Investigation into the circumstances surrounding the death of a man at HMP Preston.

Report by the Prisons and Probation Ombudsman for England and Wales

May 2008

This is the report of an investigation into the circumstances of the death of a man at HMP Preston on 16 August 2006. The cause of his death was haemorrhage resulting from a cut throat. I would like to extend my condolences to his family, to his friend and to all those touched by his death.

The investigation was led by one of my investigators. An independent review of the man's medical care in prison was commissioned from Preston Primary Care Trust. The review was carried out on the PCT's behalf by a Nurse Manager and a Healthcare Manager, both from Cumbria PCT.

My investigator and I would like to thank the management and staff at HMP Preston for their assistance and co-operation during the course of this investigation.

It seems the man who died was naïve about prison life, and this marked him out as being different from other prisoners. Coupled with the knowledge that he had tobacco to service his heavy smoking, it seems this led to him being bullied. Nevertheless, he was not considered at serious risk of self harm or suicide and was not on any special observation regime. On several occasions during his sentence he had said that he had thoughts of self harm. But on all but one of these occasions this was dealt with outside the formal support and monitoring processes.

In the days before his death, the man was attending an Enhanced Thinking Skills course in which he fully engaged and appeared to be enjoying. However, latterly he did appear to a friend and a member of staff to have become more withdrawn.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2008**

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SUMMARY

The man who is the subject of this report was 44 years old when he died during the night of 15/16 August 2006 in his cell at HMP Preston. He had been remanded in custody in the early months of 2006 and was sentenced five months later to an extended sentence of four years and six months. This comprised a custodial term of 18 months and an extension period of three years. His parole date was in late 2006; if unsuccessful his prospective date of release was August 2007. This was the man's first time in custody.

The man who died used cannabis, smoked and drank heavily. During his induction at HMP Preston he was held on the Detoxification Unit where he completed the appropriate course and was regarded as alcohol and drug free.

A close friend of the man, wrote a letter to the Governor of Preston soon after his initial imprisonment in which he expressed concern for his mental state. This was followed a few days later by a telephone call again expressing concern. Staff saw the man, who told them that he was feeling down at the present time. The available support mechanisms were explained to him.

On 14 March, the man's solicitor contacted the doctor at Preston and expressed concern about his client's mental health. A psychiatric report was requested for the court. A Mental Health In-Reach Team (MHIT) document was opened and completed on 20 March. It indicated that an MHIT assessment was necessary.

During that assessment, the man said that he was going through hell and had been threatened by other prisoners. He also said that he had no intention of harming himself although he had cut his wrists in 1991. He added that this was not an attempt to end his life, but was in relation to an injury and an addiction to sleeping pills. On 22 March, the assessors found that no mental illness was evident but that the man was frustrated at the situation he found himself in. No follow up action was felt necessary.

On 9 May, a Consultant Forensic Psychiatrist examined the man and reported that he was not suffering from a mental disorder and did not require formal psychiatric treatment. However, he said that the man would benefit from formal work on his drug and alcohol misuse issues and from an Enhanced Thinking Skills (ETS) package.

On 8 June, the man was convicted at Crown Court and remanded back into custody for pre-sentence reports. A Registered General Nurse saw the man on his return from court and recorded that he felt well and that he did not feel like harming himself. On returning to B wing, the senior officer also spoke to him following receipt of a warning notice from Lancashire Probation saying that the man had spoken to his solicitor and had said he would attempt suicide if returned to prison. The man told the senior officer that he was not suicidal and had no intention of harming himself. The man's solicitor telephoned the Bail Information Officer at Preston on 9 June, and reported what had been said to him the previous day by the man. The Bail Officer made the Suicide Prevention Co-ordinator aware of the situation. He then spoke to

the man who was in reasonably good spirits and said he had no thoughts of self harm or suicide.

On 22 June, a healthcare staff nurse saw the man who was in an agitated state. The nurse recorded that the man was extremely wound up and talking about the problems he was having on the wing. She requested that the prison medical officer review the issues the following day. The man was seen, but was not specific about the problems he was encountering. A plan to move him from B wing with the agreement of wing managers and the doctor was noted. The note also said that, in view of the bullying problems, it was not appropriate to prescribe the man with in-possession medication for insomnia. No Tackling Anti-social Behaviour (TAB) document was opened.

On 11 July, the man requested sleeping pills and tranquillisers for stress caused by problems with his cell mate. They were refused.

The man claimed to have had suicidal thoughts, but a consultation note records that after direct questioning no symptoms of depression were evident. The man vehemently denied that he was being bullied on B wing. The doctor said that information indicated that in fact he was being bullied. The man conceded that it had taken place but said it was not for possession of his medication.

On 17 July, the man who died made an application for an Enhanced Thinking Skills (ETS) course. On the same morning, he told an officer that if his application for early release failed he would kill himself. An Assessment, Care in Custody and Teamwork (ACCT) document was opened (ACCT is the Prison Service process for assessing, monitoring and supporting prisoners at risk of suicide or self harm). A senior officer interviewed the man while completing an Immediate Action Plan. She noted that the man would stay in his present location and he would be observed at half hourly intervals. The support mechanisms were again explained to him.

An ETS tutor saw the man at lunch-time on 17 July. The officer thought that he should be subject to a Semi Structured Interview (SSI) within weeks rather than months.

At 4:20 pm on 17 July, the man was assessed by an officer who found that he was feeling isolated from his mother. He also felt low because he lacked money to support his heavy tobacco habit. During the interview, the man indicated that he did not want to die but just wished to be with his family and have enough money to cope. In answer to direct questions, the man said he had no plans to kill himself and claimed the remark he had made earlier that day about killing himself was “off the cuff” because he was feeling frustrated. At 4:50 pm on 17 July, the man met with a senior officer and the officer he had seen earlier for the first case review following the opening of his ACCT document. The outcome was that his risk of self harming was low and all parties agreed that the ACCT document should be closed.

On 25 July, the Suicide Prevention Co-ordinator met the man at an ACCT post-closure interview. The man was described as very upbeat and positive and said that he was not at risk of self harm or suicide. He was also very positive about the ETS course.

The tutors on the ETS course said that first impressions of the man who died were that he was a relaxed, laid-back man, quieter than the rest of the group but one who participated well. One tutor felt that the man was too open about himself given the environment he was in and was naïve about the prison environment.

On the evening of 13 August, the man argued with his cellmate and staff intervened. A compromise was reached and on the following morning he was moved. The officer moving the man was aware that he had been the subject of an open ACCT document some weeks before and which he had considered prior to moving him. The man's new cellmate, a former Listener (a fellow prisoner trained by Samaritans to assist other prisoners in distress), met him for the first time. He subsequently described the man as being naïve about prison life and a bit of a loner. However, he saw no indications that alerted him to the possibility that the man would take his own life and the man did not mention suicide at any time.

Another prisoner noticed that the man was getting lower in mood. On 15 August, the man was fine in the ETS group session but at the morning break he was uncommunicative. The final exercise of the ETS session that day was entitled "Asking for help" and the subject of getting help to prevent suicide was discussed in the group. One of the tutors subsequently said that the man was not "full of the joys" on that day but was not depressed. She saw no indicators that needed to be acted upon.

At 2.00pm on the afternoon of 15 August, the man's cellmate moved cells. He says that he said goodbye to the man and left him in the cell. The man was due to attend an Art class that afternoon, but the class attendance record shows that he did not arrive. After evening association on 15 August, the locking up officer counted the prisoners on the man's landing (A4). The officer noted that the man appeared to be on his own in a double cell and exchanged a few words. She remembers this interaction clearly because of the man's politeness and distinctive accent. There was nothing in his manner that was out of the ordinary.

The A wing night patrol on the night of 15/16 August, was given a handover briefing and he read the A wing Observation Book. Neither contained any mention of the man and the night patrol's attention was not drawn to his cell (cell A4-6) during the night. At around 5:45am on 16 August, he counted the prisoners on A wing and reported them correct. The night patrol remembers that the natural light in A4-6 was sufficient to see a head on the pillow without turning the cell light on. The observation flap on the door was unobstructed and the observation glass was clean.

At around 6:15am, a healthcare officer, a nurse, a prison officer and a healthcare support worker went to A4-6 to give the man his medication. The healthcare officer went into the cell and saw blood around the man's head. A blanket was pulled tight up to his chin exposing only his head. The healthcare officer and the nurse removed the blanket and saw a large wound to the left side of the man's neck. Both of them were of the opinion that the man had been dead for a while and therefore resuscitation was not attempted. At around 6:40am paramedics and the doctor confirmed and certified the death. Police arrived at around 6:45am.

Soon after 6:45am the duty chaplain was told that the man had an elderly mother living on the Lancashire coast, but that she had moved abroad to live with her family. There was some doubt as to the truth of this so the chaplain and a member of the Preston governor team went to her last known address. There was no answer which confirmed to them that the man's mother was indeed living abroad.

At 1:45pm, the chaplain contacted the man's brother and sister in law overseas and broke the sad news to them. During the telephone call, the man's sister in law asked that the man's friend be told of his death.

Because the man's family live overseas and with respect to the family wishes regarding his death, the Governor did not send a letter of condolence to them. HMP Preston was in contact with the family in the initial stages until they asked for the man's friend to be the liaison point between the family and the prison.

The man's mother returned to the UK to receive her son's ashes which she later took home.

I make seven recommendations and am pleased that they have all been accepted.

THE INVESTIGATION PROCESS.

