

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Steve McBride, a prisoner at HMP Warren Hill, on 2 September 2024**

**A report by the Prisons and Probation Ombudsman**

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100

## OUR VISION

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

## WHAT WE DO



## WHAT WE VALUE



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Steve McBride was found hanged in his cell at HMP Warren Hill on 2 September 2024. He was 40 years old. I offer my condolences to Mr McBride's family and friends.

Mr McBride, who had been given an Imprisonment for Public Protection (IPP) sentence in 2008, was recalled to prison in 2019. He was supported using suicide and self-harm prevention procedures (known as ACCT) frequently during his time in prison due to his history of self-harm and frustrations about his IPP status.

Overall, Mr McBride was well supported by staff at Warren Hill. However, four days before Mr McBride died, staff stopped ACCT monitoring, prematurely in our view. In the days that followed, there were signs that Mr McBride's risk had increased, and staff missed opportunities to restart ACCT monitoring.

On the morning of 2 September, staff failed to carry out a proper check of prisoners, which caused a delay in finding Mr McBride hanging. Then poor communication by control room staff led to a long delay in an ambulance being despatched. The prison has since taken action to address these issues.

While Mr McBride was broadly well-supported by both prison and healthcare staff at Warren Hill, there was little that staff could do to address Mr McBride's underlying frustrations about his IPP status and his chance of parole.

In its report on IPP sentences published in September 2022, the Justice Select Committee found that the psychological harm caused by IPP sentences is a considerable barrier to progression for some IPP prisoners and that the indefinite nature of the sentence has contributed to hopelessness and despair that has resulted in high levels of self-harm and some suicides. In September 2023, following a worrying increase in the self-inflicted deaths of IPP prisoners in 2022, I issued a Learning Lessons bulletin on the subject. Their frustrations are understandable and, of course, the risk is that more IPP prisoners will take their own lives unless action is taken to support them through to release.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**May 2025**

# Contents

Summary .....	1
The Investigation Process.....	4
Background Information.....	6
Key Events.....	9
Findings .....	15

## Summary

### Events

1. In March 2019, Mr Steve McBride, who had been released in 2017 following an Imprisonment for Public Protection (IPP) sentence, was recalled to prison. (An IPP is an indeterminate sentence which means that on release, the prisoner is subject to licence conditions for life.) On 4 April 2023, Mr McBride was moved to HMP Warren Hill.
2. On 13 March 2024, the Parole Board decided that Mr McBride was not suitable for release or a move to open conditions. The Board said he needed to stop misusing illicit medication and address his self-harming behaviour. Mr McBride said his drug use and behaviour was due to past trauma and that he wanted to address it. He asked to be moved to the London Pathway Unit (LPU) at HMP Brixton and his prison offender manager (POM) made a referral.
3. Mr McBride had a long history of self-harm and was frequently supported using suicide and self-harm monitoring (known as ACCT). On 8 June, during an ACCT check, staff found Mr McBride unresponsive with a ligature around his neck. After his return from hospital the next day, Mr McBride told staff that he had wanted to end his life because he had been refused parole and had had enough of being on an IPP sentence.
4. On 10 June, the prison's neurodiversity lead saw Mr McBride to discuss coping strategies. She gave Mr McBride red and green wristbands to let staff know how he was feeling. Mr McBride wore red wristbands to indicate when he was in crisis and green wristbands to indicate he was having a good day.
5. In August, the LPU told Mr McBride's POM that they were unable to accept Mr McBride because he had no outstanding treatment needs that could be addressed on the LPU. At an ACCT review later that month, Mr McBride told staff he felt he was not progressing at Warren Hill and felt trapped. At Mr McBride's request, his POM asked HMP Oakwood if they would take him. Initially they said no, but agreed to the transfer when Mr McBride's POM argued that it would be beneficial for Mr McBride to have a fresh start. Oakwood said they would contact the POM with a proposed date.
6. At his ACCT review on 23 August, Mr McBride said he was feeling good. However, at his next ACCT review on 27 August, Mr McBride said he was fed up with the parole decision and would not apply again. He said he was having suicidal thoughts. Staff recorded he was wearing red wristbands and was withdrawn.
7. At the ACCT review on 28 August, staff recorded that Mr McBride said he was feeling much better and had no thoughts of suicide or self-harm. The team agreed to stop ACCT monitoring.
8. Over the next few days, several members of staff noted that Mr McBride was wearing red wristbands. Mr McBride told staff that he was confused and did not know whether he was coming or going. Staff did not restart ACCT monitoring.

