

**Investigation into the death of a man
at HMP Preston in April 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2009

This is the report of an investigation into the circumstances surrounding the death of a man. The man died aged 35 years at HMP Preston. He had been transferred from HMP Risley to the specialist mental health in-patient unit at Preston for an assessment. On 15 April 2007, he was found by another prisoner in the showers suspended by a ligature made from his bed sheet.

He was a young man whose life had been troubled by addiction to drugs. He suffered from acute anxiety and depression and was obviously distressed about the effect this had on his life. I would like to offer my sincere condolences to the man's family. It is traumatic to lose anyone who has yet to make middle age and it must be especially difficult to lose them when they are in custody.

The investigation was led by one of my investigators. Both she and my senior family liaison officer spoke regularly by telephone with the man's father.

An independent review into the man's medical care was undertaken by the Head of Healthcare at HMYOI Thorn Cross. I am grateful to her for her assistance. I am also grateful to the prison's liaison officer who provided a high standard of prison liaison, and to the staff and prisoners on H1 landing for their co-operation with this investigation.

I have concluded that the clinical care received by the man in custody was of a high standard. The handling of his ACCT form was also generally sound. However, while I do not believe that his death could have been reasonably predicted, I have made a number of recommendations designed to improve prisoner safety.

I am disappointed that the consultant psychiatrist, who treated the man at Preston, declined to speak to both the investigator and the clinical reviewer. As yet I do not have the statutory powers necessary to compel witnesses to be interviewed. I believe that the psychiatrists input would not only have helped this investigation but would have been beneficial for the family in trying to understand the untimely death of a son and brother. I am also sorry that the prisoner who discovered the man decided not to meet my investigator. I hope that the inquest process may serve to rectify these omissions.

This report was issued in draft form in March 2008. The issue of the final report has been delayed by the need for further consultation with the man's family and the absence on long term leave of my senior investigator. I am sorry for any inconvenience and upset caused by this delay.

Stephen Shaw CBE
Prisons and Probation Ombudsman

November 2009

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SUMMARY

The man was sentenced to six years' imprisonment in April 2006. He began his sentence in HMP Manchester. He appeared to get on well with staff and prisoners but complained of anxiety and panic attacks. In June 2006, he was referred to a psychiatrist when these became worse.

In July 2006 he was transferred to HMP Garth. He complained of depression, anxiety, paranoia and panic attacks but said that he had not self harmed in the past and had no thoughts of self harm. He was prescribed various medications and treated with cognitive behaviour therapy and relaxation therapy but without apparent success. The man regularly asked to be treated with benzodiazepines but these were not considered appropriate because he had been previously addicted to them.

In November 2006, he was referred to the mental health team in Garth. He told them that he had begun to have thoughts of self harm and described his risk as "50% on a scale of 100%".

On 28 November 2006 the man was transferred to HMP Risley. He was seen by the community mental health team and was regarded as presenting a medium risk of self harm. The man continued to complain of anxiety, panic attacks and paranoia. He asked to be prescribed diazepam but was prescribed a non-addictive alternative. On 26 January 2007, he was moved to the segregation unit after refusing to return to his wing from healthcare. He said he wanted to harm himself or others and felt like hanging himself. An ACCT form (the form used by the Prison Service to monitor prisoners thought to be at risk of suicide or self harm) was opened the same day.

On 27 January the man handed a ligature to a member of staff. On 1 February, he was seen by a psychiatrist who judged that he was not suffering from psychosis. He continued to complain of anxiety, paranoia and suicidal thoughts but staff also recorded that he was eating well, demonstrated a sense of humour and mixed well with the other prisoners. On 1 March the man made cuts to his arms with razor blades while in the shower. He was immediately referred for a period of assessment to the specialist mental health in-patient unit (H1) at HMP Preston. He was transferred there on 5 March.

At Preston, staff found his behaviour confusing. He complained of anxiety, paranoia and auditory hallucinations and was seen to pace up and down and respond as if to third party voices. When spoken to by staff he was polite and appropriate and did not appear thought disordered. He also got on well with the other prisoners on H1.

On 12 March the man was seen by the visiting psychiatrist who diagnosed him as suffering from anxiety and depression and increased his medication. On 14 March he told staff that he had scratched the word 'grass' on his arm using the base of a Marvel tin. On 2 April, after a more settled period his ACCT document was closed with his consent.

On 8 April, the PIN phone clerk told the deputy manager of H1, that the man had made several telephone calls to his family in which he had said he wanted to self harm and commit suicide by hanging. The deputy H1 manager asked the man about

the phone calls but he reassured him that he was okay. Between 9 and 14 April the man was described as being settled and he had reported that his hallucinations were troubling him less. On 15 April, he was found by another prisoner hanging in the showers.

A closed circuit television (CCTV) recording of the events of 15 April showed that the man left his cell at 1.47pm carrying a towel under his arm and entered another prisoner's cell. At 1.48pm, both men left the cell and the man went into the shower room. At 2.54pm the other prisoner entered the shower room and reappeared thirteen seconds later and alerted staff.

I conclude that staff on H1 did not act unreasonably or negligently in assessing the man's risk. The man received a high level of input from the H1 staff even when his ACCT document was closed. I do not think that it was unreasonable to close that document. The man demonstrated a number of disturbed behaviours but it was not unreasonable for staff to raise doubts that these were a result of genuine psychotic illness.

The man died during the afternoon association period. At the time, one of the members of H1 staff who would normally have been mixing with the prisoners on the landing was occupied writing up an assessment on a prisoner in the main prison. I conclude that H1 provides a specialist role and its staff should not be diverted from their role by being required to perform functions in the main prison. I make a recommendation that assessments on prisoners in the main prison are carried out by staff other than those on H1. I judge that Preston's decision since the man died to offer only controlled access to the showers is correct.

During the course of the investigation a number of staff and prisoners raised concerns that the prisoner who found the man had encouraged him to attempt to kill himself. The police interviewed the prisoner after allegations made by one of the prisoners on H1. The police were satisfied that there was no evidence that the prisoner had encouraged the man to attempt to take his own life.

In her clinical review the clinical reviewer concludes that the man received access to mental health and other health professionals in prison equal to or superior to that he would have received in the community. She said:

“Unless the man had been a patient in a psychiatric hospital, it is doubtful that he would have been offered this level of care outside of prison. Therefore in this instance, the level of service provision, arguably, exceeded the provision offered in the general community.”

