Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Malachi Furey, a prisoner at HMP Forest Bank, on 27 December 2024

A report by the Prisons and Probation Ombudsman

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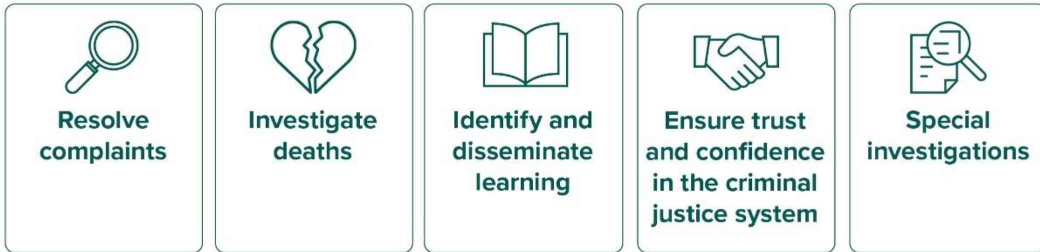
OUR VISION

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

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

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 Malachi Furey died in hospital on 27 December 2024, five days after he was found hanging in his cell at HMP Forest Bank. Mr Furey was 31 years old. I offer my condolences to his family and friends.

Mr Furey was the third prisoner to take his own life at Forest Bank in three years.

Mr Furey self-harmed by cutting several times while he was at Forest Bank and for the majority of his time there, was monitored under suicide and self-harm procedures (known as ACCT). He was being monitored under ACCT when he died.

Our investigation found that overall, the ACCT procedures were managed reasonably well and that staff set the frequency of ACCT checks in line with Mr Furey's risk.

However, the clinical reviewer found that that the mental health care Mr Furey received was not equivalent to that which he could have expected to receive in the community.

Mr Furey had no active care plans in place for managing the risks associated with his emotionally unstable personality disorder and his risk of self-harming. Also, there was no proper follow up when Mr Furey missed multiple doses of his prescribed medication. When Mr Furey asked for support from the mental health team, they asked him for more information, when they should have offered him an appointment given his EUPD and recent self-harm.

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 **October 2025**

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Summary

Events

1. On 24 October, Mr Malachi Furey was remanded in prison, charged with grievous bodily harm, and sent to HMP Forest Bank. This was not his first time in prison.

2. Mr Furey arrived at Forest Bank with a suicide and self-harm warning as he had made cuts to his arm and leg with scissors while in police custody. Prison staff started suicide and self-harm monitoring (known as ACCT). Mr Furey spent the majority of his time under ACCT monitoring apart from three weeks in November and a few days in December.

3. Mr Furey had a history of depression and had been diagnosed with emotionally unstable personality disorder (EUPD), a condition linked to impulsive behaviour, intense emotions, and self-harm.

4. Between late October and 20 December, Mr Furey self-harmed several times by cutting or reopening wounds. On several occasions, he did not collect his medication that helped him manage his EUPD. He used psychoactive substances (PS) every day. At one point, Mr Furey climbed onto the wing railings and told staff he had swallowed a battery. He was also reportedly involved in an assault on another prisoner. Mr Furey's solicitor told him that he might get a longer sentence than he had expected.

5. Late on 21 December, Mr Furey set several fires in his cell. Staff reopened his ACCT, moved him to the Care and Separation Unit (CSU – segregation unit), and increased ACCT checks to five an hour.

6. On the morning of 22 December, staff held a positive ACCT review with Mr Furey, who showed insight and engaged well. Staff reduced ACCT checks to two an hour.

7. Later that morning, Mr Furey spoke to his mother on the phone and they argued. Prison staff saw that Mr Furey was upset and frustrated. Following advice from the mental health team, they increased his ACCT checks to three an hour.

8. At 12.38pm, a prison officer noticed that Mr Furey had blocked the observation panel of his cell door. The officer got no response from him and called other staff for help. When staff opened the cell door, they found Mr Furey with a ligature around his neck hanging from the light fitting. They cut the ligature, called a medical emergency code and started CPR. Healthcare staff arrived and CPR continued. At 12.57pm, ambulance paramedics arrived. Mr Furey was taken to hospital, where he was sedated and put on a ventilator.

