Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jake O'Brien, a prisoner at HMP Forest Bank, on 12 November 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 Jake O'Brien died in hospital on 12 November 2024, three days after he was found hanging in his cell in the segregation unit at HMP Forest Bank. Mr O'Brien was 22 years old. I offer my condolences to Mr O'Brien's family and friends.

Mr O'Brien had been transferred from HMP Liverpool to Forest Bank 18 days before he hanged himself. He was a very challenging prisoner to manage safely. He had history of self-harm, substance use, anxiety, ADHD, memory issues following a head injury, learning difficulties, and borderline autism. He was being monitored under suicide and self-harm prevention procedures, known as ACCT, when he was transferred to Forest Bank, and up until he died. He was also in the process of being assessed for transfer to a medium secure psychiatric hospital and was clearly very mentally unwell.

Mr O'Brien's mental health significantly deteriorated after his reported use of illicit substances at Liverpool in September 2024. There were critical failures in Mr O'Brien's care both at Liverpool and Forest Bank, including inconsistent documentation, poor case coordination, and missed opportunities to reassess his risk after serious incidents. Communication between prison, healthcare, and external agencies was inadequate, with key information not shared.

While there is evidence of staff making concerted efforts to support Mr O'Brien, overall this is a critical report making a number of recommendations to both Liverpool and Forest Bank.

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 **December 2025**

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Summary

Events

1. On 20 November 2023, Mr Jake O'Brien was remanded to HMP Birmingham for several alleged offences, including burglary, theft and affray. He was 22 years old and reported a history of self-harm, substance use, anxiety, ADHD, and memory issues linked to a past head injury. He had been diagnosed with learning difficulties, and borderline autism. This was not his first time in prison.

2. After transfers to HMP Brinsford and then HMP Liverpool, Mr O'Brien became involved in repeated altercations and property damage, leading to being held in the segregation unit away from other prisoners and receiving disciplinary sanctions.

3. In September 2024, Mr O'Brien was found under the influence of ketamine. His mental health deteriorated, resulting in bizarre behaviour, assaults on staff and other prisoners, self-harm, and setting fires. Suicide and self-harm prevention procedures, known as ACCT, were initiated, and he was sometimes placed under constant supervision. Despite brief periods of stability, Mr O'Brien's condition worsened, marked by impulsive behaviour, paranoia, and further substance use. He subsequently moved between the segregation unit, residential wings, and the healthcare inpatient unit. A psychiatrist prescribed Mr O'Brien antipsychotic medication, but he inconsistently took this.

4. In October, a psychiatrist referred Mr O'Brien for assessment for transfer to a medium secure psychiatric hospital. This assessment happened on 16 October. On 22 October, the hospital deferred the referral for a further month of monitoring and informed the psychiatrist verbally. This was not documented.

5. The same day, Mr O'Brien transferred to HMP Forest Bank. Despite his complex presentation, there was limited handover between the two prisons and no managerial oversight. A mental health nurse from Liverpool provided a handover of his care by email to the mental health care team at Forest bank. It noted Mr O'Brien's vulnerabilities, substance use history, and that he was being monitored by ACCT. He had also not taken his prescribed antipsychotic medication for four consecutive days. The nurse noted that the outcome of Mr O'Brien's referral to a secure hospital was outstanding. Reception staff processed Mr O'Brien and he was initially placed on a standard residential unit.

6. On 23 October, the secure hospital informed Forest Bank that Mr O'Brien required close monitoring, a psychiatric review, and updated assessments. A nurse confirmed Mr O'Brien would be appointed a mental health nurse who would coordinate his care. This did not happen.

7. On 25 October, Mr O'Brien further refused his medication, attempted to jump from an upper landing on a residential unit, set fire to his cell, and concealed a blade. He was moved to the segregation unit. A nurse assessed him as fit for segregation but failed to complete the segregation healthcare algorithm (which assesses whether a prisoner can safely be segregated) properly or document it in the medical record. Mr O'Brien remained segregated due to ongoing aggression and medication refusal. This information was not shared with the secure hospital.

8. On 31 October, Mr O'Brien assaulted his mother during a private visit. A nurse assessed him, found no injuries and no treatment was required. No ACCT review followed, and the incident was not shared with mental health team or the secure hospital. The same day, he missed a psychiatric appointment due to clinic overbooking. The psychiatrist rescheduled and advised staff to alert the secure hospital if his condition worsened. Mr O'Brien then missed psychiatric appointments on 4 and 5 November.

9. On 6 November, the mental health team was informed of the assault on his mother. A nurse shared this with the secure hospital and noted he had not received a psychiatric review or detailed mental health assessment. That day, Mr O'Brien also assaulted a prison officer.

10. On 9 November, at 9.03am, staff found Mr O'Brien hanging from a light fitting in his cell on the segregation unit. They called an emergency code, cut the ligature and healthcare staff arrived and started cardiopulmonary resuscitation. At 9.20am, paramedics arrived and subsequently took Mr O'Brien to hospital.

11. Mr O'Brien died in hospital on 12 November.

Findings

12. Mr O'Brien had several risk factors for suicide and self-harm. He was a young man with a history of substance use, self-harm, anxiety, ADHD, memory issues, learning difficulties and borderline autism. He was non-compliant with his antipsychotic medication in prison which contributed to his difficult behaviour. Liverpool appropriately opened ACCT procedures when Mr O'Brien's mental health deteriorated, and he was placed under the care of the mental health team.

13. Mr O'Brien remained managed under ACCT procedures from that point on due to his escalating risks and complex mental health needs. Some aspects of the ACCT process at Liverpool were well managed and reflective of his needs, but we also found inconsistent documentation, lack of continuity in case coordinator, and missed opportunities to reassess his risk, especially after serious incidents at both Liverpool and Forest Bank. This revealed critical failures in ensuring Mr O'Brien's safety along with accurate and up to date assessments of his risks.

14. Despite Mr O'Brien's open referral for admission to a secure hospital, clinical staff at Liverpool did not request he be subject to a clinical hold (which would have involved discussions about whether he should transfer and how any subsequent transfer should be managed to ensure continuity of care). The management of his transfer was insufficiently robust with too little managerial input or oversight at either Liverpool or Forest Bank.

15. At Forest Bank, segregation procedures were not always followed despite Mr O'Brien's deteriorating mental health.

16. The clinical reviewers noted that the healthcare that Mr O'Brien received at Liverpool was good, as was his physical health and substance use care at Forest Bank. However, they found his mental healthcare at Forest Bank fell short of the required standard and was only partially equivalent to that which would have been received in the wider community.

17. The clinical reviewers identified multiple communication failures between prison, healthcare staff and external agencies, where key information was not recorded or shared, potentially affecting the accurate assessment of Mr O'Brien's risk. The clinical reviewers identified that the communication process between prison staff and the Edenfield Centre secure hospital needed improvement.

Recommendations

- The Governor at HMP Liverpool and the Director at HMP Forest Bank should ensure that all staff have a clear understanding of their responsibilities to record, share and consider all relevant information about risk, including that:
    - A consistent, case coordinator is assigned for the duration of ACCT monitoring,
    - All ACCT reviews are multidisciplinary, with healthcare staff present when the prisoner is under the care of the mental health team; and
    - Ensure that any significant risk information or incidents, such as self-harm, violent behaviour, or external concerns, trigger an urgent ACCT review in line with PSI guidance.
- The Governor at Liverpool and the Director at Forest Bank should ensure that there is sufficient senior management oversight of the transfer of complex prisoners. This should include a robust and auditable pathway for the transfer of these prisoners, including sharing risk information with relevant staff.
- The Head of Healthcare and Head of Mental Health at HMP Liverpool must implement a clear and consistent communication protocol for transferring individuals with complex mental health needs. This should include detailed handover information, timely follow-up, and confirmation of receipt by the receiving prison.
- The Heads of Healthcare and the Heads of Mental Health at HMP Liverpool and HMP Forest Bank should establish and implement robust communication protocols for prisoners awaiting medium secure hospital assessments. These must ensure timely and consistent updates to external services, particularly in cases of clinical deterioration.
- The Head of Healthcare and Head of Mental Health at HMP Liverpool should ensure that staff understand the clinical hold process as set out in Prison Service Order 3050 *Continuity of healthcare for prisoners* including how it applies to prisoners awaiting mental health assessment or transfer to a mental health secure unit.
- The Head of Healthcare and the Head of Mental Health at Forest Bank should ensure:
    - Prisoners awaiting transfer to secure hospital are immediately assigned a named nurse to coordinate care during the interim period; and

- A dedicated care coordinator is assigned to prisoners with complex needs and severe mental illness to ensure consistent, streamlined care planning and delivery.

- The Heads of Healthcare and Heads of Mental Health at both HMP Liverpool and HMP Forest Bank should ensure that all prisoners refusing critical medication are discussed at the daily safety huddle, with a clear and timely care plan developed and recorded to support clinical decision-making and risk management.

- The Director, Head of Healthcare, and Head of Mental Health at HMP Forest Bank should ensure that all prisoners in the segregation unit receive:

  - Daily healthcare visits in line with PSO 1700;

  - Accurate clinical entries in SystmOne, using the segregation template to support consistent and coordinated care;

  - Timely reporting of incidents to the mental health team within 24 hours; and

  - Mental health representation at weekly SIM meetings to support effective multidisciplinary decision-making.

- The Head of Healthcare and the Head of Mental Health at Forest Bank should ensure all healthcare staff work strictly within their roles and scope of practice, maintaining clear professional boundaries to support safe and ethical care.