9. At around 7.10am on 2 September, an officer completed the early morning roll check (count of prisoners). CCTV footage shows that she briefly opened the observation panel of Mr McBride's cell but did not look in.
10. Around half an hour later, another officer unlocked the cells on the wing for morning activities. The officer unlocked Mr McBride's cell door and opened it slightly. He did not look in or try to get a verbal response from Mr McBride.
11. After unlocking the other cells, the officer went back past Mr McBride's cell and realised that he had not had a response from Mr McBride after unlocking his cell a few minutes before. The officer opened the door fully and saw that Mr McBride was hanging from the window frame. The officer was not carrying a radio so left the cell to press the general alarm. Staff responded and radioed a medical emergency code at 7.49am.
12. At 7.52am, the OSG in the control room asked if an ambulance was required and a custodial manager confirmed it was. The OSG called for an ambulance and then transferred the call to the wing. At 8.07am, the OSG called the Ambulance Service for an update and was told that the earlier call did not transfer and was disconnected, so no ambulance had been despatched. When the OSG was asked if Mr McBride was conscious and breathing, he said he was so the ambulance operator said the ambulance would be 90 minutes. At 8.14am, the OSG called the Ambulance Service again and said Mr McBride was not conscious or breathing and an emergency ambulance was then despatched.
13. At 8.30am, paramedics arrived and assessed Mr McBride. At 8.38am, they declared life extinct.

## Findings

14. Overall, staff provided good support to Mr McBride, including the periods when he was managed under ACCT. However, we consider that staff stopped ACCT monitoring prematurely on 28 August. There were indications that Mr McBride's risk of suicide and self-harm had increased over the next few days and staff missed opportunities to restart ACCT monitoring.
15. An officer failed to carry out a proper check on the morning that Mr McBride died. This led to a delay in finding Mr McBride. The prison has since taken steps to address this.
16. There was an unacceptable delay in calling for an ambulance and in passing on relevant information to the Ambulance Service, which resulted in an emergency ambulance not being despatched until 25 minutes after the medical emergency code was called. The prison has since taken steps to address this. More broadly, HMPPS has committed to further work to explore deficiencies and identify improvements to the emergency response processes.
17. While Mr McBride received a good standard of care and support from prison and healthcare staff during his time in prison, there was very little staff could do to address the underlying reasons for Mr McBride's frustration and distress, given this was due to his IPP status over which prison staff had no control.

18. HMPPS published an IPP Action Plan in April 2023, in response to the Justice Select Committee's report on IPP sentences. It sets out a commitment to improve the prospects of progression through the IPP sentence and includes a requirement for Executive Directors to introduce IPP Delivery Plans by the end of April 2024. We are satisfied that Warren Hill has an IPP Delivery Plan with appropriate actions.

## **Recommendations**

- The Governor should review whether staff are effectively identifying objective risk factors and triggers when assessing prisoners' risk of suicide and self-harm rather than relying solely on their presentation.

## The Investigation Process

19. HMPPS notified us of Mr McBride's death on 2 September 2024.
20. The investigator issued notices to staff and prisoners at HMP Warren Hill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
21. The investigator visited Warren Hill on 9 September. She obtained copies of relevant extracts from Mr McBride's prison and medical records.
22. NHS England commissioned an independent clinical reviewer to review Mr McBride's clinical care at the prison. He and the investigator conducted joint interviews with 12 members of staff.
23. We informed HM Coroner for Greater Suffolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
24. The Ombudsman's office contacted Mr McBride's stepfather to explain the investigation and to ask if he had any matters he wanted us to consider. He asked us why Mr McBride was not checked hourly throughout the night. Mr McBride's sister appointed a legal representative, who asked:
  - Whether Mr McBride was in prison following recall due to his IPP sentence.
  - Whether consideration was given to transferring Mr McBride to a healthcare wing or hospital in view of his mental health difficulties.
  - Whether Mr McBride was being monitored under ACCT at the time of his death and the observation level.
  - If Mr McBride was not being monitored under ACCT at the time of his death, when and why had monitoring been stopped, and how had any requests made by Mr McBride to be put back on an ACCT been handled.
  - When Mr McBride was last seen alive, including what checks were made on the morning of 2 September.
  - Whether there was a delay in prison officers seeing Mr McBride ligatured in his cell and opening the cell door.
  - Whether Mr McBride left a note.These issues have been addressed in the report and the clinical review.
25. The legal representative asked another question that is not covered in this report and has been addressed in separate correspondence.
26. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

27. Mr McBride's family received a copy of the initial report. The solicitor representing Mr McBride's family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

## Background Information

### HMP Warren Hill

28. HMP Warren Hill is a medium secure prison that holds men mostly serving life sentences and indeterminate sentences for public protection. Practice Plus Group provides healthcare services Monday to Friday between 7.30am and 7.30pm, and from 7.30am and 5.30pm at weekends. Practice Plus Group also provides mental healthcare and substance misuse services.