9. On 27 December, hospital doctors withdrew treatment and Mr Furey died at 12.53am.

Findings

10. Overall, the ACCT procedures were managed reasonably well. Most case reviews were multidisciplinary and ACCT checks were set in line with Mr Furey's current risk. However, healthcare staff did not have input to either of the case reviews on 1 November or 10 December when the decision was made to close the ACCT, which is not good practice. There were also some issues with record keeping and ACCT post-closure procedures. The Head of Safety told us that action had been taken to address these issues including refresher training for staff.

11. On the morning of 22 December, Mr Furey's ACCT checks were reduced to two an hour following a positive ACCT review. Staff later increased these to three an hour after Mr Furey's emotional phone calls with his mother. We consider these were reasonable decisions.

12. Toxicology tests found that Mr Furey had PS in his system when he was found hanging. He reported daily PS use, which he linked to worsening mental health and the breakdown in his relationship with his mother. There was some evidence he was in drug-related debt. Prison managers told us Forest Bank has strengthened its approach to drugs and debt through updated procedures, better security, staff training, and more support for prisoners.

13. The clinical reviewer found Mr Furey's mental health care was not equivalent to that which he could have expected to receive in the community. Despite a suicide and self-harm warning on arrival, no formal mental health assessment was done and there were no active care plans for his EUPD. Follow up processes were unclear when Mr Furey missed multiple doses of his prescribed medication and when he asked to see the mental health team, he was asked for details of his symptoms rather than being offered an appointment.

Recommendation

- The Head of Healthcare and the Head of the Mental Health Team should introduce an audit programme to provide assurance that patients who are prescribed medication for a mental health condition have been assessed within the previous month and have care plans that reflect appropriate interventions and monitoring arrangements in place.

The Investigation Process

14. HMPPS notified us of Mr Furey’s death on 27 December 2024.

15. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact him. Five prisoners contacted the investigator.

16. The investigator visited Forest Bank on 10 January 2025. He obtained copies of relevant extracts from Mr Furey’s prison and medical records. He also obtained CCTV, body worn video camera (BWVC) footage and a recording of staff radio communications. He also obtained the HMPPS Early Learning Review.

17. The investigator interviewed five prisoners at Forest Bank on 10 January, and one member of staff over video call on 15 May 2025.

18. NHS England commissioned an independent clinical reviewer to review Mr Furey’s clinical care at the prison. The clinical reviewer and the investigator conducted joint interviews with three healthcare staff in March, by video call.

19. We informed HM Coroner for Greater Manchester West of the investigation. The Coroner gave us a copy of the post-mortem report. We have sent the Coroner a copy of this report.

20. The Ombudsman’s office contacted Mr Furey’s mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Furey’s mother wanted a copy of the report and asked whether Mr Furey was officially subject to suicide and self-harm monitoring, and if so, whether the required checks were carried out correctly. We have addressed these issues in our report.

21. Mr Furey’s mother raised additional concerns, which we have responded to in a separate letter.

22. We shared our initial report with HMPPS, Spectrum Community Health CIC and Greater Manchester Mental Health NHS Foundation Trust. They identified one factual error and asked us to include some extra information.

23. We sent a copy of our initial report to Mr Furey’s family’s solicitor. They did not notify us of any factual inaccuracies.

Background Information

HMP Forest Bank

24. HMP Forest Bank holds adult men, both on remand and sentenced, as well as young adult prisoners aged 18 to 21. The prison serves the courts of Greater Manchester.

25. The prison is managed and operated by Sodexo Limited. Spectrum Community Health CIC provides primary healthcare and clinical substance misuse services 24 hours a day, seven days a week, and pharmacy services Monday to Friday from 9.00am to 5.00pm. Non-clinical substance misuse services are provided by Change Grow Live (CGL), Monday to Friday from 9.00am to 5.00pm.

26. Greater Manchester Mental Health NHS Foundation Trust provides both primary and secondary mental health services. Primary services run from 7.00am to 7.00pm, Monday to Friday, and from 8.00am to 4.00pm at weekends. Secondary mental health team services are available from 8.00am to 5.00pm, Monday to Friday.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Forest Bank was in December 2024. Inspectors reported that safety outcomes were “not sufficiently good”. Violence levels at the prison remained high, particularly assaults between prisoners. Around 30% of prisoners said they felt unsafe. Inspectors found that low-level bullying was often ignored or not properly investigated, contributing to a culture where poor behaviour went unchallenged.