I make a recommendation that the Head of Healthcare at Preston give thought to ensuring the attendance of the visiting psychiatrists at the weekly multi-disciplinary review meetings, and draw the attention of the Head of Healthcare to comments made by the clinical reviewer about record keeping.

I conclude that the prison's response to the man's death was good but I am concerned at the length of time taken to inform his family. I recommend a change in procedure to address this in the event of other deaths at Preston.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on the day it occurred. Notices were issued to staff and prisoners at Preston telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The Coroner and police were contacted. The Coroner's Officer provided my investigator with copies of the police investigation report and the transcript of an interview with the prisoner who discovered the man. The investigator was also provided with CCTV footage recorded on the afternoon of 15 April 2007.
2. The investigator visited Preston on 25 April 2007. She met with the Deputy Governor, the Chair of the Independent Monitoring Board and the Chair of the local branch of the Prison Officer's Association. She visited H1 landing and spoke informally with staff and prisoners. She was provided with copies of the man's prison record, Inmate Medical Record (IMR) and the notices, reports and other records associated with his death.
3. The investigator returned to Preston on 22 - 24 May 2007 and 4 July 2007 and conducted interviews with eight members of staff and four prisoners. She also arranged to visit HMP Haverigg to interview the prisoner who had discovered the man but he decided he did not wish to be interviewed. She later spoke to him on the telephone. The investigator was unable to speak to a SO (one of the staff on duty on 15 April) because of his absence on long term sick leave. She asked to speak to the visiting consultant psychiatrist, but he declined. The psychiatrist also declined to speak to the clinical reviewer. Further information was obtained from the Head of Healthcare at Preston, via telephone and email.
4. A clinical review of the man's medical care was commissioned from Central Lancashire Primary Care Trust (PCT). It was agreed that the review would be undertaken by a mental health professional and would focus primarily on his treatment at Preston. The Head of Healthcare at HMYOI Thorn Cross and a registered mental health nurse (RMN), conducted the clinical review. It appears as an annex to this report.
5. My senior family liaison officer, contacted the man's father by telephone. The investigator maintained telephone contact with the father throughout the investigation. The investigator and senior liaison officer visited the father and his daughters in July 2008 to discuss the draft report.
6. The father said he wanted to know how it had been possible for his son to kill himself in a place where he was supposed to be safe and receiving treatment. He wanted to know why he was not subject to a closer watch and how he had been able to take his sheet into the showers with him. The father wanted to know whether his son could have placed the sheet in the showers beforehand. He asked for information about his son's state of mind, what medication he was on and how this had affected his mind.

HMP PRESTON

7. Preston is a category B local prison that accepts adult male prisoners over the age of 21. The Victorian part of the prison dates back to 1840. A considerable building programme began in 1999 and by 2009 the capacity will have increased from 750 to 840 prisoners. The building programme has meant a considerable amount of disruption for staff and prisoners, but despite this the prison has been ranked third best performing local prison in the Prison Service's internal rankings. A new kitchen has recently opened and a new visits centre is being built.
8. Healthcare is provided by Central Lancashire Primary Care Trust (PCT). The PCT has a contract with Lancashire Care Trust, the local mental health trust, who provide visiting psychiatrists and a Mental Health Inreach Team (MHIT). Healthcare staff are employed either by the PCT or the prison but all come under the same healthcare management structure. A strategic partnership board is responsible for monitoring healthcare delivery but the day to day management of healthcare services is the responsibility of the PCT. The Deputy Governor has input into operational issues.
9. A new healthcare centre (HCC) opened in November 2005. The ground floor of the HCC is known as H1. It is a specialist mental health in-patient facility and has 22 beds. Upstairs, on H2, there are eight general medical beds for prisoners with physical health problems. The in-patient beds on H1 are a regional facility and 12 of the beds can be used for prisoners from HMP Garth, HMP Wymott, HMP Haverigg, HMP Lancaster, HMP Kirkham Grange, HMP Buckley Hall and HMP Risley. Risley is the main user of the regional bed facility and prisoners from there can occupy up to four beds at a time. On average there are four members of staff on duty on H1 looking after a maximum of 22 prisoners. This is a relatively high ratio compared to that of a wing in the main prison. Staff on H1 are also required to perform assessments in the main part of the prison, such as deciding whether prisoners are fit to attend adjudication.
10. Referrals to the in-patient beds on H1 are made by clinical staff from the other prisons in the region. Once a referral has been received, staff from Preston visit the prisoner and decide whether to accept them. During the assessment process at Preston there are weekly multi-disciplinary meetings which discuss each prisoner and their treatment. Each prisoner on H1 has a 'named nurse' who is responsible for introducing him to the landing, planning his care, completing a careplan and making sure he attends appointments with the visiting psychiatrist. Staff on H1 try as far as possible to recreate the atmosphere of a hospital rather than a prison and the men on the unit are referred to as patients. Prisoners and staff are on first name terms and there is a lot of interaction between them during the day. The ethos of the unit is to try to give the prisoner-patients back some responsibility for their lives.

THE EVENTS LEADING UP TO THE MAN'S DEATH

Between 28 February and 8 July 2006 in HMP Manchester

11. On 28 February 2006 the man was remanded to HMP Manchester accused of offering to supply drugs. He was convicted on 28 April 2006 and sentenced to six years' imprisonment. During his induction at Manchester the man was recorded as being cheerful, polite and co-operative. He said he had been a drug user outside prison and was not concerned by being in custody. He said he had never self-harmed but had been treated for depression in the past. At Manchester he shared a cell and eventually became a wing cleaner – a trusted position.
12. Full details of the man's medical care are contained in the clinical review at annex 1 of this report. The records show that on arrival at Manchester the man said he was addicted to opiates and benzodiazepines. His GP had prescribed him temazepam and diazepam for anxiety and depression. As both these drugs are benzodiazepines, the drug team at Manchester prescribed him propranolol and citalopram instead. The majority of the entries on the man's Inmate Medical Record (IMR) during his time at Manchester are as a result of him requesting to see the doctor about his anxiety problems and dependence on benzodiazepines.
13. On 26 June 2006 the man was referred to the mental health team and psychiatrist after complaining that his anxiety and panic attacks were getting worse. He had a mental health assessment on 3 July 2006, and told staff that he had taken another prisoner's medication and it had made him feel better. He was advised to continue with the medication already prescribed for him.