### HM Inspectorate of Prisons

29. The most recent inspection of Warren Hill was in December 2019. Inspectors reported that prisoners were far more positive about relationships with staff than in similar prisons, and 95% said there was a staff member they could turn to if they had a problem. Inspectors reported that the key worker scheme was the best they had seen in operation. All prisoners were quickly allocated a key worker, who had regular meaningful contact with them and were involved in all aspects of their rehabilitation and progression.
30. Inspectors reported that there was a very comprehensive and effective safer custody policy, ACCT documents were good quality, and care plans were completed, actioned and updated regularly. Low levels of self-harm and positive prisoner well-being were underpinned by excellent staff-prisoner relationships and the prison's positive supportive culture.

### Independent Monitoring Board

31. 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 31 May 2024, the IMB reported that there had been no general increase in incidents of self-harm in the prison population since last year (when there were 11 incidents involving five individuals), but that complex cases existed and required careful management.
32. The IMB reported that about 80% of prisoners at Warren Hill have some form of personality disorder and some of these men also had mental health issues. The mental health team covered Warren Hill and the neighbouring HMP Hollesley Bay and was currently working with 44 prisoners who were in crisis. In addition, IAPT (improving access to psychological therapies) organised group sessions for prisoners who required support and was also planning to offer one-to-one sessions with a cognitive behaviour therapy specialist.

### Previous deaths at HMP Warren Hill

33. Mr McBride was the third prisoner at Warren Hill to die since September 2021. All the previous deaths were from natural causes. There are no similarities between the findings from our investigation into Mr McBride's death and the findings from our investigations into the previous deaths.

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

34. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
35. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.
36. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. When Mr McBride was at Warren Hill, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

## Imprisonment for Public Protection (IPP) sentences

37. Imprisonment for Public Protection (IPP) sentences were introduced in 2005. They were intended for high-risk prisoners who were considered dangerous, but whose offences did not merit a life sentence. Those sentenced to an IPP sentence were set a minimum term (tariff) which they had to spend in prison before the Parole Board could consider them for release. The Parole Board will direct release only if the prisoner has demonstrated that they have sufficiently reduced their risk to a level that can be managed in the community.
38. The imposition of IPP sentences was abolished in 2012 due to the inconsistent and more frequent application of these sentences than was intended. However, as of 30 September 2024 there were still 1,095 unreleased IPP prisoners in England and Wales. The majority, around two thirds, had been held for at least ten years beyond the end of their minimum term. In addition, there were 1,599 recalled IPP prisoners in custody, making a total IPP prisoner population of 2,694.
39. Data from the Ministry of Justice (MOJ) shows that in 2022, there were nine self-inflicted deaths of IPP prisoners, the highest number of self-inflicted deaths among the IPP prison population since the sentence was introduced.
40. In September 2022, the Justice Select Committee (JSC) published a report of its review of IPP sentences. The JSC found that the indefinite nature of the sentence contributed to feelings of hopelessness and despair that had resulted in high levels of self-harm and some suicides within the IPP population. They recommended that all IPP prisoners should be re-sentenced.
41. In February 2023, the Government announced that it would not re-sentence IPP prisoners. In response to the JSC report, the MOJ and HMPPS published a new

IPP Action Plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to “maximise their prospects of achieving a safe and sustainable release”.

42. In September 2023, we issued a Learning Lessons Bulletin on the self-inflicted deaths of IPP prisoners. We concluded that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. We also identified a number of risk triggers associated with IPP prisoners including parole hearings, prison transfers and change in security categorisation.