28. There were four self-inflicted deaths since the last inspection, including one that occurred shortly after the individual was released. Self-harm remained a serious concern, with 1,087 incidents involving 369 individuals over the past year. Inspectors found that leaders were not using data effectively to identify trends or take targeted action to reduce self-harm.

29. Inspectors found that the care provided under ACCT procedures was inconsistent. Many prisoners on ACCTs were not engaged in purposeful activity. Care plans were often incomplete, lacked detail about risks and support needs, and were not routinely shared with wing staff. Only 42% of prisoners on ACCTs said they felt cared for by staff. Inspectors concluded that the prison was more focused on following ACCT procedures than on genuinely preventing self-harm.

30. Drug availability remained a major concern. Over half (51%) of prisoners said it was easy to get illicit drugs, and drug testing results supported this: 38% of mandatory tests and 74% of suspicion tests were positive. While the prison had taken steps to reduce supply, such as tackling staff corruption, using body scanners, and working with police and crime units, inspectors found that efforts to reduce demand were weak. The drug strategy was outdated and lacked a clear action plan. The incentivised substance-free living (ISFL) wing offered little in the way of meaningful incentives or regular drug testing. Although clinical and psychosocial services were available, they were not well integrated.

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 most recent annual report for the year to 31 October 2024, the IMB noted a significant increase in prisoner turnover and a rise in the prison's operational capacity. Staff were managing a 13% rise in violent incidents, alongside a growing number of prisoners with moderate-to-severe mental health conditions and neurodiverse needs.

32. Although the prison had been actively recruiting new officers throughout the year, it continued to face challenges in training and retaining them effectively. The IMB also raised concerns about the limited delivery of key worker sessions, with many prisoners unaware of who their key worker was.

33. On substance misuse, the IMB reported that there were 1,512 clinical referrals and 539 non-clinical referrals during the year. Cannabis and synthetic cannabinoids (psychoactive substances) were the most commonly reported substances among prisoners who self-referred for support.

Previous deaths at HMP Forest Bank

34. Mr Furey was the eighteenth prisoner to die at Forest Bank since December 2021. Of the previous deaths, two were self-inflicted, eleven were from natural causes, two were drug related, in one the cause of death was unascertained, and one is awaiting classification. Up to the end of May 2025, there have been two further deaths, one from natural causes and one awaiting classification.

Assessment, Care in Custody and Teamwork (ACCT)

35. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. Prior to January 2025, guidance on ACCT procedures was set out in Prison Service Instruction (PSI) 64/2011. In January 2025, this was replaced by the Prison Safety Policy Framework in which the principles of ACCT remain largely unchanged. 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 irregular to prevent the prisoner anticipating when they will occur.

Key Events

36. On 24 October 2024, Mr Malachi Furey was remanded in prison, charged with grievous bodily harm, and sent to HMP Forest Bank. This was not his first time in prison. (Mr Furey had been released from Forest Bank four months prior.)

ACCT: 24 October to 1 November

37. Mr Furey arrived at Forest Bank with a suicide and self-harm warning, which said he had been found with a pair of scissors in his police cell and had made cuts to his left arm and right leg. Staff started suicide and self-harm procedures (known as ACCT) and placed him on two checks an hour.

38. Mr Furey had a history of depression, and a diagnosis of emotionally unstable personality disorder (EUPD), also known as borderline personality disorder (BPD). (EUPD is a mental health condition marked by intense and rapidly shifting emotions, unstable relationships and self-image, impulsive behaviours such as self-harm and or substance misuse, fear of abandonment, chronic feelings of emptiness, and difficulty managing stress and anger.) Mr Furey also told staff he had post-traumatic stress disorder (PTSD).

39. He told the reception nurse he was not a drug user, despite a known history of cannabis, cocaine, ketamine, and psychoactive substances (PS) use. He had previously accessed support from substance misuse services. Due to his level of risk, he was not permitted to have medication in possession.

40. Because of his behaviour during a previous sentence at Forest Bank, staff submitted a Challenge, Support, and Intervention Plan (CSIP) referral. (CSIP is used to manage prisoners who pose a higher risk of violence.) It was decided that he would be managed outside the CSIP process.