Between 8 July and 28 November 2006 in HMP Garth

14. The man was transferred to HMP Garth on 8 July 2006. Garth is a category B training prison which accepts sentenced prisoners serving more than four years. His induction booklet shows he said he had no current mental health or self-harm issues. The man said that he was not depressed, had not self-harmed in the past and had no current thoughts of self-harm. He said he had last used drugs (heroin) six months previously. During his Cell Sharing Risk Assessment (CSRA) on 8 July the man said that he suffered from panic attacks and had concerns about sharing a cell. The medical officer who completed the CSRA recommended that a single cell would be more appropriate for him due to his "medical condition". It is not clear whether this refers to his panic attacks or not.
15. During July and August 2006 he was treated for anxiety and depression with cognitive behaviour therapy and relaxation therapy. On 6 September he saw the doctor and asked for more medication. The doctor changed his anti-depressant to mirtazapine and prescribed him zopiclone (a sleeping tablet) for three days. The man had nine appointments with healthcare during September and October 2006. On each occasion he complained of increased anxiety and asked for more medication. He was given Buspar (Buspirone hydrochloride) for his anxiety, which has comparable effects to diazepam but is not a benzodiazepine.

16. On 7 November the man was seen twice by healthcare staff after complaining of anxiety. On the second occasion healthcare staff were called to the wing by wing staff. He asked for benzodiazepines to be prescribed. His medication was reviewed and he was offered more cognitive behaviour therapy instead. Following this intervention the man was referred to the mental health team in Garth. His referral form showed the reason for his referral as: "numerous attempts at anx [anxiety] management work but prefers prescriptions. Other members of team have offered/tried CBT [cognitive behaviour therapy] but no substantial response." The man was deemed to present a low risk of suicide.
17. On 14 November 2006 the man saw a member of the mental health inreach team at Garth as a result of his referral. He described his problems as panic attacks, depression, racing thoughts, paranoia and hearing a voice putting him down. He said he could not identify any particular trigger for his panic attacks, although he mentioned feeling guilty about reporting someone else for a crime in 1994. The man said he got on well with others in prison, used the gym regularly and was a wing cleaner. The assessor said that the man seemed very anxious to be prescribed diazepam. He said the man had recently described suicidal thoughts since coming to Garth, and he had discussed these with his colleagues and agreed to monitor them through case meetings. The man said he had no history of self-harm or suicide but had had thoughts before and had intended to act upon them. He described his intentions on these occasions as "50% on 100% scale". The assessor made an appointment with the man for the following week to undertake self-help methods. He was prescribed chlorpromazine (an anti-psychotic principally used in the treatment of schizophrenia).
18. The man had his second appointment with the mental health inreach team on 23 November 2006. The assessor described him as much calmer and the man told her that his thoughts had been more settled since using chlorpromazine although he was worried that it might be affecting his kidneys. A third session was arranged for a fortnight later.

Between 28 November 2006 and 5 March 2007 in HMP Risley

19. On 28 November 2006 he was transferred to HMP Risley. Risley is a category C training prison and this therefore represented a progressive move for him. At his first reception health screen on the same day the man told staff he was suffering from depression, anxiety, phobias, paranoia and panic attacks. He was described as "edgy and jumpy" and his risk of self-harm was recorded as "medium". No thoughts of self-harm or any psychosis were identified. On 29 November he saw the doctor and asked to be prescribed diazepam but this was declined.
20. On 7 December the man was seen by the community mental health team at Risley about his anxiety and depression. He was prescribed a new anti-depressant (fluoxetine) on 11 December, and went on to see healthcare staff on at least 17 occasions during December 2006 and January 2007 to complain about paranoia, anxiety and racing thoughts. On one occasion he handed a razor blade to staff because he said he had been having thoughts of self-harm. On 26 January 2007, he was located on the segregation unit after refusing to

return to his cell from the healthcare centre. He told staff that he felt like harming himself, staff or other prisoners.

21. Also on 26 January 2007 the man was interviewed by a Registered Mental Nurse (RMN) and an ACCT form (Assessment, Care in Custody and Teamwork – the Prison Service’s process for monitoring prisoners thought to be at risk of self-harm and suicide) was opened. The man said he wanted to hang himself and send a note to his father. He said he did not want to go back to the wing because of paranoid thoughts and the concern he would hurt someone. The man was assessed by a member of staff trained to interview prisoners when ACCT forms are first opened. He told the ACCT assessor that he felt very stressed and had thoughts of self-harm, and that only his family kept him going. The ACCT assessor concluded that it was necessary to get a medical opinion of the man’s current mental state because staff were concerned that his behaviour did not correspond to the symptoms he described.
22. On 27 January the man’s ACCT was reviewed. He attended the meeting and brought an A4 piece of paper on which he had recorded how he felt. He described feeling very low and wanting to end his life. He said he had paranoid thoughts and thought that other prisoners wanted to harm him. Later that afternoon the man spoke at length to an officer he had known on a previous sentence. The officer described him as feeling very low and depressed and said that he removed a ligature from his cell. On 1 February the man saw a doctor who was a psychiatrist. The doctor concluded that the man was not suffering from psychosis.
23. On 10 February, staff considered closing the man’s ACCT form after he had appeared much more cheerful during the previous week. By 12 February, he was recorded as being “low” again and the form was kept open. On 21 February, he had his medication increased and appeared to improve over the next few days. Throughout his time on the segregation unit the man was recorded as eating well, demonstrating a sense of humour and taking part in association with the other prisoners. On 26 February, he appeared down again and handed in some pieces of metal which he said he had used to scratch his arms. He was moved to a cell with a camera in it on the same day. On 1 March he made cuts to both his arms using a razor while in the showers. As a result, he was referred to Preston for assessment.
24. On 2 March the man was visited by the Deputy Manager of the in-patient unit at Preston and an RMN at Preston. The Deputy Manager and RMN concluded that the man appeared to be suffering from an anxiety disorder and was not “floridly psychotic”. They decided to admit him to Preston for a period of assessment.

