Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aaron Taylor, a prisoner at HMP Garth, on 28 August 2023

A report by the Prisons and Probation Ombudsman

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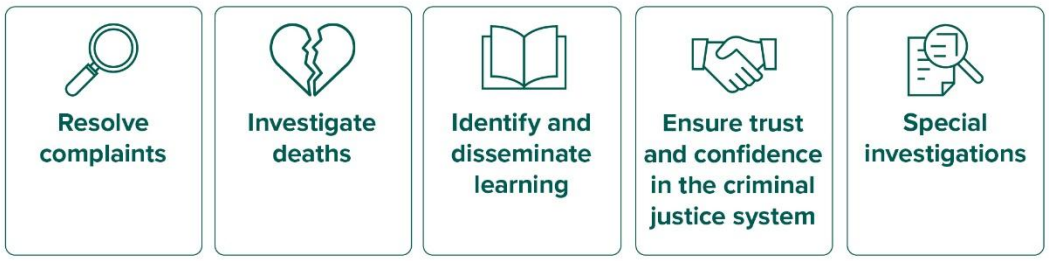
OUR VISION

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

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 Aaron Taylor was found hanged in his cell on 28 August 2023 at HMP Garth. He was 32 years old. I offer my condolences to Mr Taylor's family and friends.

Mr Taylor was recalled to prison seven months before he died. He struggled with being in prison and the potential length of his sentence. He was supported by HMPPS suicide and self-harm monitoring procedures on three occasions while at HMP Garth.

My investigation found there was a missed opportunity for further suicide and self-harm monitoring following a self-harm incident three weeks prior to Mr Taylor's death. However, I am satisfied that there was no particular evidence to indicate that Mr Taylor's risk of suicide had dramatically increased in the days before his death.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2024**

Contents

Summary

Events

1. On 3 January 2023, Mr Aaron Taylor was recalled to HMP Preston for breaching his licence conditions relating to a 10-year sentence for wounding with intent. He had a history of self-harm.

2. Prison staff managed Mr Taylor under Prison Service suicide and self-harm monitoring procedures (known as ACCT) when he arrived at Preston after he told them that he intended to self-harm and would kill himself given the chance.

3. On 7 February, Mr Taylor transferred to HMP Garth after reporting being sexually assaulted by a prisoner at Preston. He lived on the prison's Residential Support Unit and was supported by ACCT procedures a further two times.

4. On 4 August, Mr Taylor self-harmed. Staff did not start ACCT procedures.

5. At around 7.20pm on 27 August, an officer saw Mr Taylor in his cell during the evening routine check. The night officer did not do the morning routine check between 5.00am and 6.00am.

6. At 8.07am on 28 August, an officer unlocking prisoners' cells for work, opened Mr Taylor's observation panel and found it to be obstructed. The officer did not attempt to gain a response from Mr Taylor and continued unlocking prisoners.

7. Another officer was one minute behind and was conducting routine welfare checks on prisoners. When she saw that Mr Taylor's observation panel was obstructed, she entered his cell and saw that he had ligatured from the light fitting. The officer immediately radioed a medical emergency code and untied the ligature. The first two staff that arrived at the cell decided not to start cardiopulmonary resuscitation (CPR) because it was clear that Mr Taylor had died. The third officer arrived and started CPR. Healthcare staff arrived shortly after and agreed that CPR was not appropriate. Ambulance staff arrived at 8.30am and confirmed that Mr Taylor had died.

Findings

8. Mr Taylor had been subject to ACCT monitoring three times at Garth. Staff managed the process well; multi-disciplinary reviews were held and actions to address his immediate needs were completed.

9. Mr Taylor self-harmed three weeks before he died, but staff did not start ACCT procedures. However, Mr Taylor did not present as in crisis in the days before his death and we do not think there was sufficient evidence for staff to consider him a high suicide risk.

10. The officer on night duty did not complete the morning routine check and falsified records to say that he had.

11. The officer who was unlocking prisoners for work the morning Mr Taylor died did not take appropriate action when he found that Mr Taylor had covered his observation panel, and he did not attempt to gain a response from him.

12. The clinical reviewer concluded that Mr Taylor's clinical care was equivalent to what he could have expected to receive in the community. She found his risk of self-harm and suicide was high.

Recommendation

- The Head of Healthcare should ensure that all healthcare staff are aware of their responsibilities regarding ACCT procedures, including communicating with wing staff if there are concerns around suicide and self-harm.

The Investigation Process

13. HMPPS notified us of Mr Taylor's death on 28 August 2023.

14. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. Five prisoners responded. Two prisoners asked to remain anonymous.

15. The investigator obtained copies of relevant extracts from Mr Taylor's prison and medical records and viewed CCTV and body worn video camera (BWVC) footage. She also obtained the HMPPS Early Learning Review and HMPPS Investigation Report.

16. NHS England commissioned a clinical reviewer to review Mr Taylor's clinical care at the prison.

17. The investigator interviewed three members of staff at Garth in February 2024. She and the clinical reviewer jointly interviewed healthcare staff. The investigation was transferred to another investigator.

18. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted to Mr Taylor's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Taylor's family did not have any questions but asked for a copy of this report.

20. Mr Taylor's family received a copy of the initial report. The solicitor representing Mr Taylor's family did not provide a response.

21. 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.

Background Information

HMP Garth

22. HMP Garth is a category B training prison and holds long-term and life-sentenced prisoners. It is part of the Long-Term High Security Estate (LTHSE). Greater Manchester Mental Health NHS Foundation Trust provides physical health, mental health, social care and clinical substance misuse treatment 24-hours a day and seven days a week. Delphi is subcontracted to provide psychosocial substance misuse services. There are seven residential wings and a segregation unit next to the prison's healthcare department. Prisoners live in single cells.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Garth was in November 2022. The inspection noted that the Residential Support Unit and Building Hope Unit provided targeted support for vulnerable prisoners and those re-entering mainstream conditions, respectively. The number of places on the Residential Support Unit had increased since the previous inspection, so that more vulnerable prisoners could be accommodated. These units provided calmer environments and offered valuable input from psychology services to support prisoners. However, the daily regime and the frequent planned or unplanned cancellations of unlocking prisoners' cells limited the potential to provide structured activities that would support progression. Self-isolators were managed and supported well, and residential staff had more day-to-day input into their care.

24. Inspectors reported self-harm had reduced since the last inspection in 2019. The safer custody department had worked hard to deliver training to staff in the new version of assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide and self-harm, but in practice the quality of support delivered was inconsistent. Assessments were usually good, but care plans, risks and triggers were often incomplete, and some daily interactions and supervisor checks were missing. Leaders were aware of this, and work was under way to address the issues. Most prisoners who were or had been subject to ACCT monitoring were positive about staff support.

Independent Monitoring Board

25. 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 30 November 2022, the IMB reported they did not identify any significant issues in relation to how well prisoners' health and well-being needs were being met. The IMB noted that the number of deaths at the prison had reduced compared to previous years. There was a death in custody plan in place, against which, good progress was being made.

26. The safer custody department had delivered training to staff regarding the new ACCT procedures. Many prisoners had complex issues and were subject to ACCT procedures. Complex case meetings took place for prisoners who were identified as having significant needs and vulnerabilities, with a view to either continuing or

varying the ACCT process. Healthcare representatives and prison staff took part in assessments and the support of prisoners subject to the ACCT process, which clearly worked well. The IMB monitored this area and attended assessment meetings by invitation.

Previous deaths at HMP Garth

27. Mr Taylor was the 15th prisoner to die at Garth since August 2020, and the third self-inflicted death. By the end of April 2024, there had been two self-inflicted deaths since Mr Taylor's death.

Assessment, Care in Custody and Teamwork

28. 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. 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. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

29. On 11 December 2015, Mr Aaron Taylor was sentenced to 10 years in prison for wounding with intent. On 5 November 2021, Mr Taylor was released from HMP Preston. On 3 January 2023, he was recalled to HMP Preston for breaching his licence conditions.

30. When he arrived at Preston, Mr Taylor said he had thoughts of suicide and would kill himself given the chance. Staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT). Observations were set at four per hour and three meaningful conversations throughout the day. Mr Taylor engaged well with the ACCT reviews and staff provided ongoing support.

31. Between 6 and 8 January, staff put Mr Taylor under constant supervision due to his lack of engagement with the ACCT process. Once he started to engage again, his observations reduced to four per hour.

32. On 11 January, staff from the Offender Management Unit (OMU) told Mr Taylor he was subject to a full recall, which meant he would have to serve another seven years in prison. Mr Taylor struggled with this information and said that he 'did not have it in him' and would not be around to serve the sentence. Staff continued to observe Mr Taylor four times per hour and have three meaningful conversations with him per day. Staff noted he engaged with the regime and interacted with his peers.

33. On 3 February, Mr Taylor told staff that another prisoner had sexually assaulted him. His clothing was taken as evidence, and he was taken to Royal Preston hospital. Mr Taylor told staff he did not have any thoughts of self-harm or suicide. A few days later, the police interviewed Mr Taylor and offered the opportunity to stay at the Safe Centre at Royal Preston hospital, but he declined. (Mr Taylor refused to name the perpetrator and so the police investigation did not proceed.)

HMP Garth

34. On 7 February, Mr Taylor transferred to HMP Garth.

35. The ACCT remained opened following Mr Taylor's transfer from Preston. That day, Healthcare staff completed his initial health screen and referred him to the mental health team, drug and alcohol services and the GP. Mr Taylor had an extensive history of impulsive reactions to situations and his needs were complex. He had a history of self-harm by cutting himself, ligaturing and ingesting foreign objects. Mr Taylor was allergic to wasp stings and was prescribed an epi-pen.

36. A mental health nurse completed a mental health assessment. The nurse noted there were no current concerns or risks to Mr Taylor or others. There was no evidence of current mental health issues, thoughts of self-harm or suicide. The nurse noted Mr Taylor was on an ACCT and told him how to contact support services.

37. On 8 February, Mr Taylor told staff that he had been assaulted in his cell. He would not disclose who the perpetrator was, but said he believed the assault was because

of the on-going investigation into the incident at Preston and that he had been labelled a 'grass'. Mr Taylor had abrasions to his head and torso and healthcare staff assessed and treated him. Mr Taylor said he would not self-isolate, however staff applied for him to move to the Residential Support Unit (for vulnerable prisoners that need additional support with mental health, debt, personality disorders or learning difficulties) so that his contact with the general prison population was carefully managed.

38. On 9 February, Mr Taylor moved to the Residential Support Unit. Staff gave him distraction packs and encouraged him to find employment on the wing, but he declined. He generally kept to himself and said that he did not like to mix but would come out of his cell for showers and to collect meals.

39. Mr Taylor had a generalised anxiety assessment, and the result indicated he had moderate anxiety. As a result, a GP at the prison prescribed Citalopram 20mg (an antidepressant) on 13 February. The GP referred Mr Taylor to Manchester Survivors (which supports male victims of sexual assault) and to the psychology team to address the incident at Preston.

40. On 21 February, Mr Taylor's ACCT was closed because he became more settled.

41. Between March and May staff started ACCT monitoring twice because Mr Taylor had self-harmed by making superficial cuts to his arms. Mr Taylor told staff his 'head had gone'. On both occasions, Mr Taylor was well supported by staff. The care plan (designed to identify the main areas of concern and the actions required to reduce risk) included that he should maintain contact with external support, such as his family and partner, keep his mind busy with distraction packs and apply for work. Observations were appropriately staggered with the frequency amended to reflect Mr Taylor's mental state and care needs at the time. Mr Taylor kept in regular contact with his mother, sister and partner, and staff helped to maintain this contact on the occasions he ran out of phone credit. Mr Taylor's ACCT was closed on 2 May. During his post-closure review staff noted that he said he felt better as he was engaging with his peers and the regime, and he had no thoughts of suicide or self-harm.

42. Between May and July, Mr Taylor self-isolated twice because he felt under threat on the wing and for being in debt (there is no further information in his prison file about the nature of the debt). Staff offered regular support to him. His keyworker also saw him regularly. On 7 June, Mr Taylor moved to another part of the Residential Support Unit, which he said he was happy with.

