Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brendan Teague, a prisoner at HMP Garth, on 7 October 2023

A report by the Prisons and Probation Ombudsman

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

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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 Brendan Teague died on 7 October 2023, after being found hanged in his cell at HMP Garth. He was 46 years old. I offer my condolences to Mr Teague's family and friends.

Mr Teague had a significant history of using substances, attempted suicide and self-harm, depression and anxiety. In December 2020, he contracted COVID-19 and was hospitalised. This had a traumatic impact on him and he suffered from anxiety, that later affected his day to day living in prison.

Mr Teague's anxiety led to him being appropriately supported under suicide and self-harm procedures (known as ACCT) on two occasions in May and September 2023. He received good one-to-one psychology input to help him manage his anxiety, and generally staff were responsive and supportive to his needs.

The clinical reviewer concluded that the healthcare Mr Teague received at Garth was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

Mr Teague had medication in his system when he died which had not been prescribed to him. The prison is taking proactive steps to reduce drug supply and the diversion of medication.

I make no recommendations.

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 **September 2024**

Contents

Summary

Events

1. On 29 March 2017, Mr Brendan Teague was remanded to prison, charged with attempted murder, and taken to HMP Durham. This was not his first time in prison. On 27 October, he was sentenced to 18 years imprisonment. He had a history of attempted suicide and self-harm, substance misuse and depression with panic attacks.

2. In November 2017, Mr Teague transferred to HMP Garth.

3. In December 2020, Mr Teague contracted COVID-19 and was admitted to hospital. While he made a full recovery, he stated that the illness caused him to experience flashbacks and he had anxiety. He was prescribed antidepressant medication.

4. In May 2023, Mr Teague referred himself to the mental health team because of his anxiety. He was assessed and diagnosed with a high level of depression and severe anxiety. He was referred to a psychologist and from July, regularly received one to one support.

5. During his time at Garth, Mr Teague was supported under ACCT procedures on two occasions, in May and September 2023. On both occasions he reported feelings of anxiety. Staff stopped ACCT monitoring on 27 September. Mr Teague was not being supported by ACCT procedures when he died.

6. On the morning of 7 October, during a routine check, prison staff found Mr Teague hanged in his cell. Prison and healthcare staff provided emergency care. At 6.09am, paramedics confirmed that Mr Teague had died.

7. After he died, toxicological analysis showed that Mr Teague had several medications in his system which had not been prescribed to him.

Findings

8. Mr Teague had several risk factors for suicide and self-harm. He had a history of attempted suicide and self-harm, substance misuse and depression and anxiety. Broadly, we concluded that Mr Teague received good support from the ACCT process. However, we identified some omissions in the management of the second ACCT, and particularly the ACCT review on 27 September. We do not think that there was evidence that Mr Teague was at imminent risk of suicide at the time, however. Garth is currently investigating these issues so we make no further recommendation.

9. Neither prisoners nor prison staff observed any obvious signs that Mr Teague was in crisis in the ten day period leading to his death. We have concluded that he hid the extent of his anxiety, and it was reasonable that staff did not identify him to be an imminent risk of suicide.

10. The post-mortem found that Mr Teague had taken olanzapine, mirtazapine and clonazepam before he died. None of these medications had been prescribed to him,

so he must have obtained them illicitly. Garth has reviewed their drug strategy and we are satisfied that they are taking appropriate steps to tackle drug misuse and medication diversion.

11. The clinical reviewer concluded that Mr Teague's healthcare was of a good standard and at least equivalent to that he could have expected to receive in the community.

12. We make no recommendations.

The Investigation Process

13. HMPPS informed us of Mr Teague's death on 7 October 2023. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Teague's prison and medical records, CCTV and body worn video camera (BWVC) footage. He also obtained North West Ambulance Service records.

15. The investigator interviewed ten members of staff at Garth and three prisoners.

16. NHS England commissioned a clinical reviewer to review Mr Teague's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed staff.

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

18. The Ombudsman's office contacted Mr Teague's parents to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Teague's parents asked about the circumstances that led to their son's death, including whether COVID-19 had contributed and what mental health support he had received in prison. We have answered these questions in this report.