1. My investigator first visited HMP Preston on 23 August 2006 and met the Governor. He was given a full briefing about the circumstances surrounding the man's death. Preston's Family Liaison Officer was nominated as Liaison Officer for the investigation. Offers to meet representatives of the Prison Officers' Association and the Independent Monitoring Board were accepted.

2. Notices to staff and prisoners were published inviting anyone who might have information relating to the man who died to make themselves known to the investigator. Five prisoners at Preston later spoke to the investigator and one was interviewed at HMP Garth. The investigator met with relevant prison staff including members of the Independent Monitoring Board (IMB), Chaplaincy, Probation Service, and the Safer Establishment Team.

3. Copies of the man's prison and medical records were made available to the investigator. On 22 August, Preston Primary Care Trust (PCT) was requested to commission a clinical review. This was carried out on their behalf by a Nurse Manager and a Healthcare Manager, both employees of Cumbria PCT. This report was received on 30 April 2007, following the clinical reviewers' receipt of the post mortem report on 19 March.

4. One of my family liaison officers and the investigator visited the man's friend who had been nominated by the family as their contact in the U.K. During the visit the man's friend raised a number of concerns about the circumstances under which the man had died and the way that Preston handled the family's loss.

5. The matters raised by the man's friend which are relevant to this investigation were:

   - The man's friend had written to the prison about the man asking them to arrange a psychiatric assessment. He had sent a copy of the letter to the man's solicitor. What action was taken by the prison on receipt of this letter?

   - Why was the man not transferred to a psychiatric hospital given his state of mind?

   - Were prison staff concerned about the man on the day of his death and, if so, what measures were taken to reduce the risk of him self-harming?

   - Was the man on a cell watch on the evening that he died?

   - Why was the man left alone in his cell on the day that he died?

   - What was the reason that his cellmate was moved?

   - Given his frame of mind, should the man have been allowed to have a safety razor?

- What medication was the man prescribed, and what evidence is there to show that he was taking it in the correct dose at the correct time?

- Among the man's prison papers, is there a report of another prisoner attacking him and resulting in an eye injury?

- If the man reported this to staff, what was done about the incident?

- Did the Post Mortem show any evidence of cannabis or other drug in the man's body at the time of his death?

- Was it, as the chaplain said, that the man's cellmate fell ill and was taken to hospital in an ambulance?

6. The man's friend also raised concerns about access and facilities for visitors to prisoners at Preston. Whilst these are not directly relevant to the investigation, the Governor may wish to consider these questions separately:

   - What are the arrangements in place for elderly and disabled access to the social visits area?

   - Is there any disabled parking near to the prison gate?

   - Can the staffing for booking social visits be increased so that the phone is answered in a reasonable amount of time?

   - Could more flexible visiting arrangements be made for social visits at the prison?

   - Can the amount of locker space for social visitors be increased?

7. The man's friend also raised concerns about the manner in which the prison handled the funeral arrangements and his visit to Preston following the man's death:

   - Why did the prison not send a card or flowers to the man's funeral?

   - What can be done about the way that the Governor handled his meeting with the man's friend? The man's friend alleges that he was kept waiting from 11.00 to 12.55. He says that, when he finally saw him, the Governor said that he could not answer any questions raised as there was a Prisons and Probation Ombudsman investigation. The man's friend says he was seen for just 15 minutes.

HMP PRESTON

8. Preston is a category B local prison with an operational capacity of 690. It takes remand and convicted adult male prisoners from the Crown and Magistrates' Courts serving Lancashire and Cumbria. Healthcare at Preston has been provided by the Preston Primary Care Trust since April 2004.

9. Preston's last announced inspection by HM Chief Inspector of Prisons, Ms Anne Owers, was in July 2004. Preston was recognised as an overcrowded prison within a restrictive Victorian infrastructure. However, the Chief Inspector found that Preston provided a generally safe and decent environment based mainly on good relationships between staff and prisoners. Ms Owers' report did note that the anti-bullying strategy was under-developed, something that the Violence Reduction Strategy in conjunction with the Tackling Anti-Social Behaviour (TAB) Strategy attempts to address. The inspection report also recommended improvements in the safer custody approach to the management of prisoners' safety.

10. Preston runs an Enhanced Thinking Skills course that was praised by Ms Owers and her team. There is also a Safer Establishment Committee which has ownership of the Assessment, Care in Custody and Teamwork (ACCT) Implementation Protocol. The purpose is to provide guidance to staff in the use of the ACCT approach to the care of prisoners identified as being at increased risk of suicide or self harm. Strategies relating to the Care for the Suicidal (dated 31 August 2005) and Violence Reduction (dated 31 July 2006) are in place.

KEY EVENTS

Events Leading up to the night of 15 August

11. On 16 February 2006, the man who is the subject of this report was remanded in custody at HMP Preston by the Magistrates' Court. He had been charged with wounding with intent to cause grievous bodily harm.

12. On reception, the man was subject to a health screening which recorded that he had an injury to his face consisting of a bruised and swollen right jaw. A note records that the man told the reception healthcare worker that he had been assaulted on 10 February, and was treated in hospital for his injuries. The man said that he was well and that he drank alcohol socially and used cannabis. No special restrictions were noted on the health screen form. A note indicates that a medical/psychiatric report was required by the court and that this was the man's first time in prison. The man also told the healthcare worker that he had never received treatment from a psychiatrist or taken medication for mental health problems. He said that he had never tried to harm himself and did not feel that he wanted to do so at that time. He was deemed fit for normal location, work and any cell occupancy. Because of his injuries, the man was referred on to see the doctor.

13. The record of prescribed medication shows that the man was given a prescription for 500 mg of paracetamol, four times daily for seven days. (This medication was not given in-possession and the prescribing record shows that he received it twice on 17 February (his second day in custody). The man was also prescribed 400mg tablets of ibuprofen three times daily for seven days and 250mg of flucloxacillin, an antibiotic, four times daily for five days. These medications were given to him in-possession, in line with local prescribing practice.

14. A cell sharing risk assessment was completed and Section 2 indicates that there was reason to believe that a previous self harming document might exist. The investigator found no trace of this document (not surprisingly since it was the man's first time in custody). There were no other indications that the man was considered anything other than at low risk of self harming, and as suitable for multi-occupancy cell accommodation. He was allocated a cell on D wing

15. A Late Arrivals Immediate Needs Assessment was opened later in which it was recorded that the man said that he was not concerned about being in custody but that he had committed an act of self harm in 1990 (no details were recorded). The next entry noted that the man replied that he felt he was at risk of self harm, but the answers to the two subsequent questions about how likely that event was and whether he was suffering from withdrawal have not been recorded. The following question showed that the man said he had used cannabis three days earlier. His disposition during interview was recorded as cheerful and polite. Later, in the Follow Up Assessment section of the Custody and Care Plan Assessment document, the question about self harming is repeated. The man's recorded response was that he did not feel

at risk of self harm. This section does not record when this interview took place or who conducted it. No action appears to have been taken on initial reception after he said that he was at risk of self harming.

16. On 17 February, the man went through the Preston induction process, including anti-bullying and Counselling, Assessment, Referral, Advice, Throughcare (CARAT) sessions in respect of drug use. He was interviewed by the Bail Information Officer, and also attended a Well Man Assessment screening.

17. During the Well Man assessment, the man indicated that he suffered from asthma and was on flixotide to treat it along with two other medications the names of which were not recorded. He also said that he smoked cigarettes and used alcohol heavily. There was no current history of substance abuse recorded, but it was noted that heroin and cocaine had been used in the past. (The clinical reviewer has noted that no baseline observations were recorded during this assessment).

18. A long time friend of the man who died, wrote a letter to the Governor of Preston on Friday 17 February in which he expressed concern for the man's mental state and urged that he be kept "on a suicide watch" until assessed by a psychiatrist. He also wrote that the man was subject to eccentric behaviour which was not understood by others. He added that he would be attempting to obtain bail for the man during the following week and requested a visit be arranged for him.

19. On Monday 20 February, a note on the man's wing history sheet indicates that the wing senior officer (SO) received a telephone call from the man's friend expressing concern that the man had been behaving in an uncharacteristic manner when he had seen him on 16 February. Following these contacts, the man was seen by an acting senior officer. The man told him that he had suffered from depression in the past and was feeling a little down at present. The Listeners Scheme was explained to him and he said that he was aware of the scheme and had already made contact with them. (Listeners are prisoners trained by the Samaritans).

20. During 20 February, the man was moved from D wing to B wing where the wing SO, who is also the suicide prevention co-ordinator, interviewed him. The SO recorded that, after an in depth interview, he was of the opinion that the man was not at risk of self harming and that he was aware that staff, Listeners and Samaritans were available to help him if required. During an interview with the investigator, the SO described the man as being "OK" and that he seemed a genuinely nice man. He said that the man was generous and would befriend other prisoners and give them some of his tobacco if they had none. He recalled that the man's cell was "burgled" several times, during which he lost his tobacco. The man who died was known to have problems with his cellmates if they did not keep themselves clean.

21. During his initial period on remand, the man was on the Detoxification Unit where he completed the course and was regarded as drug and alcohol free. He gave negative test results for alcohol and illegal substances.

22. On 21 February, a member of the Probation Department wrote a short report indicating that the letter sent by the man's friend had been received on 20 February and its contents brought to the attention of wing staff the suicide prevention co-ordinator and the Probation Department. Copies of the letter were provided to all relevant parties. A note was made by a member of the Probation Department indicating that the suicide prevention co-ordinator's interview with the man had taken place, his concerns were being addressed and notes had been made in the wing file and observation book. She also noted that a telephone call was made to the man's friend confirming that his letter had been received, that his concerns had been raised directly with the man, and that at that stage there was no cause for concern. The man's friend in turn had said that he would be supporting the man as much as was possible.

