

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Ashley Gerrard a prisoner at HMP Preston on 18 July 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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

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

Mr Ashley Gerrard was found hanging in his cell in the segregation unit at HMP Preston on 17 July 2016 and died in hospital the next day, never having regained consciousness. He was 30 years old. I offer my condolences to Mr Gerrard's family and friends.

Although Mr Gerrard's risk of suicide in the two days leading to his death may not have been immediately apparent, his behaviour was volatile and deteriorating and he was emotionally distressed. I am concerned that staff appear to have relied too heavily on his reassurances that he was all right and did not consider adequately these changes, his recorded history and risk factors in the round. Mr Gerrard appears to have been involved with illicit drugs at Preston and, while staff had to manage the security risk that he posed, a better balance should have been achieved between necessary controls and his welfare.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**April 2017**

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# Summary

## Events

1. On 23 December 2015, Mr Ashley Gerrard was remanded to Preston charged with burglary and using a firearm to resist arrest. Mr Gerrard had a history of suicide attempts, self-harm and mental health problems. He arrived with a suicide and self-harm warning form because he had told police officers that he would kill himself if he was remanded to prison. Prison staff began Prison Service suicide and self-harm prevention procedures (known as ACCT) when he arrived, assessed him as at a high risk of suicide and constantly supervised him for three days. On 29 December, staff concluded that Mr Gerrard's risk of suicide and self-harm was low and ended ACCT monitoring.
2. When Mr Gerrard first arrived at Preston, a doctor prescribed him antidepressant medication. On 16 June, Mr Gerrard stopped taking the medication because he thought it was causing a rash on his face. He did not resume taking the medication until 11 July.
3. Staff submitted a number of security intelligence reports indicating that Mr Gerrard was involved in the supply of drugs in the prison, in particular New Psychoactive Substances (NPS) as a result of which he was subject to a range of sanctions. On 7 April 2016, a targeted search found that Mr Gerrard had a mobile phone. As a result, Mr Gerrard was made subject to closed visits. Due to ongoing security intelligence concerns, Mr Gerrard was still subject to closed visits when he died. On 4 July, Mr Gerrard was again linked with the supply of drugs in the prison and he was dismissed from his job in the prison gardens.
4. On 16 July, Mr Gerrard climbed onto a wall. He was distressed and frustrated and discussed a number of concerns with staff, including that he had been subject to closed visits for too long and was having relationship problems. Mr Gerrard told an officer that he had considered hanging himself, but had chosen to climb the wall instead. About three hours later, staff persuaded him to climb down and he was moved to the segregation unit where he was treated as an escape risk and subject to frequent checks.
5. A manager talked to Mr Gerrard to explore whether he was at risk of suicide and self-harm. Mr Gerrard said he had no thoughts of either and staff concluded that he did not need to be supported by ACCT procedures. They did not record that they had considered all of his risk factors for suicide and self-harm. Segregation unit staff recorded no concerns about him that evening and a nurse assessed him as able to cope with a period of segregation.
6. At around 3.15pm on 17 July, Mr Gerrard phoned his girlfriend several times. They argued and accused each other of being in relationships with other people. A supervising officer realised that Mr Gerrard was upset but Mr Gerrard reassured him that he was all right. The officer did not tell other staff about Mr Gerrard's phone call.
7. At about 4.30pm, another supervising officer unlocked Mr Gerrard's cell to give him his evening meal. He found Mr Gerrard hanging from a ligature made of sheets, which he had tied to the ceiling light fitting. The supervising officer

radioed a medical emergency, and officers and nurses attended and attempted resuscitation. Paramedics arrived promptly and, after continued resuscitation, detected a pulse. At 5.29pm, paramedics transferred Mr Gerrard to hospital. Sadly, he did not regain consciousness and died, with his family beside him, the following afternoon.

