to a Listener, but he said that he had spoken to a lot of them, with no positive result.

69. At 9.10am on 4 December, a SO chaired an ACCT case review which a mental health support worker attended. He recorded that although Mr Davies did not make eye contact, he appeared more talkative than usual. The support worker noted that although Mr Davies continued to report feelings of shame, guilt, and fear, he did not disclose thoughts of suicide or self-harm. He also noted that the psychiatrist planned to review him the following week. Attendees decided that as Mr Davies' support actions were complete and that he had ongoing support from the mental health team, they would stop ACCT monitoring. However, there is no record that the support worker saw the PCLDS assessment.

70. At 1.34pm, Mr Davies spoke to his sister by phone for 37 minutes. In the prison's family liaison log, which was started after he died, it is recorded that Mr Davies' sister contacted the prison that afternoon and spoke to a member of staff called 'Emily'. It says that she had concerns about Mr Davies' mental health and did not want ACCT monitoring to stop. There is, however, no record of this in Mr Davies' electronic prison or medical record.

Event between 5 and 6 December

71. At around 7.50pm on 5 December, an Operational Support Grade (OSG) looked through Mr Davies' cell door observation panel to conduct a roll check and saw that he was lying on his bed awake, watching TV, with the light on. At interview, she told the investigator that he said he was OK and that she told him to press his cell bell if he needed anything. She added that she did not see anything unusual or have concerns about him.

72. At around 1.55am on 6 December, the OSG conducted an ACCT check and decided to check those prisoners on the post-closure period of ACCT monitoring at the same time. She told us that as she was doing this, she saw that Mr Davies' light was on and that this was unusual for him. At 2.11am, she looked through Mr Davies cell observation panel and saw him sat on the floor under the window, with his back against the wall, and a piece of green material round his neck. She tried to get a response from him and radioed a medical emergency code blue. She waited outside the cell for additional staff to arrive.

73. At 2.13am, CM A arrived with CM B and the OSG told them that Mr Davies was dead. CM B looked through the observation panel, saw Mr Davies in an upright position, with a ligature around his neck and entered the cell. He held Mr Davies while CM A cut the ligature and laid Mr Davies on the floor. In his prison statement, CM B said that Mr Davies' body was stiff and cold. Around 30 seconds later, an officer arrived and started cardiopulmonary resuscitation (CPR).

74. At 2.15am, two nurses arrived at the cell, carrying emergency medical bags. One nurse attached a defibrillator and conducted a full assessment while officers continued CPR. At 2.23am, a nurse advised staff to stop CPR, as it was clear that Mr Davies had died. (His eyes were pinned, his skin was mottled, and he was cold to touch.)

75. At 2.23am, an ambulance arrived at the prison. At 2.30am, the first paramedics arrived at the cell. At 2.33am, a paramedic pronounced that Mr Davies had died.

Contact with Mr Davies' family

76. At 3.20am, the prison appointed a family liaison officer (FLO). At 5.00am, the FLO and the deputy governor visited Mr Davies' wife and broke the news of Mr Davies' death.

77. On 7 December, the FLO phoned Mr Davies' wife and recorded that Mr Davies' sister would also act as his next of kin.

78. On 23 December, a security intelligence collator took over as the FLO. On 30 December, she phoned Mr Davies' sister and his wife to introduce herself and to offer her support.

79. The FLO provided support to Mr Davies' family until his funeral, which she and the deputy governor attended on 7 January. The prison contributed towards its cost in line with national policy.

Support for prisoners and staff

80. After Mr Davies' death, the deputy governor and a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

82. The post-mortem report concluded that Mr Davies died from hanging. Routine post-mortem toxicology tests did not detect illicit substances in Mr Davies' system.

Findings

Managing risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase a prisoners' risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. The policy guidance annex to PSI 64/2011 covers the changes introduced by ACCT version 6, which Bristol introduced in July 2021.

84. Prison staff at Bristol responded appropriately when Mr Davies presented as low and monitored him under ACCT procedures on two occasions. There was some good practice. Healthcare staff were frequently involved in the ACCT process and staff demonstrated understanding. However, we had some concerns about the management of the ACCT process.

Care plans

85. PSI 64/2011 states that completing a care plan is an integral part of the ACCT process and that it must reflect the prisoners needs, level of risk and the triggers of their distress. The policy guidance annex to PSI 64/2011 states that care plan support actions should be set to mitigate and lower risks.