23. The suicide prevention co-ordinator also noted on 21 February that he had allowed the man a telephone call to his friend and that the man was very happy after the call had finished.

24. On 24 February, the man who died saw a doctor at Preston complaining of the pain caused by the facial injuries. He was again prescribed paracetamol for 14 days (not in-possession) and 400mg ibuprofen three times daily for 28 days (in-possession). An appointment was also made for the man at the Ear Nose and Throat (ENT) Department.. The man had been expected there for an appointment on the day prior to his initial imprisonment but the appointment was not kept. It was therefore re-arranged for 9:45 am on 9 March 2006. The man also made an application to see the bail information officer. On 27 February, after receiving the man's application, the bail information officer explained the bail procedures and issued a special letter for his solicitor.

25. On 1 March, the man completed an Oral Health Assessment and wrote on the assessment that he was receiving several paracetamol daily for painful teeth. He said that he had a broken cheek and that he wanted to see a dentist. The man also made a request to see the bail information officer who explained that the bail application was in process.

26. On 3 March, the man returned to Magistrates' Court where he was convicted of two minor drug offences and an assault on police. He was given 12 month conditional discharges for all three of the offences. He returned to Preston on remand to await his appearance on the grievous bodily harm charge.

27. On 5 March, the man's friend and his wife visited the man at Preston. The following day, the man attended a Labour Board. He made a request to attend education and was placed on English and Creative Writing classes.

28. The man reported sick on 8 March when he said that he was in a lot of pain. The man was prescribed co-codamol four times daily as necessary for 14 days, and the night dose was issued in-possession. A nightly dose of zopiclone (7.5mg) was also prescribed in-possession to help him sleep. Neither zopiclone nor the in-possession element of the co-codamol prescription was written up in the in-possession section of the Prescription and Administration Chart. A note on the continuous clinical record added that the man was hoping for bail the following week.

29. On 9 March, the man was taken to the ENT Clinic where he was seen by doctors. He was discharged after being told that he would need a small operation to re-align his nose. The appointment would be made for the week commencing 13 March to see a Consultant at the local Preston hospital. The appointment was made for 17 March, but the man cancelled it because his mother was arriving from overseas to see him.

30. During the early evening of 12 March, the man made a request for a cell move because he was not getting on with his cellmate. The officer receiving the request refused, and told him to see his landing staff the following day.

31. On 13 March, the man's friend visited him. An intelligence report was received by security staff stating that the man was being driven to distraction by his cellmate and that, if it continued, a serious assault might result.

32. On 14 March, following a court appearance, the man's solicitor contacted the medical officer at Preston expressing concern that the man had said that he had committed his offences because God had told him to do so. A psychiatric report was requested for the court. A clinical note was made to discuss the case with the Lancashire Care NHS Trust Mental Health In-Reach Team (MHIT) and included the possibility that the man had had substance abuse problems previously. The MHIT needed to be aware of addiction possibilities with prescribed painkillers.

33. A Mental Health In-Reach Team Document was opened that day, and the section titled Pathway 1 was completed by 20 March. The Signposted Outcome indicated that a mental health assessment was necessary. Pathway 3 was then followed. During the assessment, the man stated that he was not guilty of the offences he was charged with. The man said he was going "through hell" and that he had been threatened by other prisoners. He also said that he had no intention of harming himself, although he had cut his wrists in 1991. He said that this was not an attempt to end his life, but was in relation to an injury and an addiction to sleeping pills. By 22 March, a conclusion by the assessors, both Senior Mental Health Nurses, indicated that no mental illness was evident, but that the man was frustrated at the situation he found himself in. The assessors noted that the man repeatedly requested sleeping pills during the assessment. They recorded that no follow up action was necessary.

34. On 20 March, the man was prescribed propranolol (a beta blocker to help him calm down) to be taken twice daily for 14 days. On 22 March, he was

prescribed co-codamol (also for 14 days). Both of these drugs were re-prescribed on 3 May and periodically until his death in August.

35. On 23 March, 31 March and 6 April the man received visits from his mother and friends.

36. On 11 April, the man was still complaining of pain from his facial injuries. He requested that the appointment he had cancelled be re-arranged. He was prescribed a 14 day course of Tramadol four times daily for the pain and five days of Zopiclone at night to help him sleep. The next day, Preston staff contacted the hospital about an ENT appointment and were told that a further referral must be made. The prison medical officer subsequently wrote to the surgeons at the hospital requesting that the man be seen regarding his injuries.

37. A note made by the prison medical officer on the continuous clinical record dated 19 April indicates that the man was again prescribed zopiclone for a further three days, but that no more of the drug would be given. However, he was in fact re-prescribed the drug by the same doctor for a three day period on 9 June. He was also prescribed diclofenac, an anti-inflammatory, to be taken three times daily for 28 days. On 24 April, the man was re-prescribed Tramadol for 14 days, followed on 8 May by a further 28 day prescription for the drug.

38. On 27 April, a reply was received from a consultant ENT surgeon, indicating that a routine appointment would be sent for the man to be seen for re-evaluation at the Maxillo-facial Department. On 2 May, the prison medical officer again wrote to the Maxillo-facial Department requesting an appointment for the man.

39. On 9 May, a Consultant Forensic Psychiatrist examined the man and met with the prison's visiting psychiatrist to discuss his situation. The Consultant Forensic Psychiatrist concluded in a report dated 8 June that the man was not suffering from a mental disorder at the time of interview and did not require formal psychiatric treatment. However, he would benefit from formal work on his drug and alcohol misuse problems, and from an Enhanced Thinking Skills (ETS) package either within or outside the prison setting. The man told the Consultant Forensic Psychiatrist during the interview that he had had a difficult time when first imprisoned, but recently had become more skilled at looking after his possessions and denying other prisoners attempts to obtain tobacco from him. No mention was made in the report of a risk of self harm.

40. On 11 May, the man reported to healthcare staff that he was experiencing increased headaches. He was advised to report 'special sick', a procedure whereby a prisoner can gain medical attention for ailments that require attention during the day or night without a scheduled medical appointment, when necessary to get paracetamol (which he did until 16 May), and to drink plenty of fluids.

41. On 12 May, a management quality record check took place and comment was made by the suicide prevention co-ordinator that no entries had been made for two months on the man's history record.

42. On 16 May, the man reported to healthcare staff that he was in increasing pain and was unable to sleep because of it. He was prescribed amitriptyline (an antidepressant) and propranolol.

43. On 19 May, the man reported a pain in his groin and was diagnosed as having left epididymo-orchitis. He was admitted under bedwatch escort to the local Preston hospital, where he remained for four days returning to prison on 24 May. He remained on antibiotics for a further 21 days. A letter dated 5 June from the Urology Department indicated that no routine follow up appointment was required.

44. On 25 May, the man who died made an application to see the bail information officer regarding an assessment for a place in a hostel. He was assessed on 31 May by the bail information officer.

45. A note by the prison medical officer dated 2 June, in the continuous medical record said that the man was repeatedly begging for DF's (codeine-based pain killers) and that co-codamol had been prescribed for seven days. On 6 June, a registered nurse noted that the man was found to be secreting the co-codamol at the mid-day treatments. The man complained that the analgesia was not effective. The nurse explained that the pain would not be controlled if the treatment was not taken at the appropriate times, and that secreting medication was not acceptable. The nurse also recorded that a note would be put on the prescription chart. (No note to this effect is evident on the appropriate chart).

46. On 8 June, the man who died entered a guilty plea and was convicted at Preston Crown Court. He was remanded for pre-sentence reports until 7 July. In a report prepared by the bail information officer, dated 8 June, the man was deemed suitable for a place in an Approved Premises (probation/bail hostel), but no beds were available at that time and he was therefore returned to HMP Preston. In the same report, the bail information officer identified that the man was on an open Assessment, Care in Custody and Teamwork (ACCT) document. His later interview notes, dated 26 September, said that he "believed" that the man was on an open ACCT. (There is no record of the man being on such a document). The bail information officer also noted that the man was not regarded as being vulnerable to abuse or bullying.

47. The registered nurse spoke to the man on his return from court when he said that during the previous morning he had been stressed, but that following his court appearance he felt well and did not feel like harming himself. A note by the nurse said that no ACCT document was opened at this time. On the evening of his return to B wing, the wing SO spoke to the man at length. This was as a result of a warning notice sent by Lancashire Probation staff at court informing the prison that the man had spoken to his solicitor and had said that

if he returned to prison he would attempt to commit suicide. The man told the wing SO that he was not suicidal and had no intention of harming himself.

48. The man's solicitor telephoned the bail information officer on 9 June regarding the pre-sentence reports. During the conversation, the solicitor reported what the man had said to him the previous day. The bail information officer then said he would ensure that the Suicide Prevention Co-ordinator, was made aware of the situation and that the wing made an entry into their observation book. The bail information officer then spoke to the man at length. Although he was concerned about having no tobacco, the man said he was in reasonably good spirits and had no thoughts of self harm or suicide.

49. The man saw the prison medical officer on 9 June and told him that he had secreted his medication to enable him to sleep at night. He also told the doctor that he would probably get a community sentence when he went back to court. The prison medical officer advised the man that he should not need strong pain killers at this stage and prescribed paracetamol, zopiclone, amitriptyline, propranolol and ofloxacin (an antibiotic).