## Key Events

43. In July 2008, Mr Steve McBride was convicted of attempted murder and given an Imprisonment for Public Protection (IPP) sentence, with a tariff (minimum term) of two years and 91 days. He was released in February 2017 but recalled to prison two months later. (IPP prisoners are subject to a life licence on release.) Mr McBride was released again in January 2018.
44. In March 2019, Mr McBride was again recalled to prison charged with further offences and was sent to HMP Bedford. Mr McBride had been diagnosed with personality disorder and depression.
45. In September 2021, Mr McBride took an overdose of prescribed medication. Staff started suicide and self-harm monitoring (known as ACCT). Over the next three years, Mr McBride was frequently supported using ACCT procedures due to his poor mental health.

## HMP Warren Hill

46. On 4 April 2023, Mr McBride was moved to HMP Warren Hill. He was supported using ACCT multiple times throughout 2023 and 2024.
47. On 13 March 2024, the Parole Board decided that Mr McBride was not suitable for release or a move to open conditions. The Board said that in order to be granted parole, Mr McBride needed to stop misusing illicit medication and address his self-harming behaviour. The Parole Board said that Mr McBride could address these issues at Warren Hill.
48. Later that month, Mr McBride's prison offender manager (POM) saw Mr McBride to discuss his recent parole hearing. Mr McBride told the POM that his drug taking, and self-harm were because of the trauma he had experienced in the past. They agreed that he needed further support.
49. Mr McBride said that he thought he would benefit from therapy but was aware that Warren Hill could not offer trauma therapy. Mr McBride asked to move to a different prison, and to be referred to the London Pathway Unit (LPU) at HMP Brixton. Mr McBride said that he had been there before but had not benefited because he had held back during group sessions.
50. On 3 June, after further discussions with Mr McBride, his POM made a referral to the LPU.
51. On 7 June, Mr McBride pressed his emergency cell bell and told staff that he had made cuts to his arms. Staff started ACCT monitoring. They set observations at four an hour.
52. At an ACCT review later that day, Mr McBride told staff that his POM had spoken to him about moving to a London prison and he did not want to move. Mr McBride said that he was hearing voices, and they were telling him to harm himself. Mr McBride said that he would like a medication review because he thought his medication was no longer helping.

53. On 8 June, during an ACCT check, staff found Mr McBride unresponsive in his cell with a ligature round his neck. Staff started CPR and when paramedics arrived, they took Mr McBride to hospital. The following day Mr McBride returned to prison, and a prison manager held a multidisciplinary ACCT review. He recorded that Mr McBride said that he wanted to end his life because he had been refused parole and had had enough of being on an IPP sentence. The case review team placed Mr McBride under constant supervision.
54. On 10 June, the neurodiversity lead saw Mr McBride to discuss coping strategies. She gave Mr McBride red and green wristbands to wear to let staff know how he was feeling. The red wristband indicated that Mr McBride was in crisis and green indicated that he was having a good day.
55. Later that day, a prison GP saw Mr McBride and agreed to increase his venlafaxine (an antidepressant) dosage.
56. On 12 June, a supervising officer (SO) held a multidisciplinary ACCT review. The case review team decided that Mr McBride no longer needed to be monitored under constant supervision in the daytime. The team reduced observations to four an hour.
57. On 14 June, a SO held a multidisciplinary ACCT review. Mr McBride said that he wanted to go to a psychiatric unit to deal with his trauma. He repeatedly told the team that he was ill and that prison was not helping him. Mr McBride said that he had current thoughts of suicide and self-harm and was planning to hang himself. The team placed Mr McBride back under constant supervision.
58. Staff held daily ACCT reviews with Mr McBride, and, on 19 June, a prison manager chaired a multidisciplinary ACCT review. Mr McBride said that his medication was starting to work and that he was feeling much more positive and could manage the voices in his head. Mr McBride said that he knew where to ask for help if he was feeling low and had no current thoughts of suicide or self-harm. The team stopped constant supervision and set observations at four an hour.
59. Throughout June, staff held regular ACCT reviews. Ongoing support was offered from prison staff, the mental health team and neurodiversity staff.
60. On 9 July, a SO held a multidisciplinary ACCT review. Mr McBride said that he did not need to be monitored anymore, that he was feeling positive and knew that he could ask for help if needed. The team agreed to stop ACCT monitoring. They noted that Mr McBride would remain under the care of the mental health team.
61. On 16 July, staff held a post-closure review and recorded that Mr McBride said he felt like he had turned a corner and was feeling positive about the future.
62. On 20 July, an officer saw Mr McBride for a key worker session. Mr McBride told him that he was in a much better place. Mr McBride said that he had turned a corner, and that neurodiversity staff were helping him with coping strategies. Mr McBride said that he was working on the wing servery and that it was good for his mental health. He said that he had worn the red wristbands only once that week.
63. On 29 July, Mr McBride attended a video call assessment with the LPU at Brixton, to decide if he was suitable to be moved there.