19. Mr Teague's family received a copy of the initial report. They did not make any comments.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Garth

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

HM Inspectorate of Prisons

22. The most recent inspection of HMP Garth was in November 2022. Inspectors noted that self-harm had reduced. The safer custody department had worked hard to train staff in ACCT case management, but the quality of support was inconsistent. Inspectors noted that although the prison had worked to reduce drug supply, drugs remained easily available and the mandatory drug testing rate had reduced. Garth offered a range of mental health services, interventions and support, but there were long waits for some psychological therapies. There was limited evidence of additional mental health training for officers.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 November 2022, the Board noted that the effects of the COVID-19 pandemic had begun to lessen and the prison had started to move towards a more normal regime, although this had not yet been fully achieved. On the whole, prisoners had responded positively to the required restrictions but some frustrations had begun to manifest themselves. The report noted that Garth had ongoing staff recruitment and retention problems which meant that there were many inexperienced staff in the prison. Safety had been improved by physical changes to the prison.

Previous deaths at HMP Garth

24. In the three years prior to Mr Teague's death, 14 prisoners died at Garth. Ten of these were due to natural causes, two were self-inflicted, and one was due to drugs. None of the investigations following these deaths raised issues relevant to Mr Teague's death. To the end of July 2024, there have been two deaths since that of Mr Teague, one of which was due to drugs and one was self-inflicted.

Assessment, Care in Custody and Teamwork (ACCT)

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

26. 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. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

27. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. In March 2017, Mr Brendan Teague was arrested, charged with the attempted murder of his stepbrother and remanded to HMP Durham. This was not his first time in prison. He had a history of attempted suicide and self-harm, substance misuse and depression and panic attacks. Shortly after committing the alleged offence, he had tried to take his own life by taking heroin, an overdose of several different types of prescription medication and drinking vodka.

25. On 27 October, Mr Teague appeared in court and was sentenced to 18 years imprisonment.

HMP Garth

26. On 9 November 2017, Mr Teague transferred to HMP Garth. When he arrived, a nurse recorded that he had a history of attempted suicide and self-harm and substance misuse, including the use of Subutex (a type of opioid drug) and heroin and crack cocaine. He was currently prescribed methadone as well as antidepressant medication. Both these medications were continued on his arrival. Mr Teague denied that he had any thoughts of suicide or self-harm. The nurse referred him the substance misuse and mental health teams. Mr Teague was seen by substance misuse clinical staff at regular intervals to monitor his methadone prescription.

2020

27. On 9 December 2020, Mr Teague tested positive for COVID-19 and was isolated in a single cell, in line with prison service guidelines. A healthcare COVID-19 care plan was initiated.

28. On 13 December, Mr Teague was admitted to hospital after a decline in his physical health. He was initially located in the Intensive Care Unit and was placed on a ventilator until 21 December, after which his condition improved. On 27 December, he was moved to a less acute ward. On 29 December, he was discharged from hospital and returned to Garth.

29. It was recorded in Mr Teague's medical records that, following this hospital admission, he experienced flashbacks and anxiety.

2022

30. On 22 March 2022, at the request of the hospital physician who was following up on all COVID-19 patients who had been admitted to hospital, healthcare staff completed a number of tests on Mr Teague. No abnormalities were recorded.

31. On 13 July, Mr Teague again tested positive for COVID-19. Due to his previous experience of being hospitalised, Mr Teague was reluctant to accept treatment. However, once healthcare staff explained to him why checks and observations were necessary, he consented. Healthcare staff monitored Mr Teague and also provided him with a pulse oximeter (to monitor his blood oxygen levels and pulse) to assist him in identifying the early risk factors associated with COVID-19.

32. Healthcare staff completed daily welfare checks until 19 July. Mr Teague reported that he felt well on each occasion and had not experienced any adverse symptoms of COVID-19. His physical health observations were all within the normal range.

2023

33. On 15 March 2023, Nurse A, from the mental health team (who worked with the substance misuse team), completed the regular review of Mr Teague's methadone treatment. Nurse A undertook an assessment of Mr Teague's withdrawal signs that indicated that he was not experiencing any withdrawal symptoms. Staff made no change to his methadone dosage and a further review was planned.

34. On 18 May, Mr Teague told staff that he wanted to self-isolate on the wing. He said he was not scared but wanted to take some time out to reflect on how ill he had been when he had COVID-19 in 2020. He said he wanted some quiet time away from everyone on the wing. Staff reminded Mr Teague of the support available to him and said that they would continue to monitor him.

35. On 22 May, Mr Teague applied to see the mental health team. He stated that he felt on edge when around people and he would start to shake. He said the impact of having COVID-19 and being hospitalised had "ripped a huge part of his soul away" and he did not know what to do. An appointment was booked for him to see a nurse.

36. The same day, Officer A saw Mr Teague for a key work session. Mr Teague told the officer that he had self-isolated the previous week because he wanted a change in his methadone dose and felt that he needed to "get his head around" this. However, since then, he had fully engaged with the regime and said he felt much better. He was also working in a prison workshop.

37. On 23 May, when Mr Teague attended the medication hatch, he told Nurse A that he was struggling on his dose of methadone. Nurse A scheduled an appointment later that day to discuss his concerns. However, when Mr Teague attended the appointment, he said that he had no issues with his methadone dose but instead wanted to talk about other issues. He talked about his history of anxiety and depression with panic attacks and that he had experienced panic attacks the last time that he left prison. He admitted that he had been struggling and had self-isolated. He said he had only self-isolated for one day, as he felt this would not resolve his problems and would only make things worse. Mr Teague was unable to identify any specific trigger to his behaviour but said that the increased noise levels on the wing and being around more people affected him. He said he had not attended work recently as the noise in the workshop affected him too. He said he would only attend the medication hatch at the end of a session when there were fewer people there. Mr Teague said that the time he had spent in the ICU at hospital, after contracting COVID-19, had been very traumatic for him. He said he had experienced hallucinations and paranoid thoughts.

38. Nurse A undertook two assessments on Mr Teague using Generalised Anxiety Disorder assessment (GAD7, a screening tool to for anxiety) and a Patient Health Questionnaire (PHQ9, a screening tool for depression). The results highlighted that Mr Teague had a high level of depression and severe anxiety. Mr Teague said that he wanted to address his anxiety but did not want to address his past traumatic

experiences, which he disclosed included being sexually abused. Nurse A referred Mr Teague to the mental health team for a medication review and to explore treatment options available to him.

39. At the mental health team's referral meeting the next day, Mr Teague was placed on the waiting list to see the psychologist to be assessed for an anxiety treatment plan. The psychiatrist reviewed Mr Teague's medication and increased the dose of his sertraline (antidepressant) medication.

40. On the morning of 29 May while administering medication, mental health Nurse B noticed a red mark on Mr Teague's neck which appeared to be from a ligature. When asked why he had a red mark around his neck, Mr Teague stated that he had had a lot going on but was now okay. As he walked away from the medication hatch, he stated that the marks were two weeks old. Nurse B telephoned Supervising Officer (SO) A, the wing supervisor, and informed her of his concerns regarding Mr Teague and requested that a welfare check be completed.

41. Shortly afterwards, SO A spoke to Mr Teague in the wing office. Mr Teague said that the marks on his neck were two weeks old and had occurred when he had been self-isolating and wanted to be alone. When probed further, Mr Teague assured SO A that he no longer had any issues and had had no thoughts of suicide or self-harm. He said that he did not talk to staff at the time but after his conversation with SO A, felt that he could do so in the future, if his mood was low. SO A noted that she had no concerns for Mr Teague's welfare at that time.

42. In the meantime, Nurse B had discussed Mr Teague with Nurse A. Nurse A and Nurse B agreed to attend the wing to review Mr Teague and did so that afternoon. Mr Teague repeated that he had made a ligature two weeks previously. When the nurses viewed the marks around Mr Teague's neck, they believed that they had been made more recently. Nurse A thought that he would have noticed the marks if they had been there the previous week, as he had seen Mr Teague on 23 May. Mr Teague refused to engage any further in the discussion about the incident. Nurse A started ACCT procedures. Staff placed Mr Teague on four ACCT observations an hour.

43. The next morning, 30 May, SO A chaired a multidisciplinary ACCT case review, which included a representative from the mental health team. Mr Teague was initially reluctant to engage and said that being on an ACCT contributed to his anxiety. He was adamant that the ligature markings on his neck were two weeks old. He said that at the time he was struggling with anxiety and the loud noise in the workshop along with the current regime. However, since then he said he had resolved his issues and had no thoughts of suicide or self-harm. SO A said that Mr Teague should speak to her whenever he attended the workshop and if his problems continued, they would find a way to manage this.

44. The case review team noted that Mr Teague sounded irritable during the meeting when he was asked questions about triggers to his self-harming behaviour and whether he would seek staff support. Mr Teague said that he preferred to speak to his peers, not staff, if he had any concerns. Despite stating that he was struggling with noise due to a change of prison regime, he declined the offer of a move to smaller and quieter wing. The mental health nurse agreed to discuss Mr Teague at

their next team meeting. Staff set ACCT observations at three per hour and scheduled the next review for 5 June.

45. On the same day, Officer A saw Mr Teague for a key work session and raised no concerns.

46. At his key work session on 5 June, Mr Teague said that he felt much better and did not need to be monitored by ACCT procedures. He said his peers on the wing had supported him. His key worker noted that Mr Teague still worked in the prison workshop and complied with the prison regime.

47. On the same day, SO A chaired a multidisciplinary ACCT case review, which included a representative from the mental health team. Mr Teague became frustrated and tearful at times but eventually opened up about losing six family members, being imprisoned and spending time in the hospital with COVID-19, leading to him having anxiety and to tie a ligature. He explained that going to work in the woodwork workshop caused him anxiety due to the loud environment. The case review team reassured Mr Teague that if he could not cope in the workshop he would be moved. Mr Teague stated that, for now he was okay as his workshop had been closed since his last ACCT review. He was happy to wait to see how he felt. He said he was keen to work with the mental health team and requested to see a psychologist due to his extreme mood swings, stating that he preferred one to one support. The review team agreed to refer Mr Teague to the psychologist (he had already been referred on 24 May) and mental health team. Mr Teague appeared happy with the actions proposed and stated that he had spoken to his family and had a support system in place. The staff agreed to lower his ACCT observations to two per hour and scheduled his next ACCT review for 9 June.

48. The next day, 6 June, the mental health team discussed Mr Teague and assigned Ms A, assistant psychologist, to work with him.

49. SO A chaired a multidisciplinary ACCT case review on 9 June. She had no concerns about Mr Teague. Mr Teague said he had no thoughts of suicide or self-harm, although he had still not been seen by the psychologist. SO A agreed to follow this up. Mr Teague confirmed that he was not currently attending work as the workshop tutor was unwell. The case review team reduced Mr Teague's ACCT observation to one per hour.

50. At his multidisciplinary ACCT review on 15 June, SO A noted that Mr Teague had no thoughts of suicide or self-harm, was settled and happy. It was confirmed that he had an upcoming appointment with the psychologist. He requested to work part-time in the workshop to reacclimatise himself to the workshop environment. The case review team agreed that the ACCT could be closed.

51. On the same day, Nurse A completed Mr Teague's 13-week review of his methadone treatment. Mr Teague engaged well and said he had no thoughts of suicide or self-harm. His methadone dose remained the same and a further review was booked for 13 weeks.

52. On 23 June, during a key work session, Mr Teague said that he felt better now that he was no longer being monitored by ACCT procedures. It was agreed that Mr Teague could reduce to part time hours in the workshop due to his mental health.

53. On the same day, SO A attempted to conduct Mr Teague's ACCT post-closure interview with him but Mr Teague refused to engage. Mr Teague did state, however, that he had no thoughts of suicide or self-harm and that he was now working part time in the workshop.

54. At his key working sessions on 5 July and 13 July, Mr Teague reported that he had no issues on the wing and said he enjoyed associating with his peers and attended work regularly.

55. On 21 July, Ms A assessed Mr Teague. He said that he had struggled with anxiety, felt unmotivated to get up in the mornings and had lost his 'zest for life' and confidence in himself. His anxiety had increased when he attended the workshop (so he had now stopped going) and when around groups of people. He said that he did not speak to his family much because of his anxiety and did not want them to know that he was struggling. He talked about his history of depression, the death of family members and being hospitalised because of COVID-19. He said he had experienced hallucinations and flashbacks ever since. Mr Teague said that he had regular thoughts of killing himself but had no intention of acting on these. He did not want to be monitored by ACCT procedures and felt that being on ACCT increased his anxiety. He said that his peers supported him, although admitted that he would not talk to them in any depth about his difficulties. Ms A agreed to see Mr Teague weekly to support him and to continue her assessment.

56. In further psychology sessions over the coming weeks with Mr Teague, Ms A discussed ways of recognising and coping with his anxiety, created a crisis plan for him and provided him with in cell work to complete. Mr Teague described himself as an overthinker. He told Ms A that he was not very open with staff, and although he presented as consistently anxious, Ms A noted that he tried to engage in the sessions. Mr Teague talked about his childhood trauma and family bereavements. Ms A noted that Mr Teague's mood improved after he spoke to his family, something he had not done for around six weeks. When he talked about the friends he had on the wing, he explained that he spoke to them around once a day and kept the conversations superficial. Mr Teague said he still had regular thoughts of suicide, particularly at night, when there was less to distract him, but he had no plans or intent to harm himself.

57. During the later sessions, Mr Teague reported that he felt much better, and his mood was good. He was thankful for the support he got from attending his psychology sessions and said the contact he had had since with his father, also helped. His anxiety remained the main issue that he wanted to address and said this would help him to live a 'normal life'. Mr Teague understood that self-isolating and not going to work supported his anxiety short term but not long term. He also recognised that when there had been restrictions on movement in the prison due to COVID-19, and the corridors were quieter, he found going to work easier. Now that the routine and regime had changed, he struggled more with his anxiety. He recognised that he was not as used to being around people and this worsened his anxiety and isolating from people increased his overthinking.

58. At his key work session on 31 July, Mr Teague said that he was settled on the wing. He said he had not attended work lately due to being ill but was feeling better now.

59. When Ms A saw Mr Teague on 30 August for his psychology session, he spoke about how frustrated he had felt the previous day, after he had attended the medication hatch twice, only to find lots of prisoners queuing. He said that he had initially felt scared. These feelings then turned into anger and frustration and resulted in him having a verbal altercation with staff, during which he threatened violence. Mr Teague said that he did not mean to do this and it was part of the difficulties he had when trying to manage his cycle of anxiety. He said he had had thoughts of "ending it all" but stated that he had this regularly and had no plans or intent to act on these thoughts. Mr Teague spoke about coming off methadone in preparation for his parole hearing. Ms A agreed to see Mr Teague for a further session the following week.

60. On 6 September and 12 September, Mr Teague did not attend his sessions with Ms A. Ms A attempted to contact Mr Teague on his in-cell phone, to ascertain why he had not attended. He did not answer the calls. At interview, Ms A told us that she had eventually managed to speak to Mr Teague. Mr Teague told her that he had not attended the sessions because he felt anxious about walking to the healthcare unit, where the sessions were held. Ms A arranged for future sessions to be conducted on Mr Teague's wing.

61. On 16 September, SO B conducted an annual review of Mr Teague's enhanced IEP level. It was noted that there had been a recent decline in Mr Teague's behaviour as he had received a few negative entries. These related to him refusing to attend work.

62. On 18 September, the substance misuse team noted that Mr Teague had tested negative for illicit drug use.

63. On the same day, Ms A saw Mr Teague. Mr Teague said that he had struggled for the past couple of weeks. He said that he had made a noose two days earlier, although he had no intention to end his life. Ms A explained to Mr Teague that his actions showed that he was at risk and although Mr Teague stated that he did not want to be managed by ACCT procedures (because it made him feel worse), Ms A started ACCT procedures. SO B completed the ACCT Immediate Action Plan and put Mr Teague on hourly observations. He noted that Mr Teague could access Listeners (prisoners trained by the Samaritans to provide confidential peer support) and was provided with distraction packs to use in his cell.

64. On 19 September, Officer B, completed Mr Teague's ACCT assessment. Mr Teague said that he was frustrated that he was now being monitored by ACCT procedures and felt that the disclosure he had made to Ms A, and her informing others, was a breach of his trust. He said he had no intention to take his life and he had just had a fleeting thought about it. He said he had no current thoughts to harm himself and was happy on the wing. He said he was not attending work as he still struggled when around big groups of people. He said that was receiving psychological support for this, however, was unsure if he now wanted to attend any further sessions because he no longer believed the service was a confidential one. Officer B noted that Mr Teague not attending work was a warning sign of his increasing risk.

65. SO B, case co-ordinator, later chaired the first ACCT case review. Officer B and Ms A both attended. Staff had no concerns about how Mr Teague presented or his

demeanour during the review. Mr Teague said that he had been struggling but was currently doing better. He said that he had always had thoughts to end his life but had no plans or intent to act on these. He said that he was being supported by wing staff and the weekly psychology sessions he attended had helped him with his difficulties. He also now spoke to his father and sister regularly and they acted as part of his support network. SO B told us at interview that Mr Teague had reiterated several times during the review that he had not harmed himself, and his actions were a result of him feeling stressed. The staff agreed that they would reduce Mr Teague's ACCT checks to three conversations a day and it was noted in the ACCT care plan that Mr Teague should try and attend one workshop session. Staff scheduled the next ACCT review for 27 September.

66. On 22 September, a member of the chaplaincy team visited Mr Teague and conducted a welfare check. No concerns were noted. At a key work session the next day, staff again raised no concerns.

67. On 26 September, Ms A saw Mr Teague. Mr Teague described himself as being content and settled and although he said that he frequently had suicidal thoughts, he had no plans or intent to act on these. He said that he had been practising some of the strategies learnt during his psychology sessions and that they had helped him to calm down during times when he had struggled. He said he struggled when he attended the medication hatch and work because of the loud and busy environment of these areas. Ms A noted that Mr Teague's mood was good and he talked about his future and aspirations he had in his working life. She scheduled her next session with Mr Teague for 7 October. Ms A told us at interview that she intended to continue sessions with Mr Teague focusing on his anxiety. She said that Mr Teague engaged well in this session and was motivated to work on issues that challenged him.

68. At 9.30am, SO A recorded in Mr Teague's ACCT document that she had chaired an ACCT review with him. (She recorded this on prison computer records, at 9.42am). At interview, she confirmed that this had taken place in the wing office. CCTV shows that Mr Teague and SO A went into the wing office for two minutes that morning between 9.23am and 9.25am.

69. SO A did not record that any other staff were present but at interview she told us that a wing officer was present. She also said that healthcare staff were invited to the review and had said they would provide verbal input, but they did not. SO A noted that Mr Teague engaged well in the review. He talked about not wanting to always burden staff with how he felt, but agreed that if he ever needed to, he would ask staff to contact the mental health or psychology team for additional support. Mr Teague said that he had no thoughts of suicide or self-harm and felt that being monitored by ACCT procedures was a little "overboard", especially as he had not actually harmed himself. He had still not recently attended work due to his anxiety, although he said he was happy and was able to deal with his feelings a lot better now. SO A had received positive feedback from wing staff about Mr Teague's general behaviour. She recorded that staff agreed to stop ACCT monitoring and scheduled an ACCT post-closure interview for 5 October. The ACCT care plan was updated noting that the only action on it (for Mr Teague to attend work) had been completed (despite Mr Teague still not attending work).

70. At 9.36am, a different member of staff recorded on Mr Teague's computerised record that he had refused to attend his ACCT review. Staff noted that, as Mr Teague had had a period of settled behaviour and had not had any attempted suicide and self-harm incidents, ACCT monitoring would be stopped.

71. On the same day, mental health Nurse C and Ms B, a recovery worker from the substance misuse team, saw Mr Teague for his 13-week review of his methadone treatment. They assessed that Mr Teague was not experiencing any withdrawal symptoms. As he only had two years left of his prison sentence before he was released on parole, Mr Teague requested the formulation of a reduction plan for his methadone prescription. He said that he wanted to be drug free upon his release from prison. Staff advised Mr Teague that a reduction (of 2mls) would be added to his care plan and the prescriber would ensure that his dose was changed.

72. On 29 September, a member of the chaplaincy team conducted a welfare check on Mr Teague. No concerns were noted.

73. Prisoner A, who lived on the same wing as Mr Teague, said that he last had a conversation with him around the beginning of October. He believed that that Mr Teague had given up on life and was worried about being released.

74. On 5 October, SO B completed Mr Teague's seven-day ACCT post closure review. He had no concerns about Mr Teague and the ACCT remained closed.

75. On 6 October, Ms B recorded that a recovery peer mentor (a fellow prisoner trained to support peers with substance misuse issues) on C Wing, had spoken to Mr Teague. Mr Teague had told the mentor that he wanted support from the substance misuse team. Ms B sent a task to the admin team to arrange for someone to meet Mr Teague.

76. Due to technical issues with the downloading of Mr Teague's phone calls, we were unable to listen to the calls he made in the days before his death. However, the HMPPS Early Learning Review which took place after he died noted that Mr Teague called his father and stepmother at 10.31am. The review noted that the call lasted approximately 30 minutes and Mr Teague did not raise any concerns.

77. Staff raised no concerns about Mr Teague during the day. When Operational Support Grade (OSG) A completed the evening routine check (a regular check undertaken by prison staff to ensure that the prisoners are in their cells and are accounted for) at 7.20pm, he had no concerns about Mr Teague. During his checks, OSG A noted that several prisoners, including Mr Teague, had covered their observation panels (which is not allowed). He told these prisoners to uncover the panels, which they did. Mr Teague was not subject to any further checks during the night and did not press his emergency cell bell.

Events on 7 October

78. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 7 October. He also obtained information from the North West of England Ambulance Service. The following account has been taken from all sources.

79. At around 5.00am, OSG A and OSG B started their morning routine check on C Wing. At 5.04am, when OSG B arrived at Mr Teague's cell, the observation panel was covered and Mr Teague failed to respond when she called his name. OSG B continued to check cells close to Mr Teague's before returning to his cell to try again to rouse a response. When she could not, OSG B alerted OSG A who attended and also tried to get a response from Mr Teague by shouting his name and banging on his cell door. Mr Teague did not respond.

80. According to Garth's local security policy, three officers must be present to unlock a cell during the night. At 5.12am, OSG A radioed for the Intervention Team to attend the wing, so he could enter Mr Teague's cell. Officer C, Officer D and Officer E arrived at Mr Teague's cell at 5.15am. When they unlocked and entered Mr Teague's cell, they immediately saw him hanging from a ligature (made from a bedsheet) attached to the ceiling light fitting.

81. At 5.16am (according to the control room log) Officer D radioed a medical emergency code blue (used when a prisoner is unconscious or having difficulty breathing). Staff in the control room called an ambulance immediately and instructed the prison healthcare team to go to Mr Teague's cell.

82. Officer C supported Mr Teague's body while Officer E cut the ligature and they laid him on the floor. Mr Teague showed no signs of life. Officer E started cardiopulmonary resuscitation (CPR) and rotated this with Officer C and Officer D.

83. Nurse D arrived within three minutes of the emergency code blue call. She checked Mr Teague for signs of life and noted he was totally unresponsive, was cold to touch but was not stiff. She used emergency equipment that included a defibrillator and oxygen to treat Mr Teague.

84. The first ambulance paramedics arrived at 5.32am and took over the care of Mr Teague. A second paramedic crew arrived at 5.37am. At 6.09am, paramedics confirmed that Mr Teague had died.

Contact with Mr Teague's family

85. The prison appointed Officer F and Officer G as family liaison officers. They left the prison at 10.00am and at 1.05pm, they arrived at Mr Teague's father's home address and broke the news of Mr Teague's death. In line with HMPPS policy, Garth offered a contribution to the cost of Mr Teague's funeral.

Support for prisoners and staff

86. The prison posted notices informing other prisoners of Mr Teague'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 his death.

87. After Mr Teague's death, the staff involved in the incident were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

Post-mortem report

88. The post-mortem report concluded that Mr Teague died from hanging. Toxicology results found methadone (which he had been prescribed) in his system. The toxicology report also noted that Mr Teague had olanzapine (an antipsychotic), mirtazapine (an antidepressant) and clonazepam (used to treat seizures and panic disorder) in his system. These drugs had not been prescribed to him.

Findings

Management of Mr Teague's risk of suicide and self-harm

89. Prison Service Instruction (PSI) 64/2011 on safer custody sets out the procedures (known as ACCT) that staff should follow when a prisoner is assessed as at risk of suicide and self-harm. It requires that ACCT case reviews are multidisciplinary and that the case coordinator ensures that healthcare staff (or other appropriate staff, such as mental health staff involved in their care) are always invited to attend the first case review or provide a written contribution to them and any subsequent case reviews where they are relevant to supporting the prisoner.

90. Mr Teague was supported under ACCT procedures on two occasions at Garth: from 29 May for 17 days and from 18 September 2023 for nine days. On both occasions, he had apparently made a noose and stated that he had had suicidal thoughts. Mr Teague said several times that he had thoughts of suicide but had no plan or intention to act on these. Broadly, we are satisfied that Mr Teague received reasonable support from the ACCT process, and in particular, recognise that Nurse A conducted an appropriate holistic assessment of Mr Teague's risk factors which led to the opening of the first ACCT.

91. However, we found conflicting recorded information as to whether the ACCT case review on 27 September took place, at which the ACCT was closed. This was the last ACCT review before Mr Teague's death. SO A recorded that she had held the ACCT review. Six minutes later, staff recorded that Mr Teague had refused to attend the review. SO A told us at interview that the review did take place and she chaired it. CCTV showed that Mr Teague had only attended the wing office (where the review took place) for two minutes (from 9.23am to 9.25am). No healthcare staff attended or provided a written contribution – an omission given Mr Teague was working closely with Ms A, the psychologist.

92. The PSI states that at the first ACCT case review, a prisoner's most pressing needs in relation to his risk of suicide and self-harm should be identified and a care plan should be completed, giving detailed and time-bound actions aimed at reducing the level of risk posed. When Mr Teague's ACCT was first opened, the care plan noted that he should attend a session of workplace activity to help address his anxiety. When ACCT monitoring was stopped on 27 September, Mr Teague had still not attended work. His care plan was closed although this action had not been completed. Furthermore, the "Risk, Triggers and Protective Factors" sections were blank.

93. Overall, we consider it would have been difficult for SO A, within the two-minute time frame and without any supporting input from healthcare staff, to make an appropriate assessment of Mr Teague's risk. While we do not think that the decision to end ACCT monitoring on 27 September, 10 days before Mr Teague's death, was plainly wrong in the circumstances, we do not think it offered staff the best opportunity to holistically assess his risk. Garth began an investigation into the issues associated with this ACCT review, but had not completed the investigation by July 2024.

94. Since Mr Teague's death, Garth has introduced and completed additional ACCT training for case coordinators along with an improved quality assurance process for the management of ACCTs, and in light of the ongoing internal investigation, we make no recommendation.

95. After the ACCT was closed, several staff, including a member of the mental health and substance misuse team, a member of the chaplaincy team and an SO (who completed the ACCT post-closure review) saw Mr Teague and none raised any concerns about him or observed any obvious signs that he was in crisis leading up to his death. We have concluded that Mr Teague hid the extent of his anxiety, and it was reasonable that staff had not identified him as at imminent risk of suicide when he died.

Clinical care

96. The clinical reviewer concluded that the clinical care Mr Teague received was of a good standard and was equivalent to that which he would have received in the community.

97. Mr Teague's next of kin asked about how COVID-19 may have affected him. The clinical reviewer did not identify any concerns regarding Mr Teague's clinical care related to COVID-19 and is satisfied that his increased risk was managed satisfactorily by the healthcare staff at Garth. It was noted, however, that Mr Teague experienced unpleasant symptoms due to COVID-19, including hallucinations and at the time of his hospitalisation, felt that the hospital doctors were trying to harm him. These experiences had a detrimental effect on him in the subsequent years and clearly had an effect on his mental state.

Mental health

98. Mr Teague was appropriately treated with medication for depression. After he referred himself to the mental health team in May 2023, when he said that he was struggling with anxiety, he received a comprehensive, one-to-one assessment and support from the psychology team. The mental health team thought that Mr Teague would benefit more from a psychological approach in relation to his anxiety than medication and he was still engaging with this treatment plan at the time of his death. The clinical reviewer agreed with this approach and found that Mr Teague's mental health care was appropriate.

Substance misuse and the availability of illicit medication

99. Mr Teague had a long history of substance misuse and was treated with methadone throughout his time at Garth. He was regularly reviewed by the substance misuse service. The clinical reviewer concluded that his substance misuse care was appropriate.

100. However, the toxicology report identified that Mr Teague had mirtazapine, olanzapine and clonazepam in his system. As none of these medications had been prescribed to him, he must have obtained them illicitly. The prison was unaware that Mr Teague was taking illicitly obtained medication while he was there and there had been no previous suspicions that he was using illicit substances.

101. We do not know how Mr Teague obtained these medicines. He may have obtained them from another prisoner who was prescribed them or they may have been illicitly brought into the prison.

102. The prison has an Integrated Substance Misuse Strategy dated December 2021 which sets out the actions that Garth plans to take to eliminate the supply of drugs, reduce demand and promote user recovery. Following the death of a prisoner from drugs at Garth in November 2022, we recommended that further work needed to be done to reduce the availability of illicit drugs and diverted medication. Garth reviewed their drug strategy in April 2024, so that it continued to reflect changes in local or national policy and was responsive to any emerging threats. The strategy includes measures to prevent the diversion of medication. We make no recommendation but clearly the Governor and drug strategy lead will want to continuously review the local strategy to ensure it remains relevant to issues at Garth.

Governor to note

Emergency response

103. Mr Teague's observation panel was covered at 5.04am when staff did their routine check. The two OSGs tried for some time to rouse a response from Mr Teague, before eventually calling for other staff to attend eight minutes later. We understand that staff could not see into the cell and therefore did not want to go in without the required three officers being present, as required by Garth's local security strategy. Strictly speaking, staff should have radioed a code blue when Mr Teague was not responding but we can understand why they chose not to do that given the early hour and the possibility that Mr Teague was asleep. In any event, once more staff were requested they went straight to Mr Teague's cell and radioed a code blue.

104. While it seems unlikely that the delay affected the outcome for Mr Teague, given a nurse said he was cold to the touch, the Governor will wish to consider whether there is any learning from this incident to ensure there is no delay to staff requesting assistance and going into cells in emergency situations.

Inquest

105. The Coroner's inquest held on 27 May 2025 determined the medical cause of death to be hanging. The jury returned a narrative conclusion, stating that Mr Teague hanged himself.

Prisons & Probation Ombudsman
Independent Investigations

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

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100