50. On 11 June, the man's personal officer noted in the man's history record that he had introduced himself, explained the Incentives and Earned Privileges (IEP) Scheme, and learned from the man that he was smoking a huge amount of tobacco (which the personal officer attributed to being a coping mechanism).

51. On 22 June, the duty nurse noted in the continuous clinical record that she had called in during the late evening to see the man regarding his agitated state and sleep deprivation. The nurse recorded that he was extremely wound up and constantly talked about the problems he was having on the wing. She advised the man to report the problems to the wing staff and to put in an application to see the doctor regarding his sleeping problems. The nurse noted that day staff would be informed and a request made for the prison medical officer to review the issues the following day.

52. On 23 June, the man was seen at 9:00am about the problems on the wing. He was not specific about the difficulties he was encountering, save to say that there had always been problems. A plan was recorded to refer the man to the doctor and, with the agreement of the wing SO, he would be moved from B wing.

53. An appointment to see the prison medical officer was offered to the man later on 23 June, but he did not attend. A note by the doctor indicates that the man had expressed a wish to officers to stay on B wing. The note also contained a suggestion that, in view of the bullying issues, prescribing medication for insomnia in-possession was not appropriate. If the medication was required, it should be taken in front of a nurse during the evening. According to the Prescription and Administration Record Chart, no medication was issued. A note on the history sheet identified that a prison officer had sorted out a move for the man from B to D wing, but that he had declined the move. The entry went on to say: "Therefore if he says he is being bullied tell him that the

problem is his and not wing staff unless he engages with staff." No Tackling Anti-social Behaviour (TAB) document was opened at this time.

54. At 7.00pm on 4 July, the man made his last telephone call. This was to his friend's son. A note in his record said that the conversation was positive and the man had spoken about the possibility of getting out of prison in three days time.

55. A pre-sentence report, written by a Probation Officer was completed on 5 July. The report said there were no previous or current indicators of self harm, but that if the man were imprisoned his mental health might need to be monitored.

56. On 7 July 2006, the man was sentenced at Crown Court.

57. On 8 July, the man was seen by the allocation staff at HMP Preston who categorised him as a category C prisoner and allocated him to HMP Haverigg.

58. On 11 July, the man reported sick, complaining of pain in his left arm. The prison medical officer prescribed him diclofenac and noted that the man wanted stronger pills. He also requested sleeping pills and tranquillisers to deal with the stress caused by problems with his cellmate. These were refused. The note recorded that the man had claimed to have had suicidal thoughts, but the consultation note went on to say that, after direct questioning, he showed no symptoms of depression and was happy that he only had four months of his sentence left to serve. He also seemed happy when the doctor offered to make a telephone call to expedite his transfer to Haverigg. The note recorded that the man vehemently denied that he was being bullied on B wing. When the doctor said that information from several sources indicated that in fact he was being bullied, the man admitted that bullying had taken place but said it was not for his medication.

59. On 12 July, the man started Art classes. On 17 July, he made an application to the Education Department to be considered for an Enhanced Thinking Skills course. At 11.15am on the same morning, the man told a prison officer that if his parole application failed he would kill himself. The prison officer opened an ACCT document. At 11.30am, an Acting SO interviewed the man and completed the Immediate Action Plan. She noted that the man would stay in his present location, having said he was happy with his cellmate, and that he should be observed at half hourly intervals. She also explained the use of the Samaritans' telephone and highlighted the Listeners scheme to him.

60. In an interview with the investigator a Programmes Group officer working on G wing and an ETS tutor, said he went to the man's cell during the lunch break to introduce himself and to talk about his application for the ETS course. During their conversation the programmes group officer asked why the man wanted to take this particular course. He replied that he needed to be doing something and that he was concerned about his mother whom he felt he had let down. The programmes group officer believes that the man

was uncomfortable in the wing environment. He told my investigator that the man's demeanour made him think that he should be interviewed sooner rather than later. His view was that the man should be seen for the semi-structured interview within weeks rather than months. The programmes group officer said that the time between first contact by application and joining the ETS course can vary widely, but on this occasion the time was quite short at less than two weeks.

61. At 4.20pm on 17 July, the man was assessed at interview and the assessing officer found that the man was feeling isolated because his mother was now overseas and would not return until August. He also felt low because he lacked money to support his heavy tobacco habit. The man told the assessing officer that he had self harmed years previously because of a relationship, but had not done so recently. During the interview, the man said that he did not want to die but just to be with his family and have enough money to cope. In answer to direct questions, the man said he had made no plans to kill himself saying that he made the earlier remark about killing himself "off the cuff". The man said that he might be starting on an ETS course and that he would like to take part in an IT or Arts course.

62. At 4.50pm, the man met with the Acting SO and the assessing officer in B wing office for the first case review following the opening of the ACCT document. The outcome of the review was that his risk of self harming was low and, in that light, all parties agreed that the ACCT document should be closed. During the interview, the man was told that the Education Department had been contacted about his attending more classes. The man was told that he would be assessed for an ETS course on Wednesday 19 July. The man also re-iterated that he was not at risk of self harm. On the morning of 18 July, an ACCT quality check was performed and an appropriate entry made on the ACCT document.

63. Intelligence information was received on 17 July that the man had written a letter to a friend requesting that money be sent to another prisoner's relative in order for money to be sent to the other prisoner to buy tobacco for the man. In the same letter he stated that he was in debt.

64. On 19 July, the man left the Art class early to attend an ETS assessment. (An assessment is undertaken to establish the suitability of candidates prior to the start of the ETS course). ETS documentation shows that he was subject to the semi-structured interview during which he was described as very motivated to attend the course and very engaged in the interview. The man was placed on the waiting list for an ETS course.

65. On 25 July, the man attended hospital for an appointment at the Maxillo-facial Clinic. The man returned with a prescription for co-codamol and diclofenac. The prison medical officer recorded in the continuous clinical record that he did not allow the co-codamol because of the man's previous addiction and the bullying he was suffering, but that diclofenac could be given if he was in pain.

66. The suicide prevention co-ordinator also met the man on the same day at an ACCT post-closure interview. The man was described as very upbeat. He said that he was not at risk of self harm or suicide, and was very positive about the ETS course. (An ETS tutor subsequently told my investigator that prisoners with open ACCT documents are not accepted on the ETS courses because of the added pressure of the sessions and because the content may cause additional problems for an already vulnerable person).

67. On 26 July, the man was informed by a letter dated that day of a placement on ETS course 28 starting 31 July. On 29 July, he was moved from cell B3-26 to cell A4-10. This surprised the B wing senior officer (the suicide prevention co-ordinator) who assumed that the move was because the man was now convicted.

68. The man joined the ETS course on Monday 31 July in what is known as the pre-course session. There were ten other prisoners on the course. The lead tutors were a female probation services officer and a male prison officer. At interview the female lead tutor said her first impressions of the man were that he was a relaxed, laid back kind of man. He was quieter than the rest of the group, one or two of whom, she said, were quite vocal. She remembered that the man had had some stresses that morning and believed that they concerned his cellmate. Both ETS lead tutors commented that the man participated well in the group. The male lead tutor added that he felt that the man was sometimes too open about himself given the environment he was in, and that he was very naïve about the prison environment.

69. At the ETS that day, the man who died met a fellow prisoner whom he had seen occasionally during the earlier part of July. The fellow ETS course member told my investigator that, because of his body language and defensive nervous manner, the man was vulnerable. The fellow ETS course member recognised in the man the way he was himself when he first came into prison. He added that the man was not comfortable in the prison environment and that he was struggling in the main prison.

70. The man who died missed the second session of the ETS course on 1 August because of a medical appointment. The continuous clinical record shows that he reported sick. The man said he was depressed, anxious and had a poor sleep pattern. An entry by the prison medical officer noted that the man was "now on A wing and that he was not being bullied, but his mood seems to be sinking and adds that he is exhausted from lack of sleep. Impression - looks depressed." The man was prescribed a 28 day course of paracetamol, propranolol and mirtazapine (an anti-depressant). A final note indicated that the man would be seen in two to three weeks. The In-Possession Prescription chart shows on 2 August that the prison medical officer also re-prescribed diclofenac for a further 28 days.

71. A letter from a doctor at the Department of Oral and Maxillo-facial Surgery at the outside hospital, dated 25 July and received at Preston on 1 August, indicated that a CT scan was to be arranged and that a review of the man's case would take place when the scan results were received. No indication of

when that appointment was scheduled is evident in the continuous clinical record.

72. At interview, the fellow ETS course member said that the man told him that he was being bullied and intimidated on A wing, he was not told the names of the people doing the bullying. The fellow ETS course member said that the bullying consisted mainly of verbal insults, threats and insinuations that the man was a sex offender. The man did not mention to him that he was being physically abused and the fellow ETS course member had no knowledge of any previous injury being inflicted. The man did say that he had reported the bullying to staff. There are no notes or other indicators that this was the case or that the man said anything about feeling suicidal.

73. Midway through the first week of the ETS course, the fellow ETS course member said that he went to a G wing officer, explained the man's circumstances and asked if it was possible for him to be moved from A wing to G wing. The G wing officer had no objection and made a telephone call to staff at the Observation, Classification and Allocation Unit (OCA) Labour Board. They indicated that the man should put in an application to the Labour Board for the move. The fellow ETS course member said that, as far as he was aware, the ball was now rolling.

