

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in December  
2014, while a prisoner at HMP Preston**

## ***Our Vision***

*To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision.*

This is the investigation report into the death of a man, in December 2014, after suffocating himself at HMP Preston six days earlier. I offer my condolences to his family and friends.

One of my investigators carried out the investigation. A clinical reviewer was appointed to review the man's clinical care in prison. The prison cooperated fully with the investigation.

The man had spent six months in HMP Forest Bank earlier in 2014. Staff had concerns about his mental health and he had twice been admitted to the prison's inpatient unit for monitoring, but he was not formally diagnosed with a mental illness. In October, he was released on licence but recalled in November after he found it difficult to cope, threatened to slit his own throat and failed to attend a probation appointment.

The man arrived at Preston on 26 November. Although prison staff had received a warning about his recent suicidal intent, they did not begin suicide and self-harm monitoring and the reception nurse did not refer him to the mental health team. The next day, an offender supervisor identified his risk of suicide and a manager began monitoring. A mental health nurse wanted to admit the man to the prison's healthcare unit for assessment, but there were no beds available.

Staff were required to check the man once an hour in the day and twice an hour at night. On the evening of 28 November, the night patrol officer recorded that he had checked the man as required, but CCTV footage shows that he did not actually make all of these checks. Just after 9.30pm, the officer checked the man and was concerned that he had a plastic bag and might harm himself with it. He asked the night manager to contact him. The manager spoke to the officer but neither treated it as an emergency and, ten minutes later, he arrived and unlocked the cell. The man had suffocated himself with the plastic bag. He was taken to hospital, but died.

The investigation found that the reception officers and nurse at Preston did not act on risk information or properly assess the man's risk of suicide and self-harm. The mental health nurse who saw the man later, did not document her referrals.

After staff identified the man's risk of suicide and self-harm, I am satisfied that they agreed an appropriate frequency of observations. While this did not affect the outcome for the man, I am concerned that the night patrol officer did not carry out the monitoring checks that he had recorded. Once the night patrol officer identified the concern about the man, I consider that he should have stayed at the cell and kept him engaged, until the night manager arrived. The patrol officer did not communicate his concern very well, which delayed the manager attending, and there was then a further delay, as the control room did not call an ambulance as soon as an emergency alarm was raised.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

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## SUMMARY

1. On 5 March 2014, the man was, remanded to HMP Forest Bank. He arrived with a suicide and self-harm warning form but staff did not think that he needed monitoring. He subsequently received a 14-month sentence. The man was prescribed antidepressant and antipsychotic medication to manage his symptoms, but had no formally diagnosed mental illness.
2. The man was released on licence on 3 October and was in contact with mental health services. On 19 November, he threatened to slit his throat. After failing to attend a probation appointment, his offender manager recommended his licence should be revoked and he was recalled to prison. On 26 November, the man was taken to HMP Preston.
3. Despite a warning alerting them to the man's risks, reception staff did not begin Prison Service suicide and self-harm monitoring procedures, known as ACCT. The next day, 27 November, an offender supervisor saw the warning and a manager began ACCT procedures. A mental health nurse wanted to admit the man to the prison's inpatient unit for assessment, but the unit was full. She referred him to the mental health team. The man was in a cell on his own. Later, an officer was worried about him and arranged a prisoner peer supporter and a nurse to speak to him.
4. Staff were required to check the man once an hour in the day and twice an hour at night. That evening, the night patrol officer recorded that he had checked the man every half hour, but CCTV evidence shows he did not do all of these checks. At 9.30pm, he checked the man and was concerned that he had a plastic bag, which he might use to harm himself. At 9.31, he informed the night manager he was concerned, but the night manager did not recognise the request as urgent. The officer did not stay at the cell but checked the man intermittently. The last check was at 9.38pm and he said that the man still had the bag in his hand. The night manager arrived at 9.40pm, unlocked the cell and found that the man had suffocated himself by holding the bag over his head. They called an emergency, but the control room did not call an ambulance until two minutes later. Staff attempted to resuscitate the man and paramedics took him to hospital. He never recovered and died on 4 December.
5. We are concerned that reception staff at Preston did not identify and act upon basic risk information, a problem we have raised with the prison a number of times before. The mental health nurse who saw the man on his second day did not record what she had done in his medical record. Despite his recent threats of suicide, the case review assessed his risk as low.
6. Although this did not affect the outcome, it is unacceptable that earlier in the evening of 28 November, the night patrol officer recorded checks, which, he had not made. The night patrol officer should have stayed with the man when he identified his concerns and poor communication with the night manager led to an unnecessary delay in going into the cell to remove the bag. Emergency response procedures were not in line with national Prison Service instructions. We make six recommendations.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Preston about the investigation, inviting anyone with relevant information to contact him. No one responded.
8. The investigator visited Preston and interviewed a prisoner on 9 December 2014. He interviewed staff at the prison in January and February 2015.
9. NHS England North commissioned a clinical reviewer to review the man's clinical care at the prison.
10. We have sent a copy of this report to HM Coroner for North Lancashire, Preston and South West Districts.
11. One of our family liaison officers contacted the man's sister to explain the investigation process. She wanted to know more about the time her brother had spent in Forest Bank, as she believed that he had been sexually assaulted at the prison and that this had affected his subsequent mood.
12. The man's sister asked for more information about the suicide and self-harm procedures at Preston, her brother's treatment for his mental health problems and why staff allowed him to have a plastic bag in his cell, when he had been identified as at risk of suicide.
13. The man's sister received a copy of our draft report and her solicitor responded on her behalf. We have subsequently made some factual amendments to the final report for accuracy. The family liaison officer has written to the man's sister about the other matters raised in separate correspondence.

