Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Davey Price, following his release from HMP Forest Bank, on 27 October 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Davey Price was found hanged from a tree on 27 October 2023, following his release from HMP Forest Bank eleven days earlier. He was 29 years old. We offer our condolences to his family and friends.

5. Mr Price had a history of post-traumatic stress disorder (PTSD), anxiety and depression and had previously attempted to take his life in the community. On 23 August 2023, he was remanded to HMP Leeds for assault and breach of a restraining order, and, on 30 August, Mr Price was transferred to HMP Forest Bank.

6. At Forest Bank, prison staff managed Mr Price under HMPPS suicide and self-harm prevention procedures (known as ACCT), because he deliberately overdosed on illicit medication. The ACCT procedures were poorly managed. There was little input from mental health professionals, case reviews were inconsistently attended, and support actions did not consider important upcoming events including court appearances.

7. On 16 October, Mr Price went to court where he was convicted of stalking and possessing a bladed article and received a suspended sentence. He was released on licence.

8. Mr Price was released unexpectedly from court. As a result, there was no healthcare discharge planning and healthcare staff at Forest Bank did not refer Mr Price to community mental health services. Mr Price's community offender manager was concerned with his mental health and, following his release, referred him to the local Complex Dependency Team.

9. Staff at Forest Bank were unprepared for Mr Price's release from court. Better information sharing might have allowed healthcare staff to more effectively plan and prepare for the possibility of his release. National instructions on managing the risk of suicide and self-harm do not provide any guidance for prison staff when a prisoner is subject to an unplanned release from court. This should be rectified to ensure that important risk information is always shared with probation colleagues.

Recommendations

- The Head of Healthcare should ensure that pathways are in place to provide effective support and referral for prisoners under the care of the mental health team who might be released from court.

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

    - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff and those providing through the gate services where relevant;

    - A case co-ordinator is appointed who attends all ACCT case reviews whenever possible; and

    - ACCT support actions are completed with actions that are specific and meaningful with consideration given to significant upcoming events.

- The Director General of Operations for HMPPS should update PSI 64/2011 to provide instructions on sharing risk information when a prisoner is subject to an unplanned release following a court appearance.

The Investigation Process

10. HMPPS notified us of Mr Price's death on 31 October 2023.

11. The PPO investigator obtained copies of relevant extracts from Mr Price's prison and probation records.

12. We informed HM Coroner for Greater Manchester West of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. We wrote to Mr Price's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions.

14. We shared the initial report with HM Prison and Probation Service.

15. We also shared the initial report with Mr Price's sister. She did not respond.

Background Information

HMP Forest Bank

16. HMP Forest Bank is a prison in Manchester, run by Sodexo Justice Services. It serves the courts of Greater Manchester and the wider region. Spectrum Community Health CIC provides primary care and clinical substance misuse services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Forest Bank was an independent review of progress in January 2023. Inspectors reported that Forest Bank was not fulfilling its purpose as a reception prison with a resettlement function. There was no dedicated support for the increasing remand and unsentenced population which had increased to around 45% at the time of the inspection and which had increased to 57% by April 2024.

Probation Service

18. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

19. The most recent inspection of the Northwest division of the National Probation Service was in July 2020. Inspectors reported that the overall rating for the division was good. Inspectors reported that although leaders had tried to mitigate the stress of high workloads, they remained high for too many probation officers. Inspectors reported that the division's approach to ensuring that it provided services that addressed the needs of those subject to supervision was encouraging. Effective partnership work had enabled several local co-commissioned projects to address areas linked to offending.

Key Events

20. On 4 August 2023, Mr Davey Price was convicted of breaching a restraining order and received an 18-month suspended sentence. He had previously attempted to hang himself from a tree in the community and had been monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) during a short period in prison in July 2023.

21. On 23 August, Mr Price was remanded to HMP Leeds for assault, stalking and breach of a restraining order against his partner.