Between 5 March and 15 April in HMP Preston

25. The man transferred to Preston on 5 March 2007. The ACCT form, which had been opened in Risley, remained open. He was seen on arrival by the RMN who became his named nurse. The RMN recorded that the man was pleasant and appropriate and that he had no initial concerns about him. The RMN completed an in-patients careplan for him. The plan identified anxiety and depression and auditory hallucinations as problems. It was proposed to integrate the man into the wing regime to try to alleviate some of his anxiety and he was to be seen by a visiting psychiatrist to review his medication. The man was placed in a cell monitored by CCTV so that staff could observe him. This is standard practice for new admissions to H1.
26. On 6 March the man had a 'well man' assessment (an assessment given to all new arrivals at Preston that looks at the prisoner's physical and mental health). The man said that he had thoughts of suicide and self harm. The man was also seen by another RMN, as part of the ACCT process. The RMN recorded that the man said he had no suicidal thoughts but was low in mood. The Deputy Manager of H1 recorded in the man's IMR that when observed by camera in his cell the man seemed quiet with no signs of distress, thought disorder, self harm or response to third party hallucinations. A similar observation was made on 7 March. The man was reported to be settled and popular with his peers and showing no signs of anxiety or depression.
27. On 8 March told a member of staff (signature unclear) that he was getting an urge to self harm and did not want to take a razor to shave in the morning. The man's ACCT document was reviewed shortly afterwards and he told staff that he was very low in mood and would kill himself if he had the chance. He said he wanted to stop the voices and thoughts in his head.
28. His ACCT record shows that he was settled after his ACCT review, and during the next day he mixed with the other patients and appeared "wholly at ease". Nevertheless, he approached staff during association on 9 March to complain of disturbed thoughts and voices in his head. Entries on his ACCT record show that he remained pleasant and settled during 10 and 11 March.
29. On 12 March the man saw the visiting psychiatrist who made a record of the meeting in the man's IMR. The psychiatrist concluded that he was suffering from anxiety and depression with intrusive thoughts and images. He decided to increase the man's dose of citalopram (an anti-depressant) to help lift his mood. He arranged to see the man in two weeks time and said that staff should be aware of his continuing ideas of self harm. Later the same day the man was visited by the RMN from Risley. She said that the man had not changed in his presentation and was inconsistent about his symptoms. He had told her that he felt no better despite staff observations that he appeared brighter in mood.
30. On 13 March the man was observed pacing the landing and apparently responding to hallucinations. On 14 March he told staff that he had scratched the word 'grass' on his arm using the base of a Marvel tin. He said that he had heard voices telling him to cut himself and had also had thoughts of hanging

himself. One of the RMNs from Preston spent some time talking with the man about more positive coping strategies. He emphasised the importance of discussing negative thoughts with staff. On 15 and 16 March he appeared settled and interacted well with staff and prisoners. He was seen pacing outside his cell and muttering to himself during evening association on 16 March, but was polite when spoken to and expressed nothing untoward.

31. On 17 March the man was again observed pacing and “responding to stimulæ”. However, it was noted that this only appeared to happen when staff were within earshot. In all other respects he appeared to be settled and polite. He was eating well and taking his medication. On 18, 19 and 20 March he spent a lot of time in his cell. Staff wrote on his ACCT document that the man appeared to be a bit down but was polite and responsive when approached and told them he was “ok” when asked. On 20 March, he attended a music group and joined in positively. Staff observed no evidence of paranoia or anxiety throughout the day. He continued to pace outside his cell at times. On 21 March the man spent the day in his cell and declined association and the relaxation group. He complained of hearing voices but expressed no thoughts of self harm.
32. On 22 March the man was seen again by the visiting psychiatrist. The psychiatrist said he thought the man appeared brighter but the man told him there had been no change in how he felt. He said he complained of hearing a voice in his head calling him a grass. The man said he was not eating and did not think that his medication was helping. He said he visualised himself hanging but had no formal plan to commit suicide. The psychiatrist decided to stop his olanzapine (an anti-psychotic used in the treatment of schizophrenia) and prescribed him a short course of zopiclone to help him sleep. He arranged to see him after one week. Later the same day the man told an RMN that the voice that called him a grass was getting to him and that he was not eating properly. The RMN noted on the man’s ACCT form that close observations of him were required.
33. During 23, 24, 25 and 26 March the man remained mostly in his cell and ate a single meal a day. He told staff he was fine but just not hungry. No self harming behaviour was noted and the man was recorded as being polite and sociable when spoken to. He was thought to be low in mood and was seen occasionally pacing and shouting. On 26 March, a food refusal chart was started to formally monitor his diet. He was seen by the visiting psychiatrist the same day. He told the psychiatrist he felt no better and would like to starve to death. He said he was still hearing the voice calling him a grass. He had no active suicidal ideas but would like to be dead. The psychiatrist said he thought that the man was improving but the man thought that he was not. The psychiatrist made adjustments to the man’s medication because he complained of night cramps. The man asked for and was given chlorpromazine (the anti-psychotic which he had received in Garth). The man’s ACCT was also reviewed on 26 March.
34. Between 28 March and 1 April the man remained mostly in his cell, eating occasionally and pacing. Staff said that he responded well when spoken to and was not demonstrating any significant risk. He asked to go on association on 29 March. On 30 March the Deputy Manager of H1 wrote in the man’s IMR that it

was difficult to determine the authenticity of his behaviour. The man's personal hygiene was good and he managed to focus when spoken to. On 31 March, another member of staff (signature unclear) noted that he was still pacing and responding to voices but appeared to be able to turn it on and off when staff spoke to him. The member of staff said it was difficult to determine whether his behaviour was genuinely psychotic, but it was consistent while he was in his cell.

35. On 2 April the man saw the visiting psychiatrist again. The psychiatrist wrote in the man's IMR that the man reported the same symptoms but did not appear as troubled. He said he had not been taking his citalopram regularly and was advised to take it as instructed. The psychiatrist increased the man's dose of citalopram and prescribed promazine at night. He arranged to see him in two weeks' time.
36. On the same day the man's ACCT was reviewed. The review was attended by the Deputy Manager, the man, prison chaplain and the prison's probation department. The man's risk was recorded as "low". The notes of the review said that the previous week had been a more settled time for the man and his ability to cope with his mental health issues had improved. There was no evidence of any intention to self harm and there had been no crisis issues. With his agreement, it was decided to close the ACCT form.
37. On 3 April the Deputy Manager of H1 wrote in the man's IMR that he continued to pace incessantly and respond to third party hallucinations. The Deputy Manager added that the nature of this behaviour had yet to be fully assessed. On 4 April one of the RMN said that the man had not voiced any concerns and had told staff he was feeling fine. On the same day the Deputy Manager wrote on the IMR that he had spoken to the man's father on the telephone. The nature of the conversation is not recorded. At interview the Deputy Manager said that he could not remember exactly what the father had said but he had given him a summary of his son's progress in Preston and told him he would tell his son that his father had rung. The father told my investigator that he had been extremely worried about his son and had expressed concerns about his mental state. He said that he had asked Deputy Manager to make sure his son was OK and the Deputy Manager had told him that his son would be watched very closely. He said he was told that a decision would be made on his son's future in two weeks' time.
38. On 5 April the RMN said that the man continued to pace and talk to himself but when staff approached him he told them he was fine. An entry on the IMR on 6 April (signature unclear) said that the man was pacing up and down but appeared to be able to turn the behaviour "on and off as required". Later the same day the RMN decided to challenge the man about his behaviour. The man told him he was hallucinating and that he could see his mother and the rooms in his house. The RMN suggested that these might be stress related and talked to the man about coping strategies and diversional techniques.
39. On 7 April the man asked the Deputy Manager whether he believed he was hallucinating. The Deputy Manager replied that he thought the man felt his hallucinations were real. The Deputy Manager said he told him that it was

important that he made an effort to try to come through this unsettled period. Later the man joined in with association.