64. The POM subsequently received a decision letter from Brixton which said they would not be able to accept Mr McBride because he had no outstanding treatment needs that could be addressed on the LPU. When she told Mr McBride that he had not been accepted at Brixton, he asked if he could go to HMP Oakwood.
65. On 19 August, Mr McBride told staff that he was hearing voices and had made scratches to his wrist. An officer started ACCT monitoring and set observations at four an hour.
66. On 20 August, a SO held a multidisciplinary ACCT review. Mr McBride told the team that he was frustrated because he had not been approved for a move to the LPU. Mr McBride said that he did not feel like he was progressing at Warren Hill and felt trapped. The SO recorded that Mr McBride appeared withdrawn. The team agreed to continue ACCT monitoring and set observations at four an hour during patrol state (when prisoners are locked in their cells), and one observation every two hours at other times.
67. On 20 August, the POM contacted Oakwood to ask if they would accept Mr McBride. Staff at Oakwood told her that they thought there was no more they could offer Mr McBride and that the move would not be beneficial. She explained that she thought it would be beneficial for Mr McBride to have a fresh start. Oakwood agreed to accept Mr McBride and said they would get back to her to agree a date.
68. On 23 August, a SO held a multidisciplinary ACCT review. Mr McBride told the team that he was feeling good, and that he was not having intrusive thoughts or hearing voices anymore. She noted that Mr McBride was wearing green wristbands. The team agreed that Mr McBride would remain on ACCT monitoring with reduced observations of one an hour during patrol state, and a quality conversation in the morning, afternoon and evening.
69. On 27 August, a SO held a multidisciplinary ACCT review. She noted that Mr McBride was withdrawn and was wearing red wristbands. Mr McBride said that the coping mechanisms were not working and the Parole Board decision in March was affecting him. He said that he was fed up with it all and that he would not apply for parole again. Mr McBride said that he was having thoughts of suicide and self-harm but had no immediate plans to end his life. She recorded that Mr McBride was disengaged throughout the review. The case review team scheduled a review for the next day and increased observations to one an hour during the day and two an hour during the night.
70. Later that day, a custodial manager (CM) recorded that Mr Mc Bride pressed his emergency cell bell and asked to speak to a Listener (a prisoner trained by the Samaritans). Mr McBride told the CM that his head was all over the place and that he was losing hope of getting his parole. The CM recorded that by the end of the conversation Mr McBride was smiling and laughing.
71. On 28 August, a SO held a multidisciplinary ACCT review. She recorded that Mr McBride started the review on a positive note and said that he was feeling much better overall and acknowledged the low feelings he had were only temporary. The case review team noted that he was wearing green wristbands. Mr McBride told the team that he had used a virtual reality headset in the sensory room, which he described as 'amazing' and likened to relaxation therapy. Mr McBride said that he

no longer wanted to move to a different prison and wanted to stay at Warren Hill. Mr McBride said that he had had thoughts about ending his life a couple of days ago but reasoned it would not be worth it. He said that he now had no thoughts of suicide or self-harm. The team agreed to stop ACCT monitoring.