## **HMP PRESTON**

14. HMP Preston is a local prison holding up to 842 men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. There is an inpatient mental health facility and an integrated mental health team who treat prisoners living on the wings.

### **Her Majesty's Inspectorate of Prisons**

15. The most recent inspection of HMP Preston was in April 2014. Although the Inspectorate found some deterioration in certain areas, they also saw much that was good. The inspectors found that the prison had taken prompt action to address recommendations that the Prisons and Probation Ombudsman had made after previous investigations into deaths at the prison. Many ACCT case reviews were multidisciplinary, but continuity of case management was lacking. Too many prisoners reported feeling unsafe. The inspectors noticed some complacency and negativity among the staff and considered that they needed to re-engage with prisoners. There was an impressive range of good quality mental health support, but waiting times for an assessment after a routine referral were too long.

### **Independent Monitoring Board**

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In the IMB's most recent annual report for the year March 2014, the IMB were concerned about the reduction in staffing levels at the prison, but considered that officers cared for prisoners humanely.

### **Assessment, Care in Custody and Teamwork (ACCT)**

17. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. 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. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

### **Previous deaths at HMP Preston**

18. Since 2012, we have investigated the deaths of 17 prisoners at Preston, including the man. Of these, 11 were from natural causes, which, is partly because Preston has an inpatient unit, which is used as a regional facility, including for end of life care. One death was unexplained and five were apparently self-inflicted. Our investigations into self-inflicted deaths have found repeated failures by staff to identify suicide risk factors at the earliest opportunity and put in place ACCT procedures. We have also been critical of the quality of ACCT caremaps.

## KEY EVENTS

19. On 3 March 2014, the man went to his local GP surgery under the influence of alcohol and drugs, demanded access to mental health services and threatened his GP with a knife. The police arrested him and he was charged with possession of a knife, possession of cannabis and common assault. He pleaded guilty on 5 March and was remanded to HMP Forest Bank to await sentencing.

### 5 March – 3 October 2014

#### HMP Forest Bank

20. The man arrived at Forest Bank with a suicide and self-harm warning form noting that he had threatened to kill himself in police custody. Prison staff assessed he was no longer at risk and did not begin ACCT suicide and self-harm prevention procedures.
21. On 6 March, a GP prescribed the man a 28-day course of fluoxetine (an antidepressant). On 20 March, a mental health nurse concluded that he was suffering from low mood rather than a mental illness. She referred him to another GP, who saw the man on 3 April and prescribed 5mg of olanzapine (an antipsychotic) daily, after he reported auditory hallucinations and feeling threatened. The community mental health team subsequently advised that the man did not have a serious mental illness and that his mental health problems were due to long-term alcohol misuse.
22. On 23 May, the man was sentenced to 14 months in prison. During his time at Forest Bank, he repeatedly told healthcare staff that he saw insects, spiders and snakes crawling over him. In May, they assessed him in the inpatient unit and, in June, the GP increased his daily dose of olanzapine. On 28 July, a nurse referred him to a psychiatrist but he did not see one before his release.
23. On 30 July, the man transferred to HMP Kirkham (an open prison) but he returned to Forest Bank the same evening. Managers at Kirkham refused to accept him because they had been given no warning about his mental health needs and considered him unsuitable for an open prison.
24. On 27 August, healthcare staff readmitted the man to the inpatient unit. He had not left his cell, eaten or collected his medication for three days. He said he felt paranoid and alleged that he was being bullied. (It is not clear what action was taken on this allegation.) There is nothing in his security records, general prison records or in his healthcare records to indicate that he was the victim of sexual assault at Forest Bank. On 30 August, a doctor restarted his olanzapine at the original 5mg dose. In early September, he moved to the vulnerable prisoner unit, at his own request, because of his paranoia.