22. Mr Price was allocated a community offender manager (COM).

23. At his initial health screen, Mr Price told a nurse at Leeds that he had harmed himself two months previously during his first time in custody. He said that he could now deal with his emotions better and had no intentions of harming himself as he was in a good relationship and had a young child. (Mr Price did not tell the nurse that he was prohibited from contact with his partner by a restraining order.) At his secondary health screen, Mr Price told a nurse that he had post-traumatic stress disorder (PTSD), anxiety and depression. He said that he was not prescribed any medication.

24. On 24 August, a resettlement officer completed Mr Price's basic custody screen (to identify the key issues to prioritise in Mr Price's resettlement plan). Mr Price told her that he planned to live at his friend's address in Wigan on release and that he was previously a self-employed plasterer and would return to this work. Mr Price said that he had no issues with substance misuse and said that he had PTSD, depression, anxiety and paranoia. He said that he had been assessed by the prison healthcare team, who would refer him to the mental health team if necessary. Mr Price said that he was not registered with a community GP and did not want support to register with one.

25. On 30 August, Mr Price was transferred to HMP Forest Bank.

26. At his initial health screen Mr Price told a nurse that he had PTSD, anxiety and depression and had no thoughts of self-harm. She referred Mr Price to the mental health team.

27. On 2 September, prison staff started ACCT procedures after Mr Price said that he had taken 70 tablets (which he had seemingly obtained illicitly). A nurse sent him to hospital where hospital staff carried out tests and sent him back to Forest Bank. On 8 September, prison staff closed the ACCT procedures when Mr Price told them that he felt a lot better and had no thoughts of self-harm and suicide.

28. On 14 September, the COM completed police checks for the address in Wigan where Mr Price intended to live.

29. On 20 September, a nurse saw Mr Price for a mental health triage appointment. Mr Price told her that his mental health had deteriorated in March after the birth of his son, as this triggered memories of previous abuse. He said that he had attempted to end his life in the community by hanging himself. Mr Price said that he was previously referred to a mental health service in Wigan and was allocated a support

worker but accepted that he could have made more use of the service. Mr Price said that his mental health led to relationship problems with his partner, who had moved back in with her parents. He said that he had been recalled for two breaches of the restraining order and for assault. Mr Price denied any thoughts of suicide or self-harm. The nurse referred Mr Price to the Psychological Wellbeing Practitioner team (PWP - a Greater Manchester Mental Health NHS Foundation Trust service based in the prison) to help him manage his anxiety.

30. On 25 September, the COM met a senior probation officer. The COM told the senior probation officer that, in February 2019, police officers found Mr Price in a tree with a rope around his neck. On that occasion, the officers had detained him under section 136 of the Mental Health Act. He told her that on 20 March 2023, Mr Price had attempted to hang himself from a banister rail after he had an argument with his partner.

31. On 30 September, Mr Price took 20 tablets of his cell mate's medication. Prison staff restarted the ACCT procedures. Including the case reviews held in September, healthcare staff attended just two of six ACCT case reviews and a different member of staff chaired each case review. No support actions were added when the ACCT procedures were restarted.

32. On 9 October, prison staff searched Mr Price's cell and found a block of cannabis resin, two wraps of white powder, paper containing a psychoactive substance (PS), a mobile telephone charger, an improvised weapon, numerous bank account details and a debt list. Prison staff charged Mr Price with an offence against prison discipline.

33. On 11 October, a nurse added Mr Price to the GP waiting list at Forest Bank to discuss his medication options. She discussed with Mr Price that he should remain on the PWP service waiting list.

34. On the same day, prison staff closed the ACCT procedures. They noted that Mr Price was mentally "in a good place" and that he believed the ACCT process was no longer needed.

35. On 12 October, the COM had a video link meeting with Mr Price, who told him that he had overdosed on medication when he first entered custody. Mr Price said that he had spoken to the mental health in-reach team. He admitted being a heavy drinker and said that he had not used drugs when he was last in the community.