41. Mr Furey was moved to a cell on the induction wing.

42. On 25 October, he was prescribed quetiapine (an antipsychotic) to treat his EUPD.

43. The same day, a Senior Prison Custody Officer (SPCO) chaired Mr Furey's first ACCT review, which was multidisciplinary. The SPCO noted that Mr Furey engaged well and told staff he wanted to "keep his head down" in prison and that his partner wanted him to turn his life around. He said he had self-harmed in police custody due to stress but had no current thoughts of suicide or self-harm. Mr Furey asked to remain on the induction wing, but staff advised against this due to concerns about increased exposure to illicit substances and limited access to work or education. The review team reduced ACCT checks to one an hour.

44. On 29 October, Mr Furey self-harmed by cutting his left forearm. He declined treatment from healthcare staff and refused to have the wound inspected. A nurse noted that a referral was made to the mental health crisis team. (A nurse carried out an initial mental health assessment on 30 October.)

45. That day, Mr Furey did not attend the medication hatch to pick up his quetiapine.

46. On the morning of 30 October, a SPCO chaired Mr Furey's second ACCT review, which was multidisciplinary. Mr Furey told staff he had self-harmed out of frustration over incorrect prison records, which listed him as convicted when he was in fact on remand awaiting trial. A nurse noted Mr Furey's long-standing pattern of responding to stress through self-harm. Mr Furey told staff he had no current thoughts of suicide or self-harm. The review team kept ACCT checks at one an hour.

47. Mr Furey did not attend the medication hatch to collect his quetiapine. He also failed to collect it the next day.

48. On the morning of 1 November, a SPCO chaired Mr Furey's third ACCT review. The review was not multidisciplinary, as no healthcare staff attended or contributed. The SPCO noted that Mr Furey engaged well. He appeared settled, maintained good eye contact, and said he felt safe and supported on the wing. He had recently been given a cleaning job trial, which he was very pleased about, and had had positive contact with his mother. Mr Furey told staff he had no thoughts of suicide or self-harm and said he would speak to staff if needed. The review team decided to close the ACCT.

2 - 21 November

49. On 12 November, Mr Furey was visited by his solicitor. Prisoners told us that after this visit, Mr Furey had been crying in his cell. They said he was facing a longer sentence than expected, potentially up to 12 years. Prisoners said Mr Furey had previously served seven years in prison and was worried that his mother might die before he was released.

50. On 18 November, Mr Furey submitted a request to see someone from the mental health team. The team responded, asking for more information about his symptoms.

51. On 21 November, the Early Days in Custody (EDIC) Manager, held a key work session with Mr Furey. The EDIC Manager noted that Mr Furey had been removed from his job as a unit cleaner due to misuse of PS.

52. That afternoon, Trafford Community Mental Health Team (CMHT) emailed the prison's mental health team requesting an update on Mr Furey's mental health. They said he had been involved in a serious incident prior to returning to custody and that they were investigating it.

53. Healthcare staff reviewed Mr Furey's medical records and confirmed he was not open to the community mental health team. They noted that Mr Furey was under Trafford Living Well, had contact with the criminal justice team, and that his GP was monitoring his medication. Healthcare staff noted it was unclear why the community team had contacted the prison.

ACCT: 21 November to 10 December

54. That evening, Mr Furey self-harmed by making a cut to his right leg. He accepted treatment but declined pain relief. He told staff he had self-harmed due to stress. Prison staff reopened his ACCT and arranged for the mental health team to speak to him the next day.

55. On 22 November, a SPCO chaired Mr Furey's fourth ACCT review. The review was multidisciplinary, including a member of the mental health team. Mr Furey told staff he had self-harmed the previous day because he felt frustrated that his mother had promised to send him £30, which he had not received. He said he felt much better after speaking with his family. Mr Furey said he had no further thoughts or plans of suicide or self-harm and described himself as a very reactive person who did not stop and think in the moment. Based on his presentation, the review team decided to close the ACCT.

56. On 26 November, Mr Furey self-harmed again by cutting his arm. Prison staff reopened his ACCT and placed him on two checks an hour.