74. The G wing officer remembered the fellow ETS course member approaching him, although not the date of that approach, with a view to getting the man re-located from A wing to G wing. He remembers making a telephone call to the Labour Control office and asking if the man fitted the G wing criteria. He told my investigator this was the only time he spoke about a possible move for the man to G wing.

75. The criteria for prisoners being located on G wing are strict and include that their records should not contain convictions for offences of arson, violence and other offences of a very serious nature. The G wing officer said that prisoners on G wing are borderline category D prisoners, who would in the normal course of events move to open prisons. The man did not fit those criteria, and it is not clear if he knew of the fellow ETS course member's approach or if he was told that this was the case.

76. According to an entry on the A wing Observation Book, at 9.05pm on 13 August a disturbance took place in cell A4-10 between the man and his cellmate. The entry noted that the two men were arguing and nearly coming to blows. It went on to say that a compromise was reached, but that they needed talking to the following morning.

77. An A wing early duty prison officer was on duty on the morning of 14 August. The early duty officer told my investigator that, when coming on duty, he checked the wing Observation Book as usual and noted that an altercation had been reported on the previous evening in A4-10. Subsequently, both the man and his cellmate spoke to the early duty officer about the dispute. It had revolved around the man's wish to go to bed early at around 8:00pm and his cellmate's wish to watch television until late in the evening.

78. The early duty officer satisfied himself that one or other of the two men should move cells. He told my investigator he was aware that the man had been subject to an ACCT document, which had been opened and closed some weeks before, and which he said he also considered prior to moving him. He added that he did not want the man to become depressed again simply because he was not getting on with his cellmate. He also said that he thought that neither of the men had much in common so a move would be beneficial to both parties.

79. Some days earlier, another man located in A4-6 had asked to move from that cell into A4-10. The early duty officer allowed the exchange to take place and the man made the move from A4-10 into A4-6. Both parties were happy with the outcome. Later that day the A wing SO spoke to the man about the move and was told that the problem was now resolved. The man appeared happy with the arrangement.

80. On 14 August, hospital escort risk assessment and prison escort record documentation were completed indicating that the man was to attend a medical appointment at outside hospital on 16 August. The documentation recorded that the man was a suicide/self harm risk. The attached Prisoner Security Information stated "ACCT open and closed 17/7/06". The section on further information about risk recorded that intelligence was available that the man had sent out mail requesting money be sent to another prisoner because he was in debt.

81. A prisoner was already located in cell A4-6 when the man arrived. At interview, he said that he met the man who died for the first time at around 9.30am on 14 August. The new cellmate said that during a previous sentence at HMP Garth he had been a trained Listener. (At the time of the man's death, he was not an active Listener.)

82. The new cellmate said that he and the man who died had a number of conversations during which the man spoke about the reason he was in prison and that he would be going out on parole towards the end of 2006. The man also said that he had been allocated for transfer to HMP Haverigg, a move that he was apprehensive about. He talked about his mother who was overseas and whom he felt he had let down. They also talked about the man's ETS course.

83. The new cellmate said that the man was a heavy smoker. It was well known amongst the other prisoners that he always had tobacco and people often tried to borrow it from him. The new cellmate added that he had declined an offer made by the man to have some of his tobacco. The new cellmate said that on the morning of 15 August the man was paid at the prison canteen and had about five packs of tobacco.

84. The new cellmate also described the man as being naïve about prison life. He said that, although the man seemed a bit of a loner, he saw no indications that pointed to a possibility he would take his own life. The man did not

mention suicide at any time. The new cellmate said that, had he seen anything to alert him, he would have informed staff immediately.

85. The female lead ETS course tutor told my investigator that in later sessions the man confirmed her first impression: he was a laid back kind of man.

86. In contrast, the man's fellow ETS course member said that he noticed the man was daily getting a little lower in mood. He said that on 15 August, the day prior to his death, the man was fine in the group sessions but at the morning break time just sat in the toilet smoking and not saying anything. The fellow ETS course member said that he tried to get the man to talk but could not. The second and final session on 15 August was entitled "Asking for help" and the subject of getting help in when contemplating suicide was discussed in the group. The female lead ETS course tutor told my investigator that the man was not full of the joys but was not depressed as far as she was aware. She saw no indicators that needed to be acted upon. When the morning session finished, the man returned to A wing. That was the last time the fellow ETS course member saw him.

87. On the afternoon of 15 August the man's new cellmate was offered a job as a cleaner. He accepted and was required to move cells to one on A2 landing. At 2.00pm, he moved out of A4-6. He told my investigator that at this time the man was still in possession of all his tobacco.

88. On 15 August, the early duty officer returned to duty at lunchtime for a late shift on A wing. He noted nothing out of the ordinary. The man was due to attend an Art class that afternoon, but the class attendance record shows that he did not attend. The reason for this is not known.

89. At about 6.15pm a female late duty officer started working as a patrol officer on A4 landing along with the early duty officer. They opened each occupied cell for the removal of meal trays from the cells and to allow out those prisoners going to the gymnasium. (The doors are relocked once the trays are out and the prisoners attending the gym have left). The female patrol officer does not recall the man going to the gym on that evening.

90. At 6.30pm, both the patrol officers unlocked the cells for the prisoners remaining on the landing to begin their evening association period. This allows free access to all landings for prisoners. The female patrol officer told my investigator that this particular evening was quiet and the man did not come to her attention.

91. The male patrol officer said he spoke to the man's previous cellmate, in A4-10, during the evening who was suffering from a swollen leg. He remembers telling him to monitor the leg because of the possibility of deep vein thrombosis. Later that night, he was taken to outside hospital.

92. At about 7.50pm, the prisoners began to return to their cells after the association period. The female patrol officer began locking up prisoners in cells A4-1 to A4-14 and the male patrol officer locked up the other side. On

completion of the lock up and at around 8.00pm, they began to count the numbers of prisoners held on A4. The female patrol officer remained on A4-1 side of the landing and began her count from that cell.

93. On arrival at A4-6 (the man's cell), the female patrol officer noted that he appeared to be on his own in a double cell. She said to him, "Are you on your own?" and he replied, "Yes mam." She remembers this interaction clearly because of the man's politeness and distinctive accent. She told my investigator that during this brief encounter there was nothing in the man's manner or behaviour that was out of the ordinary. She completed the count of her side of the landing. The female patrol officer said that she and the other evening duty staff went off duty between 8:15 pm and 8:30 pm.

94. An Officer Support Grade (OSG) was on night patrol duty on the night of 15/16 August 2006. The OSG night patrol explained that the normal night patrol routine starts at 8:00 pm. He was given a handover briefing by the wing evening duty staff and read the A wing Observation Book. Neither contained any mention of the man who later died. He then counted the prisoners in his charge, reported the roll as correct at the prison Centre Office and returned to A wing.

95. At 10.00pm, the OSG night patrol started the 15 minute pegging on the three landings he was responsible for on A wing. (The pegging points are located at either end of the landings which ensures that each landing is visited at 45 minute intervals throughout the night). In interview, he said that night patrols are permitted to miss two pegs during the night for meal breaks, but it is not usual for him to do so unless circumstances occur that make it necessary. He added that 15 minute pegging ceases at 6:00 am and half hourly pegging takes place between then and 7:00 am when he goes off duty.

96. The OSG night patrol said that special watches on A wing - whether on men with open ACCT documents or men designated as escape risks - are conducted as required by the ACCT document or hourly for escape risk prisoners. He cannot remember if there were any special watches on the night of 15/16 August 2006.

97. The OSG night patrol recalls that the man's former cellmate was sent out to hospital from A4-10 during the night. The staff dealing with that transfer were the OSG night patrol, the Night Orderly Officer, the night duty Healthcare Officer (HCO) and the night duty Nurse.

16 August

98. The OSG night patrol told my investigator that between 5:45 am and 6:00 am on 16 August he counted the prisoners in his charge on A wing. He signed for the correct count and handed his patrol paperwork to the Orderly Officer. The OSG night patrol said that during the early morning count his memory was that the observation flap on the door of A4-6 was unobstructed and the observation glass was clean. He said that the natural light in the cell was

sufficient to see and identify a person in the bed and that everything looked normal. He said that he did not turn the cell light on.

99. The OSG night patrol said that, at around 6:15am, the night duty HCO and the D wing night patrol officer came on to A wing to give out the morning medication and went direct to A4. The night duty HCO explained at interview that part of his job is to administer medication early in the morning to those prisoners attending court or leaving the prison for other reasons.

100. The night duty HCO said that, on the morning of 16 August, the man had an appointment at an outside hospital. He said that, at around 6:00 am, he and the night duty nurse and Healthcare Support Worker (HCSW), who was observing the night duty routine as part of her induction programme, went to A wing to administer medication to the man in his cell. It is the normal security routine whilst the prison is on patrol status to have at least two prison officer grade staff present when a cell door is opened. To adhere to this rule the night duty HCO asked the D wing night patrol officer to accompany him to assist in the unlock.