## Findings

8. When staff assessed Mr Gerrard's risk of suicide and self-harm after he climbed the wall on 16 July, he said that he had contemplated suicide and it should have been apparent that he was at an increased risk of suicide and self-harm. Staff were reassured by his demeanour and did not begin ACCT procedures. These risks were heightened further following a distressing telephone conversation he had with his girlfriend in the segregation unit. We consider staff did not take sufficient account of his heightened and recorded risk factors in deciding not to begin suicide and self-harm procedures.
9. A substantial and growing body of intelligence indicated that Mr Gerrard was involved in the supply and use of drugs in the prison. We are concerned that the prison's approach to this was exclusively restrictive and failed to take account of the impact on Mr Gerrard's welfare. None of the information was passed to the police for investigation. We are concerned that the prison missed opportunities to manage his behaviour using a multidisciplinary approach, rather than focussing exclusively on his security risk.
10. Although the clinical reviewer concluded that Mr Gerrard received generally appropriate healthcare at Preston, we conclude that healthcare staff should have taken more action when Mr Gerrard stopped taking his medication.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
  - All known risk factors and triggers are considered when determining the level of risk of suicide and self-harm.
  - Initial Segregation Health Screenings assess a prisoner's wellbeing, including his risk factors for suicide and self-harm.
- The Governor should ensure that restrictive measures taken to address security threats are considered and proportionate and that their potential impact on the welfare of prisoners is taken into account.
- The Head of Healthcare should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator visited Preston on 28 July 2016. He obtained copies of relevant extracts from Mr Gerrard's prison and medical records.
13. The investigator interviewed 17 members of staff and two prisoners at Preston between July and September 2016.
14. NHS England commissioned a clinical reviewer to review Mr Gerrard's clinical care at the prison. The clinical reviewer conducted five interviews jointly with the investigator.
15. We informed HM Coroner for Preston and West Lancashire District of the investigation who gave us an initial cause of death. The Coroner advised us that no toxicology tests had been performed because samples of Mr Gerrard's blood and urine had been mistakenly disposed of. The final post-mortem report had not been produced before we published our initial report. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers and the investigator visited Mr Gerrard's mother and sister on 20 July, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Gerrard's mother and sister asked:
  - How many times Mr Gerrard had tried to kill himself at Preston, and what action staff took in response.
  - Why staff were not supervising Mr Gerrard more closely.
  - What medication had been prescribed to Mr Gerrard, when and why he had stopped taking it, and whether healthcare staff had taken any action to follow this up.
  - Whether Mr Gerrard had been subject to closed visits for longer than he should have been, and why he had lost his job.
  - Whether staff adequately assessed Mr Gerrard's risk after he climbed to the top of a wall on 16 July and how frequently they had checked him afterwards.
17. Mr Gerrard's family received a copy of the initial report. The solicitor representing them wrote to us raising some comments and questions. We have provided clarification by way of separate correspondence to the solicitor.
18. The prison service also received a copy of the initial report.

## Background Information

### HMP Preston

19. 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.

### HM Inspectorate of Prisons

20. 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. Many ACCT case reviews were multidisciplinary, but continuity of case management was lacking. The prevalence of drugs contributed to some prisoners feeling unsafe. Security was proportionate, but drug supply reduction work and responses to intelligence needed to improve. The incentives and earned privileges (IEP) scheme was adequately managed, although staff did not always challenge poor behaviour. 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

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2016, the IMB reported that the use of New Psychoactive Substances (NPS) had been a cause for concern but staff had prevented some significant drug deliveries and there had been a robust response to those caught bringing in drugs and other contraband, culminating in prison sentences for perpetrators.

### Previous deaths at HMP Preston

22. Mr Gerrard's was the second self-inflicted death at HMP Preston since December 2014. There were no particular similarities between the circumstances or findings in this investigation and previous one.

### Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## **Incentives and Earned Privileges scheme**

24. Each prison has an Incentives and Earned Privileges scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

## **New Psychoactive Substances (NPS)**

25. New psychoactive substances, now covered by the Psychoactive Substances Act 2016, are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
26. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
27. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