- The Head of Healthcare and the Head of Mental Health should ensure that prisoners relisted for psychiatric assessment are not removed from scheduled appointments. If removal is unavoidable, they must be promptly rescheduled, with the rationale clearly documented in medical records and an urgent red flag task sent to the mental health in-reach team to ensure follow-up.

- The Head of Healthcare and Head of Mental Health at HMP Forest Bank must ensure staff are trained in mental capacity assessment, consistently record capacity based on each interaction, and document these decisions clearly in medical records to support multi-disciplinary communication.

- The Director, Head of Healthcare, and Head of Mental Health at HMP Forest Bank should ensure prisoners refusing food or fluids or on limited diets receive coordinated care through:

  - A regularly reviewed food and fluid refusal log and care plan, with accurate records of intake and prescribed supplements.

  - Daily clinical monitoring, with findings documented in SystmOne and discussed in safety huddles.

  - Collaborative working between prison staff, healthcare, GPs, and mental health teams to support timely intervention and prevent deterioration.

The Investigation Process

18. HMPPS notified us of Mr O'Brien's death on 13 November 2024.

19. 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. No one responded.

20. The investigator visited Forest Bank on 18 November. He obtained copies of relevant extracts from Mr O'Brien's prison and medical records.

21. The investigator interviewed 25 members of staff and one prisoner at HMP Liverpool and HMP Forest Bank between October 2024 and August 2025.

22. NHS England commissioned two clinical reviewers to review Mr O'Brien's clinical care at Liverpool and Forest Bank. One clinical reviewer conducted joint interviews with the investigator. The other assisted with interviewing healthcare staff.

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

24. The Ombudsman's office contacted Mr O'Brien's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr O'Brien's mother raised the following issues regarding his treatment and care:

    - She questioned how Mr O'Brien had sustained multiple injuries while being monitored. He was malnourished and should have been hospitalised earlier.

    - She was not informed of his transfer to Forest Bank, which does not have an inpatient unit, and asked whether his care plan was shared with Forest Bank, and why he was placed on a standard residential wing upon arrival.

    - She reported that two prisoners witnessed staff abuse and alleged that the water supply to his cell was turned off.

    - A week before his death, Mr O'Brien told her that he was hearing voices and asked if he should kill himself.

    - She asked what checks staff carried out on the day he was found hanged.

    We have addressed these concerns in this report, the clinical review and separate correspondence. We found no evidence that staff had abused Mr O'Brien at either Liverpool or Forest Bank. Staff told us that they had not turned off the water supply to his cell at any point.

25. Mr O'Brien's family received a copy of the initial report. They did not make any comments.

26. The initial report was shared with HM Prison and Probation Service (HMPPS) and Sodexo. They identified factual inaccuracies, and the report has been amended accordingly. Their action plan is annexed to this report.

Background Information

HMP Liverpool

27. HMP Liverpool is a local adult male prison. Spectrum CIC provides primary healthcare and substance misuse services. Merseycare provide secondary mental health services. The inpatient unit holds up to 20 prisoners who require support for physical and mental health needs.

HMP Forest Bank

28. 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.

29. 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.

30. Mental health services are provided by Greater Manchester Mental Health NHS Foundation Trust, Monday to Friday from 7.00am to 7.00pm and at weekends from 8.00am-4.00pm. The secondary mental health service provides cover 8.00am to 5.00pm Monday to Friday.

HM Inspectorate of Prisons

31. 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.

32. There had been four self-inflicted deaths since the last inspection, including one that had occurred shortly after the prisoner 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.

33. 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.

34. Drug availability remained a major concern. 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, inspectors found that efforts to reduce demand were weak.

Independent Monitoring Board

35. 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 (the total number of prisoners the prison could accommodate). 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.

36. 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.

37. On substance use, 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

38. Mr O'Brien was the sixteenth prisoner to die at Forest Bank since November 2021. Of the previous deaths, one was self-inflicted, eleven were from natural causes, two were drug related, the cause of one was unascertained, and one is awaiting classification. There are no significant similarities between these deaths and that of Mr O'Brien.

39. After Mr O'Brien's death and up to the end of August 2025, there have been six further deaths: three self-inflicted, one natural causes, one drug related and one awaiting classification.

Assessment, Care in Custody and Teamwork (ACCT)

40. 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.

41. Guidance on segregation procedures states that particular care should be given to authorising continued segregation of a prisoner on an open ACCT because being segregated can increase the risk of suicide and self-harm and negatively impact the prisoner's mental health. The guidance states that continued segregation should occur only in exceptional circumstances and that ACCT case reviews must take place at the same time as segregation reviews.

Incentives Scheme

42. The Incentives scheme is designed to promote good behaviour and engagement in rehabilitation. It operates across three levels - basic, standard, and enhanced - each offering increasing incentives such as extra visits, and access to in-cell televisions. Prisoners can earn these incentives by meeting behavioural expectations, but they may lose them if their behaviour deteriorates. The scheme aims to encourage positive conduct and reduce reoffending through structured incentives and accountability.

Key Events

Background

43. Mr Jake O'Brien had his first contact with the police when he was 13 years old and had 11 convictions for 23 offences. Police had identified Mr O'Brien as a victim of child criminal exploitation, including county lines (drug supply) involvement.

44. Mr O'Brien had several vulnerabilities, including learning difficulties, Attention Deficit Hyperactivity Disorder (ADHD – a neurodiversity with symptoms including inattention, hyperactivity and impulsivity), and borderline autism (meaning he demonstrated less severe autistic symptoms). He sustained a serious brain injury in 2020 in a car accident but did not receive any follow-up neurology care due to discharging himself from the hospital. He also had a history of substance use, including crack cocaine, cannabis, benzodiazepines (sedatives), buprenorphine (used to treat opioid addiction), and opioids.

45. Mr O'Brien had a history of thoughts of suicide and suicide attempts, including an overdose of medication in 2016 and tying a ligature around his neck in 2021.

Events from November 2023

46. On 20 November 2023, Mr O'Brien was remanded to prison and taken to HMP Birmingham for alleged offences of burglary, vehicle theft, escape from lawful custody and affray. This was not his first time in prison. Mr O'Brien told staff that he had no history or current thoughts of suicide or self-harm. Staff noted that Mr O'Brien was a care leaver.

47. During his healthcare screening, Mr O'Brien reported anxiety, ADHD, and memory issues linked to his brain injury. He said he was not prescribed any medication and had no thoughts of suicide or self-harm. While in police custody, he had claimed he had swallowed drugs, but hospital tests found nothing. He had attempted to escape during the hospital visit, marking him as an escape risk. He also had a history of concealing contraband, weapons and phones.

48. On 4 January 2024, Mr O'Brien transferred to HMP Brinsford. Although he initially settled in, he received multiple disciplinary warnings for poor behaviour for abuse towards staff, fighting, misuse of his emergency cell bell, and disobeying orders. Consequently, he was downgraded to the basic level of the incentives scheme (incurring loss of privileges such as association, in-cell television and the prison shop) on several occasions, and he was twice placed in the segregation unit (where prisoners are kept separate from the general prison population and generally receive a more limited regime).

HMP Liverpool, 20 May – 22 October

49. On 20 May, following a court appearance, Mr O'Brien transferred to HMP Liverpool. During his reception screening, he reported no concerns and said he had no thoughts of suicide or self-harm. Mr O'Brien arrived on the basic incentive level.

Staff noted he was unsuitable to share a cell due to his history of violence in custody.

50. A nurse completed Mr O'Brien's healthcare screening. Mr O'Brien said he had no current mental health issues or concerns. He reported he had a history of drug use, namely cannabis, and was not prescribed any medication. Based on his mental health history, the nurse referred him to the mental health team, and he was referred to the Top Ten (a list of patients who are of concern).

51. On 30 May, a mental healthcare nurse completed a primary mental health assessment. Mr O'Brien engaged in the assessment and reported that he had ADHD. Using recognised assessment tools, no concerns were raised about Mr O'Brien's mental well-being, and he showed no signs of anxiety or depression. On 31 May, Mr O'Brien moved to the standard incentive level. On 5 June, following the Top Ten meeting, no further action was to be taken by the mental health team.

52. In July, Mr O'Brien was involved in several gang-related incidents, including fights with other prisoners and damage to prison property. Staff had to restrain him, and due to his behaviour, he was placed in the segregation unit for about a week. His incentive level was reduced to basic and staff began a Challenge, Support and Intervention Plan (CSIP), which is used to manage prisoners who pose a higher risk of violence. He was checked daily while in segregation, and no mental health concerns were recorded.

53. On 30 July, Mr O'Brien broke the observation panel on his cell door in protest over his reduced privileges and was briefly returned to the segregation unit. His privileges were restored to the standard level on 15 August.

54. On 7 September, Mr O'Brien's mother raised concerns about her son after she had had a telephone conversation with him. A nurse assessed Mr O'Brien and noted signs of drug-induced psychosis, including paranoia and bizarre thoughts. Mr O'Brien said he had taken ketamine days earlier, had not slept in a week, and feared his eyes would pop out if he lay down. He was prescribed medication to assist him to sleep in the short-term and urgently referred to both the mental health and substance misuse teams.

55. Nurse A from the mental health team, saw Mr O'Brien the same day. She noted that it was difficult to assess him due to his reported sleep deprivation and signs of drug-induced psychosis. She noted that the mental health team would attempt to assess him again the next day.

56. The next day, 8 September, a member of the mental health team saw Mr O'Brien and they discussed his insomnia. Late that night, staff started prison suicide and self-harm monitoring procedures, known as ACCT, after Mr O'Brien set fire to his cell and continued to display paranoid behaviour, stating that he "was being killed". He was relocated to the segregation unit and was checked five times an hour, in line with segregation policy. Overnight, Mr O'Brien continually misused his cell bell and appeared paranoid.