72. On 30 August, Mr McBride pressed his emergency cell bell and asked to speak to a Listener. An officer arranged for a Listener to speak with Mr McBride in the Listeners Suite. After around half an hour of speaking to the Listener, Mr McBride returned to his cell.
73. On 31 August, a SO noticed that Mr McBride's wristbands were red. Mr McBride said that he was fed up because his sister had not visited him, and he did not know what was happening with his request to move to another prison. The SO recorded that Mr McBride said that he had no thoughts of suicide or self-harm.
74. That afternoon, the POM saw Mr McBride and told him that Oakwood had agreed to a transfer. Mr McBride said that he no longer wanted to transfer to Oakwood and wanted to stay at Warren Hill. She explained to Mr McBride that Warren Hill could not offer the trauma therapy that he needed to complete before his next parole hearing. Mr McBride asked if he could go to HMP Grendon. She said that she would arrange a meeting to discuss further the following week, and they agreed that it would be beneficial for Mr McBride's key worker to attend.
75. Later that day, an officer saw that Mr McBride's wristbands were red, so she asked him how he was feeling. Mr McBride told her that he was feeling confused about whether he should transfer to another prison. She recorded that when she saw Mr McBride later his wrist bands were green, and he seemed more positive.
76. That evening, Mr McBride's key worker, was working a night shift, called Mr McBride on his in-cell phone for a key worker session. Mr McBride told him that he felt empty and did not know whether he was coming or going or what to do. The officer recorded that he spoke to Mr McBride for some time and that the call ended on a positive note.
77. On 1 September, an officer recorded that Mr McBride had a settled day and attended work in the morning and afternoon. He noted that Mr McBride had engaged well with staff and prisoners.
78. Later that day at around 5.52pm, Mr McBride called his sister. He talked to her about wanting to move to a different prison to complete the therapy he needed but said he was worried about leaving Warren Hill. He ended the call saying that he would give her a call in a few days' time.
79. Mr McBride was not subject to any checks overnight. He was last checked at 8.30pm and the member of staff recorded no concerns.

## **Events of 2 September**

80. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to staff radio communications from 2 September. She also obtained information from East of England Ambulance Service. The following account has been taken from all sources.

81. At around 7.10am on 2 September, Officer A carried out the morning roll check (count of prisoners). She told the investigator that she looked into Mr McBride's cell and saw him on the bed. However, CCTV footage shows that she briefly opened each observation panel as she walked past each cell, including Mr McBride's. She did not open the observation panels sufficiently to get a good view into each cell.
82. At around 7.45am, Officer B unlocked prisoners for morning activities. CCTV footage shows that he unlocked Mr McBride's cell door and opened it slightly. He did not check on Mr McBride or try to get a response from him. Around three minutes later, when he had finished unlocking the rest of the landing, he returned to Mr McBride's cell. He told the investigator at interview that when he walked past Mr McBride's cell, he realised he had not heard a response from him when he unlocked the cell and thought it was strange, so he opened the cell door fully. He saw Mr McBride hanging from a dressing gown cord attached to the window frame.
83. Officer B was not carrying a radio that day, as he had been supposed to be on external escort duties, not on the wing. He left the cell and ran out onto the landing and pressed the general alarm. He went back to the cell and cut the ligature from Mr McBride's neck and started CPR. Officer C responded to the general alarm and when he got to the cell he saw blood on the wall (it is not clear exactly where the blood came from, but when the ligature was cut, Mr McBride had some blood in his mouth). Officer C called a code red (a medical emergency code used to indicate severe blood loss) on the radio, but the transmission did not go through.
84. Seconds later, Officer A responded to the general alarm. She called a code red over the radio at 7.49am.
85. At 7.52am, an operational support grade (OSG) in the control room responded to the call on the radio and asked if an ambulance was required. The CM told him that it was. The OSG called for an ambulance. He asked the ambulance call operator to hold on the line while he transferred the call to the wing office, so that an officer could give more detail about what was happening. The call cleared while being transferred and did not connect to the wing office (the OSG was unaware the call had not connected).
86. At 8.07am, another OSG (who was also working in the control room) called the Ambulance Service again to ask for an update. The call operator said that the previous call had not connected and that there had not been an ambulance request logged. The operator asked if Mr McBride was breathing and conscious. The OSG incorrectly said that Mr McBride was conscious and breathing. The call operator told him that based on that information, an ambulance would be around 90 minutes.
87. At around 8.14am, healthcare staff asked the control room to call the ambulance again and request an air ambulance. Another OSG in the control room called the Ambulance Service again and explained that Mr McBride was not conscious and not breathing. The operator upgraded the call to a priority.
88. At 8.30am, paramedics arrived at Mr McBride's cell. Paramedics assessed Mr McBride and at 8.38am, declared life extinct.
89. After Mr McBride died, the police found a notebook in his cell. On the last page there was an indentation from an entry that Mr McBride had written (the actual

piece of paper was never found) which said that he had been on and off ACCTs and was fed up with feeling empty with no direction. He said he had received a couple of calls from his key workers that week and one of them saved his life as he was about to hang himself.

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

90. At around 9.00am on 2 September, a prison manager appointed two family liaison officers (FLOs). One FLO and a prison governor went to Mr McBride's stepfather's address to break the news of his death.
91. The FLO maintained contact with Mr McBride's family and offered ongoing support. The Prison Service contributed to the funeral expenses in line with national instructions.