Post release

36. On 16 October, Mr Price went to court where he was convicted of stalking and possessing a bladed article and sentenced to seven months in prison suspended for one year and six months. He was released from custody on licence. A probation service officer explained the terms of his licence and told him that he had to report to the duty officer the following day, at the Warrington probation office.

37. An operational manager in the healthcare team at Forest Bank said that Mr Price was not referred to community mental health services. She said that Mr Price was unexpectedly released at court, which the mental health team was not aware of. Mr

Price had told the mental health nurse that he did not have a date to attend court, therefore they had not discussed discharge planning with him.

38. Mr Price was not prescribed any medication at Forest Bank and so he did not receive any discharge medication.

39. On 17 October, Mr Price went to the Warrington probation office, where he met the COM. Mr Price told him that he would live with his friend in Wigan and start work as a plasterer the following day. The COM told Mr Price that his next appointment was on 24 October.

40. On 18 October, the COM asked for Mr Price's licence conditions to be changed and that they should include that he not contact his partner and child, that he comply with any requirements specified by his supervising officer for the purpose of ensuring that he address his alcohol, drug and violent offending behaviour and to provide drug testing samples when required.

41. On 24 October, Mr Price did not attend his probation appointment with the COM. Mr Price telephoned him and said that he was feeling very unwell and had tested positive for COVID-19. Mr Price said that he had been struggling with his mental health and was feeling paranoid and anxious because he feared being recalled to prison. He denied feeling suicidal or self-harming since his release.

42. Mr Price (seemingly incorrectly) told the COM that the mental health team at Forest Bank had completed a community referral before his release. The COM told him that he would chase this up. He planned to see Mr Price again on 31 October.

43. That day, the COM emailed a clinical team manager at Greater Manchester Mental Health NHS Foundation Trust and asked her if Mr Price was waiting for any mental health support. He said that Mr Price was a high-risk domestic violence offender and that social services were involved because he had a child with the victim of the domestic violence. He noted that Mr Price had said that the mental health in-reach team at Forest Bank had referred him to the Wigan community mental health service. He said that Mr Price had overdosed at Forest Bank and had spent four days in hospital. He said that Mr Price did not have a community GP. The clinical team manager told him that Mr Price was not currently engaged with mental health services and that there was no record of a referral from the prison to community services.

44. The same day, the COM referred Mr Price to the Complex Dependency Team at Wigan Council (who offer support to people with complex needs). He said that he spoke to a team manager who agreed that a referral to them was appropriate.

Circumstances of Mr Price's death

45. At 8.00am on 27 October, a dog walker found Mr Price hanging in Byron Hall Woods, Lowton, Lancashire.

Post-mortem report

46. The post-mortem report concluded that Mr Price died of hanging.

Support for staff

47. After Mr Price died a senior probation service officer offered the COM support and directed him to the workplace support service.

Contact with Mr Price's family

48. On 27 October, police informed Mr Price's partner that Mr Price had died.

Findings

Mental health support

49. Mr Price had a diagnosis of PTSD, anxiety and depression and had previously worked with community mental health services. He had a history of self-harm and suicide attempts both in prison and in the community. Mr Price was monitored under ACCT procedures at HMP Forest Bank, which ended four days before his release.

50. Mr Price was unexpectedly released from Forest Bank on 16 October 2023, when he received a suspended prison sentence. Healthcare staff at Forest Bank did not refer Mr Price to community mental health services. The operational manager said that because Mr Price was released unexpectedly from court, no discharge planning was discussed, and he was not registered with a community GP. She said that if they had known that Mr Price might be released, he could have been advised to register with a community GP and been given information about psychological support services available in his area. She said that Mr Price did not meet the threshold for secondary mental health services and a referral would have been unlikely to be accepted had they made one. (In response to our initial report, Forest Bank added that Mr Price did not meet the threshold for secondary care, but that if he had done then a referral to community mental health would have been made even following release.)