57. Around 9.30am on 9 September, staff attempted to complete Mr O'Brien's ACCT assessment with him but he was not able to engage as he appeared in crisis. He was adamant that staff were going to kill him. He self-harmed by making cuts to his

face. A manager then attempted to conduct a multidisciplinary ACCT review. Mr O'Brien's paranoia continued. He threatened staff and refused food and drink, believing they were contaminated. He appeared distressed and was banging his head on the cell door. He made several cuts to his torso, and while being examined by the nurse, attempted to escape from his cell. Staff restrained Mr O'Brien and found a small wrap suspected to be cannabis, which they believed he had concealed internally. Due to his condition, the ACCT review could not be held. Staff decided to place Mr O'Brien under constant supervision, in a safer cell (with minimal ligature points and a transparent door with staff stationed outside the cell at all times). However, upon doing his, Mr O'Brien started to make further cuts to himself and attempted to gouge out his eyeball with a prison issue plastic knife. Staff removed the knife and stayed with him in his cell throughout the morning due to his paranoia and distress.

58. Mr O'Brien told staff that he believed if he continued to self-harm, this would lead to him being sectioned under the Mental Health Act. Staff added phone credit to his account so he could contact his mother and grandmother once calmer.

59. Healthcare staff discussed Mr O'Brien at their morning meeting. They planned that Change Grow Live (CGL - substance misuse provider) would visit Mr O'Brien when he was back on the wing and the mental health inreach team (MHIT) would discuss him at their single point meeting (a meeting that discusses patients with mental health needs and devises a plan of care). A urine drug test completed was positive for synthetic cannabinoids, benzodiazepines, buprenorphine and opiates. Mr O'Brien was referred to CGL but he refused to engage.

60. Nurse A and Dr A, trainee psychiatrist, saw Mr O'Brien. Dr A considered prescribing diazepam to help calm Mr O'Brien. However, this was deemed too risky due to the potential interaction with ketamine. Dr A consulted with a senior colleague and they agreed a plan to manage the situation safely. Mr O'Brien would remain in the segregation unit. Efforts would be made to contact his family to provide support, and distraction techniques would be offered where available. After speaking with his grandmother and being given his vape, Mr O'Brien settled. Staff were instructed to continue monitoring his risks closely.

61. After a brief move to a safer cell in the inpatient unit (IPU), Mr O'Brien returned to the segregation unit after flooding his cell and making a ligature with bedding. He continued to appear paranoid and said he was hallucinating. A nurse assessed Mr O'Brien and noted he was not fit to be segregated. A prison manager completed a defensible decision log supporting Mr O'Brien's segregation and that he would be relocated to the inpatient unit once the safer cell was fixed.

62. Healthcare staff started a food and fluid refusal care plan in response to Mr O'Brien's refusal to consume prison food or water, due to his paranoid beliefs that it was poisoned. The primary care team attempted regular monitoring of his weight and blood tests. However, Mr O'Brien sometimes declined to engage with these assessments.

63. Mr O'Brien's behaviour remained volatile. At a multidisciplinary ACCT review on 12 September, staff noted multiple serious incidents over 72 hours, including setting fires, damaging cells, self-harming, assaulting staff, and escaping from the constant supervision cell. However, Mr O'Brien apologised, admitted his drug use, and said

he no longer felt suicidal. He wanted to settle and engage with support. Despite previously refusing to engage with the ACCT process, his improved mental state led to the review panel lowering the frequency of his ACCT welfare checks to two checks per hour. He moved to a standard residential wing briefly before assaulting a prisoner and returning to the inpatient unit, having been assessed as unsuitable for the segregation unit.

64. That night, staff found Mr O'Brien unresponsive in his cell. Healthcare staff treated him. He admitted to taking psychoactive substances (PS), though no illicit items were found during a search. On 13 September, Mr O'Brien swallowed a vape battery. He was transferred to hospital where he assaulted two officers and attempted to escape. Police returned him to Liverpool, where he was placed in segregation under a four-officer unlock protocol. He was no longer permitted vape batteries due to his self-harm risk, and staff increased his ACCT checks to five per hour. Dr A had advised that Mr O'Brien needed to have a drug free period and be reassessed.

65. From 14 September, Mr O'Brien's behaviour improved. He engaged with staff, denied suicidal thoughts, and expressed remorse. Staff returned his vape with restricted access, and reduced ACCT checks to twice per hour.

66. On 17 September, at a multidisciplinary ACCT review, Nurse B introduced herself as Mr O'Brien's allocated mental health nurse. He agreed to support from the substance misuse team, was open to medication and seeing a psychiatrist, and staff started a care plan.

67. On 19 and 23 September, Mr O'Brien engaged in ACCT and segregation reviews. His mood remained unstable and often worsened after calls with his mother, claiming people were trying to kill him. The panel decided to move him to the IPU and restored his incentives level to standard.

68. Mr O'Brien's mother regularly contacted the prison with concerns about her son. Ms A, psychiatric social worker, agreed to send her daily email updates on his wellbeing.

69. On 23 September, Dr A assessed Mr O'Brien, who reported feeling better, but described his head as still "muddled". He said he had no thoughts of suicide and self-harm and said he did not want medication. Dr A noted Mr O'Brien showed psychotic symptoms and challenging behaviour, likely linked to his substance use. Dr A ordered blood tests and an ECG and, with Mr O'Brien's consent, planned to prescribe him olanzapine, an antipsychotic.

70. That afternoon, staff agreed to give Mr O'Brien his vape back and his unlock status was reduced to three officers.

71. The next day, Mr O'Brien claimed to have swallowed a vape battery, then damaged his TV, threatened staff, and set fire to his mattress. He was moved to the segregation unit, although healthcare staff again assessed that he was not suitable for segregation. A defensible decision log justified segregation due to the severity of his behaviour.

72. On 27 September, Dr A prescribed Mr O'Brien olanzapine, which he now said he would not take. Mr O'Brien's family's legal team contacted the prison to inform them that Dr B, Consultant Forensic Psychiatrist, had been instructed to complete an independent assessment of Mr O'Brien, for the purposes of court. The report was commissioned to identify any general mental health concerns and whether a hospital order (meaning Mr O'Brien would be transferred to a secure psychiatric hospital) was required.

73. Throughout October, Mr O'Brien's behaviour was increasingly unstable. He alternated between periods of self-harm by cutting himself, threats of self-harm, aggression towards staff, and brief phases of stability where he engaged with the regime, took medication, and maintained family contact. As a result, the frequency of his ACCT monitoring ranged from constant supervision to two checks per hour. While in the segregation unit, MHIT staff continued to see Mr O'Brien regularly.

74. On 7 October, staff noted that Mr O'Brien's weight was low at 56.8kg, noting that he had lost 12kg over the last five months. A Malnutrition Universal Screening Tool (MUST) assessment indicated a risk of malnutrition. Although Mr O'Brien refused to have blood tests, he was referred to the primary care team to monitor his food and fluid intake, along with blood tests, in line with the Spectrum Food Refusal Policy. Dr A noted ongoing paranoia and planned a hospital referral. He advised regular weight checks and nutritional supplements if Mr O'Brien's weight loss exceeded 5%. The next day, Mr O'Brien moved to the IPU.

75. On 9 October, Dr B, attended the prison to see Mr O'Brien but was an hour late. Mr O'Brien refused to see him as he had been kept waiting, refused to return to the IPU and assaulted staff. Staff restrained him. At an ACCT review, staff increased his checks to three per hour and his incentive level was downgraded to basic for seven days.

76. On 11 October, Mr O'Brien was prescribed protein drinks due to his weight loss. By 19 October, Mr O'Brien had refused to drink any and had thrown away two of the 11 bottles he had been prescribed.

77. On the morning of 14 October, staff received an email from Mr O'Brien's mother reporting that he had told her he planned to end his life within a month. Mr O'Brien had said that he hated his life and was unable to stop harming himself even if he wanted to. At the multidisciplinary ACCT review that afternoon, these concerns were not discussed or addressed.

78. On 15 October, Mr O'Brien climbed onto the external wing window bars. He was moved to the segregation unit. While healthcare staff again assessed that he was not suitable for segregation, senior prison staff considered that the segregation unit was the most appropriate place for him. Dr A increased Mr O'Brien's dose of olanzapine. On 16 October, a psychiatrist from the Edenfield Centre, Medium Secure Hospital, assessed Mr O'Brien to consider whether he should be transferred there. Staff later reduced Mr O'Brien's ACCT checks to hourly.

79. On 18 October, the Offender Management Unit (OMU) emailed Ms B, acting Deputy Director of HMP Forest Bank, to inform her that, due to court proceedings, Mr O'Brien would be transferred to Forest Bank on 22 October. Mr O'Brien later refused to attend a video-link assessment with Dr B.

80. The healthcare team at Liverpool considered whether to request a clinical hold for Mr O'Brien (a mechanism to keep a prisoner at one prison while they undergo medical treatment or assessment) because of the open referral to the Edenfield Centre. They told the investigator that they did not formally request this because they understood that prison population pressures meant that he did not fit the criteria. No further actions were taken to manage the transfer of Mr O'Brien's clinical care from Liverpool to Forest Bank until the day of his transfer.

81. Dated on 21 October, OMU staff at Liverpool completed the form, "*Annex Q Notification of transfer of an at-risk prisoner*" and emailed this to Forest Bank's Safer Custody Team's functional Mailbox. The form noted Mr O'Brien's offences, the reason for his transfer (to attend court), that he was on an open ACCT (provided details of his self-harm incidents and behavioural issues) and outlined violent incidents that he had been involved in, in the last 12 months. There is no evidence that the information contained in the Annex Q was used by staff at Forest Bank to plan for Mr O'Brien's arrival.