101. The D wing night patrol officer said that he checked through the observation hatch before opening the cell door. He could see one occupant in the cell who was on the bed covered with a blanket pulled up to his chin. The night duty HCO then opened the door and they both went in. Immediately they saw blood on the pillow, on the bed and on the floor. The night duty HCO called the nurse, who later noted in the Continuous Clinical Record that the time was 6:25 am. She went in and saw the man lying on the bottom bunk which was on the right hand side of the cell. His head was towards the rear of the cell and his feet towards the door. They all remember that the man was on his back, with his head slightly tilted to the right. The man's arms and hands were under the blanket, which was tucked tightly around him and up to his chin. The night duty HCO went to the bed and pulled the blanket back from the man and saw that his throat was cut. The D wing night patrol officer said that he could not see the wound clearly because there was a lot of clotted blood about the man's neck. The night duty nurse has estimated that the wound was about four inches in length. She added that the man's body was stiff and that there was cyanosis (a blue colour to the skin) to the ears and lips. The night duty HCO tried to find a pulse and other vital signs, but found none. The man was very cold and stiff. The night duty nurse said that she spoke to the night duty HCO about attempting resuscitation. However, given that the man was unresponsive, the large blood loss and the presence of rigor mortis in his body, they both believed him to be dead. No cardio pulmonary resuscitation (CPR) was attempted. The night duty HCO said that, following the realisation that CPR would have no effect, he had a quick look around the cell for a suicide note but found none. They all then left the cell. The D wing night patrol officer went to the end of the landing to make a radio call for help, which arrived very quickly. The Emergency Incident Control Room Log indicates that the radio message to the Orderly Officer (radio call sign Oscar1) took place at 6:28am.

102. The night duty HCO said at interview that, when he pulled the blanket away, there was a piece of razor blade lying on the mattress by the man's right hand. The night duty nurse also recalls seeing a small razor blade on the mattress outside of the blanket and on the man's right side. She added that she noticed there was no blood on the razor blade. When later asked by the investigator, the D wing night patrol officer did not remember seeing a razor blade whilst in the cell.

103. The night duty nurse said that the night duty HCO had radioed the Night Orderly Officer to inform him of the situation. He then radioed a second time to re-iterate that he should attend urgently because there was a death in custody on A wing.

104. The Night Orderly Officer said that he met the night duty HCO, the D wing night patrol officer, the night duty nurse and the HCSW. on his arrival at the cell. He was informed by them that the man appeared to be dead. He entered the cell with the night duty HCO and the nurse and saw the man lying on his back on the lower of the two bunk beds. He saw blood on the floor and on the bedding. He also saw a razor blade on the bed at the man's right side. The Night Orderly Officer told my investigator that, from what he could see, there was an injury to the man's neck but he could not get a clear view because the bed covers were drawn up high to his chin. (He did not move the covers). In his opinion, the man was dead. The Night Orderly Officer asked those present if any of them had found a suicide note, but no one had. He told my investigator that they did not search the cell in any depth. He told everybody to leave the cell, instructing them to leave everything as it was. The Night Orderly Officer then contacted the Communications Room and instructed them to inform the police, ambulance, Governor and Duty Governor. According to the Control Room log, an ambulance was called at 6:30am. Police were called at 6:35am.

105. The D wing night patrol officer said he was then sent to the prison centre to man the telephones. He remained there until relieved by day staff. The night duty nurse said that she had radioed the prison control room to request an emergency ambulance. She then went to H1 landing to telephone the on-call doctor, a local GP. She briefed him and asked him to attend the prison. She then telephoned the local Primary Care Trust (PCT) duty manager to report what had happened.

106. The OSG night patrol was in the wing office when he heard the urgent radio message. He went straight to the landing and saw the night duty HCO and the D wing night patrol officer at the door of A4-6. He heard the D wing night patrol officer say that the man appeared to be dead. He looked through the door into the cell and saw blood on the floor. The Orderly Officer then radioed the Communications Officer and also instructed him to call an ambulance and to put the prison's Death in Custody contingency plan into action. He told the OSG night patrol to ask the communications officer to contact the chaplain.

107. According to the Control Room log, the Night Orderly Officer was informed at 6:45 am that ambulance service paramedics had arrived at the gate and he

went to escort them to the wing. The doctor had also arrived and he explained the situation on the way. On arrival at the cell, the Night Orderly Officer opened the door to admit the paramedics and the doctor. They established that the man had died and the doctor advised the paramedics not to start resuscitation. The paramedics and the doctor noted the fact of death at 6:40 am and left the cell. The Night Orderly Officer locked the door after them.

108. The duty governor arrived on A wing soon after the man was certified dead. The Night Orderly Officer briefed him and the duty governor took over control of the incident. The Night Orderly Officer asked for a padlock to secure the cell until police arrived. His recollection was that the police arrived at about 6:45 am to conduct their investigations.

109. Some 10 - 15 minutes after telephoning the doctor, the night duty nurse went back to A4-6 and found that the doctor was already there. She asked him whether the decision not to commence CPR was the right one and he agreed that it was.

The prison's response following the man's death

110. Preston's death in custody contingency plans had been activated soon after the man was found. The necessary documentation and action sheets were completed, including the writing of statements by those staff involved in the discovery.

111. The duty chaplain was informed of the man's death at 6:45 am and arrived at Preston soon after. She was told that the man had an elderly mother living on the Lancashire coast, but that she had returned to her home overseas to live. There was some doubt as to whether this had in fact happened, so the duty chaplain and one of the governors went to her last known address. There was no answer which confirmed to them that the man's mother had returned home.

112. At 7:50 am, a log of events was started at A4-6 and maintained until the man's body was taken from the establishment by undertakers. Thereafter, the cell was sealed.

113. The acting Suicide Prevention Co-ordinator was briefed and instructed by the Governor to review all open ACCT documents. Two teams of reviewers, made up of members from the chaplaincy, Probation Service and case managers, reviewed all open ACCTs. All prisoners on open ACCT documents were told of the man's death, but no extra support was needed by any of them. Later in the morning, the acting Suicide Prevention Co-ordinator spoke to the Listeners about the man's death. He asked them to be vigilant in their dealings with other prisoners.

114. Police interviewed some staff during the morning. At 8:15 am, the Governor debriefed those staff involved in the discovery of the man's body. The Care Team, IMB and chaplaincy were actively involved during the early morning and the following day, providing support for prisoners and staff. The Deputy Governor issued notices informing staff and prisoners about the man's death.

115. During the morning, the man's friend telephoned the chaplain regarding visits. She was unable to help him but took his telephone number and promised to call him back later. She told my investigator she was unable to tell the man's friend of his death because his family had not yet been notified.

116. At 1:45 pm, the chaplain contacted the man's brother overseas and broke the news to him. She also spoke to his wife (the man's sister-in-law) and explained the circumstances of the man's death as she knew them. The chaplain left her with telephone numbers for the Preston liaison governor and the mortuary. During the telephone call, the sister-in-law asked that the man's friend be told of his death. The chaplain did so later that day. The man's friend was shocked and angry when she broke the news to him. The chaplain then telephoned the man's sister-in-law and told her that the man's friend now knew about his death.

117. Because the man's family live overseas and in light of their wish for his mother not to know the specific circumstances of his death, the Governor did not send a letter of condolence to his family. The Preston Family Liaison Officer was in contact with the family in the initial stages following the man's death until they asked for the man's friend to become the liaison point. Assistance with funeral and other expenses was offered to the man's friend and mother. The man's mother returned to the UK to receive her son's ashes, which she later took home. Ongoing contact was maintained with the man's friend.

118. On the morning of 16 August, the ETS course was suspended for the day and the tutors visited all course members individually to break the news.

Post mortem examination

119. A Consultant Forensic Pathologist and Home Office Pathologist carried out a post mortem at Preston Royal Infirmary at 10:00 am on 17 August 2006. A toxicological examination was undertaken and a report was written dated 4 October 2006. On 14 March 2007, the post mortem report was received from the Preston and West Lancashire Coroner. It stated that the cause of death was

a) Haemorrhage and

b) Cut Throat.

ISSUES CONSIDERED DURING THE INVESTIGATION

Reception Screening

120. The man's First Reception Health Screen on 16 February 2006 recorded that he said he drank socially and used cannabis. The amount he drank and the frequency and last usage of drugs were not recorded. He said that he had been assaulted some six days before reception and received treatment at a local hospital for a broken jaw. He also said that he had not received treatment from a psychiatrist or medication for mental health problems. He denied ever having tried to harm himself or that he felt like doing so at that time. Because of bruising on his face, he was referred to the prison doctor for anti-inflammatory drugs to treat his facial injuries.

121. On the following day (17 February), the man attended a Well Man Clinic and his assessment shows that he said that he did not use drugs, but had in the past used cocaine and heroin. He said that he drank 11 pints of beer daily and also that he smoked 35 cigarettes per day and had asthma for which he took medication. His baseline observations and mental health responses were not recorded on this document.

122. Information was recorded inconsistently with regard to the man's alcohol and drug use and there is no evidence of chronic disease management or asthma screening for his reported asthmatic condition. This is something that the clinical reviewers remark upon.

123. The apparent inconsistencies in the recorded responses to questions over the initial reception period regarding the man's drug and alcohol use appear not to have been examined.

124. The reception procedure should provide the initial information from which decisions are made on the immediate and ongoing needs of the prisoner. Unresolved inconsistencies do not allow that foundation to be laid.

125. A Late Arrivals Immediate Needs Assessment was opened on the man's reception but it was only partially completed over the following 24 hour period. Although he was recorded as cheerful during his initial interview, no follow up action appears to have been taken after the man said he was at risk of self harming. On the following day's assessment, the document remains blank until the last page where the question about self harming is repeated and the man apparently responded that he did not feel at risk of self harm. The contradiction between the two assessment interviews appears not to have been addressed. It may be that one of the entries was a mis-recording of a response, but even so that anomaly should have been addressed.

The Governor should ensure that reception staff record information consistently and that, where it is not consistent, clarification is sought.