### **3 October – 24 November**

#### **On licence in the community**

25. The man was released on licence on 3 October. One of his licence conditions was to report weekly to his offender manager (probation officer) at Bury Probation Office. On 7 October, he telephoned 999 and reported feeling suicidal. He was taken to hospital and discharged. The man's probation officer was concerned about his emotional wellbeing, but found it difficult to find him a GP because of the nature of his offence. Probation staff eventually found him a GP, who prescribed antidepressants on 30 October. The man later told probation staff that he was not taking his medication.
26. During a telephone call to the probation office on 19 November, the man threatened to slit his throat and said that he had two Stanley knives and a box of paracetamol. Probation staff called the emergency services, who took the man to Fairfield General Hospital for his own safety. The hospital discharged him the same day and did not consider he had a mental illness or was an imminent risk to himself.
27. As the man's original offence had involved a knife, his probation officer gave him a warning for possessing the Stanley knives. She instructed him to attend an appointment at the probation office on Friday 21 November, but he did not turn up. On Monday 24 November, she asked the police to locate the man, but they could not find him. Due to the breach of his licence conditions by failing to attend appointments and displaying poor behaviour, and concerns about his risk, the man's probation officer requested his recall to prison. The National Offender Management Service's Public Protection Unit approved this.

#### **Tuesday 25 November**

28. On Tuesday 25 November, the police arrested the man and took him to Bury Police Station. The recall notification, issued to the police and then passed to the prison, included:

'Vulnerability issues: Risk of bullying due to being vulnerable, emotional, helpless. Recent suicide attempt and at high risk of suicide / self-harm.

'Potential arrest / risk issues: On 19/11/2014 he threatened to kill himself by slitting his throat. For further details please contact the offender manager.'

#### **Wednesday 26 November**

##### **HMP Preston**

29. On Wednesday 26 November, the man was taken to HMP Preston as Forest Bank was full. A Person Escort Record (PER) accompanies prisoners as they move between police stations, courts and prisons. It should include information about the prisoner's risk. Escort officers gave prison staff the man's escort record and recall notification. The escort record noted that he

had threatened to commit suicide in 2012; had mental health problems; and was taking antidepressants. It also showed that he had previously committed a number of violent offences, had been found with cannabis and that he was an alcoholic.

30. Supervising Officer (SO) A spoke to the man when he arrived and signed his escort record. The SO told the investigator that she would normally read the escort record and recall notification, put both documents into a new prisoner's core record and briefly interview him. Although she could not remember dealing with the man, she was confident that she would have asked him about suicide and self-harm as she does so routinely. However, the SO did not record anything about him in his prison record or open an ACCT document.
31. Nurse A assessed the man, but did not read his core record, the recall notification or the escort record. The nurse said that he does not normally read these documents or check a prisoner's clinical record. The only form he would normally take note of is a suicide and self-harm warning form, but the man did not have one.
32. Nurse A said that the man was quiet and had answered his questions but did not talk at length. The man reported that he had been treated in a psychiatric hospital several years earlier and had a history of schizophrenia and memory loss. He said he was not currently receiving treatment and had not taken medication for years. The nurse assessed the man's behaviour and mental state as appropriate. He had no concerns about him and did not refer him to the GP or the mental health team or start ACCT procedures.
33. The man moved to the first night centre, where Officer A interviewed him. The officer did not see the escort record or the recall notification as they remained in the man's core record, in reception, which is routine procedure at Preston.
34. Officer A wrote in the first night assessment booklet that the man was not at risk of self-harm and had last harmed himself more than three years earlier. He noted in the man's 'Day 1 Compact' that he was uncooperative and confused, but there were no concerns about him. He ticked to indicate that there were immediate issues that, if dealt with, would help the man to settle in during his first 24 hours, but he did not record what these were. The officer did not begin ACCT procedures.
35. Another officer completed the man's cell sharing risk assessment and provisionally assessed him as a high risk to other prisoners as he did not have a copy of the man's previous convictions. This meant that he could not share a cell on his first night. At 9.30pm, the man went to cell 28 in the drug dependency unit on C1 landing, as there was no space in the first night centre. He was not receiving treatment for substance misuse.

#### **Thursday 27 November**

36. On the morning of Thursday 27 November, the man finished his induction. Officer B completed a second day interview and finalised the man's cell sharing risk assessment after checking his list of previous convictions. He assessed him as a standard risk, which meant he could share with another

prisoner. Chaplain A from the prison chaplaincy interviewed the man and did not record any concerns.