82. Ms A emailed Mr O'Brien's mother to update her on his wellbeing. She reported that no concerns had been raised about Mr O'Brien, but he had not taken his antipsychotic medication since 18 October. Supervising Officer (SO) A led an ACCT and CSIP review with input from mental health staff and the psychiatrist. Mr O'Brien engaged well but refused his antipsychotic medication as he believed he no longer needed it. The review panel was unaware of his upcoming transfer.

83. On 22 October, an ad-hoc ACCT review was held, ahead of Mr O'Brien's transfer. He reported feeling well, denied thoughts of suicide or self-harm, and said he had eaten the day before. Staff continued providing snacks due to his dislike of prison food. Around 2.30pm, Ms A informed Mr O'Brien's mother of his transfer.

84. Nurse B attempted to contact the Forest Bank mental health team and reception nurse by phone that afternoon (from 4.46pm) to give a verbal handover. However, they did not answer the phone so she left messages. (Forest Bank's mental health in-reach team's hours are 9.00am to 5.00pm.)

85. At 5.19pm, Nurse B emailed Forest Bank's MHIT to hand over Mr O'Brien's care. She noted that Mr O'Brien had transferred that afternoon and was under the care of the psychiatrist and MHIT. She wrote that his care had begun on 9 September, due to concerns that he had used ketamine, and that he had ADHD, learning difficulties, a past head injury, dissocial traits, and mood dysregulation. He was currently subject to one ACCT welfare check an hour and he had not taken olanzapine for four days. Nurse B noted that Mr O'Brien had been assessed by the Edenfield Centre on 16 October. The outcome of this assessment was pending. She noted that Mr O'Brien was also under Trafford Social Services and was awaiting an independent psychiatric assessment for court.

86. Nurse C, Matron for the mental healthcare team at Liverpool, told the investigator that the Edenfield Centre had verbally informed Dr A of their decision to defer Mr O'Brien's referral for one month and be updated on his progress, but this was not recorded in his medical notes so no one but Dr A was aware.

HMP Forest Bank, 22 October onwards

87. Mr O'Brien's digital Person Escort Record (DPER – a document that accompanies prisoners when they move between police stations, courts and prisons which sets out the risks they pose) highlighted several risks. It noted his history of violence towards staff and prisoners, that he concealed drugs and weapons, was a risk of escape, had drug use and mental health issues, including anxiety, ADHD, and learning difficulties. It also stated that he was being monitored under ACCT and CSIP procedures and was prescribed protein drinks and olanzapine.

88. Mr O'Brien arrived at Forest Bank around 5.30pm on 22 October. Prison Custody Officer (PCO) A completed his reception screening interview. He noted that Mr O'Brien was subject to ACCT and CSIP monitoring and that he was not suitable to share a cell with another prisoner. No immediate risks were identified. At interview, PCO A could not recall any of his interaction with Mr O'Brien or the documents he reviewed when making his assessment.

89. Nurse D completed Mr O'Brien's healthcare screening. She noted that Mr O'Brien had arrived at Forest Bank on an open ACCT. Mr O'Brien told her he was on an ACCT because he had made scratches to his face. He said that he had not previously self-harmed, was not prescribed any medication (both of which were inaccurate), had no diagnosed mental health issues but had ADHD and a history of substance use. Mr O'Brien said that he felt fit and well. His weight was recorded as 56kg. Nurse D sent an electronic task to the mental health team referencing that Mr O'Brien had ADHD. She completed a medication in possession risk assessment (MIPRA) incorrectly noting he was not subject to ACCT procedures and could have his medication in his possession. Mr O'Brien was located on the induction wing but did not receive an induction interview screening. No one more senior than PCO A reviewed Mr O'Brien on his arrival at Forest Bank.

90. On 23 October, a pharmacy technician reviewed Mr O'Brien's prescribed medication and reversed his MIPRA to note that he could not have his medication in possession, because he was subject to ACCT monitoring. Healthcare staff prescribed Mr O'Brien's medication. Mr O'Brien's mother contacted Liverpool and requested that his signed consent form be sent to Forest Bank, allowing them to discuss his medical issues with her. Ms A then emailed Forest Bank's mental health team, asking them to obtain Mr O'Brien's consent to share clinical information with his mother, as the original consent only covered his care at Liverpool.

91. Early that morning, Nurse E, primary mental health team, saw Mr O'Brien and completed a Wellman screening. This was a short assessment to review whether a prisoner requires any support. Mr O'Brien denied that he had any mental health issues, said he had no current thoughts of suicide or self-harm and had no substance use issues. At interview, Nurse E told us that, at the time of conducting the screening, she was not aware that Mr O'Brien was subject to ACCT monitoring or had any mental health history, as this information had not been provided to her. The ACCT document should have accompanied Mr O'Brien to his appointment.

92. At 9.15am, Senior Prison Custody Officer (SPCO) A chaired Mr O'Brien's first multidisciplinary ACCT review at Forest Bank. The review panel noted that Mr O'Brien engaged well and was happy as Forest Bank was more accessible for his family to visit him. Mr O'Brien said that he had had issues with drugs, namely

ketamine and PS, at Liverpool, but believed that this was not a problem now, and declined to be referred to the substance misuse team for support. He said he had no thoughts of suicide or self-harm and denied that he was on any medication, although it was confirmed that he was prescribed olanzapine. The review panel maintained hourly ACCT checks and scheduled his next review for 29 October.

93. Nurse F, the mental health team duty worker, reviewed Mr O'Brien's records, following a referral from the Safer Custody Team. She noted prior correspondence from Nurse B and Dr C, psychiatrist from the Edenfield Centre. She noted, incorrectly, in Mr O'Brien's medical record that he had been located on a standard residential unit at Liverpool. She also noted that she had spoken to Dr B who had not been able to review him at Liverpool but would try now he was at Forest Bank. (Dr B was the Clinical Lead for Health and Justice, Greater Manchester Mental Health NHS Foundation Trust.) Nurse F referred Mr O'Brien to the Neurodiversity Pathways Team due to his ADHD diagnosis, and the substance misuse and primary mental health team. She added that he would be referred to the MHIT if needed.

94. On the same day, Dr C emailed the mental health team. He noted that, given Mr O'Brien's diagnostic complexity and vulnerability, it was important to ensure he remained well. Although he had showed substantial improvement when he was seen the previous week, Dr C wrote that the Edenfield Centre was deferring their decision for one month. Dr C recommended that Mr O'Brien be reviewed by the MHIT and psychiatrist within the next month and that they provide the Edenfield Centre with an update. Dr C noted that if there were any concerns about a relapse in Mr O'Brien's mental state or an increase in his risk of harm to himself or others, the Edenfield Centre should be contacted sooner. Nurse F noted that Mr O'Brien would be allocated a nurse from the MHIT, a psychiatric appointment had been booked for the following week, and he had been added to the appointment lists for blood and ECG tests. Mr O'Brien moved to A Wing, a standard residential wing.

95. On 24 October, SPCO B chaired an ACCT review with a chaplaincy member. No healthcare staff attended. Mr O'Brien appeared disengaged, gave brief responses, and denied any current or past thoughts of suicide or self-harm. Staff reduced ACCT checks to one every two hours during the day and hourly at night. A substance misuse worker later saw Mr O'Brien. He said he had no intention to use drugs again and refused any support.

96. On 25 October, a nurse from the Neurodevelopment Team reviewed Mr O'Brien's referral for assessment. It was noted that although Mr O'Brien had reported he had ADHD, he had declined treatment. The nurse suggested that Mr O'Brien's behaviour might be better explained by psychosis rather than ADHD and a plan was made to await his psychiatric review before considering any ADHD treatment.

97. That evening, Mr O'Brien refused medication, attempted to jump over the wing railing, requested a transfer, and later set fire to his cell. He was aggressive, refused to return to his cell, and threatened further fires. Staff observed bizarre behaviour and found a concealed blade while restraining him. Due to safety concerns and ongoing ACCT monitoring, he was moved to the segregation unit. (Forest Bank does not have an IPU.)

98. A nurse assessed Mr O'Brien as fit for segregation but did not complete the segregation healthcare safety algorithm correctly or record it in his medical notes.

She incorrectly noted he was compliant with medication and not awaiting secure hospital assessment.

99. That evening, Mr O'Brien called his mother twice. He was upset that his television had been removed and threatened to start a fire if his belongings were not returned. His mother reassured him that he would be transferred to hospital within 14 days and urged him to stay calm. He eventually settled.

100. On 26 October, during the morning management duty segregation rounds, staff noted Mr O'Brien would be provided with in-cell education (books) and a radio. Ms C chaired an ACCT review. Mr O'Brien gave no clear reason for his behaviour, dismissed his medication needs, and refused advice. He said he had no thoughts of suicide or self-harm and had strong family support. The panel agreed to arrange a private visit with his mother. Staff increased Mr O'Brien's ACCT checks to two an hour. The nurse correctly completed the segregation healthcare algorithm, noting he was fit to remain and was awaiting secure hospital transfer. Staff added a family visit to his care plan. The nurse present noted that Mr O'Brien was under the care of the MHIT and would be seen by a doctor three times a week, while in the segregation unit.

101. On 28 October, Mr A, manager, chaired an initial segregation review board to assess whether Mr O'Brien should remain segregated. Mr O'Brien did not attend due to ongoing threats toward staff. He had refused medication and continued to behave aggressively. The board concluded he needed to engage with the mental health team, take his medication, and improve his behaviour. A follow-up review was scheduled for 4 November. The nurse deemed him fit to remain in segregation but incorrectly noted he was not awaiting secure hospital assessment.