86. We consider that not all aspects of the two ACCT care plans for Mr Davies were sufficient. We are particularly concerned about the quality of the care plan for the ACCT procedures started on 13 November. Staff did not record Mr Davies' upcoming court appearance as a key trigger date or add a support action at the first ACCT case review. At interview, a SO told the investigator that his main concern after Mr Davies left was to check that he was alright. While this was clearly well intended, we consider that the attendees should have reconvened and agreed support actions in Mr Davies' absence.

87. The subsequent support actions focussed on Mr Davies' mental health but were limited in scope. There is no record that staff considered an action to encourage his engagement in meaningful activity, support him to access physical activity, facilitate his integration into the wing or access peer support. While we accept that staff tried to encourage Mr Davies to participate in the regime and mix with other prisoners, we consider that it would have been more meaningful if staff set out in his care plan how they planned to support him to change his behaviour.

88. We are also concerned that prison staff did not consider a support action to involve Mr Davies' family in the ACCT process. The annex to PSI 64/2011 states that case coordinators should identify and discuss potential sources of support at case reviews. Mr Davies' family contacted the prison multiple times, and we consider that it may have been beneficial for them to have had formal involvement in the ACCT process. Although Mr Davies often reported feeling worried about what his family might think, he had also identified certain family members as protective factors against his risk of suicide and self-harm. We therefore consider that the prison could have done more to involve Mr Davies' family in the ACCT process.

Assessing the level of risk

89. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide or self-harm. Staff judgement is fundamental to the ACCT system, which relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is very important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.

90. Staff considered that Mr Davies was at low risk of suicide and self-harm and stopped ACCT procedures on 16 October despite the presence of risk factors. These included that it was his first time in prison, that he had history of mental health difficulties and that his personal relationships had broken down. This should have caused more concern as these factors raised his risk. Instead, staff relied too heavily on Mr Davies' comments that he did not intend to harm himself.

91. When staff stopped ACCT procedures on 4 December, they did not assess Mr Davies as at high risk of suicide or self-harm. A SO told the investigator that he saw that the support actions in the care plan were complete and, with a mental health nurse's agreement, stopped ACCT procedures. When asked if he had read Mr Davies' comment of 2 December about things getting worse after court and there being no way out, he said that he could not remember. He went on to say that he was busy that morning as he had to do his assurance checks, ACCT background checks and to prepare for afternoon visits.

92. While we appreciate the pressures of working in a prison environment, particularly at weekends when staffing levels are reduced, it is vital that sufficient time is given to ACCT reviews. Mr Davies continued to have risk factors which were not fully explored, such as his concern about his relationships, his history of emotional instability, allegations of a further offence, high levels of anxiety and recent thoughts of hopelessness. In this context, we consider that Mr Davies presented as at high risk of suicide or self-harm and that staff should have kept ACCT monitoring in place for him.

93. At interview, the mental health nurse told us that he felt that ACCT monitoring should end as Mr Davies was in a "physically safe place" on the vulnerable prisoners' wing. However, he had lived there since ACCT procedures started. He also said that as Mr Davies was under secondary services, he believed that the mental health key worker would see him three times a week which was incorrect. The mental health team manager told the clinical reviewer that the mental health nurse had since received training. She also said that with hindsight, they should have asked prison staff to change the time of the ACCT review so that the mental health key worker could attend.

94. We consider that prison and healthcare staff prematurely stopped ACCT procedures on both occasions that Mr Davies was subject to ACCT monitoring. While we cannot know whether keeping ACCT procedures in place on 4 December would have changed the outcome for Mr Davies, it would have given staff the chance to monitor his emotional response over a longer period and enabled him to be reviewed by a psychiatrist.

Reception processes for returning prisoners

95. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court, sentencing at court or being questioned by police are factors that may have a significant impact on the health of a prisoner. For those prisoners passing through reception, prisons are required have protocols in place for screening them to identify potential healthcare or suicide and self-harm issues.

96. Prison and healthcare staff did not review Mr Davies after he returned from court on 3 December. The prison told us that staff only review prisoners returning from court if they have a change in circumstance. While Mr Davies' circumstances remained the same, attending court had been identified as a trigger for self-harm and he was subject to ACCT monitoring. Prison staff should not have necessarily reviewed Mr Davies in reception, but they should have held an ACCT review. Mr Davies made several concerning comments before going to court and continued to present as depressed. A SO told us that he arranged an ACCT review for 4 December as some prisoners are so "shell-shocked" after going to court that the outcome does not always "sink in". We consider that Mr Davies was at high risk of suicide or self-harm and should have had an ACCT review on 3 December.