## Key Events

28. On 23 December 2015, Mr Ashley Gerrard was arrested and charged with burglary and using a firearm to resist arrest. While in police custody, Mr Gerrard tied a paper suit around his neck and tried to strangle himself with it. He said that he would try to kill himself if he was remanded to prison. A police officer completed a suicide and self-harm warning form, noting this information. This was not Mr Gerrard's first time in prison.
29. At Preston, a nurse noted that Mr Gerrard had engaged with community mental health services, including an informal admission to a mental health hospital in 2008. He said that he was prescribed two antidepressants, citalopram and mirtazapine. She recorded that Mr Gerrard interacted well with her, and said that he had thoughts of suicide. Mr Gerrard said that he did not want to live any more and felt very depressed. The nurse immediately began Prison Service suicide and self-harm monitoring procedures (known as ACCT), and referred him for a mental health assessment. The next day, a prison GP prescribed Mr Gerrard sertraline (an antidepressant) because he said that citalopram and mirtazapine did not help him. Mr Gerrard took sertraline every day (except for a period in June and July) until his death.
30. On 24 December, during the ACCT assessment interview, Mr Gerrard said that, six months earlier, he had tried to hang himself from a tree, and that his girlfriend had stopped him from stepping in front of a train. Mr Gerrard was very tearful and repeated that he wanted to kill himself at the earliest opportunity. Officers assessed Mr Gerrard as at a high risk of suicide and self-harm and constantly supervised him for three days. On his first night at the prison, he cut his arm and tried to strangle himself with his t-shirt. A mental health nurse attended Mr Gerrard's ACCT reviews and assessed his mental health. She offered him support, and referred him to a Psychological Wellbeing Practitioner (who works with patients with mild to moderate depression). Mr Gerrard said that he did not want any support or to engage in therapy. On 29 December, staff concluded that Mr Gerrard was now at a low risk of suicide and self-harm and ended ACCT monitoring. Mr Gerrard raised no further concerns about his mental health at Preston and had limited contact with the healthcare department after his early days at the prison.
31. On 24 February, Mr Gerrard started working with the prison's waste management team and moved to a small unit for trusted prisoners. Two days later, a prisoner told an officer that Mr Gerrard had brought Spice (a New Psychoactive Substance - NPS) onto the unit and was smoking it at night. The officer submitted a security report. Under Preston's local NPS protocol, prisoners suspected of using or trading NPS can be sanctioned under the Incentives and Earned Privileges (IEP) scheme, including being demoted to basic level. Their applications for employment in the prison can also be affected, they may face disciplinary hearings and the matter can be referred to the police. No immediate action was taken in response to the officer's security report, and no one referred Mr Gerrard to the substance misuse team.

32. On 10 March, the officer submitted another security report after some prisoners said that Mr Gerrard had brought NPS for himself and his friends, and that another prisoner had had a seizure as a result. On 11 March, the officer submitted a third security report that a prisoner had told him that Mr Gerrard was expecting items (possibly NPS and mobile phones) to be thrown over the prison's perimeter wall. A security manager analysed the three reports and, on 11 March, Mr Gerrard was dismissed from his job and was moved to a standard residential unit.
33. On 7 April, during a random search, an officer found that Mr Gerrard had a mobile phone in his possession. The officer downgraded Mr Gerrard to basic on the IEP scheme, submitted a security report and charged Mr Gerrard with a disciplinary offence, to which he pleaded guilty.
34. Mr Gerrard spent two days in the segregation unit as punishment and the security department decided that he should be subject to closed visits, which meant that Mr Gerrard and his visitors were separated by a panel of glass and could not have physical contact. Staff reviewed the decision on 10 May and 14 June, and concluded that closed visits were still necessary because of security intelligence suggesting Mr Gerrard was involved in the supply of drugs in the prison. Mr Gerrard was still subject to closed visits when he died on 18 July.
35. In April, officers submitted seven security reports that Mr Gerrard was threatening prisoners and asking other prisoners to bring drugs and mobile phones into the prison. On 11 April, the prison gave Mr Gerrard a job in the horticulture workshop working in the prison gardens, and the next day, staff raised his IEP status to standard because he was considered to be behaving well. On 26 April, Mr Gerrard punched another prisoner and he was charged with a disciplinary offence and downgraded to basic level on the IEP scheme. That day, Mr Gerrard was sentenced to six years and four months imprisonment.
36. On 4 June, an officer submitted another security report that Mr Gerrard had bullied a prisoner and intelligence linked this with the use of drugs. Although the contents of the numerous security reports meant that Mr Gerrard remained subject to closed visits, there is no evidence that any other targeted action was taken to investigate the allegations further, refer them to the police or sanction Mr Gerrard further.
37. On 21 June, Mr Gerrard told a nurse that he had stopped taking his antidepressant medication because he thought it was causing a rash on his face. The nurse referred Mr Gerrard to the GP for a review. Preston does not have a written medication non-compliance protocol, but healthcare staff told the investigator that nurses were expected to record the names of any prisoners who stopped taking mental health medication, review them and explore why they had stopped. She did not add Mr Gerrard's name to the medication non-compliance log and his decision not to take his antidepressants was not reviewed until a prison GP assessed him three weeks later on 11 July. According to healthcare records, Mr Gerrard did not collect his antidepressants between 16 June and 11 July.