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

92. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer support) to identify prisoners most affected by the death.
93. After Mr McBride's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. Listeners were deployed and the staff care team also offered support.
94. The prison posted notices informing other prisoners of Mr McBride's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr McBride's death.

### **Post-mortem report**

95. The post-mortem report concluded that Mr McBride died from fatal pressure on neck.

## Findings

### Assessment of Mr McBride's risk of suicide

96. At the time of Mr McBride's death, Prison Service Instruction (PSI) 64/2011, governed staff responsibilities regarding ACCT suicide and self-harm prevention procedures. It required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.
97. In November 2024, a revised Prison Safety Policy Framework was issued, which was fully implemented on 1 January 2025. It states that all staff have responsibility for ensuring that ACCT procedures are started if they believe a prisoner to be at risk of suicide or self-harm. Both PSI 64/2011 and the Prison Safety Policy Framework contain guidance and mandatory instructions on using ACCT procedures to manage prisoners at risk of suicide and self-harm.
98. Staff supported Mr McBride using ACCT procedures throughout his time in prison. Mr McBride received a good level of support from wing staff, neurodiversity staff and the mental health team while in prison. We found that the ACCT process was generally managed well. Staff held frequent multidisciplinary case reviews, the care plan was of a reasonable standard and officers recorded good daily interactions with Mr McBride.
99. However, we consider that ACCT monitoring was stopped prematurely on 28 August. At the ACCT review the previous day, Mr McBride was withdrawn, his wristbands were red and he said he was having suicidal thoughts. That evening, Mr McBride asked to speak to a Listener and told staff he was losing hope of ever getting parole. Even though staff noted that Mr McBride was wearing green wristbands the next day and seemed more positive, we consider that staff were too quick to stop ACCT monitoring.
100. Between 29 August and 2 September, staff noted that Mr McBride was wearing red wristbands on several occasions, and he told various members of staff that he was feeling fed up. He also asked for a Listener again on 30 August. Staff did not identify that Mr McBride's risk of suicide and self-harm had increased and that he needed further support and monitoring.
101. The investigator interviewed the staff that had spoken to Mr McBride between 29 August and 2 September, and they said that their conversations with Mr McBride had always ended on a positive note and so they did not think it was necessary to restart ACCT monitoring. We consider that risk factors were missed. We recommend:

**The Governor should review whether staff are effectively identifying objective risk factors and triggers when assessing prisoners' risk of suicide and self-harm rather than relying solely on their presentation.**

## Roll checks

102. CCTV footage shows that Officer A did not open the observation panel sufficiently to have been able to see whether Mr McBride – or any other prisoners on his landing - was in his cell. It is clear that the roll check was inadequate.
103. Around half an hour later at 7.45am, CCTV footage shows that Officer B unlocked Mr McBride's cell door, left it ajar and continued unlocking the other prisoners. When he realised that he had not received a response from Mr McBride when he unlocked his cell door, he returned to the cell and realised Mr McBride was hanging.
104. Since Mr McBride's death, a prison manager has undertaken work to ensure that staff are aware of the requirements during roll checks. Staff conducting roll checks must now get a positive response from the prisoner to assure themselves that the prisoner is alive and well. The prison has issued notices to staff setting out how to conduct a roll check and told us that the importance of roll checks is regularly discussed in morning briefings. To ensure that this has been embedded, the Deputy Governor has tasked managers with checking CCTV footage regularly to ensure that roll checks are taking place and that they are being completed correctly. We consider this an effective response to the issues identified.

## Emergency response

### Delay in calling the ambulance

105. PSI 03/2013 requires governors to have a medical emergency response code protocol in place so that the nature of the medical emergency is communicated efficiently. This ensures that staff respond quickly with the relevant equipment and there are no delays in calling an ambulance. Code blue is used when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner has severe bleeding. The control room should call for an ambulance immediately when a code is called and the member of staff calling the code should provide relevant information about the condition of the prisoner to the control room so that they can advise the ambulance service.
106. When Officer B found Mr McBride hanging, he was not carrying a radio so could not call a code blue (he had been detailed to work on external escorts that day). He left the cell and ran to the landing to press the general alarm button to alert staff that he needed assistance.
107. Office C called a code red when he arrived at Mr McBride's cell (having noticed blood on the cell wall), but there were other people communicating on the radio, so the transmission did not get through. He also responded to the general alarm and called a code red at 7.49am.
108. The OSG in the control room took three minutes to respond to the code red and then asked over the radio if an ambulance was required, which was unnecessary given a medical emergency code had been called. The OSG then tried to transfer the call to the wing but the call was disconnected. It took the OSG 15 minutes to call the Ambulance Service back, and he then told the call handler incorrectly that Mr McBride was conscious and breathing, which meant that the call was logged as a non-emergency. It took another seven minutes to provide the correct information

and it was only then, 22 minutes after the initial call, that an emergency ambulance was despatched.