97. When Mr Davies returned to Bristol on 3 December, a member of healthcare staff did not review him. PSI 07/2015 states that prisoners returning to prison after a temporary absence need only be medically assessed if they meet certain criteria, which includes prisoners with mental health problems and a history of suicide or self-harm. Mr Davies was part of the secondary care mental health team's caseload and was subject to ACCT monitoring. We therefore consider that he met the criteria and should have had a medical review.

98. The PCLDS nurse forwardFed his court assessment on 3 December to a prison mental health nurse rather than to the mental health team's central mailbox. This meant that mental health staff were not aware of his concerns when Mr Davies returned to Bristol. We consider that it was possible that if certain information in the report been picked up by the mental health team, such as Mr Davies' continued low mood and the concern about his emotional response to social stressors, he would have been referred for an urgent wellbeing review.

Recording observations and conversations

99. PSI 64/2011 states that staff must follow the level of conversations stated on the ACCT document and must record these immediately or as soon as practical. The ACCT annex to PSI 64/2011 states that conversations with prisoners should be meaningful and that staff must be aware of what is contained in a prisoner's care plan to understand the context of any conversation. It also notes that written summaries also need to be meaningful and sufficiently detailed to convey the key details of what was discussed.

100. Most conversations and observations were recorded as complete but there are some instances where they appear to have been missed. Although this did not impact on the circumstances of Mr Davies' death, it is vital that all observations and conversations are completed as indicated in the ACCT document.

101. While there is some evidence that staff held good quality conversations with Mr Davies, a lot of their recorded interactions with him were brief and descriptive. For example, there are multiple entries in the ACCT ongoing record where staff described Mr Davies as not wanting to interact but did not record whether there was a specific reason for his lack of interaction or explain what they did to facilitate a meaningful conversation.

102. We are concerned that staff did not always complete the morning and afternoon summary section of the ACCT ongoing record. While some of the completed summaries did contain sufficient detail, there were occasions where staff wrote very little information. For example, there were several entries where staff noted 'no concerns' or that Mr Davies refused to engage, with little detail. We are also concerned that healthcare staff did not complete the section in the ongoing record that requires them to summarise any clinical intervention.

103. While we appreciate that there may be challenges in engaging prisoners in meaningful conversations, it is an essential part of the ACCT process and will help staff to better understand and mitigate a prisoner's risk. We also consider that daily supervisor checks and suitably detailed summaries from prison and healthcare staff are vital in assuring that ACCT records are properly completed. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:

- **set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review;**
- **encourage family engagement in the ACCT process, where appropriate, to help reduce the risk of suicide and self-harm;**
- **consider all relevant factors when assessing a prisoner's risk factors and not rely solely on their behaviour and comments when deciding to stop ACCT monitoring;**
- **arrange an ACCT review for the day a prisoner is due to return from court if they are subject to ACCT procedures and a court appearance is identified as a risk factor;**
- **conduct ACCT observations and meaningful conversations as directed; and**
- **complete all aspects of the ACCT document, including the morning and afternoon summaries and daily supervisor check in the ongoing record.**

104. Bristol have accepted our previous recommendations intended to address the quality of ACCT procedures. In response to previous investigations, the prison told us that in May 2020, monthly quality assurance checks were introduced and that all case coordinators received a guidance document on identifying risks and triggers. They also said that in September 2020, they introduced a local policy to formalise

how the prison supports case coordinators, improves learning and manages ACCT procedures.

105. While we recognise that Bristol has made positive steps to improve ACCT management, we are concerned that despite implementing these changes, our investigation into Mr Davies' death shows that just over 18 months later, the assessment of risk and setting of observation requirements continued to be inadequate. We therefore consider that urgent action is now required to ensure that ACCT procedures improve. We make the following recommendations:

The Prison Group Director for Avon and South Dorset should write to the Ombudsman setting out what is being done to improve ACCT procedures at Bristol.

Clinical care

106. The clinical reviewer concluded that the care that Mr Davies received at Bristol was equivalent to that which he could have expected to receive in the community. Mental health staff completed appropriate assessments, contributed to the ACCT process and referred Mr Davies to a social prescriber for support to engage in meaningful activity. However, she identified some areas for improvement.