102. Nurse F and a prison manager held an MDT meeting with Mr O'Brien, who appeared confused, paranoid, and disengaged. He downplayed incidents, misunderstood the purpose of his hospital assessment, and refused olanzapine. He was unsure about contacting his mother but denied suicidal thoughts. The panel noted he would be assigned a nurse from the MHIT, encouraged to take his medication as prescribed, and offered continued family support.

103. Dr D, GP, saw Mr O'Brien during the morning segregation health round. He noted no concerns. Mr O'Brien's mother contacted the Safer Custody Team and expressed concern for Mr O'Brien's welfare and asked staff to remind him to call her. She said he felt safer in segregation. PCO A confirmed she would pass on the message and noted a private visit had been arranged for Thursday with his mother.

104. Later that day, Mr O'Brien's mother called again, expressing further concern. SPCO C informed her that Mr O'Brien had attended a meeting where support was offered, but he was unwilling to call her. Mr O'Brien's mother said their solicitor was working with Dr B to arrange for Mr O'Brien to be transferred to the Edenfield Centre.

105. On 29 October, staff held an ACCT review at Mr O'Brien's cell door after he refused to attend. Staff reported unusual behaviour, including him showering fully clothed. He declined to call his mother and expressed frustration with the reviews. He said he had no thoughts of suicide or self-harm or drug use issues and again refused support from the substance misuse team. Staff reduced Mr O'Brien's checks to once per hour.

106. Staff discussed Mr O'Brien at the weekly Safety Intervention Meeting (SIM), a multidisciplinary meeting intended to support the management of complex cases. However, no details were recorded regarding his care plan while in segregation.

107. On 30 October, Dr D saw Mr O'Brien during the morning segregation health round and noted no issues. Nurse F contacted Trafford Children's Services to confirm Mr O'Brien's move to Forest Bank and MHIT involvement. She received historical information from his community social worker. The care plan noted he was still awaiting allocation of an MHIT nurse.

108. At 9.45am on 31 October, Mr O'Brien was escorted to a private visit with his mother in the prison hall. At 10.04am, Mr O'Brien assaulted her. Staff restrained him and returned him to the segregation unit. A nurse saw Mr O'Brien to assess if he had any injuries. He was uninjured and no treatment was required. He was issued a disciplinary warning for his behaviour.

109. That evening, Dr E, psychiatrist, noted that Mr O'Brien had been scheduled to see him that afternoon, but the appointment was missed due to an overbooked clinic. He reviewed Mr O'Brien's records and raised serious concerns about his mental health and risk to others, noting his recent assault on his mother and being in the segregation unit. He noted that the Edenfield Centre had deferred their decision for a month to allow for further monitoring to take place. Mr O'Brien's psychiatric appointment was rescheduled for 4 November, and staff were advised to notify the Edenfield Centre and Dr E if his condition deteriorated.

110. On 1 November, Dr D saw Mr O'Brien during the morning segregation health round and noted no concerns. Over the next few days, management and GP checks on Mr O'Brien during the routine segregation rounds highlighted no concerns.

111. On 4 November, Mr B, prison manager, chaired a multidisciplinary segregation review board, which Mr O'Brien refused to attend. During the review, the primary mental health nurse reported his poor adherence with medication, that Mr O'Brien had still not been assigned a nurse from the MHIT and had been referred for psychiatric assessment. His behaviour during the review period was described as reasonably settled. Staff set targets to support his wellbeing, including taking prescribed medication regularly, engaging with his CSIP case manager to address behavioural concerns, and participating in purposeful activities. The nurse who completed the segregation healthcare algorithm properly confirmed Mr O'Brien was fit to remain in segregation but incorrectly recorded that he had not been referred or was awaiting assessment at a secure hospital.

112. Staff also tried to engage Mr O'Brien in an ACCT review at his cell door as they could not unlock him at that time. A senior manager and mental health nurse were present. The nurse noted that Mr O'Brien engaged minimally, appeared confused and distracted and made poor eye contact. She noted that he was guarded but said he was "all right" and had no thoughts of suicide or self-harm. His ACCT checks stayed at once per hour. A nurse noted that Mr O'Brien had not yet been assigned a nurse from the MHIT. Nurse F saw Mr O'Brien to obtain consent to share medical information with his mother. Despite encouragement, he refused to sign the form, saying his mother would be fine, and that he would call her later. Nurse F noted that Mr O'Brien would be reviewed by the psychiatrist the following week.

113. Mr O'Brien was not seen in the psychiatric clinic for his appointment as there were no clinics scheduled on this date. (Despite there being a clinic on 5 November, Mr O'Brien was not seen on this day either.)

114. On 5 November, Mr O'Brien refused breakfast and medication but accepted some hot water and his items from the prison shop. Staff discussed Mr O'Brien at the weekly SIM. However, no details were recorded regarding his care plan while in segregation, and no member of the mental health team was present.

115. On 6 November, Nurse F noted the MHIT had only recently been informed that Mr O'Brien had assaulted his mother. She shared this information by email with Dr B and Dr C, and it was noted that Mr O'Brien had still not seen the psychiatrist or had a detailed mental health assessment from a mental health nurse.

116. Dr D saw Mr O'Brien during the morning segregation health round and noted he was settled with no new clinical issues. That afternoon, Mr O'Brien was involved in an unprovoked assault on a prison officer, while out of his cell. He was restrained and returned to his cell. As a result, he received a disciplinary warning and lost regime privileges for seven days. He accepted his meals that day.

117. On 7 November, Mr O'Brien accepted his breakfast and no concerns were raised during management checks. However, prison and CSIP manager Bruno Sosa, reviewed his behaviour and raised serious concerns about his mental state. Mr O'Brien had shown a pattern of alarming incidents, including assaults on his mother and staff, and exhibited erratic behaviour with unpredictable mood swings. As a result, he was placed under safety unlocking procedures, requiring three PCOs and one SPCO, with body-worn cameras to always be used.

118. Mr O'Brien's mother phoned the prison's Safer Custody Team and requested that they provide her with details of Mr O'Brien's weight and raised concerns about him. As this was a healthcare matter, her concern was referred to the healthcare team to address.

119. At 1.58pm, Nurse F reviewed Mr O'Brien in his cell. She noted no new risks and planned to update his records with a full entry. However, this was not added to his medical record until 11 November, after Mr O'Brien was found hanged. She noted that Mr O'Brien appeared slightly confused, made sporadic eye contact, and showed signs of distraction. His lips were dry and although he initially asked for water, he withdrew the request when told prison staff would provide it. Nurse F advised him to stay hydrated. Mr O'Brien's mother had emailed the mental health team with concerns. When asked about consent to share medical information, Mr O'Brien said he would phone her but did not respond when asked about the assault on her. Nurse F assessed that he lacked mental capacity (a person's ability to understand information, make a decision and communicate their choice) to give informed consent. He denied any thoughts of self-harm. She informed the court and relevant parties that Mr O'Brien was unfit to attend his court hearing on 11 November, and discussed his condition with Dr B, who was present at the prison in his role as Clinical Lead.

120. At 4.43pm, Dr B attempted to assess Mr O'Brien in the segregation unit but was unable to see him. He could not recall why. Based on recent reports, he concluded that Mr O'Brien was acutely unwell, with erratic behaviour and complex underlying

issues. He expressed concern about risks to Mr O'Brien and others, noting Mr O'Brien lacked capacity to make informed decisions. Dr B recommended reviewing the earlier decision not to admit him to hospital and planned to raise this with the MDT. He also suggested a possible assessment in an Acquired Brain Injury (ABI) unit and noted he would contact the Edenfield Centre to explore this option.

121. On 8 November, Dr D saw Mr O'Brien during the morning segregation health round, noted he was settled and had no new clinical issues.

Events on Saturday 9 November

122. The investigator watched CCTV and body worn video camera (BWVC) footage. He also reviewed information from NHS Ambulance Service. The following account has been taken from all sources.

123. PCO B and PCO C started duty around 6.40am on 9 November and received a handover from the night duty officer. No concerns were raised about Mr O'Brien. All the stipulated ACCT checks overnight had been completed.

124. At 7.02am, Ms D, manager, conducted an ACCT check on Mr O'Brien. At 7.22am PCO B and PCO C carried out an ACCT check on Mr O'Brien and provided him with a breakfast pack. Mr O'Brien was in bed at the back of the cell. They opened his door and put his breakfast at the side of the cell. When asked if he was okay, Mr O'Brien gave staff a thumbs up.

125. Assisted by the PCOs, at 7.45am, the pharmacy technician arrived on the wing to dispense medication. Mr O'Brien refused his medication but accepted a protein drink, which they left in his cell while he remained in bed. At 8.00am, Mr O'Brien was stood at his cell door when PCO B walked past. He asked the PCO to turn off his night light and thanked him when it was done. At 8.04am staff completed another ACCT check. Mr O'Brien was in bed.

126. At 9.00am, Ms E, manager, and a member of the chaplaincy team arrived on the wing to conduct the morning segregation round. PCO C started the process of escorting them to each cell to check on the welfare of each prisoner. They arrived at Mr O'Brien's cell at 9.02am. When Officer C opened the cell observation panel, he saw Mr O'Brien hanged from a ligature (made from a torn bedsheet) attached to the light fitting. Mr O'Brien's feet were off the floor. Officer C shouted to colleagues on the landing for assistance, unlocked and went into the cell. Ms E radioed a code blue (an emergency code indicating that a prisoner has either stopped or is having difficulty breathing) at 9.04am, and staff in the control room called an ambulance immediately.