40. On 8 April the Deputy Manager was contacted by the PIN phone clerk who reported that during, telephone conversations the man had told members of his family that he wanted to self harm and commit suicide by hanging. He had also said he was feeling depressed. The Deputy Manager said that he asked the man about the phonecalls and he told him that he was "ok" and denied that he had ideas of self harm. The man did complain of auditory and visual hallucinations, but the Deputy Manager wrote in his IMR that he did not believe his behaviour was consistent with that of someone genuinely experiencing these symptoms.
41. On 9,10,11 and 12 April the man was reported to be more settled and his hallucinations were reported to have diminished. On 13 April one of the RMNs said that the man told him he was still seeing and hearing things but he seemed "quite settled and pleasant in manner and mood". On 14 April another RMN on H1 wrote that the man had had a settled day and had interacted well with the other prisoners and spent time out of his cell.

THE EVENTS OF 15 APRIL 2007

From accounts of staff and prisoners

42. There were two RMNs, two healthcare officers and a nurse on duty on H1 on Sunday 15 October. My investigator spoke to all of them apart from one of the RMNs who is on long term sick leave. My investigator also spoke to the wing cleaner and who was a prisoner-patient on H1. She spoke to the prisoner who discovered the man on the telephone after he declined to be interviewed. My investigator was given access to the transcript of the prisoner who discovered the man, police interview and to the witness statements made by staff and prisoners after the man's death.
43. The prisoner-patient said he had known the man quite well in Preston. He said that, before lunch at about midday on 15 April, he went to the man's cell and found him and another prisoner inside. He said he went to enter the cell but the man gave him a "nasty look". The prisoner said that he thought that the man and the other prisoner were talking in a suspicious way because they went quiet as soon as he appeared. He said it was very unusual for the man not to be friendly towards him as they had a good relationship.
44. The other prisoner said that, shortly after 2.00pm during the association period after lunch had come into his cell carrying his towel. The prisoner said he told the man he was going to make a cup of tea and the man told him he would have one but wanted to have a shower first. The man then left his cell. The prisoner said he went to ask Healthcare Officer (HCO) Close for some nail clippers and then went outside for a cigarette and to drink his cup of tea. The prisoner said that he went back to his room at some point and listened to music because there was nothing to watch on TV. He said he also went to see another prisoner, but the other prisoner had recently been given his methadone treatment and was sleepy. When he returned to his cell again the prisoner said that he began to wonder why the man was still in the shower. He picked up some dirty laundry to put in the laundry basket in the shower area and went to find the man.
45. The prisoner said that when he entered the shower area he could not hear water running. He called "Ian" and got no reply so he opened the cubicle door. The prisoner said he saw the man suspended from the shower head and immediately alerted staff.
46. A healthcare officer said that, at about 10.45am on 15 April, he had interviewed a prisoner from the main prison that staff had concerns about. Nothing remarkable happened on H1 that morning and after the interview he went for his lunch break. He returned to duty at 1.30pm and later, during the prisoners' association period, he sat at the nurses station on H1 to write up his notes of the morning interview. A RMN was also at the nurses station. The healthcare officer said he saw a prisoner go into the shower room and come out again. He said the prisoner said to him, "you need to go in there, you need to go in there". The healthcare officer said he and the RMN went into the showers and he noticed a white material about three inches above the cubicle door attached to the pipe. He said he immediately thought it was a ligature and the RMN opened the cubicle door. As

The RMN opened the door, the cleaner, came past them and supported the man's body.

47. The healthcare officer said that he did not remember many details about the noose as his attention was on the man. He said his gut reaction from the man's colour was that they were too late to save his life. The healthcare officer said that another healthcare officer had also arrived and he cut the ligature from around the man's neck. The healthcare officer then went back to the nurses station, shouted to a RMN to collect the emergency bag and called the control room for an ambulance.
48. The healthcare officer said that, when he returned to the shower area the man was on the floor. The emergency equipment was there and staff were trying to resuscitate him. An RMN decided to use the defibrillator but was unhappy that there was a lot of water on the floor so the man was moved to the association room. The RMN continued to try to resuscitate him and the healthcare officer went to meet the ambulance crew. He said that the ambulance crew attached a monitor to the man and got a flat line reading. They then pronounced him dead.
49. A healthcare officer said that he must have unlocked the man at least twice on the morning of 15 April, but that he did not remember the morning particularly. He said that this meant that the man probably came out for his meals and accepted his medication as normal. The healthcare officer said that after lunch at about 2.00pm all the prisoners were unlocked for association. He went to a prisoner's room which was near the nursing station in order to help him write a letter to his mother. The prisoner attracted his attention to a commotion outside and he went to the shower room. The healthcare officer said he could see a piece of white sheet visible above the shower door and immediately went to open the door. As he opened the door the cleaner took the man's weight while he used his 'fish' knife (a special knife carried by all prison staff to cut ligatures) to cut the sheet. The healthcare officer said he and the cleaner then laid the man on the floor and he and an RMN began CPR. The healthcare officer said his immediate reaction was that he was already dead because he was cold and his tongue was sticking out. He said he and the RMN decided that the area was too wet to safely use the defibrillator on the man, so they moved him across the corridor to the association room. He said the defibrillator instructed them to continue CPR, which they did until the paramedics arrived and pronounced the man dead.
50. The cleaner said he was playing on the PlayStation in cell number one and decided to make himself a cup of tea. As he walked down the corridor he saw a prisoner outside the shower room pointing "like he was hitching a lift". He said he went into the shower room with two healthcare officers and an RMN and. He said a healthcare officer opened the shower cubicle door and the prisoner went past the healthcare officer and supported the man's weight. He then helped lay him on the floor and staff began CPR.
51. An RMN said she was at the nurses station doing an assessment on a new prisoner when she heard a prisoner say to another RMN, "you'd better come through" (indicating to the shower area). She said she remembered the RMN

and two healthcare officers entering the shower area together and then one of the healthcare officers came out and said they needed an ambulance. He went to the nurses station to call for an ambulance and she got the emergency bag and oxygen cylinder and gave it to an RMN . The RMN said she then went to H2 landing to get the defibrillator. She then helped a nurse (who had been supervising the prisoners on the exercise yard) to lock the other prisoners in their cells.