107. The clinical reviewer considered that healthcare staff did not review Mr Davies' antidepressants in line with the Royal College of General Practitioners' guidance on safer prescribing in prisons. She noted that he should have had a medication review within the first two weeks of the prescription being issued. This would have been particularly important for someone at risk of suicide and self-harm.

108. Mental health staff did not create a care plan for Mr Davies and there is no record of the psychiatrist's appointment with him on 11 November. The mental health key worker told us that she created a care plan in the prison's electronic medical record, but it failed to save due to a technical issue. However, she accepted that she could have re-written the care plan. The psychiatrist said that the same issue, which causes the system to shut down, meant that his entry also failed to save. The prison told us that the issue is a national problem, but that new internet cabling had improved functionality. While we appreciate that it is not solely a local issue, it is critical that staff ensure their entries have saved to the system to maintain continuity of care.

109. The clinical reviewer considered that healthcare staff did not always respond to requests for welfare crisis visits promptly. For example, on 14 November, when Mr Davies left the ACCT review upset, a SO requested a welfare visit for him for the following day. However, that review did not take place and Mr Davies was not seen until 17 November. Again, on 29 November, when Mr Davies presnted in crisis, a welfare visit was scheduled for the following day. While we appreciate that operational pressures might have been a factor, crisis visits should be prioritised and take place at the earliest possible opportunity, ideally on the same day that they are requested. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **review prisoners' starting antidepressants in line with Royal College of General Practitioners' guidance;**

- **record actions and decisions about a prisoner's ongoing care in their medical record and check that the entries have saved; and**
- **conduct welfare crisis visits as soon as possible, ideally on the same day as the request.**

The Head of Healthcare should ensure that prisoners returning to Bristol following a temporary absence are offered a medical review if they meet the criteria set out in PSI 07/2015.

The Head of Healthcare should ensure that PCLDS staff forward mental health assessments and any other pertinent information about a prisoner's risk to the mental health team's central mailbox.

Emergency response

Management of incident

110. Bristol's local policy instructs staff to use a medical emergency code blue to indicate that a prisoner is unconscious or has breathing difficulties. Calling an emergency code should trigger the control room to call an ambulance, and for all healthcare staff to attend with the appropriate equipment.

111. PSI 24/2011 on the management and security of nights states that staff have a duty of care to prisoners, themselves and other staff, and that the preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life, a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.

112. The OSG responded promptly after she found Mr Davies hanging and called an appropriate emergency medical code. She waited outside until additional staff arrived and did not enter Mr Davies' cell. At interview, she told us that she did not enter the cell as she forgot that she had a cell key in her emergency pouch. She said that she was not required to use a key on nights and in that moment, failed to remember that she had it. Although we appreciate the distress of seeing a prisoner in such circumstances, we are concerned that she did not enter Mr Davies' cell given that she could see into the cell, and it was clear that there was a risk to life.

113. While we recognise that staff responded promptly and that the delay in entering the cell would not have affected the outcome for Mr Davies, in other circumstances, it could be critical. We therefore make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life threatening situations.

Resuscitation

114. In September 2016, Professor Sir Bruce Keogh, the National Medical Director at NHS England, wrote to the Heads of Healthcare for prisons, introducing new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council

Guidelines 2015 (updated in 2021) which state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”.

115. CM B, who entered Mr Davies’ cell with CM A, told the investigator that he did not start CPR as Mr Davies’ body was cold and stiff. An officer told us that she started CPR because she did not know how long Mr Davies had been unconscious and that she was not trained to make a medical decision. We are satisfied that, in the circumstances, her action was appropriate.

116. Healthcare staff assisted with resuscitation efforts for eight minutes before asking officers to stop CPR. At interview, a nurse told us that she was aware of the national guidance on when not to perform CPR and that she asked staff to stop CPR after an assessment. While we understand the commendable wish to attempt and continue resuscitation, we consider that healthcare staff should have stopped sooner.

117. The clinical reviewer considered that deciding whether to perform CPR is a difficult decision for medical staff as they are trained to preserve life. She concluded that as CPR did not continue for long and that she had been assured by the Head of Healthcare that staff had reflected on the circumstances of Mr Davies’ death and were aware of the guidance, she did not make a recommendation. We agree with the clinical reviewer.

Learning lessons

118. We have identified a number of concerns in this report. We consider that it is important that staff learn from our findings. We recommend that:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman’s findings with them.

Inquest

119. At the inquest, which took place on 13 May 2025, the Coroner concluded that Mr Davies died as a consequence of ligature suspension (hanging).

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