Physical Healthcare

126. The clinical reviewers made an assessment of the care provided for the man who died by Preston's GP and healthcare team. They note that, "Overall we observed the care he had been given was appropriate. Of particular note was the care taken to arrange and ensure he received proper treatment for his maxillo facial injuries at the hospital local to his home." The man was also promptly treated for epididymo-orchitis which involved admission to a Preston hospital for four days.

127. The man was prescribed appropriate medication for the conditions with which he presented, and the Prescription and Administration Record Charts record that medication was administered in line with current policies. He was given some medication in-possession and there is no evidence to indicate that he was not using it correctly.

128. The clinical reviewers comment that the notes made in the man's medical record with regard to his physical health lacked baseline observations on his second reception screening or his mental health assessment.

The Governor should ensure that healthcare reception documents are fully completed.

129. The man's friend expressed a belief that there was an incident of a prisoner attacking the man that resulted in an eye injury and that he (the man) reported this to staff. I have found no other evidence that this incident took place or that it was reported. It follows that no action was taken against any other prisoner.

Mental Healthcare

130. The man's friend wrote a letter dated 17 February 2006 to the Governor. He followed this up with a telephone call to a member of wing staff on 20 February outlining his concerns about the man's mental state. He said that the man should be in a psychiatric hospital and recommended that a "suicide watch" be kept on him until an assessment could be made of his mental health. The man was then separately seen and interviewed at length on 20 February by two members of staff, one a designated suicide prevention officer. Based on their interviews, both members of staff came to the conclusion that the man was not at risk of self harm. The following day, the man was allowed a telephone call to his friend. After the call he was described as being "very happy".

131. Following a telephone call made to the prison doctor by the man's solicitor on 14 March 2006, in which he expressed concern about the offences and the reasons for them, the man was referred by the doctor to the Lancashire Care NHS Trust, Mental Health In-Reach Team (MHIT) for assessment. The man was seen on 22 March by two Senior Mental Health Nurses and was assessed as having no evidence of mental illness but was frustrated at the situation he found himself in. No further MHIT follow up was thought

necessary and there was no further involvement by them during the remainder of the man's time at Preston.

132. A Consultant Forensic Psychiatrist interviewed the man on 9 May 2006 for a psychiatric report dated 8 June 2006. His opinion was that the man had a lifetime history of alcohol, sedatives and cannabis use but he could find no suggestion that he was suffering from long term or serious mental illness. The Consultant Forensic Psychiatrist believed that the man was suffering from the effects of alcohol and cannabis when committing the offences for which he was imprisoned. Since being in custody, those issues had resolved themselves.

133. The clinical reviewers note that, following a consultation with a nurse in late June, the man was seen to be agitated and complained of sleep deprivation. He was given a GP appointment which he did not attend. The reviewers say, "the GP made note of this and there was clearly a discussion between GP and nurses. In our opinion this was an opportunity to have involved mental Health Nurses to make further assessment – no referral was however made." The clinical reviewers go on to say, "On 01/08/06 the man was seen by the prison GP who noted that he appeared stressed, anxious and complained of a poor sleep pattern. The doctor noted as follows: 'the man's mood seems to be sinking, exhausted. Impression – looks depressed. Commenced – mirtazapine 75mg nocte. Propranolol 160 MG daily. See 2/3 weeks.' They then say, "As reviewers we have observed that there was no evidence at this time [01/08/06] that he [the man] was referred to the mental health team despite these findings and prescription; there is no available evidence that the risk of suicide or self harm was assessed at this time; or that consideration was given to opening an ACCT document. We can only assume that the concerns noted by the doctor were not transmitted to Wing Staff either."

134. The man's mental healthcare needs were assessed by MHIT in March 2006. No major issues of concern were raised and no further action was thought necessary. I believe this was an appropriate response. The man was seen by a forensic psychiatrist in May 2006 for a court psychiatric report requested by his solicitors. The information contained was not available to the prison healthcare team.

135. However, by late June the man was reported as being agitated. By early July and into August, the indications that the man's health was suffering were noted by the doctor, appropriate medication was prescribed and a note was made to see him in two or three weeks time. No referral to the mental health team was made. The ACCT procedure was implemented on 17 July but was lifted after about six hours. I agree that, as noted by the clinical reviewers, opportunities were missed to involve the mental health team.

136. The clinical reviewers also say that there was a lack of communication between the doctor and the mental health team and/or the prison following diagnosis of depression and prescribing of anti-depressants.

MHIT should be notified whenever indications are present that mental health issues are involved.

Self Harming

137. During the time he was in custody, the man made several references to self harming, particularly when facing difficult situations. However, when interviewed formally, the man said on each occasion that he did not feel suicidal or at risk of self harm. On a single occasion on the morning of 17 July 2006 an ACCT document was opened after the man told a member of staff that he was feeling suicidal. On 25 July, the man was seen by the Suicide Prevention Co-ordinator who recorded that he was extremely positive, in a good frame of mind and had said he was not at risk.

138. The clinical reviewers have commented, "Having seen the ACCT document it is concerning that no input had been asked for from either the Healthcare department or the mental health team." The implementation guide for ACCT at HMP Preston states that, "Where issues [such as health, mental health, drugs / alcohol issues] are suspected or known to be relevant, a referral to the appropriate specialist staff must form part of the CAREMAP and those workers must be involved in subsequent care reviews." The clinical reviewers conclude that there is no indication that Healthcare was involved in the ACCT procedure when it was invoked. Indeed, there is no mention in the medical notes of the ACCT procedure having been implemented. This is contrary to the requirements of the Caring for the Suicidal Strategy (Health Care Centre Responsibilities). However, the ACCT register (entry 172/06) indicates that Healthcare was informed that the ACCT document had been opened, although no time or date for that action is evident. No entry was made on the register when the ACCT document was closed. Nor was it noted that a follow up interview took place, although the Suicide Prevention Co-ordinator conducted the interview on 25 July.

The Governor should ensure that the ACCT implementation guidance is adhered to.

The Governor should ensure that staff completing the ACCT register indicate the time and date and who completed the action.

139. Staff and prisoners who encountered the man during the last few days of his life saw no significant change in his behaviour or mood. This included his final cellmate. The members of staff who dealt with the man on 14 August during his move from one cell to another after the dispute with his cellmate were well aware of his having previously been the subject of an open ACCT document. They took this into account and reported that the man appeared happy following the move. The only exception was that one of the ETS tutors said that, on the day before his death, the man "was not full of the joys but did not appear depressed". She did not think there were any indicators that needed to be acted upon.

140. The fellow ETS course member said he noticed that over time there was a progressive deterioration in the man's mood. He said that on 15 August the man was fine in the ETS group sessions but at the morning break he was not communicative. The final ETS session after the break on the morning of 15 August was entitled "Asking for help". The subject of getting help when contemplating suicide arose and was discussed within the group. The fellow ETS course member has questioned whether the man was suitable for the ETS course, "because it may have made him go places in his mind that he wasn't prepared for and weren't the best things he could have been doing."

Bullying

141. The subject of bullying has arisen several times during this investigation. During his induction, the man was informed about the anti-bullying scheme. He signed the Preston Anti-Bullying Agreement, although no details were completed on the form and no date appeared next to the signature. The document also did not bear the signature of the witnessing staff member.

142. Statements made by staff and prisoners indicate that the man was naïve about prison life. He was in jail for the first time, felt out of place there, and it seems he was rather too open about himself and his attitude to other prisoners and their offences. He suffered from the theft of his property, principally tobacco, until he began to take better care of it. The man's closest prisoner friend, the fellow ETS course member, said that he was aware of some bullying taking place, but did not know the extent or the detail of it. Another prisoner was also aware of the bullying on B wing, but did not report the matter until after the man's death.

143. The man who died did mention being bullied to a probation officer who then spoke to a member of wing staff about it. But no note was made of the matter in the wing Observation Book by the probation officer or the member of wing staff to whom it was reported. The man did not himself report to wing staff any incidents of bullying. MHIT staff in their assessment on 22 March recorded that he had said that he had been threatened by other prisoners. In late June, healthcare staff were aware that the man was having unspecified problems with others on B wing. The doctor spoke to the wing SO who knew about the man's problem and agreed to move him to D wing. However, the man did not want to move wings and refused to do so. Although I question how professional it was, a note on the man's history sheet that I have quoted in this report indicates the frustration felt by a member of staff following the man's refusal to move wings to stop the bullying. In mid July, the man admitted to the prison doctor that he was being bullied. After an outside hospital appointment in late July, medication prescribed by the hospital was withheld from the man on the doctor's instructions, partly because it was thought unnecessary and partly because of his perceived vulnerability to bullying.

144. The anti-bullying co-ordinator at Preston knew the man who died, but was unaware of any bullying that was affecting him and no such information

reached him. Consequently a Tackling Anti-Social Behaviour document was not opened.

145. The co-ordinator is a part time post. At interview, he said this does not allow enough time to do the anti-bullying job properly. He said that facility time is limited for both him and his deputy and he believed the co-ordinator's job is not taken as seriously as it should be. He thinks the Tackling Anti-Social Behaviour forms are cumbersome and difficult to use, and he is trying to get them revised and simplified. At interview, he also said that he performs quality checks on the process, but agreed that current monitoring is not robust. The document when closed should be stored with the core record but this is often not the case.

146. It seems that the man was vulnerable to bullying as a result of a combination of his naïveté about prison life (including his forthright views on other people's drug taking) and his own tobacco habit. There is some evidence that staff were aware of the man's problems with bullying. However, the man did not come forward formally to seek help in combating it.

The Governor should review the Tackling Anti Social Behaviour strategy to ensure that it is a sustainable and robust process which underpins the Violence Reduction Strategy and is understood by staff.

Record keeping

147. The clinical reviewers note that the man's medical record was incomplete in that the reception screening tool and the follow up Well Man tool were only partially completed, entries in the clinical record were difficult to read, and the distinction between health professionals was unclear. They recommend that, in line with NMC professional guidelines, every entry should have the author's name, designation, date and time clearly appended to each entry.

The Governor should ensure that healthcare staff adhere to professional guidelines in the completing of medical records.

148. The clinical reviewers say there were good points to note in that overall the clinical record communicates that the man was well cared for in terms of his healthcare needs. They also say that, whilst he was an in-patient in the local hospital, the clinical record evidenced that regular communications were maintained with regard to discharge planning.

The man's friend**'s questions and concerns**

149. The man's friend has asked whether prison staff were concerned about the man on the day of his death and whether he was on a cell watch on the evening that he died. The staff who came into contact with the man the day prior to his death have said that there was nothing in his demeanour that gave them concerns about his safety. He was not therefore subject to special observations.

150. The man's friend has also raised the issue of the man's access to a razor blade. It is policy at Preston to allow normal access to a safety razor unless there are exceptional circumstances. There appear to have been no such circumstances that applied to the man.

151. The man's friend complained to my family liaison officer and investigator about his meeting with the Governor of Preston following the man's death. He said that the Governor kept him waiting for over an hour and, when he finally saw him, it was for 15 minutes only. The Governor told the man's friend that he could not answer any of the questions raised because there was to be a Prisons and Probation Ombudsman investigation into the death. It was not known why the man's friend was asked to wait to see the Governor and a delay of an hour would justify an apology.

152. In their response, dated 20 November 2007, to the draft report the Prison Service said that the man's friend's appointment was for around 11am but the Governor was unavoidably delayed. The Liaison Officer and the Safety and Decency Manager took the decision to see the man's friend pending the Governor's arrival. They discussed the man's death with him in some detail although some of the issues raised were related to aspects of the case that the Coroner would deal with. When the man's friend met the Governor later most of the issues had already been aired. The man's friend recalls that the Governor could not answer any of his remaining questions because there was to be a Prisons and Probation Ombudsman investigation into the death.

153. As I understand it, the Governor's response to specific questions about the circumstances surrounding the man's death was reasonable. In the past, I have been critical of Governors who have shared information that was not borne out in my subsequent investigations. Nevertheless, I understand why the man's friend would have found this very difficult in the immediate aftermath of his friend's tragic death. The Governor has since made it clear that no slight was intended and if this impression was given he would like to extend his apologies to the man's friend.

Visits

154. The man's friend has also raised the issue of social visits at Preston; in particular, the arrangements in place for access to the social visits area by elderly and/or infirm visitors. He has queried disabled parking arrangements and transport for the infirm from the prison gate to the visits area. (The man's friend was of course bringing the man's mother to Preston for visits to her son).

155. I understand that there is disabled parking immediately outside the prison gate, but it is restricted to a single space. If the space is taken, a subsequent visitor requiring disabled parking facilities must go elsewhere. However, arrangements are regularly made by gate and visits staff for dropping off disabled visitors at the gate by people who are able and can park away from the prison in the normal way. Car parking at Preston in the vicinity of the

prison is extremely limited, but the Governor will wish to note the man's friend's concerns.

156. Wheelchair users or those too infirm to use stairs are disadvantaged in that they cannot access the visits booking and waiting area because there are several steps to negotiate. The local council has been approached by the prison for permission to construct a ramp, but this has been denied. Currently, wheelchair users are given access to the main gate vehicle lock in which to wait. There is also a wheelchair kept at the gate for infirm people who cannot walk the long distance to the visits room. (At the time of my investigation, this wheelchair was out of commission for health and safety reasons. No replacement wheelchair was available). This situation is evidently far from ideal.

157. A new visits complex with appropriate access separate from the main gate is under construction at the rear of HMP Preston. I hope and believe this will resolve the matter of disabled access and parking in the near future.

158. The man's friend has also complained that the time taken to answer the telephone for booking social visits indicates that the staffing levels are inadequate and that visiting arrangements should be more flexible. I am conscious that this is a problem that applies at many prisons and do not find it acceptable. However, whilst it is true that there are periods during the day when the booking system at Preston comes under some pressure, during the time my investigator was present the booking system worked well with delays kept to a minimum. The flexibility of visiting times will be addressed following the construction of the new visits complex. Again, I hope this will resolve the matter.

159. Finally, the man's friend has asked if the amount of locker space for social visitors could be increased. Again, I understand this is an issue that will be addressed when the new visits complex is constructed.

CONCLUSIONS

160. The clinical review team concludes that the medical care the man who died received at Preston was appropriate, with no suggestion that it was below current medical standards. I agree.

161. During the time he was in custody, the man made several references to self harming. But when subsequently interviewed formally, he said on each occasion that he did not feel suicidal or at risk of self harm. On one occasion the opening of an ACCT document was considered after his return from court, but in light of the man's comments was in fact not opened. On only one single occasion was an ACCT document opened and it was closed the same day. The clinical reviewers conclude that there is no indication that Healthcare was involved in the ACCT procedure when it was invoked. However, the ACCT register does suggest that Healthcare was informed that the ACCT document had been opened, although no time or date for that action is noted and the entry is incomplete.

162. There is a difficulty for all prison staff in supporting and managing prisoners, like the man who is the subject of this report, who may raise the possibility of self harm and then recant. In this case, I believe that staff took a balanced approach in their dealings with the man. Once the ACCT document was opened on 17 July, those staff dealing with him on the wing did so in the proper manner. However, it is of concern that there is no complete record of involvement by Healthcare.

163. It is also of concern that Probation, Healthcare and wing staff were all aware of bullying that victimised the man, but little was done to address the matter. The man's own reluctance to talk to anyone about it also hindered any action they could take. Other than the Bail Information Officer who reported the matter to wing staff, little action was taken to follow it through and no formal report was made. This suggests that the Tackling Anti-Social Behaviour system at Preston is not as robust as it could be, nor fully understood by many staff and prisoners.

164. The gradual slide in the man's mood over several weeks, whilst recognised and being treated by the medical staff, went unnoticed by those around him. It was only partially recognised by the ETS tutor and his close friend, the fellow ETS course member.

165. It is possible only to speculate what caused the man to make such a determined attempt to end his own life. It seems likely that the man's state of mind, the fact of his cellmate moving to another landing leaving him alone in his cell for the first time since reception into Preston, and the subject of the final ETS session on 15 August, coincidentally came together to provide the circumstances and opportunity.

RECOMMENDATIONS.

1. **The Governor should ensure that reception staff record information consistently and that, where it is not consistent, clarification is sought.**

   Accepted

   Response: Although stated in the report that this was a concern in reception, it is suggested that the responsibility for clarifying inconsistent information would be during the First Night Centre process and second day interview when the more in-depth interviews take place with each prisoner. Although the second day interview now pulls together the information, this does not include the well man assessment as this is retained in the prisoner's IMR. The Healthcare manager is to take this forward with the healthcare staff. The Principal Officer has discussed with the first night centre staff in terms of ensuring that inconsistent information is addressed

   Target date for completion: December 2007

2. **The Governor should ensure that healthcare reception documents are fully completed.**

   Accepted

   Response: Healthcare reception documents form part of the healthcare audit calendar. An audit has recently taken place and staff have been reminded about the importance of fully completing the reception documents.

   Target date for completion: Completed. Forms part of the audit calendar and will be repeated in 2008.

3. **MHIT should be notified whenever indications are present that mental health issues are involved.**

   Accepted

   Response: MHIT are contacted whenever there is an indication that mental health problems might be present. This process will be more robust when the primary care mental health team are in place and form a crisis intervention response.

   Target date for completion: The crisis intervention team have been recruited and will be in place in January 2008.

4. **The Governor should ensure that the ACCT implementation guidance is adhered to.**

   Accepted

   Response: The ACCT implementation guidance is currently under review. Once this is completed it will be published to staff along with a staff information notice bringing the implementation guide to the notice of staff.

   Target date for completion: Implementation guide to be reviewed by the end of December 2007 – staff information notice to be published at this point.

5. **The Governor should ensure that staff completing the ACCT register indicate the time and date and who completed the action.**

   Accepted

   Response: Staff Information Notice to be published reminding staff of the importance of signing and dating any comments in the ACCT documentation.

   Target date for completion: Staff Information Notice to be published by the end of November 2007

6. **The Governor should review the Tackling Anti Social Behaviour strategy to ensure that it is a sustainable and robust process which underpins the Violence Reduction Strategy and is understood by all staff.**

   Accepted

   Response: The Tackling Anti-social Behaviour Strategy has been reviewed and new documentation has been developed. There is now a full time Tackling Anti-Social Behaviour officer working within the safety and decency team. TAB training takes place at regular intervals to ensure that all staff are fully aware of the procedures. Staff can also contact the TAB officer for support and guidance in the use of the TAB documentation and procedures.

   Target date for completion: Completed.

7. **The Governor should ensure that healthcare staff adhere to professional guidelines in the completing of medical records.**

   Accepted

   Response: The completion of medical records forms part of the healthcare audit calendar. An audit has recently taken place on the completion of the medical records. The clinical records training will be repeated as part of the PCT training plan. Completion of medical records is now also a core objective of the personal development plan of healthcare staff.

   Target date for completion: Staff to attend the training by end of May 2008.