37. At about midday, offender supervisor A in the prison's Offender Management Unit, checked the man's core record because he was a new prisoner. She read the man's probation officer's risk assessment record (OASys) and the recall notification and noted recent serious concerns about the man's risk of suicide and self-harm. The offender supervisor tried to telephone staff on C1 landing several times, but could not get a reply. She then contacted custodial manager A who was the orderly officer that day, and told him that the man was a potential suicide risk.
38. Custodial manager A went to speak to the man, who repeatedly said that he felt paranoid and uncomfortable on the wing. He said he could not guarantee that he would not harm himself, but had no specific plan to do so.
39. At 12.30pm, custodial manager A began ACCT procedures. He wrote on the ACCT immediate action plan that the man should be referred for a mental health assessment but did not make the referral himself. The custodial manager asked staff to check the man four times an hour until his assessment interview and case review. He recorded that the man would not sign the ACCT immediate action plan because of his paranoia.
40. At 2.10pm, the man had a physical health assessment. He then spent time on the wing during the association period, when prisoners are not locked in their cells and are able to mix with each other.
41. At 3.10pm, a mental health nurse, Nurse B, assessed the man as part of the routine for new prisoners. The nurse said that she read the man's previous clinical record from his time at Forest Bank, but did not know that he had been recalled or had recently threatened suicide.
42. Nurse B said that the man found it difficult to engage but answered her questions. He told her that he had been prescribed olanzapine at Forest Bank but had not taken any medication since his release. He reported thoughts of suicide but the nurse could not establish if he had current intent or a specific plan. The man said that he felt paranoid, low, suicidal and isolated. He had recently lost weight and had not been eating properly. He seemed disorientated, vulnerable, worried, vague and somewhat guarded in his responses. The nurse thought that the man might be having a relapse of mental illness.
43. Nurse B said that she tried to arrange for the man to be, admitted to the prison's inpatient unit for a mental health assessment and monitoring, but the unit was full. She said that she added him to the waiting list by writing his name on a white board in the inpatient unit. She telephoned an officer on C1 landing and asked them to let the man know.
44. Nurse B said that she also sent a handwritten referral to the integrated mental health team, to consider the man at the next referrals meeting. However, the investigation found that it was unlikely that anyone from the team would see him quickly as, due to staff shortages, there was a waiting list of about 100 prisoners at the time and prisoners waited as long as five months to be seen.

45. At 4.10pm, Officer C interviewed the man for an ACCT assessment. He noted that the man seemed confused and distracted and was unhappy to be back in prison. He felt anxious and paranoid and these feelings were getting worse. The officer wrote in the triggers section at the front of the ACCT document that the risk of suicide and self-harm was higher when the man felt paranoid. The man said several times that he 'felt bad', but would not explain this. He said that he had last tried to harm himself two years before, by taking an overdose, but had no current plans to harm himself and no thoughts of suicide.
46. Officer C told the man that someone would probably share his cell with him. The man said he did not want to share a cell and wanted to move to A Wing, where he had friends. He said he was in contact with his family but did not expect them to visit while he was at Preston.
47. At 5.10pm, the man moved to cell 17 on C3 landing. This was a double cell but he was the only occupant. At about 6.30pm, Officer D spoke to the man during a routine ACCT check. He had not collected his dinner and said he could not concentrate on the television. He kept repeating that he felt very paranoid. He gesticulated a lot and talked fast and repetitively.
48. Officer D arranged for a Listener, A, to speak to the man and explain life on the wing. (Listeners are prisoners trained by the Samaritans to support other prisoners in distress.) She said she wanted him to see a friendly face. The Listener spent about 15 or 20 minutes with the man and they walked up and down the landing for a while. The man was worried that the other prisoners would call him a 'nonce' (a sex offender) because of his age. The officer left a voicemail, asking the integrated mental health team to see the man and asked the emergency response nurse, Nurse C, to check him.
49. At 7.10pm, Nurse C went to see the man in his cell. He was sitting on his bed, crying. He said he felt paranoid and guilty about his offence. The nurse spent about twenty minutes trying to reassure him. The man said that he felt better after their chat and thanked her for coming. He was smiling as she left and seemed more settled. The nurse noted her visit in the ACCT document and his clinical record.

### **Friday 28 November**

50. At 10.15am, an officer wrote in the ACCT record that he had tried to explain the ACCT process to the man but he had seemed confused. He kept shaking his head and saying, 'I don't know'.
51. At 10.55am, a panel consisting of Supervising Officer (SO) B (the ACCT case manager), SO C (a safer custody manager) and a mental health nurse. Nurse D from the inpatient mental health unit, held the first ACCT case review with the man. A member of the chaplaincy team had been invited but was unavailable. SO B said that he had read Officer C's assessment before the review but was unsure if they had spoken about it. Officer C did not attend the case review.

52. Neither SO B nor SO C had met the man before and they did not look at his prison record beforehand. They knew that he had been recalled to prison and had received mental health treatment at the Fairfield Hospital. They did not know that he had threatened suicide the week before he returned to prison. Custodial manager A had not included the information about the man threatening to cut his throat the week before when the offender supervisor A told custodial manager A alerted him to his risk and he opened the ACCT document. The man had not told Officer C about this during his assessment interview, so there was no reference to this recent information about his risk contained in the recall document.
53. Nurse D thought that the man seemed flat and absent. She explained to him that there was a waiting list to be seen by the integrated mental health team. SO B recorded that the man had obvious mental health issues. The man said that he had suicidal thoughts but was unable to act on them and had no specific plan. He said he was unhappy about being at Preston rather than Forest Bank. He said he did not want any visits but planned to write to and telephone family and friends. The panel recorded that they had explained sources of support.
54. The ACCT panel assessed that the man's risk of harm to himself and the likelihood of further risk behaviours was low, because the man said he had no specific current plan to harm himself. They set the frequency of observations at once every hour during the day and twice every hour at night and scheduled the next case review for 4 December.
55. SO C recorded two issues on the man's ACCT caremap: a referral to the integrated mental health team (completed by Nurse D in addition to Nurse B's earlier referral), and family contact, which required the man to write to or telephone his family before the next ACCT case review. The man made no telephone calls during his time at Preston.
56. During the afternoon association period, staff saw the man standing at his cell door. At 6.00pm, Officer E had a conversation with him but recorded that it was very difficult to understand what he was saying.
57. Officer F was in charge of C3 and C4 landings overnight. The man was the only prisoner subject to ACCT monitoring on those landings that night. The officer wrote in the ACCT document that he had checked the man at 8.00pm, 8.30pm and 9.00pm. However, CCTV footage shows that the officer checked the man at 8.22pm and 8.47pm. The officer told the investigator that the man seemed reluctant to interact and just nodded his head during these checks.
58. Officer F checked the man at 9.30pm and CCTV footage confirms that he went to the cell. The cell light was on and the officer said that the man was lying on the lower bunk. His head was towards the door and hidden behind the end of the bunk bed, so was not visible from the observation panel. The officer told the investigator that he saw the man's chest rising and falling. His right arm was stretched out and he had a plastic bag in his hand. The officer asked him if he was okay, but got no reply. He was worried that the man might put the plastic bag on his head, so he wanted to remove it from the cell. He went back to the office and, at 9.31pm, he radioed to ask the night manager, to contact him on the office telephone.

58. The night manager heard the message, but as there was no indication that it was urgent, carried on with his usual evening duties and telephoned Officer F a few minutes later. The officer told him that a prisoner subject to ACCT procedures was holding a plastic bag, but was breathing. He asked the night manager to come to the cell. The night manager told the investigator that it had not seemed like a crisis call, there was no sense of urgency and he did not know exactly what was happening.
59. The assistant night manager was also at the gate and went with the night manager to C3. On the way to the wing, they stopped in the centre of the prison to lock away a set of keys in a safe.
60. The CCTV footage shows that Officer F went between the office and the man's cell three more times. At 9.33pm, he took 20 seconds to check the cell and return to the office. At 9.35pm, he spent 40 seconds going back and forth to the cell. At 30 seconds past 9.36pm, he went to the cell again and then back to the office a minute and a half later at 9.38pm. The officer said that he kept going back to the cell because he was worried that the man might use the plastic bag to harm himself. Each time he returned to the cell, the officer said that the man was lying in the same position and had not moved. He was still clutching the plastic bag in his hand, which remained down by his side. His chest was rising and falling each time he checked.
61. At exactly 9.40pm, the night manager and the assistant night manager arrived at the cell and had a brief conversation with Officer F. The night manager looked through the observation panel. He could partially see the man's head and what he thought, with hindsight, was condensation inside the plastic bag reflected in the light. The night manager said he had no doubt that something was wrong.
62. The night manager unlocked the cell. The man was lying on his back in the lower bunk clutching a plastic bag (used to deliver prisoner's orders from the prison shop) over his head. He had twisted it tightly around his neck in order to suffocate himself. Both of his hands were locked together holding the knot at his throat. Either the assistant night manager or the night manager pulled the plastic bag off the man's head. At 9.40pm, the assistant night manager radioed a code blue emergency. (The appropriate medical emergency code when a prisoner is not breathing.) The officer in the control room retransmitted the code blue message across the radio network.
63. The man was not breathing, so the night manager and assistant night manager lowered him to the floor and began cardiopulmonary resuscitation. The night manager gave rescue breaths and the assistant night manager performed chest compressions.
64. There was a delay of almost two minutes in calling an ambulance after the assistant night manager called a code blue, because the officer in the control room waited for further clarification. She said that her recent experience of staff misusing the codes to request a quick healthcare response, rather than in a genuine life-threatening emergency, meant that she had been reluctant to call 999 without more information. At 9.42pm, (one of the other night patrol staff) radioed the control room from C3 landing to ask for an ambulance. The

officer in the control room said that she was already in the process of telephoning the emergency services, because she had just heard over the radio network that someone had requested a defibrillator and had therefore realised that it was a life-threatening emergency.

65. Nurse E and Nurse F went to the man's cell with an emergency response bag and an oxygen cylinder. The CCTV shows that by 9.44pm, they were treating the man in the cell. Nurse E asked the assistant night manager and the night manager to continue cardiopulmonary resuscitation while she prepared the equipment. The nurses inserted a plastic airway and gave oxygen using a bag and mask. They attached a defibrillator to the man but the machine repeatedly advised not to shock him and to continue cardiopulmonary resuscitation.
66. At 9.49pm, a first response paramedic car arrived at the prison and the paramedic reached the cell at 9.53pm. An ambulance arrived at 9.55pm and the crew reached the cell at 10.00pm. At 10.33pm, the ambulance took the man to the Royal Preston Hospital, where he was, treated, in the critical care unit.
67. The prison had contact details for the man's son and his ex-wife. At midnight, the duty governor asked Greater Manchester Police to inform them what had happened, rather than telephoning them, as she believed this would be better done in person. The police initially visited the address for the man's son but found he no longer lived there. They then located the man's ex-wife, told her what had happened and gave her the prison's telephone number. She telephoned the prison and put them in touch with the man's sister, who went to the hospital and stayed with him. With the agreement of other family members, including another sister, this sister acted as his next of kin and main family contact.

### **Royal Preston Hospital**

68. Prison chaplain B was assigned as the prison's family liaison officer and spent time with the man's sisters at the hospital to support them.
69. On Wednesday 3 December, tests showed that the man had sustained severe brain damage and would not recover. That evening, with the consent of the man's family, hospital staff withdrew treatment. Prison chaplain B and chaplain C took turns to stay with the man's sisters throughout the night. The man died at 8.45am the next morning, Thursday 4 December.
70. On Friday 5 December, the acting governor, A, and chaplain C visited the man's sisters to offer condolences and support. A post-mortem examination found that the man died after asphyxiating in his prison cell. This led to brain death and bronchopneumonia. The man's funeral took place on 16 December. The prison contributed towards the cost, in line with national guidance.

### **Staff and prisoner support**

71. Staff told the investigator that they had felt well supported after the incident, but we found no record that a manager debriefed them immediately after the

emergency response. There is no record of any support being offered to prisoners following the initial incident. A notice to prisoners was issued on 5 December, announcing the man's death and offering support to prisoners.

## ISSUES

### Management of the man's risk of suicide and self-harm

#### *Reception procedures*

72. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, about early days in custody, both list risk factors and potential triggers for suicide and self-harm. The man had a number of these when he arrived at Preston, including his recent threat to kill himself, his recall to prison, his history of depression and recent contact with psychiatric services. He was also in the early days at an unfamiliar prison.
73. PSI 74/2011 includes a mandatory requirement for reception staff to examine a prisoner's Person Escort Record (PER) and any other available documents, and interview the prisoner to assess the risk of suicide and self-harm. Although the man arrived with a clear warning about recent suicidal thoughts, none of the reception or first night staff began ACCT procedures, which did not begin until the next day, when an offender supervisor spotted the warning about his risk. We are not satisfied that the staff read the available information and complied with the instruction. We have identified this failure in two previous investigations about reception procedures at the prison within the last twelve months.
74. SO A did not remember seeing the man or having any serious concerns about him. She said that she would normally read the recall notification and the escort record. However, there is no record that she did this and we would have expected her to open an ACCT if she had read the warning about his risk or record the reasons why she did not. The SO said that, since the man's death, managers have asked staff working on the reception front desk to record their decision-making on the PER history sheet and the electronic prison record to demonstrate that they have considered risk information.
75. Nurse A, the reception nurse, was, given, the core record containing the recall notification and escort record, but did not read them or the man's clinical record. He said that he does not normally look at any of these sources of information, although the PER has a section specifically about healthcare issues. The recall notification contained brief and pertinent risk information about the man's recent suicidal thoughts. Had the nurse looked at his clinical record, he would have noted that the man had received treatment for mental health problems at Forest Bank. Without any of this information, the nurse did not identify the man's risk of suicide and self-harm and based his decision solely on how the man's appeared when he saw him. He did not refer him to a GP or to the mental health team.
76. In line with the routine procedure at Preston, the man's records, including his recall notification and his escort record, remained in reception when he went to the first night centre and went to the prison's Offender Management Unit the next day. This meant that when Officer A conducted the man's first night interview, he did not have access to the important risk information, particularly as reception staff had not identified it or recorded it.

77. We are concerned that there are continuing failures in reception procedures at Preston, which need to be addressed urgently. It is important that managers ensure that all reception staff are trained to assess risk and are fully aware of their responsibilities. We make the following recommendation:

**The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:**

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk in an appropriate manner.**
- **Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records.**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.**

#### *ACCT procedures*

78. When the man's offender supervisor identified the man's risk of suicide the next day, the custodial manager, A, immediately began ACCT procedures and set a high interim level of observations. Officer C assessed the man promptly that afternoon.
79. The first ACCT case review was multidisciplinary, including a mental health nurse. The panel set a cautious and reasonable level of observations. However, the case manager recorded the level of risk as 'low'. Guidance in the ACCT document advises case managers to assess the prisoner as a raised risk of suicide if there is evidence of recent suicidal intent. SO B did not know about the man's recent threat to slit his throat because this specific information, although spotted in the recall notification by the offender supervisor had not been recorded in the ACCT document.
80. SO C completed the ACCT caremap. She recorded a goal of family contact, but no member of staff was given responsibility to help him. The man made no telephone calls and does not appear to have written to anyone. The man's probation officer, told us that he lacked motivation or much social support in the community and it seems unlikely that the man was sufficiently motivated to make telephone calls and write letters without prompting.
81. PSI 64/2011 says that case reviews should consider and agree whether any items, which the prisoner might use to self-harm, should be removed from them. Removal of items should be kept to a minimum and must never be automatic as this can make vulnerable prisoners feel worse. The man's family asked why he was allowed to have a plastic bag in his cell. Although there was no record that the case review discussed this, we are satisfied that there was no reason why the case review would have concluded that an item such as a plastic bag would be removed, as there was no information to suggest that the man was at risk of suffocating himself.

82. Officer F was responsible for checking the man twice an hour on the evening of 28 November. PSI 64/2011 requires that ACCT checks are made at random intervals within the specified frequency so that the prisoner cannot easily predict them. The officer recorded entries at 8.00pm, 8.30pm, 9.00pm and 9.30pm. This in itself was unsatisfactory. However, viewing of the CCTV footage from C3 landing shows that only the last entry was accurate. The officer did not make checks at 8.00pm, 8.30pm or 9.00pm. Instead, CCTV shows that he carried out checks at 8.22pm and 8.47pm.
83. The Safer Custody Lead for prisons in the North West of England was commissioned by the acting governor to conduct an internal investigation into the events on the evening of 28 November, including how Officer F conducted the ACCT checks. The internal investigation did not recommend any disciplinary action, but recommended that staff should be reminded of the requirements of Prison Service Instruction 64/2011. The police interviewed the officer and decided not to take further action because his actions did not meet the evidential threshold to support a charge that he acted in a wilfully neglectful manner.
84. We are concerned that ACCT procedures were ineffective because essential information about risk was not incorporated into the ACCT document, caremap actions were not well targeted and observations were conducted as required. We make the following recommendation:

**The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:**

- **ACCT documents should include all information about a prisoner's risk and case reviews should assess the level of risk taking into account all risk factors. The level of observations should reflect this risk;**
- **Case managers should ensure that caremap actions are tailored to meet the individual needs of the prisoner, are time bound and given to a named member of staff as necessary.**
- **Staff should perform checks as instructed on the ACCT front cover, at random intervals, and record observations in the ongoing record as close to the time of the check as possible.**

### **Clinical care**

85. Nurse A did not read the man's clinical record, escort record or recall notification and did not refer the man to any further services. He said that he did not usually make mental health referrals in reception because a mental health nurse triages new prisoners on their second day. However, the role of the reception nurse is to perform a holistic assessment of any physical or mental health problems and make appropriate referrals at the earliest opportunity. Prisoners might have urgent mental health problems that require immediate attention and can be particularly vulnerable on their first night.
86. Nurse B said that she referred the man for admission to the mental health inpatient unit and to the integrated mental health team after she assessed him the next day. However, there is no evidence of these referrals in the man's

clinical record. The nurse said that one was a handwritten form and the other written on a whiteboard. We make the following recommendation:

**The Head of Healthcare should ensure that nurses assessing new prisoners consult all available sources of information and make appropriate referrals based on the prisoner's individual needs. All patient contact and referrals should be documented in the clinical record.**

### Emergency response

87. Officer F became concerned about the man when he visited the cell at 9.30pm, but it was almost ten minutes later, before the night manager, arrived and found him suffocated with a plastic bag on his head. In his original radio transmission to the night manager at 9.31pm, the officer did not mention that it was a life-threatening incident, or express any urgency. He simply asked the night manager to telephone him. As the night manager did not realise the situation was urgent, it was several minutes later before he called the officer.
88. While he waited for assistance, Officer F went back and forth between the cell and the office because he had asked the night manager to call him on the office telephone. He told the investigator that the man was holding the plastic bag in his hand, which was down by his side, each time he checked him. He was concerned that the man might put the bag over his head, but he took no further action other than to ask the night manager to come to the cell, as he did not consider this was an emergency. Two minutes after the officer's final check at 9.38pm, the night manager opened the cell and found that the man had suffocated himself. We consider that Officer F should have remained outside the cell once he became concerned, communicated with the night manager by radio and monitored the man through the observation panel until help arrived. This would have allowed him to intervene urgently if necessary and call an emergency.
89. While Officer F should have made his concerns clearer and stayed at the cell, we also consider the night manager should have acted with more urgency. He knew there were concerns that a prisoner subject to ACCT procedures had a plastic bag in the cell. This should have been his priority, yet the journey from the gate to C3 landing, which should take between one or two minutes at night when all prisoners are locked away and most gates left open, took the night manager and assistant night manager about five minutes. They stopped to lock away keys in a safe in the centre of the prison. While this was official procedure, one of them could have gone directly to the cell while the other performed this task.
90. We are concerned that Officer F did not communicate his concerns about the man's risk effectively or monitor him appropriately until help arrived. We also consider that the night manager's response lacked the urgency we would have expected when concerns had been raised about a prisoner already identified as at risk of suicide and self-harm. This ineffective handling gave the man the opportunity to suffocate himself. We make the following recommendation:

**The Governor should ensure that night staff who have concerns about the behaviour of a prisoner identified as at risk of suicide or self-harm, request immediate assistance, clearly stating the nature of the risk, and keep the prisoner under observation until help arrives.**

91. PSI 03/2013 requires control room staff to call an ambulance automatically, as soon as an emergency medical code is broadcast. On 14 October 2014, the Governor issued a staff information notice, which reminded staff of this requirement. The officer, who worked in the control room, knew that she was supposed to call an ambulance automatically and said that she detected from the assistant night manager's tone that the incident was serious. However, she said that she did not call an ambulance immediately as staff at Preston often used emergency codes for inappropriate and trivial reasons, such as a cut finger. She therefore waited for clarification before calling an ambulance, causing a further delay of almost two minutes. During our interviews, the assistant night manager, the night manager, Nurse E and Nurse C all gave similar accounts of how codes were often used inappropriately.
92. We are concerned that it appears that emergency codes are frequently used inappropriately by prison staff at Preston to summon a member of healthcare staff when it is not an emergency. Staff need to understand the importance of using the codes only in defined emergencies, as set out in Prison Service Instruction 03/2013, and that misuse is dangerous. We make the following recommendation:

**The Governor should ensure that all staff understand the need to use emergency medical codes in line with PSI 03/2013 and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further information.**

### **Staff support**

93. PSI 08/2010 about Post Incident Care requires managers to hold a short debrief meeting before staff go home when they have been involved in a potentially traumatic incident. All staff directly involved in the incident, including healthcare staff, should be invited. We found no evidence that managers held a debrief meeting for the staff involved in the emergency response and offered them support, either at the time or after the man's death. We had similar concerns after the death of another prisoner at Preston in May 2014. We make the following recommendation:

**The Governor should ensure, in line with PSI 08/2010, that all staff, including healthcare staff, are included in a hot debrief after a potentially traumatic incident or death and are offered support.**

## RECOMMENDATIONS

1. The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:
  - Have a clear understanding of their responsibilities and the need to record relevant information about risk in an appropriate manner.
  - Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records.
  - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.
2. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
  - ACCT documents should include all information about a prisoner's risk and case reviews should assess the level of risk taking into account all risk factors. The level of observations should reflect this risk;
  - Case managers should ensure that caremap actions are tailored to meet the individual needs of the prisoner, are time bound and given to a named member of staff as necessary.
  - Staff should perform checks as instructed on the ACCT front cover, at random intervals, and record observations in the ongoing record as close to the time of the check as possible.
3. The Head of Healthcare should ensure that nurses assessing new prisoners consult all available sources of information and make appropriate referrals based on the prisoner's individual needs. All patient contact and referrals should be documented in the clinical record.
4. The Governor should ensure that night staff who have concerns about the behaviour of a prisoner identified as at risk of suicide or self-harm, request immediate assistance, clearly stating the nature of the risk, and keep the prisoner under observation until help arrives.
5. The Governor should ensure that all staff understand the need to use emergency medical codes in line with PSI 03/2013 and that control room staff call an ambulance immediately an emergency medical code is received, without waiting for further information.
6. The Governor should ensure, in line with PSI 08/2010, that all staff, including healthcare staff, are included in a hot debrief after a potentially traumatic incident or death and are offered support.