127. Officer C supported Mr O'Brien's body and cut the ligature using his anti-ligature knife. Assisted by Officer B, they laid Mr O'Brien on the floor. Mr O'Brien showed no signs of life. The officers removed the ligature from around Mr O'Brien's neck. Nurse G arrived at 9.05am, and took over his care. She checked Mr O'Brien for signs of life and started cardiopulmonary resuscitation (CPR). Further healthcare staff arrived within a minute.

128. Ambulance paramedics arrived at 9.20am and took over Mr O'Brien's care. After approximately 25 minutes of CPR, the paramedics established a pulse and

transferred Mr O'Brien to hospital, where he was admitted to the Intensive Care Unit. Mr O'Brien died on 12 November at 6.25pm.

Contact with Mr O'Brien's family

129. The prison appointed SPCO B and Reverend A as family liaison officers. At 10.00am on 9 November, Mr B phoned Mr O'Brien's mother, who had been identified as his next of kin, to inform her of the events that had occurred that morning and that her son was in a critical condition in hospital. Mr O'Brien's mother was on holiday in Wales and travelled straight to the hospital. Mr B met her there. Mr O'Brien's family were with him when he died.

130. Forest Bank contributed to funeral costs in line with national instructions.

Support for prisoners and staff

131. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner 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.

132. After Mr O'Brien's death, a prison manager debriefed all 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.

133. The prison posted notices informing other prisoners of Mr O'Brien'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 O'Brien's death. However, those whose ACCT was at a post closure stage were not reviewed and Listeners were not deployed to offer support to prisoners.

Post-mortem report

134. The pathologist gave Mr O'Brien's cause of death as hypoxic ischaemic brain damage (caused by a lack of oxygen to the brain) with pneumonia caused by hanging. No toxicological analysis was undertaken.

Inquest

135. The Coroner's inquest the concluded on 6 May 2026 determined the medical cause of death to be hypoxic ischaemic brain damage with pneumonia and hanging.

136. The jury returned a narrative conclusion, stating that it was unclear whether Mr O'Brien intended to end his life, or whether the self-ligature was during a period of mental health crisis when he was unable to comprehend the consequences of his

actions. As a result of Mr O’Brien’s death, the Coroner issued a Regulation 28 Prevention of Future Deaths report.

Findings

Management of Mr O'Brien's risk of suicide and self-harm

137. At the time of Mr O'Brien's death, Prison Service Instruction (PSI) 64/2011 governed staff responsibilities regarding ACCT suicide and self-harm prevention procedures. It required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. In November 2024, a revised Prison Safety Policy Framework was issued, which was fully implemented on 1 January 2025. Both PSI 64/2011 and the Prison Safety Policy Framework contain guidance and mandatory instructions on using ACCT procedures to manage prisoners at risk of suicide and self-harm.

138. Managing Mr O'Brien's risk to himself was challenging for prison and healthcare staff. He had several factors that increased his risk of suicide and self-harm: he was a young man and a care leaver, with a history of substance use and mental health issues, including a previous head injury, learning difficulties, borderline autism and ADHD. His behaviour was impulsive and unpredictable.

ACCT management

139. When Mr O'Brien arrived at HMP Liverpool, his behaviour was poor. From 7 September until his death, he was monitored under ACCT procedures after reported ketamine use. His behaviour worsened, posing risks to himself and others, which led to increased support from the mental health team, who saw him regularly. His ACCT observation levels varied from constant supervision to checks every two hours. To manage his behaviour and provide stability, Mr O'Brien was frequently moved between the segregation unit, residential wings, and the IPU. Across his time at Liverpool and then Forest Bank, he was involved in at least 29 incidents, including assaults on staff and other prisoners, substance use, self-harm, damaging cells and setting fires. Staff had to use force countless times due to Mr O'Brien's unpredictable behaviour and noncompliance. He did not always engage fully with the healthcare team, follow advice, eat and drink properly or take his medication. Staff were aware of Mr O'Brien's unpredictable and impulsive behaviour and recognised some of the factors that helped protect and support him.

140. We found that some aspects of the ACCT procedures were reasonably well managed considering the complexities of Mr O'Brien's needs. His case reviews were reasonably timely and multidisciplinary, with input from the healthcare team. However, we also identified some deficiencies. Information about Mr O'Brien's well-being was not always recorded and shared with staff and therefore could not be considered when assessing his overall risk of suicide and self-harm.

141. PSI 64/2011 instructed that a consistent trained case coordinator should lead all ACCT reviews unless unavailable in exceptional circumstances. Mr O'Brien had 22 ACCT reviews, most of which were multidisciplinary and reasonably well managed. However, at Liverpool, six of the 17 reviews were led by different coordinators, disrupting continuity of care. At Forest Bank, all five reviews were conducted by different coordinators. We noted that concerns raised by Mr O'Brien's mother on 14

October about his suicide risk were not reflected in the following ACCT review. The ACCT review on 24 October lacked healthcare staff involvement, despite Mr O'Brien being under the care of the mental health team. Staff also failed to update the ACCT care plan noting that he was not taking his medication. More seriously, no urgent ACCT review was held, as stipulated by PSI guidance, after Mr O'Brien assaulted his mother on 31 October, despite the nature of the incident and the clear need to reassess his risk.

142. The shortcomings identified highlight the need for stricter adherence to ACCT procedures to ensure that risk assessments are timely, comprehensive, and responsive to evolving circumstances. We make the following recommendation:

The Governor at HMP Liverpool and the Director at HMP Forest Bank should ensure that all staff have a clear understanding of their responsibilities to record, share and consider all relevant information about risk, including that:

- **A consistent, case coordinator is assigned for the duration of ACCT monitoring,**
- **All ACCT reviews are multidisciplinary, with healthcare staff present when the prisoner is under the care of the mental health team; and**
- **Ensure that any significant risk information or incidents, such as self-harm, violent behaviour, or external concerns, trigger an urgent ACCT review in line with PSI guidance.**

Management of Mr O'Brien's transfer to Forest Bank

143. Although Mr O'Brien's transfer from Liverpool to Forest Bank seems only to have come to light a few days before he transferred, both prisons had notice of the transfer. We have considered how well the transfer of a young, complex and vulnerable man was managed by HMPPS staff at both prisons. (Consideration of how Mr O'Brien's clinical care was transferred is included in a later section.)

144. There was no evidence that senior staff at Liverpool considered how best to manage the transfer to ensure staff at Forest Bank were fully appraised of Mr O'Brien's risks to himself and others. We find this surprising given his behaviour at Liverpool and how his risk had been managed there.

145. Staff in the Liverpool OMU had sent information via an *Annex Q: Notification of Transfer of an At-Risk Prisoner* to the Safer Custody Team Functional Mailbox. We found no evidence that this information was considered in advance of Mr O'Brien's arrival, that anyone, specifically a senior manager, took responsibility for the transfer. There is no evidence that anyone considered what needed to be in place to ensure Mr O'Brien was safely received at Forest Bank or that relevant information was properly shared in advance with staff who would be responsible for managing him at Forest Bank.

146. When Mr O'Brien arrived at Forest Bank, staff were unaware had been referred to hospital or that he had been transferred from the segregation unit. Reception staff, who receive basic training on assessing and mitigating risk, were left to make important decisions about how Mr O'Brien was managed. Unsurprisingly, we found

omissions in the actions and decisions of the reception officer and nurse on duty when Mr O'Brien arrived at Forest Bank.

147. We make the following recommendation:

The Governor at Liverpool and the Director at Forest Bank should ensure that there is sufficient senior management oversight of the transfer of complex prisoners. This should include a robust and auditable pathway for the transfer of these prisoners, including sharing risk information with relevant staff.

Clinical Care

148. The clinical reviewers concluded that Mr O'Brien was a very complex individual who was clearly very mentally unwell. They noted that the clinical care Mr O'Brien received at Liverpool was of a good standard and was equivalent to that which he would have received in the community.

149. The clinical reviewers noted that the physical and substance misuse care Mr O'Brien received at Forest Bank was good and equivalent to what he would have received in the community. However, his mental healthcare fell short of the required standard and was only partially equivalent to that which he would have received in the community.

150. The clinical reviewers highlighted that at Liverpool, the mental health team worked well with Mr O'Brien. He had an allocated mental health nurse, they regularly reviewed his care plan and responded quickly when needed. His mental health worsened after he used ketamine, which led to psychosis, but it was noted that he was more stable when he took his prescribed medication, although this was intermittent. Mr O'Brien was seen frequently by the mental health team, including the psychiatrist, who reviewed his condition, adjusted his medication, and referred him to a specialist secure hospital. The team worked together closely to support his care.

Transition of healthcare management and communication with the Edenfield Centre

151. On 22 October, the Edenfield Centre verbally advised the psychiatrist at Liverpool to pause Mr O'Brien's referral for one month. However, this update was not recorded in Mr O'Brien's medical record, nor was it shared with Forest Bank during the transfer process (essentially because no one but the psychiatrist knew).

152. We found no evidence indicating whether the Edenfield Centre had been informed of Mr O'Brien's non-adherence to medication at that time. This omission is significant because the decision to defer Mr O'Brien's referral was based on Liverpool's report of his stability in behaviour and compliance with antipsychotic medication, information that was no longer accurate.

153. Upon Mr O'Brien's transfer to Forest Bank, a nurse at Liverpool sent a brief handover email and attempted to call Forest Bank but did not follow this up further. Forest Bank staff confirmed that they received the email but no voicemail. However, the email failed to include critical details about Mr O'Brien's high levels of self-harm and violence, as well as his experience of paranoia. This information was essential to inform his risk assessment and management upon arrival. As a result, the

handover was inadequate, and the mental health team at Forest Bank did not have a full understanding of Mr O'Brien's needs. In a review following his death, Greater Manchester Mental Health NHS Foundation Trust (GMMH) identified this issue and recommended improvements to communication during prison transfers for individuals with complex needs. To prevent similar failings, a transfer pathway document is being developed, requiring both written and verbal communication during such transfers.

154. The investigation found that although Mr O'Brien was in segregation, experiencing a decline in mental health and refusing medication, Forest Bank did not update the Edenfield Centre until 6 November. This was despite Dr C's specific request for updates on any deterioration in his condition. The lack of communication before this date was a missed opportunity to share critical information. We share the clinical reviewers' concern that the Edenfield Centre should have been notified when Mr O'Brien was segregated on 25 October, as timely updates could have enabled a quicker assessment and potential transfer, ensuring he received appropriate care sooner.

155. It remains unclear whether the Edenfield Centre was informed of Mr O'Brien's clinical deterioration, as noted by Dr B on 7 November. There is no record of this communication in Mr O'Brien's medical notes. Although Dr B stated in interview that he had spoken with the Edenfield Centre, he could not recall the date or details, and no follow-up actions were documented. This lack of documentation raises concerns about the reliability of communication and continuity of care. A clearer, more consistent approach is needed to ensure all agencies involved in a prisoner's care are kept informed and can respond promptly to changes in their health.

The Head of Healthcare and Head of Mental Health at HMP Liverpool must implement a clear and consistent communication protocol for transferring individuals with complex mental health needs. This should include detailed handover information, timely follow-up, and confirmation of receipt by the receiving prison.

The Heads of Healthcare and the Heads of Mental Health at HMP Liverpool and HMP Forest Bank should establish and implement robust communication protocols for prisoners awaiting medium secure hospital assessments. These must ensure timely and consistent updates to external services, particularly in cases of clinical deterioration.

Clinical hold

156. Clinical hold is a term used to ensure that a prisoner is not transferred to another prison if they are receiving medical treatment or are awaiting the outcome of a referral at the nearest hospital and a transfer to another prison could compromise their care and treatment. At Liverpool, healthcare staff told us that they discussed requesting a clinical hold for Mr O'Brien but did not apply for this. They told us that they understood that, due to prison capacity constraints, clinical hold was only agreed for prisoners who were receiving direct hospital care, such as chemotherapy or radiotherapy, or were awaiting urgent cancer referrals. They thought that Mr O'Brien did not meet the criteria.

157. Ms F, Head of HMPPS Health and Social Care Team, told us that while prisons had been encouraged to reduce the number of clinical holds to help manage population pressures, these decisions should be clinically led and prisoners receiving certain types of treatment, including those waiting for assessment or transfer to a secure hospital should not be moved if possible. If transfer cannot be avoided, a comprehensive health and operational handover should occur to mitigate the risks associated with such a move. She told us that Liverpool did not have any prisoners on a clinical hold for mental health reasons between 1 October and 8 November 2024, which she considered indicated a wider issue with the healthcare team's understanding of the clinical hold process.

158. The clinical reviewers concluded that a clinical hold would have been appropriate for Mr O'Brien, due to his worsening mental health (including his refusal to take medication) and the pending Edenfield Centre decision. We make the following recommendation:

The Head of Healthcare and Head of Mental Health at HMP Liverpool should ensure that staff understand the clinical hold process as set out in Prison Service Order 3050 *Continuity of healthcare for prisoners* including how it applies to prisoners awaiting mental health assessment or transfer to a mental health secure unit.

Allocation of a mental health in-reach nurse at Forest Bank

159. Mr O'Brien's mental health care at Forest Bank lacked coordination. Most communication between services was handled by Nurse F, who was acting in a temporary role. This liaison should have been managed by an allocated mental health nurse and used to inform a care plan. Despite being in Forest Bank for over two weeks, Mr O'Brien had not been assigned a dedicated nurse from the MHIT, meaning his care plan was never properly developed.

160. Staff told us that the prison's nurse assignment system can take up to five weeks. Prisoners are rated using a red, amber and green system based on behavioural risk. Mr O'Brien's base risk level was high and he showed escalating risks - setting fire to his cell, jumping over railings, assaulting his mother and staff, and refusing antipsychotic medication, yet was not rated as high risk (red), which would have triggered urgent support. Nurse F did her best to monitor Mr O'Brien daily and arrange necessary health checks, but she was not in a position to coordinate his overall care. His complex needs required a structured and joined-up approach, which was not in place.

161. Following Mr O'Brien's death, a review by GMMH identified weaknesses in the coordination between the mental health and primary care teams at Forest Bank. Mr O'Brien should have been assigned a named mental health nurse earlier to ensure integrated care. The delay contributed to missed opportunities for supporting the decline in his mental health. A more coordinated approach could have led to better updates for the Edenfield Centre, possibly prompting a hospital transfer, although we recognise it is unclear in what timeframe this would have occurred. We make the following recommendation:

The Head of Healthcare and the Head of Mental Health at Forest Bank should ensure:

- **Prisoners awaiting transfer to secure hospital are immediately assigned a named nurse to coordinate care during the interim period; and**

- **A dedicated care coordinator is assigned to prisoners with complex needs and severe mental illness to ensure consistent, streamlined care planning and delivery.**

Adherence to prescribed antipsychotic medication

162. At Liverpool, Mr O'Brien frequently refused his prescribed antipsychotic medication. Healthcare staff recorded that he appeared to settle during periods when he adhered to the prescription. At the time of his transfer to Forest Bank, he had not taken his medication for four days. However, his medical records contained no entries indicating that this had been escalated, discussed with him, or actively monitored by the healthcare team.

163. By 9 November, when Mr O'Brien was found hanged in his cell, he had gone nearly 20 days without taking his medication, which would have negatively affected his mental health. We found no evidence that the issue of his non-adherence was followed up, discussed with him, or monitored by the mental health team at Forest Bank. It was also unclear whether the mental health team discussed this with any of the other teams, including prison staff.

164. The lack of recorded information about Mr O'Brien's non-adherence to his medication reflects a significant gap in clinical oversight and continuity of his care. We make the following recommendation:

The Heads of Healthcare and Heads of Mental Health at both HMP Liverpool and HMP Forest Bank should ensure that all prisoners refusing critical medication are discussed at the daily safety huddle, with a clear and timely care plan developed and recorded to support clinical decision-making and risk management.

Segregation

165. In accordance with Prison Service Order (PSO) 1700, when prisoners are located in the segregation unit, a segregation health safety algorithm is completed that assesses their suitability to remain segregated. This algorithm is regularly reviewed dependant on that individual's behaviour, presentation, mental and physical health. Healthcare staff are required to complete every question in the health safety algorithm to properly assess a prisoner's risk and suitability to be segregated.

166. Staff at Liverpool and Forest Bank made consistent efforts to manage Mr O'Brien's increasingly violent and unpredictable behaviour. Alongside addressing his risk of self-harm, they used disciplinary measures such as incentive scheme warnings. At Liverpool, he was moved to the segregation unit several times after damaging his cell, self-harm incidents and assaulting staff. These decisions were appropriate and based on clear evidence of the risk he posed to others and himself. Segregation was used as a last resort, following detailed discussions between prison and healthcare staff and supported through the segregation healthcare algorithm and

the prison's defensible decision documents. Attempts were also made to locate Mr O'Brien in the IPU, but this was not always sustainable due to his behaviour.

167. Additionally, at Liverpool, healthcare staff saw Mr O'Brien daily during segregation rounds, as per national policy. The mental health team saw him four days a week, and the GP saw him on the other three. This provided a well-rounded approach to his care, that involved both mental health and primary healthcare staff.

168. However, at Forest Bank, the same segregation procedures were not followed. Mr O'Brien was appropriately placed in segregation at Forest Bank given his unpredictable and dangerous behaviour. However, despite his mental health significantly deteriorating during his time there, this did not trigger a reassessment of his suitability for continued segregation. Notably, after he assaulted his mother on 31 October, no mental health review or update to his segregation healthcare algorithm was carried out, missing a key opportunity to evaluate his condition in the context of being segregated.

169. Further concerns were raised about communication and information sharing. The assault incident was not reported to the mental health team until five days later, with the Head of Healthcare, Ms F, only learning of it during the weekly SIM on 5 November. No mental health staff attended that meeting, highlighting poor multidisciplinary coordination. Forest Bank acknowledged that SIM meeting minutes did not accurately reflect discussions about Mr O'Brien. The prison has since taken steps to ensure that SIM meetings are properly minuted with key points highlighted.

170. On 8 November, a nurse deemed Mr O'Brien unfit to attend court. This was another missed opportunity to reassess his suitability for continued segregation using the segregation healthcare algorithm.

171. A review of Mr O'Brien's records revealed errors and omissions in the completion of the safety healthcare algorithm by healthcare staff. For example, on 25 October, a nurse failed to note his referral to a secure hospital unit and incorrectly recorded that he was taking his medication. No information was provided about recent self-harm. Similar issues occurred on 28 October and 4 November, raising concerns about the consistency and oversight of his care.

172. We also found that at Forest Bank, daily healthcare checks in the segregation unit were not carried out as required by PSO 1700. Records show that only the GP made entries, often stating "no concerns", despite Mr O'Brien's evident mental health issues and refusal to take medication. In interview, the GP acknowledged that his notes did not reflect the seriousness of Mr O'Brien's condition. PSO 1700 requires a doctor or nurse to assess segregated prisoners daily and properly document these visits. This did not happen in Mr O'Brien's case.

173. The issues identified raise concerns about prisoner safety, and the lack of coordinated and responsive care within the segregation unit at Forest Bank. To address these concerns and strengthen clinical oversight and communication, we make the following recommendation:

The Director, Head of Healthcare, and Head of Mental Health at HMP Forest Bank should ensure that all prisoners in the segregation unit receive:

- **Daily healthcare visits in line with PSO 1700;**
- **Accurate clinical entries in SystmOne, using the segregation template to support consistent and coordinated care;**
- **Timely reporting of incidents to the mental health team within 24 hours; and**
- **Mental health representation at weekly SIM meetings to support effective multidisciplinary decision-making.**

Dr B's role

174. Dr B, Clinical Lead at Forest Bank, initially was instructed by Mr O'Brien's family solicitor to provide an expert court report regarding the deterioration in Mr O'Brien's mental health and fitness to plead. However, his attempts to assess Mr O'Brien at Liverpool were unsuccessful due to missed appointments and refusals to engage.

175. After Mr O'Brien transferred to Forest Bank on 22 October, Dr B became involved again, this time in his role as Clinical Lead at the prison. On 7 November, he recorded Mr O'Brien's mental health was deteriorating and his possible need for transfer to the Edenfield Centre. However, during interview, he could not recall if he saw Mr O'Brien for a face-to-face assessment, and there is no evidence he followed up with the Edenfield Centre as planned.

176. On 23 October and 6 November, Nurse F recorded that she had spoken to Dr B, in his capacity as the Clinical Lead at Forest Bank and sought advice and shared relevant information. On 6 November, Nurse F recorded Mr O'Brien's worsening mental health and a recent assault on his mother. She forwarded this information to Dr B and the Edenfield Centre, to support his referral. We found no confirmation that this information was received or acted upon.

177. Our investigation highlighted a conflict of interest due to Dr B's dual roles, acting both as the family's appointed expert and as Clinical Lead at Forest Bank and therefore with some responsibility for Mr O'Brien's day to day care. This blurred the lines of responsibility and created confusion about his role in Mr O'Brien's care. Despite intentions to help, his involvement lacked clarity and documentation, particularly regarding communication with the Edenfield Centre. During interview, Dr B could not recall when he spoke with Dr C. No record of this contact exists. We make the following recommendation:

The Head of Healthcare and the Head of Mental Health at Forest Bank should ensure all healthcare staff work strictly within their roles and scope of practice, maintaining clear professional boundaries to support safe and ethical care.

Cancelled psychiatrist appointments

178. Following Mr O'Brien's missed psychiatry appointment on 31 October, the next clinic was held on 5 November but was fully booked. He was then scheduled for the next available clinic on 11 November, by which time he had been admitted to

hospital. Ms H, Service Manager for Health and Justice Services, explained that if an urgent issue had arisen during this period, the healthcare team was expected to contact other doctors within the wider Health and Justice network for assessment. However, Mr O'Brien's case was not considered urgent enough to trigger this response.

179. In situations where clinics are full and multiple urgent cases arise, the healthcare team is expected to use a multi-disciplinary triage approach to prioritise patients and reschedule less urgent appointments as needed. This process was not applied in Mr O'Brien's case. We make the following recommendation:

The Head of Healthcare and the Head of Mental Health should ensure that prisoners relisted for psychiatric assessment are not removed from scheduled appointments. If removal is unavoidable, they must be promptly rescheduled, with the rationale clearly documented in medical records and an urgent red flag task sent to the mental health in-reach team to ensure follow-up.

Mr O'Brien's mental capacity

180. Mr O'Brien's mental capacity was mentioned during interactions with staff, but these were only opinions and there was no evidence that a formal capacity assessment was undertaken. Dr B raised concerns about his capacity on 7 November, but no assessment was planned or completed. Such an assessment could have helped determine how best to support Mr O'Brien's needs. We make the following recommendation:

The Head of Healthcare and Head of Mental Health at HMP Forest Bank must ensure staff are trained in mental capacity assessment, consistently record capacity based on each interaction, and document these decisions clearly in medical records to support multi-disciplinary communication.

Food and fluid refusal

181. Staff at Liverpool noticed that Mr O'Brien had lost a lot of weight. Although food was available, he ate very little and irregularly, because his paranoia made him distrust prison meals. Instead, he was prescribed and mostly drank protein drinks and sometimes ate sealed snacks. His care plan required regular weight checks due to his medication, but he often refused to be weighed. Between arriving at Liverpool and moving to Forest Bank, he had lost nearly two stone - about 18% of his body weight. This level of weight loss should have led to more support for his nutrition and physical health, but this did not happen.

182. HMP Forest Bank's *Food and/or Fluid Refusal Policy* intends to ensure that prisoners who stop eating or drinking are properly identified, monitored, and managed. The policy outlines procedures for prison staff, including guidance on treatment, care, and consent to treatment. However, in Mr O'Brien's case, despite longstanding concerns about his food intake, staff only recognised his weight loss on 11 November, following an email from his mother. This delay highlights a lack of proactive monitoring and the need for better planning and teamwork when

supporting individuals with long-term mental health needs who are refusing food or fluids.

183. We found no evidence that staff started a food and fluid refusal log or care plan to record what Mr O'Brien was offered or refused, nor that any such plan was reviewed or acted upon. Although he was prescribed protein drinks, there was no record of how much he should take each day. The response to Mr O'Brien's nutritional needs was disjointed, with the mental health team working in isolation and limited coordination between prison staff, primary care, GPs, and mental health services. We make the following recommendation:

The Director, Head of Healthcare, and Head of Mental Health at HMP Forest Bank should ensure prisoners refusing food or fluids or on limited diets receive coordinated care through:

- **A regularly reviewed food and fluid refusal log and care plan, with accurate records of intake and prescribed supplements.**
- **Daily clinical monitoring, with findings documented in SystmOne and discussed in safety huddles.**
- **Collaborative working between prison staff, healthcare, GPs, and mental health teams to support timely intervention and prevent deterioration.**

Substance misuse

184. Mr O'Brien had a history of substance use and tested positive for multiple drugs, including ketamine, at Liverpool in September 2024. However, he declined support from the substance misuse team. Although there was no evidence that he was a frequent user during his time at Liverpool, his drug use had a lasting impact on his mental health and behaviour. From around 7 September, his drug use appeared to have triggered a deterioration in his mental health, leading up to his death. We are satisfied that Mr O'Brien was offered appropriate access to substance misuse services and support in relation to its impact on his mental health but generally refused to engage.

185. Liverpool faces significant challenges with drug conveyance, including being among the UK's top ten prisons affected by drones. Drugs enter through various routes such as reception, visits, mail, drones, and corruption. Liverpool's drug strategy centres on three pillars: restricting supply, reducing demand, and building recovery, and aims to strengthen partnerships both inside and outside the prison to address the drug problem holistically.

186. Ms I, Head of Drug Strategy, told the investigator that Liverpool had introduced measures to restrict supply, including photocopying mail, tackling drone activity, and sharing intelligence with external agencies. The prison was also working with Leeds Trinity University to implement a recovery-oriented care system and was involved in a prototype project with the National Drug and Alcohol Team and the MOJ Science Office to use technology and other testing methods to detect Psychoactive Substances (PS).

187. Ms I acknowledged that reducing drug demand was challenging, as recovery relies on individual choice. The prison is working with a professor at Leeds Trinity University to develop and expand their substance misuse services (SMS). They are also focusing on making disciplinary hearings for drug misuse rehabilitative and encouraging prisoners to engage with SMS.

188. We note that Liverpool is continually striving to reduce both demand and supply of drugs and have introduced several important measures to try to address this. Given the measures that Liverpool are already taking, we make no recommendation.

Director and Head of Healthcare to note

Contemporaneous record keeping

189. The investigation found that several entries in Mr O'Brien's medical records had been made retrospectively, several days after Mr O'Brien had been seen by a member of the healthcare team. Notably, a mental health nurse completed a comprehensive assessment on 7 November, that was not documented until 11 November, two days after Mr O'Brien had been transferred to hospital after he was found hanged in his cell. Staff should ensure that they record all clinical notes contemporaneously.

Postvention procedures

190. Listeners were not deployed to the segregation unit and prisoners who were in the post-closure period of their ACCT were not reviewed as they should have been. The Director and Head of Healthcare will want to ensure that postvention procedures are fully followed in future.

Good practice

191. Ms A at Liverpool demonstrated exemplary practice in her care for Mr O'Brien. She maintained frequent and transparent communication with Mr O'Brien's mother, often exceeding daily contact, to ensure consistent information sharing. In addition, she voluntarily provided compassionate support to Mr O'Brien's mother after he died. Her commitment to person-centred care and strong family engagement went beyond expectations and should be formally recognised and commended.

Information received in November 2026

192. After issuing our final report in December 2025, we received information in November 2026 that overnight on 8 to 9 November 2024, staff did not complete Mr O'Brien's ACCT checks as they should have done. This contrasts with paragraph 123 of this report in which we state they were completed. We reviewed the ACCT documentation at the time which indicated the checks had been completed. We did not verify these against CCTV footage since we knew that Mr O'Brien was alive the next morning, following the overnight checks.

193. Sodexo was aware that the checks were not completed and the records falsified but they did not inform us. Several officers were subsequently dismissed following

disciplinary proceedings. We understand that this evidence was provided to the Coroner. The Head of Prisoner Safety told us that it was an oversight that we were not informed. It is of significant concern that we were not informed of the falsification of the records at the time and have written to the Director of Forest Bank to highlight this issue.

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