52. An undated note in the man's handwriting and addressed to his father was later recovered from his cell. He wrote he could not cope and was in a hole and needed to "get out". A copy is attached in the annexes to this report.

The CCTV footage

53. CCTV recorded on 15 April shows that the prisoners on H1 landing were locked in their cells between 12.30pm and 1.30pm. At 1.47pm the man is seen leaving his cell carrying a towel under his arm. It is also possible to see another lighter coloured object under his arm which may be part of a sheet. The man walks into a prisoner's cell at 1.47pm. At 1.48pm, both men leave the cell. The man walks directly to the shower room. The prisoner is seen walking in and out of his cell and the common room a number of times.
54. At 2.54pm the prisoner is seen entering the shower room carrying a piece of clothing. Thirteen seconds later, he walks into the corridor and is seen attracting the attention of staff. Eleven seconds later staff enter the shower room. Fifteen seconds after that, they are seen carrying the man to the common room.
55. At no point between 1.30pm and 2.54pm does anyone else enter the shower room.

ISSUES CONSIDERED DURING THE INVESTIGATION

The prison's response to the man's death

56. The man was discovered in the shower room at approximately 2.55pm. By virtue of the fact that he was located in the healthcare centre he received prompt treatment from medically qualified staff. He was immediately cut down and placed on the floor. Staff administered CPR at a rate of 30 chest compressions to two effective breaths. This is in line with the latest Resuscitation Council guidance. An ambulance was called at 3.00pm and arrived at the prison at 3.05pm. An automated external defibrillator was quickly made use of and the instructions given by the machine were followed until the paramedics arrived on H1 at 3.10pm. In terms of emergency aid, I conclude that the man could not have received any more timely or delivered by more qualified staff. Sadly it appears that, by the time he was discovered, it was too late to save his life.
57. In accordance with Preston's death in custody contingency plans a log was kept of events that happened after the man was found in the showers and witness statements were taken from the staff and prisoners involved. The other prisoners who were on open ACCT documents were checked as required. The relevant authorities were informed as required by these contingency plans. The Governor, the Duty Governor, the IMB and the care team all attended the prison within a couple of hours of the man being discovered. A hot debrief took place the same afternoon. Staff told my investigator that they found this debrief helpful. I consider that the death in custody contingency plans were followed in a timely and efficient way.
58. The prisoners interviewed told my investigator that they had been told personally about the man's death and had been offered support if they needed it. The cleaner said he had been visited by the Governor and had been offered a lot of support from staff. I am pleased to hear that this was the case.
59. The staff involved in the attempt to revive him were mostly very content with the support they were offered after his death. Some staff were unhappy that they had been immediately asked to check the other prisoners on open ACCT documents. I appreciate the necessity of checking the wellbeing of prisoners deemed to be at risk of self harm and suicide in the aftermath of a death in custody - indeed it is a formal requirement of Prison Service Order 2710 'Follow up to deaths in custody'. I am also aware that staffing levels on weekends may be quite reduced and that this may make it difficult to allow those staff who have been directly involved at the scene of a death to be relieved of their duties even for a short time. Nevertheless, I think it is good practice where possible to allow staff a choice of whether to carry on with their duties or to have a break. I make no formal recommendation in this regard, but I have drawn the comments of staff to the Governor's attention.
60. The Duty Governor and the chaplain, drove to the father's home in to break the news of his son's death. They arrived at 8.20pm and remained with him until one of his daughters joined him. The Duty Governor told my investigator that she had not been able to break the news to the father sooner because she had been

busy with her duties as Duty Governor (among other things she had responsibility for implementing the death in custody contingency plans) and because of the distance it had taken to travel between Preston and the fathers home. I have said on many occasions that I believe it is properly the responsibility of the Prison Service to break the news of a death to the bereaved family. I am pleased to see that on this occasion the message was delivered in person and I think this is good practice. However, I also believe that the news should be delivered as soon as possible. I have seen too many cases where families have heard the news of their relative's death via radio, television or the prison grapevine. Although fortunately that did not happen in this case, there was a high risk that it might have done given that the family were visited some five hours after the man was pronounced dead. If the main delay was, as I have been told, that the Duty Governor was first required to complete duties at the prison then it would seem sensible that the Duty Governor does not double as the family liaison officer.

I recommend that Preston's local death in custody contingency plans should provide that, in the aftermath of a death, the Duty Governor should identify an appropriately senior and trained person to inform the next of kin quickly and as a matter of priority. If the Duty Governor is the only appropriately trained member of staff available to visit the family, the role of Duty Governor should be passed to another member of staff.

61. On 20 April the governor subsequently placed in charge of liaising with the family, phoned the father to offer him the opportunity to visit Preston. The liaison officer also offered financial assistance with the funeral. The liaison officer subsequently attended the funeral and personally delivered the man's property to his family. These actions properly follow the requirements of Prison Service Order 2710 Follow Up to Deaths in Custody.

The man's clinical care

62. The clinical review is at annex 1. It provides a more detailed overview of the treatment of the man's mental health problems by the Prison Service. In summary the clinical reviewer concludes that the man suffered from acute anxiety and depression. During his time in prison he was seen by a number of mental health professionals and offered a wide range of therapies to address his anxiety and depression. The clinical reviewer concludes that the man preferred medication to therapy in the treatment of his symptoms. He asked for different medications on a significant number of occasions and was keen to be prescribed the benzodiazepines that he had been receiving in the community. He was not prescribed these in prison because of his addiction to them. The clinical reviewer believes that not being allowed benzodiazepines may have compounded his anxiety, although clearly it would not have been appropriate to have received them.
63. In terms of access to mental health and other health professionals the clinical reviewer believes that the man's care exceeded that which he might have had access to had he not been in prison. She writes:

“Unless the man had been a patient in a psychiatric hospital, it is doubtful that he would have been offered this level of care outside of prison. Therefore in this instance, the level of service provision, arguably, exceeded the provision offered in the general community.”

64. With regard to the care he received in Preston the clinical reviewer concludes that he was appropriately reviewed each time his presentation changed and his careplan amended to reflect this. The man was seen daily by members of staff including his named nurse, and his case was reviewed weekly. He was seen regularly by a visiting consultant psychiatrist.
65. The weekly case review meetings are intended to be multi-disciplinary and attended by H1 staff, the Mental Health Inreach Team and the visiting psychiatrists. An examination of the minutes of the meetings for the period that the man was in Preston shows that a visiting psychiatrist was not present at any of these meetings. Staff told my investigator at interview that they consulted with the psychiatrists, and the clinical reviewer was told that the psychiatrist's observations were passed to nursing staff at the end of the psychiatrist's sessions. There is indeed evidence in the meeting minutes that the opinion of the psychiatrist has been fed in. The reason for the non-attendance of the psychiatrists at the weekly review meetings appears to be that their time in Preston is wholly taken up with sessions with the prisoners. I am slightly concerned at the absence of the visiting psychiatrist. Although attempts are clearly made to input their conclusions into the meetings I am not sure this is as effective as taking an active part in discussion. Inevitably their opinions cannot always take into account the most recent events.

I recommend that the Head of Healthcare considers whether it is possible to re-structure the weekly timetable to allow the visiting psychiatrists time to attend the weekly patient review meetings without diminishing the time they spend with prisoner-patients.

66. The clinical reviewer concludes that the man communicated his distress in a confusing and complex way. He presented with a number of behaviours, such as pacing and responding as if to voices, which he appeared to be able to switch on and off. Staff noticed that he presented these behaviours when he knew he was being observed, and was able to stop and respond rationally and politely when spoken to. Staff also noticed that this behaviour had become more pronounced after he had seen another prisoner with a genuine psychosis display such behaviour on the wing. The clinical reviewer concludes that, while it is impossible to say whether he was genuinely hearing voices and seeing hallucinations, he was being appropriately reviewed and monitored. It was not unreasonable for staff to doubt that he was displaying symptoms of genuine psychotic illness. Whereas the man appeared to be able to communicate his mental distress to his family, as he did in several telephone conversations on 8 April, he reassured staff that he was okay.

67. The clinical reviewer makes a number of comments in her 'recommendations' section relating to record keeping. I draw these to the attention of the Head of Healthcare at Preston.

General observations on the man's ACCT form

68. The man's ACCT form was opened appropriately after he told staff that he had thoughts of self harm. Throughout the man's time in Risley, his ACCT was reviewed regularly at appropriate intervals. He attended the reviews along with wing staff and an RMN. He also had daily visits from an RMN and a member of the Independent Monitoring Board. The CAREMAP and the front sheet, which lists the number of observations that should take place, were updated appropriately. The form was quality checked by management on a daily basis. The man was appropriately referred to the specialist facility at Preston after cutting his arms in the showers.

69. At Preston he was placed on 15 minute visual observations with the requirement that staff record three conversations per day on the on-going record. He was also placed on hourly observations during the night. The record shows that these requirements were adhered to. In addition the man's ACCT form was quality checked by management on a daily basis and there is evidence of this in the on-going record. His ACCT was reviewed on 8, 12, and 26 March and on 2 April, when it was closed. Each review was attended by a manager, the man and an appropriate selection of mental health staff and members of the chaplaincy and probation department. On one occasion the man's RMN from Risley attended.

70. On 14 March the man self harmed by making superficial scratches to his arm. He volunteered to staff that he had hurt himself and was seen by an RMN who spent some time talking to him. All ACCT documents should be reviewed as soon as possible after an incident of self harm. There is no evidence that a review took place in response to this incident.

71. The man's ACCT was closed on 2 April. Guidance to staff requires that a post-closure interview should take place. I have not seen any evidence that the man had a post-closure interview before he died. I draw no particular conclusion from this omission. It may be that there was an intention to have a post-closure interview and he died before it took place. I am not persuaded that a post-closure interview or a review after the self harm of 14 March would have changed the outcome of events. Nevertheless, these are requirements of the ACCT process and I draw them to the attention of the Suicide Prevention Co-ordinator at Preston who may wish to make sure that they do not indicate a more widespread problem.

72. On 8 April the man made several telephone calls in which he told members of his family that he felt like ending his life. The Deputy Manager spoke to the man about these conversations and the man denied that he had made the remarks or had any intention to harm himself. At interview the Deputy Manager said that, based on his experience of the man and his conversation with him he did not consider that it was appropriate to open another ACCT document in the light of

these telephone conversations. Had a post-closure review taken place this decision might have been more fully explored.

73. I consider that, apart from the omissions noted above the man's ACCT form was completed to a generally high standard at Risley and at Preston. I am impressed with the regular attendance at reviews at Preston of staff from the chaplaincy and the probation department, and I am very pleased to see that the man's RMN from Risley attended a review to provide continuity of care. I understand that the selection of staff from the probation department for reviews is done on a rota basis, and this means that the same member might not consistently attend the same prisoner's reviews. My investigator discussed this with members of the probation department at interview, and staff seemed to feel that it might benefit them to attend the same prisoner's reviews and thereby improve their input into the ACCT process. I understand that the probation department intend to look into the feasibility of this. To satisfy myself that it is being considered, I make the following recommendation:

I recommend that the chaplaincy and the Head of Probation review whether it is possible for the same member of staff to consistently attend the same prisoner's ACCT reviews.

The decision to close the man's ACCT form

74. Guidance to prison staff on closing ACCT documents says that an ACCT must only be closed by the review team at a case review when it is judged safe to do so. That is, that the problems that caused the ACCT to be opened have been solved or reduced, and that the prisoner has access to appropriate support and knows who to contact if the problems recur.
75. The man's final review took place on 2 April. The review was chaired by the Deputy Manager and attended by the man, prison chaplain and a member of the prison's probation department. The man's level of risk was reviewed as low. It was noted that the previous week had been a more settled one for him and he had shown an improved ability to deal with his mental health problems. The man had not expressed any crisis issues or given any intention or shown evidence of self harm.
76. At interview the prison chaplain said that he remembered that the man had expressed a concern about going back to Risley. He said there had been no evidence that the man had self harmed or had expressed an intention to self harm, and he had appeared to be improving. The prison chaplain said that the Deputy Manager had explained clearly that, if the man decided he was unhappy that his ACCT had been closed, then it could be re-opened. He said the ACCT was closed with the man's full consent. The prison and probation officer said that she did not remember anything particular about the man's ACCT review on 2 April but did remember that he was content for it to be closed.
77. The Deputy Manager said that, at the time of the man's review on 2 April he had been totally confident that it was the right step to close the form. He said that he

had felt the man was progressing well. The other members of staff at the review were confident that the document could be closed.

78. All of the staff and prisoners interviewed during this investigation were surprised and shocked by his death. A prisoner who said, he was a good friend of the man, said the man had told him that he had visions of himself hanging but had told him that he could not cut himself. The prisoner said that despite this he had not thought that he was “the type to commit suicide”. He said that the man “couldn’t concentrate on anything” and he thought the man’s head was too “messed up” to have planned his suicide. A prisoner, who had a lot of contact with the man in the days before his death, described talking to him as “like having ten conversations in one”. He said the man had difficulty concentrating and appeared to quickly lose interest in subjects. He did not think he was suicidal.
79. Much of this report focuses on the judgements made by individuals. It is my job to assess those judgements based on what each individual knew, or should have known, at the time. In this case, I am not persuaded that the Deputy Manager was wrong to close the ACCT document. If the man had not died and I had reviewed his ACCT document, its closure on 2 April would not have given me cause for concern. I consider that this is a good test of whether a judgement was reasonable at the time it was made. I think it is also important to understand that prisoners on H1 have a high level of interaction with staff and other mental health professionals and enjoy a significant amount of time out of their cell. The fact that the man was no longer being monitored under ACCT did not mean that he was not being watched and spoken to several times a day by staff. He had daily contact from mental health nurses and was seen regularly by a visiting psychiatrist.

The role of staff on H1 landing

80. On the afternoon association period on 15 April there were four H1 staff on duty on H1 landing. The nurse was supervising the prisoners on the exercise yard, a health care officer was helping a prisoner write to his mother, an RMN was doing a review on a new patient and another healthcare officer was writing up notes from a review he had been required to do that morning on a prisoner in the main prison. An RMN was on duty on H2 but happened to be passing through H1 when a prisoner raised the alarm. At interview a healthcare officer said that his usual practice during association was to mix with the H1 prisoners and check what they were doing and whether they had any problems. He was upset and angry that he had been required to do a review in the main prison because it and the associated paperwork had taken him away from his H1 duties at what turned out to be a crucial time.
81. During the course of the investigation, other staff expressed concerns that they were increasingly being required to attend to prisoners in the main prison and this was taking them away from the specialist function they provided on H1. It was the view of staff that on some of these occasions it was not necessary for a specialist mental health nurse to attend. My investigator raised this with the Clinical Operations Manager. She said that Preston was looking into setting up a

crisis response team made up of staff other than those on H1 to cover assessments on prisoners in the main prison. At the time of writing Head of Healthcare told my investigator that funding had been identified for two additional members of staff and interviews were in progress.

82. It is not possible to say whether the man's death could have been averted had the healthcare officer been performing his H1 duties on the afternoon of 15 April. The man had reasonably been deemed not to be at risk of attempting to kill himself and there was no extra duty on staff to watch him more than any other prisoner. However, if it is judged that four staff are required to be on duty to fulfill a duty of care to prisoners on H1, it is not appropriate for one of them to be tasked with other duties. H1 is a specialist in-patient facility for seriously ill and vulnerable prisoners and performs an important and all too rare function in the Prison Service. I welcome steps taken by Preston to ensure that the expertise of H1 staff is not diverted and their function not diluted. In order to satisfy myself that this course of action is taken forward, I make the following recommendation:

I recommend that the Governor of Preston ensures that staff on H1 are not diverted from their primary responsibilities by making appropriate operational arrangements for a dedicated team to complete assessments on prisoners in the main prison.

Access to the showers on H1

83. At the time of his death, prisoners who were not deemed to be at risk had free unsupervised access to the shower room on H1 landing during association. After the man's death, the showers were examined to see whether it was possible to box in the piping to prevent it being used as a ligature point. This was found to be impossible and prisoners are now only permitted controlled access to the showers under staff supervision.
84. The ethos at Preston is that the healthcare centre operates, as close as is practically possible, like a hospital. This is to give physically and mentally ill prisoners back some responsibility for their own lives. In many prisons, prisoners may have access to showers as rarely as once a week and have little control over or responsibility for their lives. Until the tragic events of 15 April 2007, Preston's policy of allowing those prisoners not deemed to be at risk daily unsupervised access to the showers would have been viewed as positive and humane in keeping with the decency agenda. The man's death highlights the difficulty of balancing security and decency. Quite properly, it has also led to a re-examination of the question of access to the showers. In the light of his death, I conclude (albeit with some regret) that the correct course of action was to change the policy to allow prisoners only supervised access to the showers.

A Prisoner

85. During the course of the investigation a number of staff and prisoners told my investigator that they believed that the prisoner may have in some way encouraged the man to attempt to take his own life. As a result of allegations made by another prisoner he was interviewed under caution by the police. The

police are satisfied that there is no evidence that the prisoner had been involved in the man's death and no charges have been brought against him.

CONCLUSION AND RECOMMENDATIONS

86. The standard of clinical care received by the man during his time in prison was very high. It is unlikely he would have received such care had he been in the community. The handling of his ACCT form was generally sound and I do not believe it could reasonably have been foreseen that he would take his own life.

87. I make the following recommendations:

- 1. I recommend that Preston's local death in custody contingency plans should provide that, in the aftermath of a death, the Duty Governor should identify an appropriately senior and trained person to inform the next of kin quickly and as a matter of priority. If the Duty Governor is the only appropriately trained member of staff available to visit the family, the role of Duty Governor should be passed to another member of staff.**
- 2. I recommend that the Head of Healthcare considers whether it is possible to re-structure the weekly timetable to allow the visiting psychiatrists time to attend the weekly patient review meetings without diminishing the time they spend with prisoner-patients.**
- 3. I recommend that the chaplaincy and the Head of Probation review whether it is possible for the same member of staff to consistently attend the same prisoner's ACCT reviews.**
- 4. I recommend that the Governor of Preston ensures that staff on H1 are not diverted from their primary responsibilities by making appropriate operational arrangements for a dedicated team to complete assessments on prisoners in the main prison.**

Good practice:

- 5. During the course of the investigation my investigator became aware that weekly prisoner/staff meetings initiated by a PO were held on H1. All prisoners are invited to attend to talk about whatever issues they want. The man attended one of these meetings and his suggestion that prisoners be given hot chocolate (as had been the practice at Risley) was taken up. I consider such meetings to be an example of good practice.**