38. On 4 July, a package containing drugs was thrown over the prison wall into the horticulture workshop area. Another prisoner told staff that Mr Gerrard had asked him to collect two parcels of drugs from the horticulture workshop. The prisoner said that Mr Gerrard had bullied him and he was very concerned about his safety. An officer submitted a security report and Mr Gerrard was dismissed from his job. We do not know whether staff explained to Mr Gerrard why he was being dismissed. There is no evidence that staff investigated the matter any further and Mr Gerrard was not subject to any antisocial behaviour monitoring. The security department noted that staff should consider searching Mr Gerrard, but there is no record that this happened. The prison did not refer the allegations about Mr Gerrard's involvement in drug dealing to the police.
39. On 7 July, a nurse recorded that Mr Gerrard was not collecting his antidepressant medication and placed his name on the non-compliance log. On 11 July, a locum prison GP reviewed Mr Gerrard following a nurse's referral on 21 June. The GP noted that Mr Gerrard had a rash on his forehead, which was not caused by the sertraline. He prescribed cream for the rash and re-prescribed sertraline.

### **Saturday 16 July**

40. At around midday on 16 July, Mr Gerrard climbed to the top of a wall opposite the exercise yard. An officer raised the alarm and an officer, who was a trained negotiator and gym instructor, attended the yard immediately to speak to Mr Gerrard. The officer knew Mr Gerrard because he was a regular gym user.
41. The officer told the investigator that Mr Gerrard was anxious, distressed and tearful. Mr Gerrard said that he was frustrated and complained that he had been subject to closed visits for longer than other prisoners and that this was affecting his relationship with his family. He said that his girlfriend had left him. He said that he did not know why he had been sacked from his horticulture job. He complained that his mother had sent him a cheque for £200, but it had been paid into his savings account, which meant he was not able to access it. (Staff told us that, when they are unable to identify who has sent money in, it is paid into the prisoner's savings account while the matter is investigated. Mr Gerrard's account records show that on 5 July, £200, which was sent in without sender's details, was paid into his savings account.)
42. Mr Gerrard told the officer that he had suffered from depression since he was young, had mental health problems and needed to see someone from the mental health team. He said that he had been thinking about his brother, the anniversary of whose death in a car accident was in June. Mr Gerrard told him that everybody was against him and he wanted staff to listen to him. Mr Gerrard said that he had considered hanging himself, but had decided to climb up the wall instead. The officer said that he did not take Mr Gerrard's comments seriously and thought he was frustrated, but not at any risk of suicide or self-harm. He did not know that Mr Gerrard had a history of suicide attempts and self-harm, or that he had been monitored on an ACCT in December 2015.
43. The officer told Mr Gerrard that the duty governor would talk to him and address his concerns. At around 3.00pm, Mr Gerrard climbed down and was

escorted to the segregation unit, to await a disciplinary hearing. Managers placed Mr Gerrard on the list of prisoners considered an escape risk as a precaution. This meant that Mr Gerrard had to wear high visibility clothing and became subject to close control including hourly checks and requiring permission before making any phone calls, so that staff could listen to the calls as Mr Gerrard made them.