57. On 27 November, a SPCO chaired Mr Furey's fifth ACCT review. The review was multidisciplinary. Mr Furey told staff he had self-harmed because he was unable to put credit on his phone and speak to his family. Staff explained that he would have been able to do this the previous day when unlocked and should have used that time to do so. Mr Furey said he felt better after topping up his phone and speaking with his family. He said he had no current thoughts of suicide or self-harm. As a precaution, razors were removed from his possession. The review panel reduced ACCT checks to one an hour.

58. On 28 November, Mr Furey attended a video link court hearing. His case was adjourned to 24 March 2025. Prison staff noted that he understood the outcome, and a welfare check was completed.

59. On the evening of 1 December, Mr Furey reopened a wound on his right leg. He told staff he had done so due to stress. Healthcare staff attended, but no treatment was required.

60. On the morning of 2 December, a SPCO held Mr Furey's sixth ACCT review. The review was multidisciplinary. The SPCO noted Mr Furey engaged well. Mr Furey told staff he made cuts to his legs due to the stress of being on the induction landing but would not elaborate, and he wanted to move to another landing. He said he was speaking with his mother and partner daily. He said he had not been taking his medication but knew he should. He said he had no current thoughts of suicide or self-harm. The review team kept ACCT checks at one an hour.

61. That evening, Mr Furey climbed onto the railings of E2 landing and said he had swallowed an AAA battery. A nurse noted that prison staff requested a healthcare assessment to determine whether Mr Furey was suitable for transfer to the Care and Separation Unit (CSU – the segregation unit). She said she tried to speak to Mr Furey to assess his needs, but prison staff were uncooperative and dismissed her involvement. Despite this, Mr Furey came down from the railings without the use of force and returned to his cell independently, with no injuries or medical concerns.

62. On 3 December, a SPCO chaired Mr Furey's seventh ACCT review. The review was multidisciplinary. A nurse attended and noted that Mr Furey appeared in a stable mood and showed no signs of mental illness. Mr Furey said he had climbed onto the railings the previous day out of frustration from being locked in his cell for 24 hours and wanting to be moved off the wing. He said the request was not related to avoiding drug debt. Staff agreed to explore relocation options.

63. Mr Furey told staff that during a previous sentence he had been waiting to see a psychiatrist. He said he wanted his medication increased, despite not taking it as prescribed, but agreed to restart it. He admitted to ongoing use of illicit substances (likely PS) but refused to engage with substance misuse services. The review team set ACCT checks at one every two hours.

64. That afternoon, prison staff contacted healthcare staff and reported that Mr Furey was well and had no abdominal pain following his earlier claim of swallowing a battery.

65. On 5 December, Mr Furey was moved to B2 landing.

66. On 10 December, a SPCO chaired Mr Furey's eighth ACCT review. The review was not multidisciplinary, as no healthcare staff attended or contributed. The SPCO noted that Mr Furey engaged well. Mr Furey told staff he felt much better since moving to B2 landing. He stated he had not self-harmed or experienced any thoughts of self-harm since the move. He said he had regular contact with his family, who were supportive, and that he would speak to staff if anything changed. Based on his presentation and progress, the review team decided to close the ACCT.

17 to 20 December

67. On 17 December, the SPCO conducted Mr Furey's post-closure ACCT review. He had no concerns and considered the ACCT could remain closed.

68. On 18 December, Mr Furey assaulted another prisoner. Prison staff submitted a CSIP referral. However, after reviewing the incident and considering his mental health needs, it was decided that Mr Furey would be managed through ACCT, the Incentives Framework (a scheme to reward good behaviour), and prison rules.

69. On 19 December, prison staff placed Mr Furey on the basic regime for 21 days. This meant he had fewer privileges, including limited canteen orders (from the prison shop).

70. On 20 December, Mr Furey did not attend an appointment with a GP to discuss his ongoing refusal to take medication. No reason was given. (Mr Furey had missed pharmacy appointments on 4, 6, 10, 11, and 12 December.)

71. Later that day, a Prison Custody Officer (PCO) held a key worker session with Mr Furey. The PCO noted that she challenged his recent behaviour. Mr Furey said he was unhappy about being on the basic regime and not being able to submit a Christmas canteen order. However, staff later authorised him to place an order, and the PCO noted that Mr Furey was pleased with this outcome.

ACCT: 21 December

72. On 21 December, at around 11.10pm, Mr Furey set a small paper fire in his cell. The fire service was not required. Shortly after, he set additional fires, and at 11.27pm, prison staff moved him to the CSU. Body Worn Video Camera (BWVC) footage showed Mr Furey walking calmly and compliantly to the CSU. Prison staff reopened his ACCT. Mr Furey told staff he had had enough and that his family had

abandoned him since his last release, which had led to his return to prison and a probable lengthy sentence. He said he was struggling to cope and that this was his only option. Prison staff placed him on five ACCT checks an hour.

Events of 22 December

73. On the morning of 22 December, the EDIC Manager carried out a welfare check on Mr Furey. No concerns were raised at that time.

74. At 10.22am, the EDIC Manager chaired Mr Furey's ninth ACCT review, which was multidisciplinary. The EDIC Manager noted that Mr Furey engaged well during the review, but staff noted he had "burned bridges" across several wings due to repeated negative behaviour. Staff told him that vaping was no longer allowed in CSU, which caused him further anxiety. He declined an offer to return to his previous wing, which the EDIC Manager believed may have been due to debt or threats on the wing.

75. Mr Furey told staff he had set fire to his cell as a cry for help. He spoke about ongoing family issues, including that his mother had withdrawn some of her support. He also expressed concerns about his relationship with his partner and said he used PS daily on the wings.

76. Mr Furey said his addiction to PS had contributed to problems with his mother, who was no longer visiting regularly. Mr Furey said he would be willing to work with the substance misuse team on G&H wing. He was referred to CGL (Change Grow Live) for assessment and support and added to the primary care mental health team waiting list. The review team set ACCT checks at two an hour.

77. Between 11.42am and 11.49am, Mr Furey made five phone calls to his mother. The calls were heated and ended abruptly twice. During the calls Mr Furey sounded distressed and said he was in the CSU for his own protection due to suicidal thoughts. He mentioned another prisoner had received a 28-year sentence for slashing someone's face and was being transferred to a mental health hospital. (Mr Furey was on remand for a similar offence.)

78. He was frustrated that his mother had not contacted someone he believed could provide a witness statement for his court proceedings. She said she had tried, but eventually told him to find someone else to do it. The conversation was emotional. Mr Furey's mother said she felt overwhelmed by his repeated requests. Mr Furey insisted he was only asking her to do something she had promised two weeks earlier. The final call ended with both of them frustrated.

79. A PCO noted that Mr Furey was visibly upset and slammed the phone down.

80. At 11.50am, staff escorted Mr Furey back to his cell. Mr Furey said he was angry that his mother would not contact the potential witness. CCTV showed prison staff spent over 10 minutes with Mr Furey in and around his cell.

81. Concerned about the impact of the phone call, a SPCO contacted the mental health team. Nurse A told us she advised increasing Mr Furey's ACCT checks based on his history and risk. Prison staff raised the checks from two to three an hour.

82. Between 12.04pm and 12.22pm, prison staff checked on Mr Furey three times.

83. At 12.38pm, PCO A found Mr Furey's observation panel covered with toilet paper. PCO A called out to Mr Furey and knocked his cell door. After receiving no response, he called PCO B for support. When they opened the cell, they found Mr Furey had used a shoelace as a ligature and was hanging from a bolt in the light fitting.

84. At 12.40pm, a SPCO radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and the control room called an ambulance. PCO A and PCO B cut the ligature, laid Mr Furey on his back, and started CPR. Another PCO arrived and saw Mr Furey lying motionless with his eyes open and a mark around his neck.

85. At 12.41pm, healthcare staff arrived. CPR continued. Healthcare staff noted signs of hypoxia (lack of oxygen), pallor (pale skin), and fixed dilated pupils. CPR and ventilation continued. A defibrillator was attached, but no shocks were advised.

86. At 12.57pm, paramedics arrived. CPR continued, and Mr Furey regained a pulse (return of spontaneous circulation).

87. At around 1.15pm, Mr Furey was taken to Salford Royal Hospital, placed in the intensive care unit, sedated, and put on a ventilator.

88. In the early hours of 27 December, treatment was withdrawn. Mr Furey was pronounced dead at 12.53am.

Contact with Mr Furey's family

89. On the afternoon of 22 December, the prison's family liaison officer, telephoned Mr Furey's mother to tell her that he had been taken to Salford Royal Hospital. At 2.45pm, the family liaison officer met Mr Furey's mother at the hospital and offered support.

90. Mr Furey's family were present at hospital shortly before his death and had the opportunity to say goodbye.

91. The family liaison officer maintained regular contact with Mr Furey's mother over the following weeks, offering support and advice, including a home visit, phone calls, and assistance with funeral arrangements.

92. The prison contributed to the cost of Mr Furey's funeral in line with national policy.

Support for prisoners and staff

93. 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.

94. The Head of Prisoner Safety told us that that although a formal postvention process was not yet in place, steps were being taken to implement one. The process is awaiting final approval from Sodexo and the Samaritans before it can be fully rolled out.

95. After the emergency response, and later after Mr Furey died, a prison manager debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Sodexo also arranged for staff to have additional counselling sessions through its Spectrum Life service.

96. The prison posted notices informing other prisoners of Mr Furey'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 Furey's death, and Listeners were deployed on the wing to support prisoners if needed.

Post-mortem report

97. The post-mortem report concluded that Mr Furey died as a result of hypoxic brain injury caused by hanging. The toxicology report identified the presence of a synthetic cannabinoid 5F-ADB (PS, commonly known as "Spice") in his blood.

Findings

Management of Mr Furey’s risk of suicide and self-harm

98. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in force at the time Mr Furey arrived at Forest Bank, set out the processes (known as ACCT) that staff should follow when they identified that a prisoner was at risk of suicide and self-harm. (The policy has since been superseded by the Prison Safety Policy Framework though ACCT processes remain broadly the same.)

99. Mr Furey had several known risk factors for suicide and self-harm. He had a long history of self-harming and had previously tried to take his own life. Staff correctly started ACCT procedures when Mr Furey arrived at Forest Bank and apart from a three-week period in November and a few days in December, he was monitored under ACCT throughout his time there.

100. Staff held frequent case reviews, the majority of which were multidisciplinary, and set checks in accordance with Mr Furey’s risk. However, when the ACCT was closed at the case reviews on 1 November and 10 December, there was no input from healthcare staff which is not good practice. We also found that when Mr Furey’s ACCT was closed the case reviews were not recorded on Mr Furey’s electronic prison record (p-NOMIS) nor was the reason for the closure recorded. The post-closure review on 17 December was brief and did not show that any support had been offered.

101. In February 2025, a Deputy Director at Forest Bank issued notices reminding staff to record all relevant information on p-NOMIS.

102. The Head of Prisoner Safety told us that a national HMPPS training programme was underway to refresh staff training for ACCT case coordinators. She said that 80% of Forest Bank staff had already completed this training.

103. The Head of Prisoner Safety said that the Single Case Coordinator Model had been updated to improve consistency, so that one coordinator oversaw all reviews for a prisoner. This reduced the need for prisoners to repeat their concerns to different staff and ensured better continuity of care. The model also included responsibility for managing post-closure processes. A three-tier quality assurance system, covering shift managers, unit managers, and the safer custody team, was now in place to check that post-closure monitoring was being done properly. The safer custody team also audited this process. The Head of Prisoner Safety said staff were being trained to ensure that written records better reflect the actual care and support provided.

Setting of ACCT checks on 22 December

104. When staff moved Mr Furey to the CSU on 22 December and reopened his ACCT, they set checks at five an hour, in line with policy. (Prisoners who are segregated and on ACCT must have five checks an hour pending the next case review.) The next morning, Mr Furey had a multidisciplinary ACCT review. He was open, engaged well, and showed insight. The nurse told us it was one of the best reviews

with Mr Furey, and that he agreed to engage with CGL and the mental health team, which she said was a “massive step” for him. Staff reduced ACCT checks to two an hour. We consider this was a reasonable decision.

105. Later that morning, prison staff noticed that Mr Furey was visibly upset after an emotional phone call with his mother. After returning him to his CSU cell, they spent over 10 minutes talking with him. An SPCO contacted Nurse A for advice. Nurse A advised increasing ACCT observations. Prison staff raised Mr Furey’s checks from two an hour to three an hour.

106. It was positive that staff responded quickly to the increase in Mr Furey’s risk. They spent time talking with him and sought advice from the mental health team. We consider it was a reasonable decision to increase the frequency of checks to three an hour. In the context of Mr Furey’s past behaviour, we do not think that staff could reasonably have foreseen the actions he would take or had reason to consider him at imminent risk of suicide. We make no recommendation.

Drugs and debt

107. After Mr Furey’s death, toxicology tests showed that he had PS in his system. While at Forest Bank, he admitted to using PS every day and said it had affected his mental health and relationship with his mother. Although he first refused help, shortly before his death he agreed to be referred to Change Grow Live (CGL), the prison’s drug support service.

108. In his Annual Report 2023-24, HM Chief Inspector of Prisons highlighted that the presence of illicit drugs in prisons was a common cause of violence, bullying and debt, and that prisoners reported debt, drug problems and family breakdown among the factors contributing to self-harm.

109. In their latest inspection, HMIP noted that drugs were still a serious problem at Forest Bank. Just over half of prisoners said it was easy to get illegal drugs, much higher than the national average of 32%. This was backed up by high numbers of positive drug tests.

110. Despite Mr Furey using PS daily, losing his cleaning job because of it, and telling staff during ACCT reviews that he was using, no intelligence reports were submitted. Staff also suspected he was in debt, but this was not formally recorded.

111. A Deputy Director said the prison had taken steps to tackle drug use. The Drug Strategy had been reviewed and updated to match the national Drug and Alcohol Policy Framework. This included a new action plan linked to security efforts, such as better intelligence gathering, more searches, and physical barriers like netting in high-risk areas.

112. The Deputy Director said staff had received training on substance misuse, and there was now a stronger focus on collecting and acting on intelligence. The Incentivised Substance Free Living (ISFL) Programme had a dedicated staff member responsible for drug testing, delivery of harm reduction, and referrals to CGL. (ISFL is a prison programme where prisoners commit to staying drug-free in exchange for better living conditions, support services, and access to work and activities.) A full schedule of activities was in place, supported by CGL, along with

more access to full-time work and horticulture for those in the programme. She added that prisoners with high levels of drug use were now supported through joint working between CGL and operational managers. CGL staff were regularly present in areas of the prison where drug use was more common, offering education and support.

113. The Head of Prisoner Safety said that the CSIP process was used to support both those who commit violence and those affected by it. People involved in violence can be referred to CSIP and may also be linked with CGL for drug support. Multidisciplinary case reviews were held to coordinate help around issues like violence, debt, and drug use.

114. In light of the extensive work underway at Forest Bank, we make no recommendation.

Clinical care

115. The clinical reviewer highlighted several concerns with Mr Furey's mental health care.

116. Despite Mr Furey arriving with a suicide and self-harm warning, no formal mental health assessment was carried out. While there was evidence of historic care plans relating to Mr Furey's EUPD, there were no active care plans at Forest Bank.

117. Mr Furey missed multiple doses of his antipsychotic medication and healthcare appointments, including one with a GP to discuss his non-compliance. Mr Furey was encouraged to take his medication during various contacts with healthcare staff, however it was unclear what further follow up plans existed and to what extent it was considered that Mr Furey's medication was critical to the maintenance of his mental health and wellbeing.

118. When Mr Furey asked to see someone from the mental health team, he was asked to provide more information about his symptoms. The clinical reviewer considered that Mr Furey should have been offered an appointment, given his EUPD and recent history of self-harming. There was also no evidence of any follow up.

119. The clinical reviewer concluded that the mental health care Mr Furey received at Forest Bank was not equivalent to that which he could have expected to receive in the community.

120. We recommend:

The Head of Healthcare and the Head of the Mental Health Team should introduce an audit programme to provide assurance that patients who are prescribed medication for a mental health condition have been assessed within the previous month and have care plans that reflect appropriate interventions and monitoring arrangements in place.

Inquest

121. At the inquest, held on 18 November 2025, the jury concluded:

> "Accidental death due to the deceased being unaware of the instantaneous impact of using an improvised ligature. The act was influenced by an episode of dysregulation and with the ongoing emotional and mental health issues he underestimated the consequences of his actions."

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