109. At interview, the OSG said he was working in the control room on his own that day and when the code red was called, he did not know what to do. He told the investigator that he had never been on duty when an emergency code had been called. He said that he did not know that he should call an ambulance immediately and thought that he should wait until he received further information. He also told the investigator that OSGs at Warren Hill did not get any formal training and were trained locally by other OSGs.
110. The prison told us that all the OSGs that work in the control room have been briefed individually, and as a group, on what to do in an emergency situation and a laminated check list is now in the control room. This check list has been shared with the investigator.
111. The Deputy Governor at Warren Hill has shared with the investigator an action plan that has been implemented since the death of Mr McBride. In addition, all the SOs and CMs have completed on-line bronze commander training (a five-day course for prison managers that gives them the skills to manage an emergency incident) and have been briefed by the Deputy Governor.
112. In 2023, the PPO hosted a round table event focusing on the commonly occurring issues in emergency response. HMPPS committed to reviewing various aspects. We understand elements of that work have been completed and some remain ongoing. We continue to have significant concerns about how effectively the nature of medical emergencies in prisons are communicated to ambulance dispatchers as so clearly demonstrated in this incident.

## **Clinical care**

113. The clinical reviewer found that the care that Mr McBride received was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that the care that Mr McBride received for his mental health was comprehensive.
114. The clinical reviewer had some concerns about the psychology input for prisoners with complex needs. The clinical reviewer was also concerned that the substance misuse team had not recorded some of their interventions on the electronic medical record. The clinical reviewer made two recommendations which the Head of Healthcare will wish to address.

## **IPP sentences**

115. Mr McBride was recalled to prison in 2019 and as an IPP prisoner, had to satisfy the Parole Board that he was suitable for release again. In March 2024, he was refused parole and was told he needed to address specific issues. The Parole Board considered that Mr McBride could address his issues at Warren Hill. Mr McBride thought he needed trauma counselling and was keen to pursue a transfer to the LPU at Brixton but was not accepted. He told staff that he was fed up with the parole decision and would not apply again. He also said he was not progressing at Warren Hill and felt trapped. His POM was trying to get him a transfer to Oakwood

and was awaiting a date. However, there was little she or other staff could do to address Mr McBride's underlying frustrations about his IPP status and his diminishing hopes of ever being released.

116. Although the IPP sentence was abolished in 2012, there were still almost 2,700 IPP prisoners in prison in September 2024.
117. In its report on IPP sentences published in September 2022, the Justice Select Committee (JSC) found that "the psychological harm caused by IPP sentences is a considerable barrier to progression for some IPP prisoners. The indefinite nature of the sentence has contributed to feelings of hopelessness and despair that has resulted in high levels of self-harm and some suicides within the IPP population. In addition to this, IPP prisoners distrust the people and services that are necessary to support their progression."
118. The Government responded to the review in February 2023, when they announced that they would not be re-sentencing those currently subject to an IPP sentence. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP Action Plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to "maximise their prospects of achieving a safe and sustainable release." It includes measures to support those serving IPP sentences and to reduce the risk of suicide and self-harm.
119. The IPP Action Plan includes a requirement for Executive Directors to introduce IPP Delivery Plans for the prisons in their regions by the end of April 2024. Warren Hill has an IPP Delivery Plan which has been shared with the investigator. We are satisfied that it contains appropriate actions to support IPP prisoners and that Mr McBride received appropriate support. However, Warren Hill did not offer the course Mr McBride required to progress.

## Inquest

120. At the inquest, held from 1 to 12 June 2026, the jury recorded a narrative conclusion. They concluded that Mr McBride:

"...intentionally suspended himself with a ligature; although he did the act that lead [sic] to his death, it cannot be determined from the evidence whether he probably intended to die when he did so.

Mr McBride's IPP sentence, parole refusal, uncertainty over his sentence progression and complex health issues all had a relevant bearing on his actions on 2nd September 2024."

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100