51. The operational manager said that Mr Price had been offered a referral to the Outspoken service (a counselling service for men in prison and in the community who have experienced sexual abuse). However, Mr Price declined this referral as he did not feel ready to address the issue.

52. Mr Price's court appearance had been known to prison staff for several weeks and, two days before he went, a member of healthcare staff completed the relevant section of his Person Escort Record (a document that accompanies the person on transfer to court and lists known risks). Earlier sharing of information between prison and healthcare staff might have enabled them to more effectively predict and plan for his potential discharge. In a local prison that holds many prisoners on remand, it will often be the case that prisoners will not have a set release date and could be released relatively unexpectedly from court. While Mr Price might not have met the criteria for a community mental health referral, it is important that support is available on release for those prisoners who require it.

53. After Mr Price's release, the COM identified that a community mental health referral had not been made and contacted an appropriate provider.

54. We make the following recommendation:

    The Head of Healthcare should ensure that pathways are in place to provide effective support and referral for prisoners under the care of the mental health team who might be released from court.

Managing the risk of suicide and self-harm

55. Prison Service Instruction (PSI) 64/2011 provides instructions and guidance on managing prisoners at risk of suicide and self-harm. It states that a case co-ordinator must be appointed to chair case reviews. The case co-ordinator must ensure that healthcare staff are always invited to attend, or provide a written contribution to, the first case review and any subsequent case reviews where they are relevant to supporting the prisoner.

56. There was no consistent case co-ordinator for the six ACCT case reviews held in September and October 2023, and a different member of staff chaired each case review. Healthcare staff were present at just two of the six case reviews, despite Mr Price's mental health diagnosis. No support actions were added when the ACCT procedures were restarted, and the procedures were closed without any apparent consideration of Mr Price's upcoming court appearance or the medication review that had been requested that day. We make the following recommendation:

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

    - **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff and those providing through the gate services where relevant;**
    - **A case co-ordinator is appointed who attends all ACCT case reviews whenever possible; and**
    - **ACCT support actions are completed with actions that are specific and meaningful with consideration given to significant upcoming events.**

57. Mr Price had several significant risk factors for suicide and self-harm when he was released from prison, and which were known to prison and probation staff. He had made a serious attempt to take his life in the community earlier that year. Mr Price had been monitored under ACCT procedures in prison shortly before his release, following an overdose in custody. He had previously had contact with community mental health services and had a history of drug and alcohol abuse. Mr Price's licence conditions prevented him from contacting his partner and child.

58. The COM recognised that Mr Price had risk factors for suicide and self-harm, which he identified through work he did with Mr Price both before and after his release. However, there is no evidence that prison staff identified that there was any risk information that should be shared with the COM or contacted him to provide such information.

59. While there were no particular signs that Mr Price's risk of suicide and self-harm had increased following his release, in other circumstances better sharing of information might be crucial.

60. PSI 64/2011 instructs prisons about how to share information ahead of the planned release of prisoners who are currently being monitored under ACCT procedures or who have been monitored under ACCT in the previous 12 months. HMPPS ACCT

user guidance provides further information for staff about how to manage this. It also states that if a release is not planned (giving the specific example of those released following a court appearance) “it may not be possible” to complete these actions. The user guidance says that in these circumstances probation staff “may retrospectively contact the prison to request relevant information”.

61. Our view is that prisons should more proactively seek to share important risk information with probation colleagues following an unplanned release, to ensure that they have the best opportunity to identify any increased risk and take appropriate supportive action. We make the following recommendation:

The Director General of Operations for HMPPS should update PSI 64/2011 to provide instructions on sharing risk information when a prisoner is subject to an unplanned release following a court appearance.

Inquest

62. The inquest into Mr Price’s death concluded on 8 October 2024, and recorded a verdict of suicide.

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Prisons and Probation Ombudsman **September 2024**

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