44. Following the incident, the duty governor and the officer discussed what Mr Gerrard had said. The duty governor said that he was very concerned that Mr Gerrard had mentioned hanging himself and asked a unit manager to go and speak to Mr Gerrard immediately. The unit manager said that Mr Gerrard told him he did not have any thoughts of suicide or self-harm and that he had climbed the wall to express his frustration. He said that he was reassured by what Mr Gerrard said and by his demeanour, and did not think that he was at any risk of suicide and self-harm or needed the support of ACCT procedures.
45. A nurse assessed Mr Gerrard in the segregation unit and recorded that he had made good eye contact and engaged well. She told the investigator that she did not know much about Mr Gerrard and did not check his records before assessing him, although she said that she knew that he had been on ACCT monitoring in the past. She said that Mr Gerrard did not seem distressed when she assessed him. Mr Gerrard asked if he could speak to someone from the mental health team and the nurse told him that someone would assess him the next day, which is standard practice for newly segregated prisoners. She said that, while the purpose of her assessment was primarily to ensure Mr Gerrard had no injuries, she did not consider him to be at any risk of suicide and self-harm. She completed the segregation health assessment, answering 'no' to all of the questions, including whether Mr Gerrard had ever self-harmed in the past and whether his mental health would deteriorate if he was segregated. She concluded that Mr Gerrard would cope with a period of segregation.
46. Segregation unit staff checked Mr Gerrard once an hour, in line with their standard segregation checks and escape list requirements, and officers recorded no major concerns about him.

### **Sunday 17 July**

47. On the morning of 17 July, Mr Gerrard completed forms applying for a shower, a period of exercise in the open air and permission to make a phone call, which staff authorised. Mr Gerrard also completed a form appealing against the decision to consider him an escape risk. The duty governor also went to speak to Mr Gerrard who said that he was fine and did not have any issues.
48. At around 1.00pm, a nurse reviewed Mr Gerrard in his cell. She told the investigator that he was tearful but did not seem low in mood. She thought that he was reassured that the prison was going to address his concerns. She recorded that Mr Gerrard was worried about his relationship with his girlfriend, which he complained had been affected by the closed visits. She told the investigator that she considered Mr Gerrard's history of suicide attempts and self-harm. However, she did not think that he needed ACCT monitoring because he did not seem as distressed as he had been in December and he said he did not have any current thoughts of suicide and self-harm. She said

that Mr Gerrard believed that everything was going to be resolved and seemed positive about the future.

49. At around 2:35pm, a Supervising Officer (SO) and an officer took Mr Gerrard outside to the exercise yard. The SO said that Mr Gerrard appeared fine and so they had no concerns about him.
50. Later, staff allowed Mr Gerrard to phone his girlfriend. He rang her at 3.14pm, 3.15pm, 3.17pm and 3.19pm. Although, as Mr Gerrard was considered an escape risk, staff were supposed to listen to his phone calls as he made them, no one monitored Mr Gerrard's calls that afternoon. The investigator listened to the four short calls. During the phone calls, Mr Gerrard and his girlfriend accused each other of having relationships with other people. At the end of the last conversation, Mr Gerrard's girlfriend told him to stop calling her and to stay with the other woman. Mr Gerrard then returned to his cell.
51. The SO told the investigator that he walked past Mr Gerrard while he was on the phone and overheard him shouting and appearing to be very angry. After the call ended, he asked Mr Gerrard if he was alright and Mr Gerrard said that he was fine, although he was clearly upset. He followed Mr Gerrard to his cell and locked him in it. He had no further contact with Mr Gerrard and said that he did not have any particular concerns about him. He did not tell other segregation staff that Mr Gerrard had argued with someone on the phone, or that he had seemed upset. Staff did not record any checks on Mr Gerrard, or make any notes in his segregation file or anywhere else after midday on 17 July.
52. At about 4.30pm, the SO started to serve the evening meal to prisoners in the segregation unit. When he unlocked Mr Gerrard's cell he found him hanging from a ligature made from sheets, which he had attached to the light fitting on the ceiling. He shouted to two officers for help and they arrived quickly. One officer cut the ligature and the staff placed Mr Gerrard on the floor. At 4.35pm, the SO radioed a code blue emergency (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties) and asked for urgent staff assistance in the segregation unit. The officer in the control room called an ambulance immediately.
53. A unit manager arrived quickly after the code blue call and started resuscitation procedures. Six nurses arrived and assisted with the resuscitation attempt. The ambulance arrived at the prison at 4.43pm and three minutes later, paramedics reached Mr Gerrard's cell and took over resuscitation procedures. At about 4.53pm, paramedics detected a pulse and at 5.29pm, they took Mr Gerrard to hospital.