43. On 4 August, Mr Taylor dismantled his epi-pen, filled the chamber with faeces and injected it into his left forearm. Mr Taylor asked an officer to take him to see healthcare staff. Mr Taylor had a lump on his hand but did not tell the officer what the lump was, or that he had injected himself with faeces.

44. The officer took Mr Taylor to the medications hatch to see a nurse. Mr Taylor did not verbally tell her what had happened but passed her a note. The nurse said Mr Taylor's arm looked swollen and he explained what he had done with the epi-pen. Because she was occupied dispensing medications, she told him to leave it with her, and the officer took Mr Taylor back to his cell. Once the nurse had finished, she went to the healthcare unit and informed a prison GP, who gave Mr Taylor an

emergency appointment. The nurse said when she saw Mr Taylor in the healthcare unit and spoke to him about his intent, he did not really engage, would not maintain eye contact and was looking down. She did not start ACCT monitoring. She told the investigator that she assumed the officer had done so. (The officer did not know what Mr Taylor had done at that time). The incident was not documented in Mr Taylor's electronic prison record, or the wing observation book.

45. The prison GP discussed Mr Taylor with an on-call microbiologist. He then examined Mr Taylor and prescribed antibiotics and pain relief. Mr Taylor said that he was not suicidal and was more concerned about his physical health.

46. On 5 August, a task was sent to the mental health team to review Mr Taylor. The task was marked as 'completed,' but there is no entry in his medical record to suggest that the mental health team saw him.

47. On 11 August, healthcare staff noted that Mr Taylor's wound was smelly and black in the centre, and he subsequently attended Royal Preston hospital for surgical intervention. He returned to Garth the following day.

48. On 23 August, staff recorded that Mr Taylor was settled on the Residential Support Unit and engaged well with staff and his peers. Mr Taylor said he wanted employment in the workshop and was advised to contact the activities department to discuss this.

49. Mr Taylor made a few phone calls between 23 and 25 August. The investigator listened to recordings of the calls and noted nothing of concern. Mr Taylor did not make any phone calls in the 48 hours preceding his death. He did not receive any visits at Garth.

Events of 27 and 28 August

50. On 27 August, the Residential Support Unit was on a 'split regime' due to low staffing levels (for safety reasons, only a certain number of prisoners are allowed time out of their cell in the morning and then the remainder have time out of their cell in the afternoon). Mr Taylor had time out of his cell in the morning, but after lunch at around midday, he was locked in his cell for the remainder of the day.

51. CCTV shows that at approximately 7.20pm, Officer A completed the evening routine check and said Mr Taylor was lying on his bed. He did not document the routine check in the wing observation book. This was the last time Mr Taylor was seen alive.

52. As Mr Taylor was not on an open ACCT, staff were only required to check him during the routine check at around 5.00am or if he pressed his cell bell. Mr Taylor did not press his cell bell on the evening of 27 August or the morning on 28 August.

53. Officer A was responsible for completing the routine checks and observing prisoners on ACCT monitoring procedures at regular intervals during the night. He recorded that he had completed routine check between 5.00am and 6.00am and observed two prisoners on ACCT through the night. CCTV shows that he did not complete these checks. Following a prison internal investigation, he was dismissed from the Prison Service. We wrote to him, but he did not respond, so we have not

been able to interview him as part of this investigation. We informed the police of the falsified checks.

54. At approximately 8.07am on 28 August, Officer B unlocked prisoners for work, while Officer C conducted the welfare checks and was one minute behind Officer B.

55. Mr Taylor did not need to be unlocked for work as he was not employed. Officer B said that he accidentally opened Mr Taylor's observation panel. He saw that Mr Taylor's observation panel was blocked with tissue paper. He told the investigator that he did not think anything of it as prisoners on the Residential Support Unit often blocked their observation panels (under national policy, prisoners are not allowed to block their observation panels). He continued to unlock prisoners for work.

56. Officer C arrived at Mr Taylor's cell around a minute after Officer B. She saw that his observation panel was blocked and opened his cell door to do a welfare check. She saw that Mr Taylor had ligatured from the light fitting using bedsheets, and immediately radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). Control room staff called an ambulance immediately. Officer B returned to the cell.

57. Officer C used her anti-ligature knife to try to cut the ligature. It was too tight, so she untied the knot. Mr Taylor had clear signs of rigor mortis, so both officers decided not to start cardiopulmonary resuscitation (CPR). Another officer arrived and did not feel comfortable not to conduct CPR and started compressions until healthcare staff arrived. When healthcare staff arrived, they advised the officer to stop CPR because there were clear signs that Mr Taylor had died.

58. At 8.30am, paramedics arrived and confirmed that Mr Taylor had died.

Information received after Mr Taylor's death

59. Mr Taylor left three notes in his cell. The first note was addressed to staff asking them to telephone his mother and partner. Mr Taylor apologised to staff for having to find him and thanked them for their support. The second note was to his mother and the third to his partner. Mr Taylor indicated in the notes that it was his intention to die.

60. Mr Taylor had hidden a piece of wood in his cell. The wood had holes through it at either end, and he had tied what looked like shoelaces through it. He had then put his bedsheet through and fashioned a ligature. He had glued the wood to the ceiling of his cell and the light fixture.

61. A Custodial Manager (CM) said that fabric checks are done daily by staff just before the routine check. (Fabric checks are carried out to ensure a cell's physical condition is up to standard.) The last fabric check was completed just before 7.20pm on 27 August. Staff do not search the cell for illicit items during these checks. It is not unusual for prisoners to have wood glue as they can buy it from the canteen to use during purposeful activity such as model making. As the accommodation fabric checks are not an in-depth search of the cell, it appears Mr Taylor had hidden the wood and staff did not see it. We note that staff were not conducting an in-depth search of the cell and so it is reasonable that they would not have found the piece of wood Mr Taylor had hidden.

Contact with Mr Taylor's family

62. The prison appointed a family liaison officer (FLO) and an officer as assistant family liaison officer. On 28 August, they both visited Mr Taylor's mother to inform her of her son's death, offered their condolences and explained the next steps that would follow.

63. The prison contributed towards Mr Taylor's funeral costs in line with national policy.

Support for prisoners and staff

64. 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 and on a case-by-case basis after all other types of 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.

65. The Early Learning Review identified that Garth did not initiate Postvention procedures and parts of the contingency plan were not completed. There was a delay in the Samaritans entering the prison to offer support to staff and prisoners following Mr Taylor's death.

66. 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. The staff care team also offered support.

67. The prison posted notices informing other prisoners of Mr Taylor'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 Taylor's death.

Post-mortem report

68. The post-mortem report gave Mr Taylor's cause of death as hanging. The toxicology report did not detect any illicit substances in Mr Taylor's blood or urine.

Findings

Assessment of Mr Taylor's risk of suicide and self-harm

69. Mr Taylor had been at Garth for almost seven months when he died. He was a vulnerable prisoner but had external support from his family and partner. He felt angry for being recalled to prison after 14 months in the community and he was worried about the length of time he would have to serve in prison before he was eligible for release.

70. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Taylor had several of these risks including being a recalled prisoner, relationship instability, previous self-harm, impulsiveness, and feelings of hopelessness.

71. Mr Taylor was supported by ACCT procedures when he arrived at Preston, after he told staff he would attempt suicide in prison if he got the chance. At Preston, Mr Taylor alleged he had been sexually assaulted; however, he would not engage with police and so the investigation did not proceed.

72. Mr Taylor remained on ACCT procedures when he transferred to Garth. Shortly after arriving, he was physically assaulted by other prisoners and was moved to the Residential Support Unit for vulnerable prisoners. He was supported by ACCT procedures on two further occasions at Garth. We found that on both occasions, Mr Taylor was well supported by staff. Actions to address Mr Taylor's immediate needs were added to a care plan and actioned, and notes of conversations were detailed. Observations were appropriately staggered with the frequency amended to reflect Mr Taylor's mental state and care needs at the time. Mr Taylor's last ACCT was closed on 2 May.

73. Mr Taylor self-harmed on 4 August when he injected himself with faeces. Due to a lack of communication between prison and healthcare staff, no one started ACCT procedures. An officer did not know that Mr Taylor had self-harmed. A nurse said that she knew that Mr Taylor had self-harmed but had assumed prison staff had initiated the ACCT process. She said that on reflection, she should have followed this up and checked if an ACCT had been opened. We consider an ACCT should have been opened and staff missed an opportunity to offer Mr Taylor more targeted support. We recommend:

    The Head of Healthcare should ensure that all healthcare staff are aware of their responsibilities regarding ACCT procedures, including communicating with wing staff if there are concerns around suicide and self-harm.

74. However, we consider that there was no particular reason for staff to be concerned about Mr Taylor in the days before his death, or to consider his risk of suicide to be raised.

Blocked observation panels

75. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, says that local safety measures should explain what staff should do if the occupant of a cell cannot be seen due to the panel being covered or blocked. It goes on to say that when staff discover that a panel has been blocked, and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare.

76. The Governor at Garth issued an Order to staff in February 2022 about best practice when staff find observation panels are blocked. The Order reiterates the guidance set out in national policy. It says that if staff find observation panels obstructed, they must make an attempt at dialogue with the prisoner and try and see through the sides or top of the door if possible. Repeated obstruction of the observation panel should be managed through the Incentives and/or the adjudication policy and document it on NOMIS. If the prisoner does not respond to requests to remove the obstruction, staff must radio for assistance to enter the cell, or if they feel there is a risk to life, to make a dynamic risk assessment whether to enter the cell alone. Staff must not leave the cell door unless it is to raise the alarm.

77. A CM said prisoners at Garth do block their observation panels, for a variety of reasons. He said that, for the most part, staff stayed at the door until they got a response and that it was not the norm for staff to carry on their duties after finding a blocked observation panel.

78. Officer B said he was not surprised to find Mr Taylor's observation panel blocked as prisoners often did it on the Residential Support Unit and so it did not immediately cause concern for him. He said he was aware of the Governor's Order, but as he was unlocking prisoners for work and knew Officer C was behind him, he carried on without ensuring Mr Taylor's welfare. Officer B said that, on reflection, he would now react immediately, regardless of what task he was undertaking. The prison conducted an internal disciplinary investigation into Officer B's actions and concluded he should receive advice and guidance. We do not make any further recommendations about this.

Routine checks

79. Routine checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed. HMPPS' National Security Framework expects welfare checks to take place at routine checks including that staff are able to see the prisoner's face and confirm that they are alive and well. There are four routine checks per day to ensure the number of prisoners in the prison is correct. Two of these checks are done by the night staff between 7.00 - 8.00pm and 5.00 - 6.00am.

80. An officer conducted a routine check at 7.20pm on 27 August 2023, and noted Mr Taylor lying on his bed. It is a requirement for the routine check to be noted in the wing daily diary, but he did not do this. Mr Taylor did not need additional monitoring or welfare checks through the night and did not press his cell bell, so his next routine check would have been at between 5.00 - 6.00am. CCTV shows that the officer did not complete the morning check and falsified the records to say that he had done so. He was subsequently dismissed from the Prison Service.

Clinical care

Mental and physical healthcare

81. The clinical reviewer concluded that Mr Taylor's clinical care at Garth was, in the main, of a reasonable standard and equivalent to what he could have expected to receive in the community. She found that due to Mr Taylor's extensive history of very impulsive reactions to certain situations, his needs were complex. This, combined with his history of self-harm, impulsive behaviour and previous custodial sentences, meant his risk of serious self-harm and suicide was high.

82. On 5 August, a task was sent to the mental health team to review Mr Taylor. The task was marked as completed, but there is no evidence in his medical record to suggest the mental health team saw him.

83. The clinical reviewer made recommendations about post hospital care and record keeping, which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Good practice

84. Mr Taylor's location on the Residential Support Unit was appropriate and met his complex needs. He was a vulnerable prisoner, who needed additional support with his mental health needs and periods of self-isolation. He was noted to be a quiet prisoner who generally kept to himself. There are detailed entries in Mr Taylor's prison case notes which show he was well supported by staff during his time on the Residential Support Unit.

85. At the inquest, which took place between 20 and 29 October 2025, the Coroner concluded that Mr Taylor died by suicide.

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