### **Contact with Mr Gerrard's family**

54. At 6:40pm on 17 July, the duty manager and unit manager visited Mr Gerrard's mother, who he had named as his next of kin, and told her that Mr Gerrard was in hospital. Mr Gerrard's mother and sister arrived at the hospital at 7.45pm. Mr Gerrard remained in the intensive care unit until he died at 4.12pm on 18 July, never having regained consciousness. His family was with him when he died.

55. On 18 July at 9.15am, an operational manager, was appointed as the family liaison officer and met Mr Gerrard's mother at the hospital, and offered support. Mr Gerrard's funeral was held on 4 August 2016. The prison contributed to the funeral costs, in line with national instructions.

### **Support for prisoners and staff**

56. After Mr Gerrard's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
57. The prison posted notices informing other prisoners of Mr Gerrard's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm and those in the segregation unit in case they had been adversely affected by Mr Gerrard's death.

### **Post-mortem report**

58. A post-mortem examination established the cause of Mr Gerrard's death as hanging. The Coroner told us that the police had not secured any samples of Mr Gerrard's blood or urine for toxicology tests, so we do not know if Mr Gerrard had either his prescribed medication or illicit drugs in his system when he arrived at the hospital.

# Findings

## Assessment and management of risk

59. When Mr Gerrard arrived at Preston on 23 December 2015, he had a history of suicide attempts and self-harm, and of mental health problems. Staff initially assessed him as at a high risk of suicide and self-harm and he was monitored under ACCT procedures for five days (including three days of constant supervision). After 29 December, staff apparently had no reason to consider his risk of suicide and self-harm again until 16 July, when he climbed up the wall.
60. On 16 July, Mr Gerrard was anxious, depressed and frustrated about his situation, including that he had been subject to closed visits for over two months and had lost his job. He had relationship problems and it had been the anniversary of his brother's death. He told an officer during negotiations that he had thought about hanging himself. This was against his background of existing risk factors, and his decision not to take his prescribed antidepressants for several weeks in June and July.
61. The officer told the investigator that he did not take Mr Gerrard's comment about suicide seriously, and thought he was frustrated but not suicidal, so he did not consider beginning ACCT procedures. The duty governor was concerned by what Mr Gerrard had said and sent the unit manager to talk to him in the segregation unit. The unit manager was reassured by what Mr Gerrard said and his demeanour and also did not consider him to be at risk of suicide or self-harm. Prison Service Instruction (PSI) 64/2011, which covers safer custody, instructs that any member of staff who receives information or observes behaviour which may indicate a risk of suicide or self-harm must open an ACCT.
62. Later on 16 July, a nurse carried out the segregation health screen. She said that her primary responsibility was to check Mr Gerrard for injuries, not to assess his mental health or risk of suicide and self-harm. However, she said that she did not consider him to be at risk. She knew he had been monitored by ACCT procedures when he had first arrived, but did not know the extent of his risk then and had not looked at his medical record before assessing him. Although she assessed Mr Gerrard as able to cope with a period of segregation, it is not clear that she properly considered his mental health or risk of suicide and self-harm when she did so, as required by segregation guidelines.
63. During the morning of 17 July, staff (including a mental health nurse) had no concerns about Mr Gerrard and he participated in the segregation unit regime. At around 3.20pm, he made a number of calls to his girlfriend and they argued. As Mr Gerrard was considered an escape risk, staff should have listened to his phone calls as he made them, but this did not happen. The SO realised that Mr Gerrard was angry and upset but Mr Gerrard reassured him that he was fine. The SO did not tell any other segregation staff about Mr Gerrard's phone call or that he might be upset or vulnerable.
64. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to

determine risk. It is not an exact science. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors should be collated and considered to ensure that a prisoner's level of risk is holistically judged. We are not confident that staff applied this approach when considering Mr Gerrard's risk on 16 July where a number of dynamic risks were significantly raised and needed to be considered in light of his known risk factors. We make the following recommendation:

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

- **All known risk factors are considered when determining the level of risk of suicide and self-harm.**
- **Initial Segregation Health Screenings assess a prisoner's wellbeing, including his risk factors for suicide and self-harm.**

65. While segregated, staff should have checked and recorded their observations of Mr Gerrard once an hour. Although clearly staff had contact with Mr Gerrard between midday and 4.30pm on 17 July, no one recorded any observations in his segregation file. It seems that no one checked Mr Gerrard between 3.20pm, when the SO locked him in his cell, and about 4.30pm, when another SO unlocked his cell to give him his dinner. We cannot say whether a check between 3.20pm and 4.30pm would have prevented Mr Gerrard from taking his life, but staff should have checked him in line with their local policy. We make the following recommendation:

**The Governor should ensure that, unless managers set different levels of observations for individual prisoners, all segregated prisoners should be observed at least hourly, with a contemporaneous record completed by the person carrying out the check.**

### **Drugs, NPS, Security and Intelligence**

66. We are concerned about the prevalence of illicit drugs, including NPS, in prisons and their effect on the behaviours and health of those taking them, including an association with suicide and self-harm. While Mr Gerrard was at Preston, officers submitted a number of security intelligence reports which indicated that he was using and involved in the supply of drugs, in particular NPS, in the prison. There were also allegations that Mr Gerrard was bullying other prisoners to bring NPS into the prison, to collect drug deliveries as they came over the perimeter wall or for other drug related reasons. We have concerns about how the prison responded to the growing body of intelligence about Mr Gerrard's involvement in drug supply and use.
67. Mr Gerrard was dismissed from the prison's waste management team following receipt of intelligence that he was involved in drug smuggling. One month later, Mr Gerrard began working in the horticulture workshop, just four days after he

pleaded guilty to a disciplinary charge of having a mobile phone and despite the growing security intelligence linking him with drug supply. The horticulture workshop, where prisoners work in the prison gardens, is located against the external perimeter wall of the prison. It is questionable if this was a suitable job for a prisoner suspected of involvement in drug supply. None of the intelligence about Mr Gerrard was referred to the police, even after he was suspected of being involved when a parcel of drugs was thrown over the perimeter wall on 4 July, following which he was, again, dismissed from his job.

68. According to the prison's local NPS protocol, prisoners suspected of drug use or supply can face sanctions under the IEP scheme, through disciplinary charges or the matter can be referred to the police. The protocol notes that prisoners' applications for work in the prison may also be reconsidered in light of security intelligence. The prison's local drug strategy document recommends that staff should carry out proactive observation and supervision of those suspected of drug dealing to reduce the supply of drugs.
69. We consider that the prison missed opportunities to consider Mr Gerrard's risk holistically as a multidisciplinary team, which led to mismanagement of his risk, for example allocating him work in the prison gardens. We are also concerned that the impact of the restrictive steps taken by the prison in response to Mr Gerrard's involvement with drugs, while narrowly appropriate, did not properly take into account their potential impact on his welfare and risk of suicide and self-harm. We make the following recommendation:

**The Governor should ensure that restrictive measures taken to address security threats are considered and proportionate and that their potential impact on the welfare of prisoners is taken into account.**

### **Mental health care**

70. The clinical reviewer concluded that Mr Gerrard received good quality healthcare at Preston, equivalent to what he might have expected to receive in the community. However, PSI 64/2011 provides guidelines about managing prisoners with complex behaviour, mental health issues and depression. It suggests that prison healthcare departments devise a system whereby prisoners who do not collect their antidepressants or antipsychotic medication are followed up to find out why. Preston does not have a written policy about missed medication, however a nurse told the investigator that if patients fail to take their mental health medication for three days, nurses are expected to add the patients to a non compliance log, review them and find out why they are not taking them.
71. When Mr Gerrard arrived at Preston, a prison GP prescribed an antidepressant, sertraline, which Mr Gerrard took every day until 16 June. The clinical reviewer established that Mr Gerrard did not take his medication between 16 June and 11 July. On 21 June, Mr Gerrard told a nurse that he had stopped taking his medication because it had caused a rash on his face. She referred him to the GP but did not add his name to the non-compliance log and no one from the healthcare department took any further action to discuss his decision with him. On 7 July, a nurse noted that Mr Gerrard was not collecting his medication and added him in the non-compliance log. On 11 July, after an appointment with

the prison GP, Mr Gerrard began taking sertraline again. We conclude that healthcare staff should have taken more proactive steps to monitor and challenge Mr Gerrard's decision not to take his antidepressants and we make the following recommendation:

**The Head of Healthcare should ensure that there are effective procedures to monitor prisoners' compliance with their medication and that nurses responsible for coordinating mental health care follow up missed medication as part of an active care plan approach.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations