Investigation into the circumstances surrounding the death of a man at HMP Preston in December 2005

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the circumstances of the death of a man at HMP Preston on 27 December 2005. He was found hanging in his cell at 5:25am, but attempts to resuscitate him were sadly unsuccessful. The man had been in Preston for about a month.

I extend my condolences to the man's family and all those touched by his death. The loss of a family member is always painful, especially so whilst they are in custody. I would like to thank the family for their assistance with my investigation and I hope that I have addressed their concerns in this report.

The investigation was led by two of my Assistant Ombudsmen. I would like to thank the management and staff at HMP Preston for their assistance and co-operation. Particular thanks go to the prison's liaison manager, who helpfully arranged facilities for my investigators.

An independent review of the man's medical care in prison was commissioned from Preston Primary Care Trust. I must also like to thank the North West Regional Development Team, Prison Health, who carried out the review.

In addition to some 'housekeeping' points, I make seven recommendations in this report. Perhaps the most important concerns information sharing between staff. The clinical review has identified a further six learning opportunities that I urge the prison/PCT partnership board to take forward. However, none of this should detract from the good standards evident in the self-harm and suicide management processes at Preston, and the response to the man's death. I have drawn attention to a number of examples of good practice.

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Prisons and Probation Ombudsman **January 2007**

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SUMMARY

The man was born in 1977 in Glasgow. He was found hanging in his cell at HMP Preston in the early hours of 27 December 2005. At the time of his death, he was just 28 years old.

The man had a close relationship with his family although they had spent some periods apart. They had last seen him in August 2005 and remained in contact until the day before his arrest on 25 November 2005.

The man appeared before Magistrates' Court on 26 November charged with sexual offences. He was remanded into custody to Preston prison.

On arrival at Preston, the man was assessed by reception staff. The nurse on duty was sufficiently concerned about the level of suicide and self-harm risk to open an ACCT (Assessment, Care in Custody and Teamwork) document. (This is a regime under which prisoners at risk of self-harm or suicide are managed.) The nurse described the man's depression and deep sense of remorse and referred him to the doctor. The man also suffered from diabetes (for which he took insulin) and asthma.

As part of the man's ACCT, a plan set out the appropriate supportive regime, including his location in a double camera cell "until deemed no longer necessary", and regular observations by staff. He appeared "very low" at this point. At his case review, he expressed a wish to write to his family to let them know he was in prison. This moving letter illustrated the man's feelings of remorse and intention to seek help. He was also referred to the mental health in-reach team (MHIT) as a result of the ACCT being opened.

The man was granted 'poor coper status' at his own request due to the nature of his offence. He was allocated to F wing, a small vulnerable prisoners unit, where he remained. During his time on F wing, he was given an appropriate induction. His personal officer noted that, although he and other staff encouraged the man to spend more time out of his cell, he was quite an introverted character and did not socialise much. He was prescribed Fluoxetine for his depression by the doctor.

After his induction, the man's demeanour and mood slowly improved. ACCT records show that he was cheerful in mood and was starting to mix well with other prisoners. On 3 December, the man's ACCT was closed at a multi-disciplinary case review. This acknowledged that he was still a little low, but he was aware of the avenues of support available to him and had not attempted to self-harm since he arrived. His risk was recorded as being "low".

On 5 December, the man was reviewed by the mental health in reach team using records duly obtained from a community mental health team and outside hospital. Based on judgements made in these records that the man presented "no obvious mental illness", his lack of registered mental health illness status, the closure of his ACCT and his regular involvement with the primary care team due to his insulin dependency, he was referred to primary care with no need for a further mental health assessment. His wellbeing and general presentation were to be monitored daily by

primary care healthcare staff. If concerns arose, they were to refer him for a mental health assessment.

Despite the man's desire to seek help through counselling, his attempts were frustrated by a lack of primary care level mental health provision, particularly short term crisis counselling. The man appears never to have received any outreach mental health support and accessed no counselling services, despite attempts made by his doctor. However, the management of his self-harm and suicide risk on normal location through the ACCT process had otherwise worked very well.

On 11 December, the man and his cellmate were moved out of the camera cell to another cell on F wing to make room for a third prisoner who was on ACCT. On 16 December, the man's ACCT closure review noted that he felt better, still had down periods but no episodes of self-harm.

In the afternoon of 26 December, the man was involved in a dispute with another prisoner over the use of the pool table on F wing. The man was reprimanded by an officer and felt that he had been unfairly blamed. The man was upset and returned to his cell. Following refusal of his insulin and tea meal that evening, a nurse and two officers went to speak to the man to reassure him and try to dissuade him from his refusal of medication. The man continued to refuse treatment and an ACCT was subsequently opened by officers.

During this conversation, the man handed the nurse a note that she described in his clinical record as a 'suicide note' but the man referred to as an 'Advanced Medical Directive' (AMD) setting out his wishes. He said that "being of sound mind, body and judgement", should he go into a "diabetic coma or any medical problem including suicide", he did not wish any "medication, oxygen, blood transfusions, or any heroic life saving measures. As I do not have any more reason to live." The note was addressed to medical staff.

Healthcare and discipline staff have differing recollections as to whether the note was shown or summarised to discipline staff, and whether officers were aware of the reference to suicide or only the issue of diabetic coma. My investigators found no plans to do anything further with the AMD and that staff were unclear as to its implications. Healthcare staff also had differing recollections of the information handed over to night staff, and the various written records did not clarify this further. However, I conclude that this did not affect the outcome. The man was placed appropriately on regular half hourly observations, carried out through the night. He appeared to be unsettled, although he did sleep at times. No discussions took place about placing him a camera cell.

Just after 5:25am on 27 December, an officer found the man hanging from a bed sheet tied to the window bars in his cell. Both healthcare and discipline staff immediately lifted the man down and attempted CPR, but unfortunately attempts to resuscitate him, including those by paramedics, were unsuccessful. The man was pronounced dead at 5.45am. The post mortem report concluded the cause of death to be asphyxia by hanging.

The prison made arrangements for the police in Glasgow to contact the man's family as soon as possible to inform them of his death. The family were also contacted by the prison family liaison officer who kept in touch. The man's funeral was held on Friday 6 January 2006.

Over the time the man was on the ACCT, his mood had steadily improved and he was becoming much more sociable on the wing (although still low at times). He expressed no wish to harm himself until after he had served his sentence and made this clear to a number of staff. He had also not self-harmed since he had been in prison.

Despite the overall good level of care the man received at Preston, my report makes seven recommendations for improvements that could be made in relation to the management of suicide risk. The most significant of these concern information sharing between healthcare and discipline staff, and the treatment of advanced medical directives. I make these recommendations recognising fully the support needed by staff to make this work in practice. I also highlight some examples of good practice.

INVESTIGATION PROCESS

1. One of my assistant ombudsmen first visited HMP Preston on 3 January 2006. She was given the initial papers that had been assembled about the man and was briefed about the circumstances surrounding his death. She also met with a member of the Independent Monitoring Board. A notice to staff and to prisoners was issued by the prison, inviting anyone who might have information relating to the man's death to make themselves known. In the event no-one came forward.

2. My two investigators, both assistant ombudsmen, went to Preston to commence the investigation formally on 9 January. They toured the prison, and met with the Governor and a representative of the Prison Officers' Association. Preston Primary Care Trust was commissioned to undertake a clinical review of the man's health care whilst in custody. A clinical review was carried out by the North West Regional Development Team, Prison Health.

3. My investigators returned to Preston on 24, 25 and 26 January to interview further staff and prisoners. The operational manager was the deputy head of residential, acted as the prison liaison officer and made all necessary arrangements for interviews and ensured all papers were made available to my investigators. All the interviews were taped and transcribed and are attached as annexes.

4. One of my family liaison officers contacted the man's family. They had already asked some questions about the man's time at Preston of the prison's family liaison officer on 28 December, and he communicated these to my investigators. The family asked to see a copy of the draft report. My investigator and family liaison officer went to visit the man's parents and sister at their home in Glasgow on 30 January to discuss their concerns and the progress of the investigation so far. I have endeavoured to deal with all these issues in my report or in correspondence with the family.

HMP PRESTON

5. HMP Preston is a local prison in the centre of Preston in Lancashire. The prison was first built in 1790 and became a local prison in 1990. It receives all adult male prisoners from Crown Courts and Magistrates' Courts serving Lancashire and Cumbria.

6. The prison's residential areas consist of six main houseblocks, one of which is a small vulnerable prisoner unit, F wing, holding 33 prisoners. The cells in this unit are all double cells. Four of the cells have overt CCTV cameras in them ('camera cells'). A Listener (a prisoner trained by the Samaritans) is the single occupant of one of these cells. (The man lived in F wing throughout his time at Preston.)

7. A First Night Centre is located on the top level of D wing. It accommodates non-detoxing prisoners for the first three nights of their time in Preston, although the man did not spend any time here. All of the cells on this landing have overt CCTV cameras and observe prisoners at all times when they are in their cells.

8. The healthcare unit has very recently been refurbished and is designated as an area resource. It can take up to 30 in-patients, with 12 of the beds designated as area resource beds. Nursing cover is provided 24 hours a day. There is a full time GP who works Monday to Friday and another GP who provides out of hours emergency cover.

9. In her report of an announced inspection in July 2004, Her Majesty's Chief Inspector of Prisons reported that good systems were in place to help prisoners at risk of suicide and self-harm, although they were limited by not being part of a broader safer custody approach to managing prisoners' safety.

10. In December 2005, the certified normal accommodation at Preston was 418 and the operational capacity (maximum crowded capacity) was 620. On the night of the man's death, the prison roll was 562. Typically, there are 30 movements in and out of reception on each weekday.

KEY EVENTS

The man's admission to HMP Preston

11. At the man's appearance before magistrates on 26 November, the hearing was adjourned until 2 December. The man left with GSL escorting staff at 10.40am and arrived at HMP Preston at 11:20am. His Prisoner Escort Record (PER) included ticks for his 'risk categories' on medical condition, sex offence and suicide risk. The further information box was completed as follows, "High risk. Has tried to kill himself by overdosing on insulin three times in last week. He is diabetic..."

12. A prison officer carried out the reception interview with the man and completed form F2050 (the core prison record). Personal details such as the man's date of birth, nationality, height, weight, identifying scars or tattoos were all recorded. The man gave the name, address and phone number of his mother as his next of kin.

13. A second prison officer completed the cell sharing risk assessment. (This form is intended to identify those prisoners who may be a risk to other prisoners if they were to share a cell together.) The man was assessed as being low risk on the basis of information he gave.

14. All the cells in Preston are shared cells. In the man's case, since he was deemed at risk of self-harm or suicide, it would anyway have been considered safer practice to place him in a shared cell. However, the man said he had concerns about sharing a cell and described himself as someone who got angry and frustrated quickly. My investigators believe this may have been linked to his desire to acquire "poor coper" status (a status given to vulnerable prisoners who may not wish to be placed on a normal wing).

15. A Registered General Nurse, was on duty in reception that day. Her role was to interview and assess all new receptions. She completed the Prison Service/Department of Health form, First Reception Health Screen, on the man. This asks a wide range of questions about health including any diagnosed illnesses, alcohol and drug use, and mental health history including any previous attempts of self-harm. The form is heavily reliant on the answers that the prisoner gives.

16. The registered general nurse saw the man at approximately 12:00pm. She was particularly concerned about him and said he was withdrawn, seemed full of remorse for his offence and had said that he just wanted to end his life. She had seen details of his attempted overdose of insulin on the PER and suicide/self harm warning form completed by his escorting officer. He had his insulin medication with him, so this could be immediately prescribed. She also explained that he would have had a "Well Man" check up the next day. She spent some time talking with the man, trying to reassure him and said that he would be seen by a doctor.

17. The form was placed on the man’s Clinical Record. The man said that he had seen a doctor as an in-patient at a Hospital for depression and suicide attempts. He was waiting for an endoscopy and to see a diabetic consultant. He was receiving insulin for his diabetes and Salbutamol and Becotide inhalers for his asthma. The man reported no substance misuse problems.

18. Under the ‘Mental Health’ section, the form asks whether the prisoner has ever received treatment from a psychiatrist outside prison or stayed in a psychiatric hospital and the man replied that he had. The man also said that he had no care worker or psychiatric nurse in the community, although Preston’s Mental Health In-Reach Team later found records of his contact with a community mental health team in October and November 2005. The man said that he had received medication for mental health problems, but gave no details. In relation to self-harm, the man said that he had taken an overdose of insulin.

19. The form says that, if ‘Yes’ is recorded in answer to any of these questions, the prisoner should be referred for a ‘mental health assessment’. However, there is no corresponding tick under the ‘Planned Action’ section on page eight to initiate such a referral. The form should have been ticked for completeness, but the registered general nurse gave two reasons for not doing so, one of which raises questions about the functionality of the reception screening form. First, the registered general nurse confirmed that a mental health referral to outreach nurses would have been automatic (the day after) for all prisoners put on an ACCT (Assessment, Care in Custody and Teamwork) plan. (This is a regime under which prisoners at risk of self-harm or suicide are managed and one which the registered general nurse commenced for the man.) She knew, therefore, that he would be seen even though she had not explicitly made such a referral on the form.

20. Secondly, the form refers to referral for an actual mental health ‘assessment’ and the registered general nurse believed that the man’s mental health issues, despite being problematic, did not amount to a mental health illness sufficient to require him to have an assessment carried out. She said that MHIT only take on clients who have actually been diagnosed with a mental health illness by a psychiatrist: “They’re not automatically sent for a mental health referral because they [MHIT] don’t class people who are suicidal as having been diagnosed with a mental health problem, it’s something people can have without being mentally ill.”

21. The registered general nurse opened an ACCT for the man in accordance with the Healthcare Centre Responsibilities, set out in the local ‘Caring for the Suicidal Strategy’. She had been trained in ACCT procedures. She completed the ACCT Concern & Keep Safe form at 12:45pm. This sets out the immediate concerns the initiator has about the person, recent events, and behaviour or information that gives cause for concern. The registered general nurse referred to the information she had obtained and recommended that the man should not have any in-possession medication. She then passed this to the Unit Manager, to help him decide on the immediate action to be taken. She made corresponding entries in the man’s medical record and referred to his request

for psychiatric help. The man should have received a further reception health check within five days of arrival, but none was completed.

22. The registered general nurse kept the man behind to see a doctor because she was concerned about him. She said she was concerned at his risk of suicide, because he had so readily admitted his remorse for his offence which she felt was very unusual at this stage. He saw the doctor at about 12:50pm and the registered general nurse thought he might have been prescribed some night sedation. He was assured he would see medical staff the next day. The man saw medical staff regularly after being transferred to the wings because he could not keep his medication himself. He was seen again by a doctor on 30 November.

23. The registered general nurse's final task was to complete section three of the Cell Sharing Risk Assessment form. Again she noted the relevant information she had obtained. The registered general nurse saw the man on a number of occasions after this on F wing, whilst doing medical treatments. She said his mood seemed to 'pick up' over time, and he was getting on with the other prisoners and compliant with his medication.

24. The prison's liaison officer carried out a 'poor copers risk assessment' at the man's request, to see whether there were sufficient grounds for him to be given poor coper status and therefore located in the Residential Support Unit (RSU or F wing/vulnerable prisoners unit). The nature of his offence gave him priority and, although the assessment was not finalised until a few days later, he moved directly to F wing to cell F1-08 rather than going to the prison's First Night Centre.

25. In line with ACCT procedures, the unit manager, a prison officer (also on F wing) and the safer custody officer (responsible for dealing with operational policy and procedure in relation to ACCT in the prison) carried out an Immediate Action Plan for the man, setting out the appropriate environment and regime to support him. He was to be located in a double camera cell "until deemed no longer necessary" and observed hourly during the daytime, with three quality entries to be made on his records in the morning, afternoon and evening. During the night and on patrol state (when prisoners are locked in their cells), he was to be under half hourly observations. He was given access to a Samaritans phone and to Listeners. (Listeners are prisoner volunteers who are trained by the Samaritans in listening and befriending skills to support other prisoners.) Later that day, the man was moved to cell F1-05, a camera cell.

26. The safer custody officer, a trained ACCT assessor, then carried out an assessment interview at 3.00pm to gather information about the risks the man posed to himself. The record shows that the man had tentative suicidal ideations, linked to the guilt he felt for his offence and appeared "very low".

27. At 3.11pm, the unit manager and the safer custody officer carried out a case review with the man to consider his needs and the type of care required. They developed a caremap to show how that support would be delivered. The man

said he felt “lightened” after talking to the safer custody officer and accepting his offence. The man said that he was aware of the avenues of support available to him on the unit. They made plans for the man to contact his family by letter (finally sent on 29 November) to inform them he was in custody. This was a very personal and moving letter in which he showed great remorse, and demonstrated his intentions and desire to seek help. He wrote of his feelings about the possibility of losing his family and said he was sorry for the harm he had caused. A follow up case review was planned for 2 December. When the man had been to prison for a previous offence, his family had made clear that if it happened again they would find it difficult to come to terms with the situation. When the man’s letter of 26 November arrived they found it moving and hard to respond to, so were taking their time to respond. The man’s mother, also received a birthday card from her son, apparently sent to her shortly after his arrival in prison.

28. On the same day, the safer custody officer completed a mental health referral form for the man as part of the ACCT process. Generally in every case where an ACCT is opened, the prisoner is referred to the MHIT for a background check or to obtain information on his mental health history. The referral form identifies two “risk issues” for the man: “next court appearance” and “time of sentence”. The man described his acceptance of responsibility for his offence and that he needed help. He said that he had recently spent some time in a community mental health unit and that approximately four weeks ago he had spent a week in a psychiatric hospital. He also said that he had made at least four suicide attempts in the last month.

29. The man had a first night interview with an officer, to introduce him to Preston’s regime and take account of any concerns he may have had. His ACCT notes that, on the evening of 26 November, the man was “lying on bed watching TV as first night … quiet”, and later, “‘watching TV and chatting to cell mate, went to bed around midnight and appears to have slept through the night.”

Events leading up to the man’s death

30. F wing is a small vulnerable prisoner unit that holds 33 prisoners. The man was placed in a camera cell, F1-005, with a fellow prisoner. Although he did not remain in this cell, the man continued to share with the other prisoner and they seemed to get on well. There were five regular staff on F wing at the time and the shortfall was backfilled by staff from another wing.

31. The induction process provides new prisoners with information about the prison regime and support services available, including Listeners, bail information and anti-bullying. The local Caring for the Suicidal Strategy also says that the Duty Listeners rota will ensure that each new reception is introduced to a Listener within 24 hours. In the last HMCIP inspection report in July 2004, it was reported that access to Listeners was good and 79 per cent of respondents said they could speak to a Listener at any time. My investigators could not tell whether the man saw a Listener during his first night since this is not recorded. My investigators interviewed the Listener on F wing. He said that the man had never approached him to discuss his emotions and described the man as

someone who kept himself to himself. He was "one of those who preferred to deal with things themselves." He also said he felt the man was an emotionally unstable person and had been up and down in mood throughout his time at Preston, spending time lying on his bed. However, as far as he knew he had not discussed killing himself.

32. The Induction Checklist on the man's core record is blank, save for two references to a follow up assessment being done and a chaplaincy visit. The file contains a Custody and Care Plan Assessment opened on 26 November and carried out on 27 November. This identifies the prisoner's immediate needs such as suitability of location and being on an ACCT. In July 2004, HMCIP had also reported that some prisoners were not receiving a full induction and recommended that all prisoners should have access to the same induction programme irrespective of their location.

33. The prison chaplain saw the man on 27 November and talked with him about his concerns about his home and his offence. The man also spoke about his recent attempted overdose. The chaplain said that whenever the man wanted to see the chaplain he could put in a request and he would be seen within 24 hours. The man never attended the chapel whilst he was at Preston, although he was offered the opportunity.

34. The man saw his personal officer at some point that day. His personal officer said that he spoke to the man on a number of occasions, although never about his offence or how he was feeling. He said the personal officer scheme was not one where officers would have responsibility for particular individuals; rather, they all covered for each other. However, he would have had daily contact with the man whenever he was on shift. The last HMCIP report showed that the personal officer scheme had only recently been introduced. At that time there was little evidence it was having a positive effect on prisoners' experience. Several prisoners reported that they would not necessarily discuss their problems with their allocated officer, but would approach any member of staff with whom they got on well.

35. The HMCIP Report made a recommendation that the required fortnightly entries in wing history files by personal officers should be sufficiently detailed to provide the reader with up to date information on the prisoner and his individual circumstances. The man's personal officer made two records on the man's wing history sheet during his time at Preston: one on 16 December and the other on 19 December, saying that he did not seem to want to help himself. He noted that on a previous ACCT he had said he felt a bit depressed and lethargic. The man's personal officer had tried to encourage the man to spend more time out of his cell associating with others, but said the man was quite introverted and did not socialise much.

36. On receiving the man's referral on 28 November, the Senior Mental Health In-Reach Nurse, wrote to community mental health unit to request details of the man's mental health history including a possible diagnosis. On 30 November, the unit enclosed the information sheets received from a hospital referred to earlier in this report.

37. On 29 November, the man had an early second case review following an act of self-harm elsewhere in the prison, in line with local policy. A senior officer and an officer attended with the man and concluded that he had come to terms with his crime and no longer had any desire to self harm or attempt suicide whilst in prison. He wished to be punished for his crime "and face the consequences as a mark of respect to his victim". The man said that he would kill himself after his sentence, upon release. They recorded his level of risk as remaining "raised".

38. On 30 November, a note on the man's clinical record described him as continuing to have suicidal thoughts, low moods and wanting help. The doctor prescribed him with Fluoxetine. On 1 December, an officer recorded on the man's Custody and Care Plan Assessment follow up that he "wants counselling". On 2 December, the man was escorted to court for a hearing in relation to his offence. The hearing was adjourned until 19 December to be heard by video link. His ACCT case review was delayed until the following day. The man's behaviour was closely monitored and recorded on his ACCT document and in police records.

39. Since his arrival in Preston, the man's demeanour and mood had slowly improved. The ACCT records show him starting to associate a lot more, having cheerful moods and starting to mix well with other prisoners. On 3 December, at a multi- disciplinary case review, a senior officer made the decision to close the man's ACCT. The chaplain, the man and his personal officer attended. They acknowledged that the man was still a little low, however he was aware of the avenues of support available to him and noted that he had not attempted to self-harm since he arrived. His risk was this time recorded as being "low". The man's personal officer said that they tried to encourage the man to mix more with others on association. Prior to his death he appeared to be mixing more than when he first came onto the wing.

40. Healthcare staff were informed and a note was made on the man's medical record. Four members of staff including a governor and a senior officer carried out ACCT Quality Checks each day. The Safer Custody Team completed a 'closed ACCT quality check report', concluding that the ACCT was opened and closed appropriately.

41. On Monday 5 December, the MHIT discussed the man's case at a referral meeting led by the MHIT Manager. The MHIT manager told my investigators that the MHIT are a secondary level mental health care provider employed by Lancashire Care Trust. The Trust provides mental health services for the prison under a service level agreement commissioned by the PCT. Their primary role is identifying, maintaining and treating prisoners with "severe and enduring mental illness". The team had been operational for just over a year when my investigators spoke to the MHIT manager. They receive around 36 mental health referrals each month, of which they put forward about 12 cases for a full "assessment". However, since there are no formal primary care mental health services at Preston (the MHIT manager described this as a "missing layer"), the team have accepted responsibility for all mental health

referrals “on an interim basis”, to act as a single point of initial access. In practice, this means that cases that would not usually meet their criteria are monitored against a number of care “pathways”. These are unique to Preston and were set up by the team to mirror processes in the community. They consist of various checks on a person’s mental health history, CPA assessment, clinical records etc, to establish the level of service to which the person should be referred.

42. Due to the team’s NHS status, they can more easily access confidential medical information and gather communication than other parts of the prison, and therefore their input is invaluable. They are often used purely as a tool to gather relevant background mental health information. Based on this, the team then decide whether the case should be taken onto their caseload and a full assessment done. If not, prisoners are then “signposted” to other interventions - such as GP, primary care, or a psychiatrist - which may be better equipped to meet the prisoner’s needs.

43. In the man’s case, on the basis of (a) judgements about his mental health history, in particular that he was discharged with “no obvious mental illness” from hospital, (b) his lack of CPA registered status, (c) the closure of his ACCT on 3 December, and (d) his daily involvement with the primary care department due to his diabetes, the MHIT concluded there was no need for a further mental health assessment and referred the man to primary care. The MHIT wrote to the primary care manager, on 5 December to request that, as the man was an insulin dependent diabetic coming into daily contact with primary care, his wellbeing and general presentation should be monitored. If concerns arose he should be referred for a mental health assessment. The letter also said that information received by the MHIT indicated “more of a primary care level of contact with mental health services”.

44. The MHIT manager confirmed that primary care level contact with mental health services would involve seeing a GP perhaps once a week for anxiety or depression, being on medication, and perhaps involvement of a primary care mental health nurse. The MHIT manager also said, “there’s no talking therapy as such at primary care level. It’s only once … more people become involved that the case becomes more complex … i.e. psychologists, social workers, psychiatrists that it goes up to an enhanced level.”

45. The man remained outside the MHIT caseload and would only have come into contact with their services again if re-referred or via discussion at a multi-disciplinary team meeting. This is a forum for staff to raise concerns of clinical significance about particular prisoners at a minuted meeting. The MHIT manager also said that staff discussed certain prisoners on an ad hoc basis, just to get a more expert opinion, “sometimes people … feel … better or safer if we’re involved.”. Preston MHIT has created a notification procedure to update ACCT teams on referrals made. A feedback letter is placed on the prisoner’s ACCT folder. The man’s is blank and undated, but The MHIT manager explained that by this time the ACCT had been closed so there was no need for notification.

46. On Wednesday 7 December, a nurse saw the man and recorded in his medical record that he had refused his insulin. The readings of his blood sugar levels gave her enough cause for concern to discuss the matter with a Sister who advised her to administer insulin, to tell the man to eat a good lunch, and to re-check in the afternoon. She also made a note to discuss this with the prison doctor. The man would have received his medication from the nurses at a hatch on the wing and administered the injection by himself watched by staff.

47. On 9 December, the prison doctor saw the man and reported that he had low blood sugars. She said that his insulin had been increased before entry to prison and made a note reducing the levels. The prison doctor confirmed that the man had been self-medicating rather than self-harming on this occasion. The prison doctor told my investigators that she had spent 25 minutes in consultation with the man, which was unusual. She described him as being deeply disturbed by what he had done. The prison doctor provided my investigators with the greatest insight into the man's feelings at that time. Despite having initially denied his offence, he now admitted it and spoke of his deep regrets about the harm he had caused to his victim and the family, and his desire to seek treatment.

48. The prison doctor described the man as having been "at one stage been very close to his family and unlike the majority of my patients who have had either no childhood or very troubled childhoods, he wasn't claiming that any of his behaviour was in relation to his early life." The prison doctor said she did not consider that the man was "clinically depressed" at this time. Although he was deeply upset, she did not think he was seriously suicidal. Had she done so, she would have spoken to officers on the wings. She felt that since he was sincere about wanting to complete his sentence, he would not have considered suicide at that time. The man's parents were upset that the man had re-offended, but always knew that the closeness they previously had experienced, would return in time.

49. The man requested counselling from the prison doctor. She said that the man was aware that the sex offender treatment programme would provide support in the medium to long term, once he had started his sentence at a new prison, but he wanted short-term help to come to terms with himself and discuss his offence. She said he could not move on any further without the right type of help. The prison doctor explained to the man that there was no primary care counselling available at Preston. The prison doctor recognised the distress this caused the man and made a note to discuss the possibilities at the next multi-disciplinary meeting. The prison doctor said that, although the chaplaincy service offered counselling, there was a long waiting list, with priority given to those who were seriously suicidal. On 11 December, the man and his cellmate were asked to move out of the camera cell to F1-011 to make room for another prisoner who was on an ACCT.

50. The prison doctor discussed the man's request at the multi-disciplinary meeting which concluded that the man should be referred to outreach care. His clinical record shows an entry on 15 December, by one of the nurses, explaining that outreach does not offer counselling, so the man was then referred to the

chaplaincy counselling. The prison doctor said that she did not see the man again after this. Had she been aware that the referral had gone around in a circle, she probably would have asked to see him again to see how he felt. The prison doctor felt certain that the particular nurse who made the referral would have explained the situation to him.

51. During the course of the investigation, my Assistant Ombudsmen spoke to the chaplain who confirmed that he had received an application after 15 December, requesting counselling for the man. He explained the difficulties in providing counselling to prisoners from F wing: (a) the need to escort prisoners to the service via reception; (b) a general perception by counsellors that such intervention might not be helpful at this stage of the prisoners custody and may interrupt treatment programmes in the next prison; (c) only one of the three counsellors was actually trained in dealing with sex offenders and they felt they did not have the necessary expertise for this specialist area; and (d) there are long waiting lists for counselling. Therefore, it would not have been possible to see the man until March/April 2006, by which time he would probably have transferred to a different prison. These factors meant that there was little provision of counselling for prisoners on F wing, the man found this upsetting.

52. The safer custody officer carried out the ACCT closure follow up review with the man on 16 December. The man said that he felt better, but still had down periods. He referred to having written to his parents, but he had not received a reply. When asked whether there was anything in his life he felt positive about, he said that he felt positive about the fact that he would get help. The man appeared to be aware of the support available to him to help him cope should he have further problems. A copy of the form was passed to healthcare and put on the man's medical record. No further entries are made until the day before the man died. On 19 December, the adjourned court hearing was again adjourned until 27 January 2006.

Events of 26 December

53. A prison officer came on duty on F wing at around 12:15pm. He is not a regular member of F wing staff. At around 3:00pm, there was an argument over the pool table in the association area between some prisoners, including the man and another prisoner, over whose turn it was to play. The man's cellmate said that the other prisoner had tried to stop the men playing by tipping up the table. An officer told them to list their turns on a piece of paper on the wall, but the other prisoner ripped it off the wall. The man took the white ball off the table and went down to the wing office.

54. An officer reprimanded the man for taking the ball as it could have been a dangerous object and said that he should have come and spoken to staff before doing so. He also tried to ascertain whose turn it was. Since this could not be resolved, he withdrew all the balls from the table. The officer said that voices were raised but this was nothing out of the ordinary. The two prisoners my investigators interviewed said they felt that the reprimand had been quite loud and done openly in front of other prisoners.

55. The man and his cellmate went back to his cell and was “sulking” over the incident for the rest of the afternoon. The man had felt it was unfair to have been reprimanded when he had not been the instigator and had not been given the chance to explain himself. Unfounded allegations were made that the man’s father had telephoned the prison on Boxing Day with a message to an officer to pass on to the man that had upset him. My investigators found no evidence to substantiate this. The man’s parents have expressed their astonishment about these allegations and confirmed that he did not phone the prison. The man’s cellmate said that the man had been “up and down” in mood over the last month - and had discussed feeling depressed and suicidal - but this had not been relayed to staff. The prisoner my investigators interviewed was not the Listener on that night but the man would have been able to access one had he asked.

56. At 4:00pm, the officer was the only officer on the wing as the prison was in ‘patrol state’. Patrol state occurs at times during the day, when there are reduced staffing levels to ensure good order and discipline, as well as the overall security of the establishment, the prisoners will remain locked in their cells during these periods, but are promptly attended to in the event of an emergency. At around this time, a registered general nurse came to administer medication. She is an agency nurse, but has worked at Preston for two years. She had never come across the man before that afternoon. She noticed that he had not come for his insulin injection. The man’s cellmate said that he had alerted her to this and asked the officer to go and collect him. When he did so, the man refused and said he did not want to take his insulin. The registered general nurse told the officer that he needed to have his treatment and that she would like to talk to him. The officer again approached the man and asked him to report to the nurse. The man reluctantly went down to the treatment room and the nurse explained that he was at risk of a diabetic coma if he continued to refuse treatment. Again he refused the medication and walked away. The officer also warned him of the potential consequences of his behaviour and asked him if he understood what he was doing. The man said he did.

57. Later, one of the officers told the registered general nurse that the man had also refused his tea meal. The officer asked the nurse for her advice, and she said that they could not force him to take his insulin but should keep a close eye on him and check whether he ate or not. The officer said that both were concerned about the man at that point, but were under the impression that he would change his mind. The registered general nurse said that although his behaviour could have serious implications in the long term, this was the first incident of refusal so she was not unduly worried. She returned to the healthcare centre and made a record of the incident in the Nurse in Charge ‘Handover of Significant Events’ (used to hand over to other healthcare staff) at 4:30pm. At 6:05pm, she also made a similar note in the man’s clinical record and mentioned the pool table incident, as did the officer in the wing records.

58. The registered general nurse was still concerned about the man, so between 6:30 and 7:30pm she returned to the wing with the officer to speak to him. He radioed the assist Orderly Officer to unlock the man’s cell. He was still refusing medication, food, or drink. The three of them discussed the man’s actions with

him outside his cell door. They tried to persuade him to eat, drink and take his medication and ensured he understood the consequences of his behaviour. The prison doctor explained to my investigators separately that food refusal together with the lack of insulin would actually have the effect of slowing the deterioration down. The man's blood sugar levels would rise, but more slowly. The man said he just wanted to face the consequences and did not want any help. They offered him support from the Listener, the chaplain, a friend, or use of the Crisis Suite, and said that they could do something further the following day. The man's cellmate described the officers as having offered the man "everything you can possibly think of" and said they had given him plenty of support that night. The registered general nurse said that the man told her he did not want to talk to anybody; he had just had enough of his life. At that time, the registered general nurse said she did not think the situation was really serious, since the man could not have slipped into a coma in just one day. They were in effect buying time with him and would be able to refer him to the appropriate person the following morning.

59. The assist Orderly Officer said that he spoke to the man on a personal level to ascertain reasons for his actions and to give him reassurance. He is one of the few officers trained in mental health problems. The man said he had felt unfairly blamed and was being made out to be the bully. The assist Orderly Officer tried to reassure him that no action had been taken against him and that officers had not interpreted it that way. He also said the man was upset about not having had any contact with his family and mentioned his previous overdoses. The officer said that the pool table incident was mentioned, but the man said it was not anything to do with that. His feelings had been building up over a few weeks.

60. The assist Orderly Officer sought advice from two nurses who were on duty in healthcare that evening, as to the length of time before any symptoms could develop. He was advised that this would be at least 72 hours or maybe longer before lethargy, and eventually unconsciousness, would set in. He was able to inform the night staff and the man's cellmate about this later so they could keep an eye on the man. For his part, the man continued to ignore all requests to comply with his medication and this prompted the assist Orderly Officer to ask the officer to open an ACCT. The man said he understood what the ACCT entailed. They continued to try to persuade the man to change his mind and offer him support.

61. As part of the ACCT process, the assist Orderly Officer asked the man whether he had anything in the cell that could be used to self-harm, or a note. The man passed the registered general nurse a note he had written addressed 'To Medical Staff'. This note, described by the man as an 'Advanced Medical Directive', said that "being of sound mind, body and judgement", should he go into a "diabetic coma or any medical problem including suicide", he did not wish any "medication, oxygen, blood transfusions, or any heroic life saving measures. As I do not have any more reason to live." The registered general nurse said to the man that he sounded serious and he replied, "I am."

62. Asked by my investigators what status she would have given this note, the registered general nurse said it was legal and sounded very serious. That was why she showed it to her colleague and put it in his notes. She was under the impression that he knew what he was saying when he wrote the note and was of sound mind. When asked whether she would have abided by the man's stated wishes in the directive, the registered general nurse said she was not sure. The registered general nurse and her colleague agreed that they had offered him all the help they could give at the time. The registered general nurse told my investigators that the note did not mention anything about an intention to hang himself, just about a diabetic coma and his wish for no intervention. She said she was aware of his previous attempted overdoses, although did not know how serious he was at this time.

63. The registered general nurse told my investigators that she had shown the note to both wing officers and confirmed that they knew what he had written. However, the officer said that he did not know of the contents of the letter as the man had said it was private and for medical healthcare. The assist Orderly Officer said he had never read the note. He had asked the registered general nurse what it said, but she said she could not tell him as it was 'in confidence'. On pressing her again a little later, she told him that it said if he were to lapse into coma or get ill he was not to have any medical intervention. The assist Orderly Officer asked again if he could see the note just to clarify whether there was anything else relevant, but again the registered general nurse did not show him. The assist Orderly Officer said that bearing in mind he was only concerned about a coma situation that could be as much as 72 hours away, having asked all the questions he did not anticipate the man's intentions to take his life that night. The assist Orderly Officer had asked him if he had made any plans and the man said no. His main focus was on the man falling into a coma, not anything more deliberate or immediate: "I'd a clear picture in my mind that the following day, if there was anything going on in his mind, that we could sort it, a night's sleep. He did not mention in any way that he was going to take his life by other means. I'd absolutely no other considerations having spoken to the man. He'd concealed his end very, very well."

64. My investigators gave the assist Orderly Officer the opportunity to read the directive during interview. Asked whether having read it on the day he might have changed his opinion, he said it still did not lead him to believe that the man was going to self harm in any other way than by insulin refusal, but it did throw a slightly different slant on things. At the time though, he had to work with the information he had in front of him: "Reading the letter [now], it is quite plain something was going to happen, but like I say, I can only work on the actions that I took at the time."

65. An officer completed a self-harm/attempted suicide report and opened an ACCT at 7.15pm. He said they were unsure at the time whether suicide was intended, but the risk of self-harm via food refusal was sufficient reason to open the ACCT. The officer referred to the letter to medical staff "stating his intentions". He also referred to this in the wing history sheet as a "letter for healthcare staff regarding his actions". There had been no discussion to move

the man to healthcare since this would not have been usual practice. ACCT encourages the management of suicide/self harm risk on normal location.

66. The registered general nurse returned to healthcare and discussed the man with her colleague. She told him that the man was refusing his insulin, food and had given her a note stating he did not want medical intervention in the event of any life threatening situations. She gave the note to her colleague. He asked if wing staff were aware of the note and if an ACCT had been opened. She said they were aware and, on calling the wing, she confirmed the ACCT had been opened. She recorded these events in the man's medical record at 7.30pm. She made a note to discuss with the GP, healthcare manager and MHIT the next day. The registered general nurse said she intended this to be in relation to further intervention, but not to deal with the directive specifically. She referred to the opening of the ACCT and a "suicidal note" given to her. My investigators found no further evidence of plans to deal formally with the Advance Medical Directive.

67. At 8.00pm, the assist Orderly Officer completed the 'Immediate Action Plan' on the ACCT and indicated that the man was to stay in his double cell and a referral made to MHIT. He was to have access to the Samaritans phone, the Listeners upon request, and to the Crisis Suite if necessary. The level of staff observation was set at hourly checks during the day (with three quality comments during this time) and half hourly observations at night (with an hourly comment). The assist Orderly Officer made these decisions based on the fact that the man got on well with his cellmate and, since the man's cellmate took sleeping tablets at night, he wanted staff to observe the man more frequently. It was not because he thought the man was at any raised risk because of a diabetic coma. Two prisoners mentioned in their evidence an officer joking that if he had to return after his shift to complete forms due to the man's behaviour he would "kill him". My investigators found no further evidence to support this.

68. The option of moving the man to a camera cell was not considered. On the night of 26 December, two of the camera cells were occupied by prisoners on an ACCT, but the remaining cell was occupied by two prisoners not at risk of self harm or suicide. The assist Orderly Officer then completed a mental health referral form noting that the man's current problems were a "lack of contact with family members due to custodial offences". The reality is that there was in fact only a two to three week gap in contact between the man and his family.

69. An officer came on duty for the night shift at 7:50pm. The night duty officer is not a permanent officer on night shift or F wing, and he had never met the man before. He was responsible for checking on all the prisoners and carrying out observations on those on ACCT. He carried an anti-ligature knife and a cell key in a sealed pouch in accordance with local policy. The night duty officer was familiar with the local contingency plans for suicide that are available on each wing. The assist Orderly Officer said he briefed the night duty officer fully and introduced him to the man, making him aware of the level of support that would be offered through the night. He also asked the man to sign the ACCT in agreement. The officer informed him of the four open ACCTs.

70. At around the same time, the night orderly officer took over for night duty. He had only been working at Preston for about six weeks and it was his first experience of night duty. His responsibilities were to oversee the running of the prison at night, make checks on staff and unlock cells if necessary. The assist Orderly Officer returned to the centre of the prison to handover and informed the night orderly officer about the ACCT being opened due to the man's refusal of insulin and the potential medical risks. The night orderly officer went over to F wing during the night and spoke to the night duty officer, but there were no concerns expressed over the man at that time. The night orderly officer recalls 26 December as a very quiet night.

71. At about 8:30pm, two night nurses who are permanent night duty staff, came on duty. The registered general nurse left the prison before they arrived. Handover between shifts in healthcare is done verbally and there are three written records staff may check: the In Patient handover book, the Nurse in Charge Significant Event Handover, and the Primary Care Observation Book. The registered general nurse did not add anything to her earlier entry in the Nurse in Charge Significant Event Handover about receiving the directive. The In Patient handover book, signed by her colleague, referred to an ACCT being opened but not to the medical directive. The Primary Care Observation Book mentions neither.

72. The registered general nurse's colleague gave a verbal handover to the two night nurses that the man had refused insulin and food and that, if during the night he changed his mind, they should ensure he got access to food and prescribed medication. He also said he told them of the ACCT, but was unsure whether he had mentioned the note. Neither of the nurses recalled being told about the man's food refusal, the ACCT or the note, although the first night nurse had signed the handover sheet from the nurse stating "(the man) – RSU. Refusing insulin and food. On ACCT." There were no immediate concerns for the man's health at the time as he had only refused insulin that evening. The first night nurse said they had seen the medical directive for the first time on discovering it on the man's clinical record whilst recording incident details the following day.

73. At 9:00pm, the night duty officer began the night observation procedures requiring him to look through a small window in the cell door to check the prisoner. He first observed the man lying on his back in bed in his underwear. He made himself known, but the man did not respond. The man's cell mate appeared to be asleep and the night duty officer did not speak to him that night. At 10:00pm, he observed the man lying on the bottom bunk asleep. Throughout the night he appeared to be in and out of bed and intermittently asleep. When the man was awake, the night duty officer did not attempt to make conversation so as not to wake other prisoners. However, at 2:00am when the night duty officer observed the man on the toilet he made eye contact, appearing annoyed that his privacy was being compromised. The night duty officer said that the man's cell was well illuminated all night as the television was on. During the half hourly checks, the night duty officer did not notice anything unusual about the man. The night duty officer recorded hourly observations until 5.00am the next day when he observed the man standing up

in his cell with his back to the door. He had something in his hand, which with hindsight he questioned might have been a ligature. He looked as if he was about to use the toilet. The man did not turn around or acknowledge the night duty officer.

The prison's response to finding the man

74. Just after 5.25am on 27 December, the night duty officer was carrying out a half hourly check on the man. At first, on looking into the man's cell he thought he was just standing at the back of the cell with his arms at his side. It was then that he saw a ligature around his neck. He was hanging from the window bars facing the door and was unconscious. Realising that his radio battery was flat, the night duty officer had to run downstairs to the office to call a "Code one on F wing on F2" to the communications room by telephone. (A code one signifies to staff that there has been a hanging or attempted hanging, so that they are aware of what to expect before arriving.) At 5.27am, this message was relayed to all night staff, including the night orderly officer and medical staff. The night duty officer then immediately ran back to the cell, broke the seal on his key pouch, opened the door and entered the cell. He also broke the seal on the anti-ligature 'fish' knife he was carrying and attempted to cut the man down. Unfortunately, he could not do this on his own as the man had used a full bed sheet. The night duty officer remembered that the man looked a normal colour and, although he was quite cold on the top half of his body as the window was open and it was cold outside, he was quite warm to the touch under his arms. He was not breathing. Because the man's cellmate had taken sleeping tablets that night, he was still asleep and was woken up when other staff arrived.

75. An officer arrived at the cell first within about a minute, followed by a second officer. A third officer then arrived followed by the night orderly officer shortly after, but there was not enough room for all four officers to fit easily in the cell. Within minute, the two night nurses arrived outside the cell carrying the green emergency bag that the second night nurse had picked up from the C wing treatment room on their way. This contained oxygen, airway equipment, a blood sugar testing kit, an ambu-bag and mask. They did not consider bringing the defibrillator with them (it was also kept in the treatment room). They just wanted to get to F wing as soon as possible and assess the situation.

76. The man's cellmate was moved to another cell, accompanied by an officer for support. The three officers lifted the man up and the second officer lifted the ligature over his head. They then moved him onto the landing where there was more room so that medical staff could attempt resuscitation. The man was a tall and well-built man and the cell was very small, so the officers had trouble carrying him out. The first night nurse asked the night orderly officer to call for an ambulance. He also contacted the duty governor. The ambulance was called at 5.35am.

77. The second night nurse noted that the man was unconscious, not cyanosed (abnormal blue discoloration of the skin and mucous membranes), but very cold. Both nurses checked for signs of life but there were none. There was no rise and fall of the chest and no pulse. They then commenced Cardio-

Pulmonary Resuscitation (CPR) with the first night nurse doing chest compressions and the second night nurse giving ventilation via an ambu-bag (a mask and airbag). The second night nurse had some difficulty inserting the airway into the man's throat. She found it hard to hold the man's head up, so the first night nurse held the mask in place whilst she held the airbag. Chest compressions were continued by the second officer and then the night duty officer until paramedics arrived. The third officer left to attend to other duties. They could see the man's chest rise and fall so they knew oxygen was reaching his lungs, but there was still no response. The nurses told my investigators that with hindsight, because the ambulance was on its way and because of the man's condition, there would not have been much point in using the defibrillator. However, they did not think about it at the time. The CPR was continued until the paramedics arrived eight minutes later at 5.43am.

78. As the night orderly officer is the only member of staff with a set of keys at night, he went to the gate lodge and met the arriving paramedics. The outer and inner gates were opened one at a time, in accordance with local protocol to ensure maximum security for the prison. The night orderly officer said this would have taken a matter of minutes. He took them straight to the emergency exit to F wing, which is right opposite the ambulance gates. Fortunately, this had been taken off the night locking system minutes before the man was found by the assist orderly officer.

79. Two of the paramedics took over at this point. They hooked the man up to their ECG monitor, took a heart trace and made several other assessments. They found no activity so they decided that efforts to revive the man should cease. They pronounced life extinct at 5.45am. The paramedic recorded that the man's outer extremities were cold, that there was evidence of pooling (where the blood accumulates in one part of the body due to lack of circulation) and that the man was in asystole. The paramedics covered the man's body and put him back in the cell. The first night nurse contacted a doctor who arrived about half an hour later. At 6.55am, the doctor recorded in the medical record that paramedics had confirmed the death, the man's body was in the cell and there was no need for further medical inspection. At around 6.15am, the cell was sealed to await the arrival of the police.

80. The first night nurse then went to see the other prisoner who was very upset. She made an entry in the clinical record and on the Primary Care Observation Book. The second night nurse completed form F213SH to record details of what had happened.

The prison's response following the man's death

81. The duty governor arrived soon after and ensured all staff had completed statements. About half an hour later the acting Governor arrived and the night orderly officer gave him a verbal handover of what he had set out in the central observation log for the prison. All contingency plans for a death in custody were put in place, including contacting the relevant authorities and supporting staff.

82. The duty governor held a hot de-brief for staff involved at around 8.15am. He thanked all of the staff and they discussed what had happened. A representative from the Care Team attended and made subsequent contact with all staff who had been involved. The night orderly officer was fairly new to HMP Preston, recently promoted, and this was his first time on night shift. Both The night duty officer and the night orderly officer returned to duty that night. Although both nurses were offered Care Team support, they missed the hot de-brief because they could not be released from their shift. A manager (not their own) contacted them to see how they were coping, but this was not until the following night shift.

83. Because the man's family live in Glasgow, the acting Governor asked Glasgow Police to break the news of the death to the man's parents that morning. The prison also tried to contact a chaplain in a nearby prison. The police went to their house to inform them. Only the man's mother was at home at the time. The police offered to stay until her husband arrived, but the man's mother said it was not necessary. The police did not give clear details about exactly what had happened and simply said it was a suicide. They gave the man's mother a card with a contact number for the acting Governor and advised her to ring the prison.

84. The man's father rang the prison at about 12:00 noon and spoke to an operational manager and the prison family liaison officer. At this point, the prison's liaison manager had not been informed whether the police had made contact with the family, or what details they had been told, so he was initially unsure of what to tell the man over the telephone. Unbeknown to him, Glasgow police had in the meantime called the acting governor and told him that the family had been informed. When the man asked for the exact details of the man's death, the prison's liaison manager said that he could not disclose all the details before the post mortem, just that he had taken his own life. The liaison manager told my investigators he felt the telephone was an impersonal medium through which to convey the exact details of the death, and so he arranged to meet the family in person the next day to deliver the news. Unfortunately, the family were shocked to see details of the 'hanging' on Ceefax the next day before this meeting took place. The press release also gave details of the man's alleged offence that the family found upsetting. The family said that, despite this, the prison's liaison manager had dealt with the situation sensitively.

85. The acting Governor sent a letter of condolence to the family on 28 December with a list of agencies that could offer support. The prison's liaison manager and the Roman Catholic Priest met the family and visited the man in the Chapel of Rest. The Priest gave the family Preston's 'Death in Custody support booklet for families'. The prison's liaison manager returned some of the man's personal possessions to them. The prison offered to contribute towards the cost of the funeral. The family were asked if they wanted to visit the prison, but declined.

86. The man's family also wanted to clear his son's flat and so the prison's liaison manager made the necessary arrangements.

87. The post mortem report concluded the cause of death to be asphyxia by hanging.

88. The man’s funeral was held on Friday 6 January 2006.

ISSUES CONSIDERED DURING THE INVESTIGATION

Mental Health

Referral process and decision to refer to primary level care

89. Overall, the man was dealt with well at reception and the decision to open the ACCT was appropriate. The 'mental health assessment' box of the First Reception Health Screen form should have been ticked for completeness, since the man answered 'yes' to the questions that gave rise to a mental health assessment referral. However, the registered general nurse's comments give rise to questions over the functionality of the form. She knew that the man's mental health problems did not amount to a mental health illness sufficient to require an assessment. As the MHIT manager confirmed, such an illness would be defined as being "severe and enduring", such as paranoid schizophrenia or bipolar disorder and would relate to a secondary level of mental health care. She knew that the MHIT only took secondary level cases onto their books and that they would have concluded an assessment was unnecessary. She also said that, as part of the ACCT, the man would have been seen by outreach mental health nurses.

90. In the event, the man was referred to the MHIT as part of the ACCT process. Whilst I accept the registered general nurse's reasons for leaving the form blank, it should always indicate the planned action on the last page whether or not someone is eventually referred by MHIT for an assessment.

    I recommend that all Healthcare staff be reminded to fully complete Reception Health Screening documents and refer prisoner patients to appropriate specialist services.

91. The clinical review concludes that the decision to refer the man to primary level mental health care was a sound one. However, the clinical review also finds that a primary care service is not established both in terms of referral criteria and its provision. It concludes that the whole process of mental health services needs reviewing, including referral criteria to in-reach and primary care.

Further reception health checks

92. The clinical review finds that no secondary screen/well man assessment was completed for the man within five days of reception as required. It concludes that the practice of not requiring further screens for those prisoners moved to the vulnerable prisoner unit is unacceptable and recommends a change in practice.

Primary care level mental health provision

93. The standard of healthcare provided in prisons should be equivalent to that which prisoners could expect to receive in the community. During the man's time at Preston, he requested 'counselling' on a number of occasions, most

pertinently reflected in the letter to his family. At his follow up ACCT review, the man said that he felt positive about the fact he would get help.

94. In the man's long discussion with the prison doctor, she gained great insight into the man's feelings and he asked for counselling. He was aware Preston offered no primary care counselling, which distressed him as he wanted short-term help to come to terms with himself and discuss his offence. The man's referral for support was thereafter somewhat circular as he was passed to outreach for counselling, even though they did not offer this service, and then back to the chaplaincy where it was clear for numerous reasons that this was not the right type of support.

95. Despite this, the man was offered Listeners, the Samaritans and visits to the chapel, none of which he accepted. Officers also tried to encourage him to associate more on the wings and to take part in activities. The man was also given anti-depressants to help his depression and low mood. However, there appears to be a lack of primary care mental health provision, particularly short term crisis counselling, in the absence of other possible counselling for sex offenders at that stage of their custodial sentence. As far as my investigators could tell from the records, the man never received any outreach mental health support and accessed no counselling services. It appears that there was little if no provision for support and advice for someone in his position.

96. The MHIT's remit does not cover primary care, although provides a useful signposting service. Due to pressure on resources and the volume of self-harming prisoners, provision by the MHIT is not possible in primary care and would be inappropriate.

97. The prison doctor said that the MHIT had a "very narrow remit, narrower than you would find in a community mental health team in the wider community." She said that, although there were outreach mental health nurses from the NHS, employed in the prison by the PCT, there was still no formal system to provide a structured treatment programme similar to the community. She highlighted that the ACCT process works well in these primary level cases. However, she felt there was a gap, although she said that counselling would not have prevented the chain of events that occurred. It is disappointing that the man was unable to access this low level support despite several requests.

98. The clinical review considers whether the level of primary level mental health care available at Preston was reasonable and comparable to that expected in the community. It concludes that, although the man's needs were generally met, apart from the service provided by the chaplaincy, there was no access to primary care counselling and this was not recorded anywhere as an imminent need. It notes that a primary care service is not established in terms of provision and questions the effectiveness of a service (MHIT) that refers to another (primary care/counselling) knowing it may not be able to deliver that service. It recommends a comprehensive review of the process and delivery of mental health services at Preston, including the provision and quality of interventions and unmet need. I endorse this recommendation.

99. I understand that, at the time of completing this report, the PCT, Lancashire Care Trust and prison healthcare have already embarked on the first stages of this review and the issues raised by the clinical review were discussed at a Prison Partnership Board meeting on 26 June. I am pleased that this work has been progressed so rapidly.

Information sharing between medical and discipline staff

100. The registered general nurse recalls discussing the man's Advance Medical Directive, with an officer and the assist Orderly Officer. She also recalls showing the note to them and referred to it as a "suicide note". Neither officer recalls being shown the note and each maintains that, although they knew about the man's intentions not to be resuscitated should he go into a diabetic coma, they were not aware of the man's reference to suicide or having "no more reason to live". According to the officers, they were dealing with a self-harm issue and to some extent had not appreciated the immediacy of the risk.

101. The assist Orderly Officer considered that, had he seen the full note, he probably would not have behaved differently. The night orderly officer told my investigators that had he known about the note he might have had stronger concerns and put the man on 15 minute observations. However, he doubted whether this would have prevented the man from taking his life. The registered general nurse' colleague confirmed that, due to the nature of the contents of the note, he would have shared them with anyone relevant. He knew that discipline staff were aware of the contents, although he could not confirm they had actually seen it.

102. National guidance on confidential health information sharing states that disclosure should normally only take place with the consent of the individual concerned. Disclosure without consent can be made in exceptional circumstances if it is considered essential to protect the individual from the risk of death or serious harm (HM Prison Service Information and Practice Guidance on the Protection and Use of Confidential Health Information in Prisons and Inter-Agency Information Sharing 1/2002).

103. The ACCT: Caring for People at Risk in Prison guidance sets out guidelines for confidentiality and appropriate disclosure agreed by the Prison Service and the Department of Health. The healthcare team is responsible for providing relevant information about their patients to ACCT Assessors and Case Managers as part of the assessment. The guidelines state:

- There is a professional duty for all healthcare workers to receive patient information and use it in a confidential and professional manner at all times.
- All healthcare workers have a duty to pass on information that involves issues of patient safety, vulnerability or immediate risk to self or others to relevant staff, wherever possible, firstly ascertaining the person's consent to share this information. In situations where the individual's safety is compromised but they are unable or unwilling to give consent then health professionals have a duty of care and the relevant information may be disclosed.

- Health or social information of a sensitive nature needs to be released in a way that ensures that patient confidentiality is maintained but any issues involving their safety or vulnerability are highlighted to the relevant staff.
- Information that is received and identified by any staff as highlighting risk including physical, medical or social risks involving the prisoner or immediate others needs to be shared in a timely way with the relevant people.

104. Preston has a clear local policy on confidential health information sharing, particularly in relation to ACCT. It states that the care for prisoners at risk must be multi-disciplinary. Healthcare managers should ensure that procedures are in place to allow Unit Managers and members of Assessor teams to access relevant, risk-pertinent information about prisoners for whom they are caring. Risk-pertinent information is defined as "information relevant to understanding the level of risk and also information about how to reduce that risk". The policy also highlights that the person at risk can consent to relevant health information being shared with residential staff involved in their care by signing the ACCT plan.

105. If discipline officers were only focussed on the risk of death by diabetic coma, I conclude that it was reasonable for them to have waited until the following morning before taking further action. I also conclude that they would not have acted differently had they known the full details of the note. Indeed, officers followed all the correct procedures to support the man in his distress. Nevertheless, full disclosure of the note to the officers was both possible and desirable, in order to allow staff to assess and fully understand the level of risk and decide what support was needed to reduce it.

106. I consider that the note contained risk pertinent information that was relevant to understanding the man's safety, vulnerability and immediate risk. I consider that the reference to suicide is relevant to assessing the level and immediacy of that risk by wing staff. Staff involved had different recollections of the information shared and therefore I cannot be conclusive about what took place. While I do not consider that the full disclosure of the note, if it was not disclosed, would have prevented the man's death, I think this confusion highlights the uncertainties staff feel in relation to sharing information between different disciplines.

107. In any event, wing staff had obtained the necessary consent from the man by asking him to sign page two of the ACCT. In order to ensure that the ACCT process is effectively managed by both medical and discipline staff, Preston's local policy needs to be reinforced to reduce uncertainties around information sharing. The clinical review also concludes that, although information was shared, awareness training and education is needed on information sharing to avoid the inevitable confusion over guidelines governed by a multitude of legislation.

The Governor and Head of Healthcare should ensure that both healthcare and discipline staff are made fully aware of and understand local policy

on confidential health information sharing, and remind all staff of the importance of information sharing, particularly in relation to ACCT.

108. Generally, I note there was a good level of information sharing and contemporaneous records made in the ACCT and the clinical record. There are three records that facilitate the handover of information between medical staff at Preston. Again there are differing accounts of the information handed over verbally and the records show inconsistencies. I consider that at least the first night nurse would have known about the ACCT and food refusal since she signed the in-patient handover sheet. It is likely that neither of the nurses knew about the note. The only reference was on the clinical record and staff are not required to look at this on handover. A verbal handover should be sufficient so long as the person handing over is fully apprised. The first night nurse said that, had she been aware of the full circumstances, she would have made a decision to transfer the man to healthcare that night to keep a closer eye on him.

109. As I set out in this report, I do not consider that the man should have been transferred to healthcare. However, I do consider that staff should be given as thorough a handover as possible whether in writing or verbally between shifts. The records of the circumstances were inconsistent and the directive should have been communicated both verbally and noted in the records.

110. Whilst not a formal recommendation, healthcare staff should be alert to the need to record information in healthcare records consistently and to provide a thorough handover to staff on changing shifts

Treatment of the Advanced Medical Directive

111. Following refusal of his insulin medication and tea meal on the evening of 26 December 2005, the registered general nurse, the officer and the assist Orderly Officer went to speak to the man to reassure him and to try and dissuade him from his course of action. They pointed out the possible consequences of not taking his insulin. The man continued to refuse his treatment and an ACCT was subsequently opened by officers. During this conversation, the man handed the registered general nurse a note, that she describes in the clinical record as a "suicide note" but the man referred to as an 'Advanced Medical Directive' setting out his wishes. It said:

> "To Medical Staff
>
> I (the man) being of sound mind, body and judgement give an Advanced Medical Directive, that should I go into a diabetic coma any other medical problem including suicide I do not wish any medication, oxygen, blood transfusions, or any heroic life saving measures. As I do not have any more reason to live. Thanks for your co-operation. (signed by the man)."

112. The registered general nurse took this back to the healthcare centre and showed it to her colleague. They discussed the matter, ensured that an ACCT

had been opened by officers, and her colleague put the note on the man's clinical record.

113. The Department of Health provides guidance on providing healthcare to people in prison who have withdrawn consent to treatment in 'Seeking Consent: Working with People in Prison' (DoH July 2002). The guidance states: "If your work involves providing health care to people in prison, you need to make sure you have your patient's consent to do what you are doing, if they are able to give it. Respect for people's rights to determine what happens to their own bodies is a fundamental part of good practice. It is also a legal requirement. The fact that a patient is also a prisoner does not affect their right to determine whether or not to accept treatment, where they have the mental capacity to make such a decision."

114. The guidance continues: "Before you provide treatment for a patient, you should ensure that you have their consent to do so. For a patient's consent to be valid, the person must:

- have the capacity (be "competent") to take that particular decision
- be acting voluntarily (not under duress)
- be provided with enough information to enable them to make the decision.

> "The law presumes that an adult has the capacity to take their own healthcare decisions unless the opposite is proved. People with the capacity to take a particular decision are entitled to refuse any treatment being offered, even if this will clearly be detrimental to their health. No competent adult (defined as a person aged 18 or over) can be treated against their will."

The guidance states that healthcare staff should assess the capacity of the person to make the decision in question and the conclusions drawn should be recorded in the prisoner's clinical record.

115. The guidance goes on to consider 'Advance Directives' in which people can express clear views as to how they would like to be treated if in future they were to lose capacity:

> "If a person makes an advance refusal of certain kinds of treatment, then such a refusal is legally binding if, at the time of making the decision, the individual was competent, they understood in broad terms the implications of their decision, and the refusal is applicable to their current situation."
>
> Decisions relating to determining capacity to withhold consent are a matter for the responsible treating doctor (or nurse/healthcare officer if an emergency arises and a doctor is unavailable) in consultation with other members of healthcare. Nurses and healthcare staff would be expected to take all action to preserve life while seeking advice and attendance of a suitably qualified person.

116. Healthcare and discipline staff involved acted correctly in their approach not to force the man to accept treatment without his consent. The man was acting voluntarily when he wrote the note, and staff gave him sufficient information about the potential consequences of his action to enable him to make that decision. However, the next stage would have been to assess his competence to make that decision and therefore the legal status of the advanced directive.

117. In the circumstances, the man was not at any risk of falling into a coma immediately. Whilst I am satisfied that it was reasonable to have delayed any action to be taken until the morning, there seem to have been no explicit discussions amongst staff about whether the man had the relevant capacity to withhold consent.

118. Although the registered general nurse assessed the man as being of sound mind and recorded a plan to discuss this with the doctor, the healthcare manager and MHIT the following day, she later told my investigators that she meant this in relation to further interventions but not specifically to deal with the directive. When asked whether she would have abided by the man’s stated wishes, she said she was not sure. Asked by my investigators what status she would have given the directive, she said “it was legal and sounded very serious”.

119. The nurse also told my investigators that he had never come across a medical directive before and felt he would benefit from further training in this matter. At the end of his shift, he filed the directive on the man’s medical record. He did not inform night staff about it and said he was unaware of any other staff involvement. Two other nurses had since discussed this with the Healthcare Manager and confirmed that, had they known about it, their response would not have changed. Unless the document was witnessed by a doctor or solicitor they would not have given it more formal recognition. The first night nurse said she had never come across a directive before. Discipline staff did not discuss its implications with my investigators, referring to it only as a note.

120. Overall, my investigators found that staff did not feel properly trained or equipped in how to deal with the advanced medical directive. Preston does not have a local policy on advanced directives. The clinical review recommends the provision of awareness training and education regarding medical directives for all staff and I am pleased that the PCT have already agreed to this. I fully support this, particularly as staff have raised this as a training need.

The Governor and Head of Healthcare should develop a local policy dealing with advanced medical directives based on national policy and guidelines.

Transfer to the Healthcare Centre

121. Prison Service guidance says that healthcare staff are responsible for providing appropriate care, where the person is at risk of self harm or high risk. This does not mean that that person should be located in the healthcare centre. The clinical review concludes that the decision not to transfer the man to the

healthcare centre was reasonable. However, it also makes a recommendation that the healthcare service develop a pathway to provide an evidence base on which clinicians can base their decision to refer or not. I support the conclusion and recommendation.

Self-harm, suicide prevention and the use of CCTV camera cells

122. Prison Service Order 2700 sets out policy for identifying and managing prisoners at risk of suicide or self-harm and the care and support of such prisoners. It advocates an individualised, preventative and multi-disciplinary approach. The local policy at Preston mirrors this approach and is linked to the Violence Reduction Strategy dealing with bullying, indicating a holistic approach to safer custody.

123. The local strategy is based on a multi-disciplinary team approach rather than a purely medical model to support prisoners at risk, preferably on normal location using shared accommodation. Preston has a full time suicide prevention co-ordinator at senior officer level and an assistant officer dedicated to the ongoing implementation and monitoring of ACCT. Nearly all staff had been trained in ACCT procedures by December 2005. My investigators viewed the minutes of the local Safer Establishments Committee meetings whose membership reflects a multi-disciplinary approach.

124. The first ACCT for the man was opened on reception by a member of healthcare staff in a timely and appropriate manner, based on clear judgements about the man's behaviour and what he told staff about his previous self-harm. Possible mental health issues were identified and he was appropriately referred for support. The Immediate Action Plan and assessment interview were carried out in accordance with procedures and an appropriate level of case review followed to assess the man's state of mind. He was assessed after his court appearance on 2 December and the ACCT was closed the next day in consultation with him. Unfortunately, the ACCT closure was not noted on the man's wing history sheet. This is important information for staff on the wing to be aware of. In accordance with local policy, the post closure follow up review was held within 14 days.

125. Over time, the man's mood steadily improved. Although still low at times, he was associating more with other prisoners. He expressed no wish to harm himself until after he had served his sentence and made this clear to a number of staff. He had not self-harmed since he had been in prison. Preston has in place a quality check document that helps staff monitor the consistency and quality of the ACCT documents. This is checked and signed by a number of staff (including a senior officer and the Governor) each day. The quality of record keeping was of a good standard and the man was afforded the appropriate level of care. The only observation I have is that, despite Preston's local policy and ACCT guidance on continuity of care, the man's case reviews were carried out by different people each time.

126. On the night the man died, there were 16 open ACCTs in the prison, five on F wing. Levels of observations set were appropriate and the assist Orderly Officer took appropriate considerations into account in making that decision. The man was offered access to various avenues of support and was able to discuss his concerns with both wing and healthcare staff. His immediate action plan was timely and thorough and he was referred to the MHIT.

127. There are four overt camera cells on F wing. One of these cells is permanently occupied by the Listener. On the night of 26 December, two of the other camera cells were occupied by prisoners on an ACCT, but the remaining cell was occupied by two prisoners not at risk of self harm or suicide. This means that it would have been possible to move those prisoners in order to place the man (with his cellmate) in a camera cell, after he had been placed on the ACCT that night. However, I recognise that this might not have been practical at such a late stage in the evening. Given that the assist Orderly Officer and the officer knew that there was no risk of the man falling into a diabetic coma for the next 72 hours, it was reasonable to have waited until the next morning to make such a decision. The assist Orderly Officer said that although a camera cell had not been considered, it seemed appropriate for the man to remain in his double cell with his cellmate with whom he got on well. He also said that the observations were set half hourly with a view to increasing them to every quarter of an hour if deemed necessary during the night.

128. My investigators found that there was some confusion amongst staff about whether or not it was standard local policy to put prisoners on ACCTs in camera cells. The night duty officer said that, by and large, when a camera cell is available those prisoners on ACCTs go into them. But for some reason it was not done that evening. He also told my investigators he felt that the man should have been in a camera cell. The man's personal officer said that the prison tried to accommodate prisoners on ACCTs in camera cells, even if that meant moving those not on an ACCT around. The Suicide Prevention Co-ordinator felt that this was not standard policy as did the prison officer. The assist Orderly Officer told my investigators that it was not normal practice, but suggested that this might be something Preston could consider in the event of a suicide risk or if someone was withdrawing from drugs. The first night nurse said those on ACCT should be placed in camera cells if available. The night orderly officer said that, although they should not replace observations, prisoners on open ACCTs should be placed in camera cells, if available, as a secondary check.

129. When the man was first placed on an ACCT, it was decided to place him in a camera cell "until deemed no longer necessary". This implies that his behaviour made the use of such a cell a necessity. In addition, after the ACCT had been closed, officers made a decision to move him out of the camera cell to make room for someone else who was on an ACCT. Again this indicates the routine use of such cells for prisoners at risk.

130. I accept there are some practical difficulties in ensuring every prisoner on an ACCT is held in a camera cell. As the suicide prevention coordinator explained to my investigators, on both A and B wings there are no camera cells, and there may not be enough camera cells in which to house all those on ACCTs. I fully accept this and recognise the inadequacy of a blanket policy without consideration of the circumstances of each case. Other staff pointed out that CCTV footage can be unclear, particularly at night, and that cameras are not watched constantly when staff are on patrols. This is also highlighted in my last report into a self-inflicted death at Preston in 2005. However, placing ACCT prisoners in camera cells would provide a supplementary measure to safeguard

prisoners at risk, although it cannot replace other mechanisms such as observations. Preston's local ACCT guidance suggests that the benefits of locating the prisoner in a cell that is easier to supervise by staff should be considered.

The Governor should clarify to all staff whether or not it is standard local policy for all prisoners on ACCT to be placed in camera cells if available, and, if not, provide guidance on the circumstances in which this might be appropriate.

Staff and medical response to the man on 27 December

131. Staff responded quickly and appropriately to the discovery of the man hanging. Preston has a coded response system that enables staff to recognise the type of incident and carry the appropriate equipment there. The clinical review concludes that the code system is well established, rehearsed and utilised and that the staff response was carried out in a timely way and to a high professional standard.

132. On hearing emergency codes, medical staff take a green bag containing oxygen, airways equipment, a blood sugar testing kit, an ambu-bag and mask to the incident. There are two green bags available held in the healthcare wing, and they are quick to retrieve in an emergency. The bag is often left outside on the centre so it can be picked up on the way. Both nurses are required to respond. The defibrillator machine is also kept in the treatment room near the centre so it can also be easily accessed. All medical staff had been trained to use it in October/November 2005.

133. Both nurses told my investigators that it is not usual practice automatically to take the defibrillator to an incident. Nurses attend first, assess the situation and if necessary send someone back to the centre to retrieve it. The second night nurse was not certain if anyone other than healthcare staff had access to those keys. There was also some confusion amongst the healthcare staff interviewed over the correct use of the defibrillator. Although it would have made no difference to the man's medical care that day, the Head of Healthcare may wish to consider whether the defibrillator should be taken to medical emergencies as a matter of course.

The Head of Healthcare should consider making it local policy to take a defibrillator to a Code One emergency as a matter of course.

134. At night, the gates between the healthcare centre and the wings are left open for emergency access. When the ambulance arrived at the prison, the outer and inner gates were opened one at a time, in accordance with the local security policy. In some prisons in an emergency, the gates are opened simultaneously, to avoid undue delay for the ambulance's path. Although this process only took a matter of minutes and had no effect on the outcome of this case, I consider the double opening of gates in an emergency best practice. Whilst not a formal recommendation, I would urge the Governor to consider altering the protocol to allow double opening of the gates in an emergency.

135. When the night duty officer attempted to use his radio to call the Code One emergency, he found his batteries were flat and had to run downstairs to the office to call the communications room by telephone. Although this only delayed the message being conveyed by a matter of seconds, I consider that this was still an unnecessary delay. The night orderly officer told my investigators that this is a common problem in the prison that batteries do not charge up properly. Oscar Two who took the doubles off that night also ran out of batteries for his radio. I encounter the problem of flat radio batteries all too often in my investigations. The Governor will wish to consider if this is a general problem at Preston and if action can be taken to remedy it.

Prison response following death/support for staff

136. Although nursing staff were offered Care Team support, they missed the de-brief because they could not be released from the rest of their shift. PSO 2710 states that staff wishing to attend but unable to attend to do so should be followed up as a group or individually. I consider that nursing staff involved should have been released from duty to attend the de-brief. I do not consider that they were followed up sufficiently by their line managers or other staff.

The Head of Healthcare should remind managers of the importance of staff care and welfare in accordance with PSO 2710 and local policy, particularly the importance of attending the staff de-brief following a death in custody.

Notification of the death to the family

137. Overall the prison dealt sensitively with notification of the death to the family. Although the prison did not inform them personally, this was reasonable in the circumstances since the man’s family lived a long way from the prison and the prison made appropriate arrangements for the police to do this. The family were given a contact number for the prison’s family liaison contact. They saw the prison’s Roman Catholic priest and were offered support and advice throughout the early days after the man’s death. The prison’s liaison manager kept in regular contact with the family. He liaised with the Coroner and the man’s landlord in order to access his property.

138. In light of the advice in PSO 2710, published after the man’s death, one of my Assistant Ombudsmen asked the prison to consider contributing a further sum to the funeral costs. The Governor readily agreed in accordance with the new guidelines.

139. The prison’s liaison manager told my investigators that when the man called him he did not know whether the police had made contact with the family or the details conveyed. It was an awkward conversation in which he established that they knew of the man’s death, but he felt the telephone was an impersonal way of conveying the exact details. He felt it better to talk to them in person the next day. It was unfortunate that Ceefax published details of the man’s death and offence before this meeting took place. It is standard practice for the prison or

the Prison Service's National Operations Unit to issue a press notice including details of the offence. This is not usually done until it is confirmed that the family have been informed of the death. In this case, the family had been informed but were not in possession of all the facts. Although I appreciate the prison's liaison manager's sensitivity to the family finding these details upsetting, the prison should have released them to the family as soon as possible to avoid their finding out publicly.

Bullying and supervision on the wings

140. The man's family raised concerns about the possibility of the man being bullied on F wing. My investigators found that this was not substantiated by evidence. The man was involved in a dispute over the pool table on 26 December involving another prisoner. Both the man's cellmate and the other prisoner interviewed first described the prisoner's behaviour as 'bullying', but both later confirmed that the man was not the subject of persistent bullying. The other prisoner said that the man had never discussed being bullied with him and the man's cellmate that he had not generally been bullied on the wing.

141. The man's personal officer was unaware of any bullying against him and said that F wing was a fairly open and small wing where officers were generally aware of incidents. An officer said that the prison had a monitoring procedure that would be put in place in the event of bullying which involved both the victim or 'target' and the bully being closely monitored. The assist Orderly Officer spoke with the man about the pool table incident and the man's concerns were focussed on being unfairly blamed and being made out to be a bully himself. The assist Orderly Officer reassured him that no action had been taken against him and that officers had not interpreted it in this way. The man did not mention that he felt he was being bullied, just that he had been unfairly treated by staff.

142. The most recent report by Her Majesty's Chief Inspector of Prisons showed that bullying was not being effectively tackled at Preston and made a recommendation to ensure an effective anti-bullying scheme. Preston has since developed a Violence Reduction Strategy under which tackling anti-social behaviour procedures are governed. This is closely aligned with the Suicide Prevention Strategy with relevant violence reduction information being cascaded to safer custody meetings. Under the strategy, bullying is defined as "conduct motivated by a desire to threaten, hurt, or frighten someone. It can be physical, verbal, psychological, emotional, or economical and involves an imbalance of power. It is usually repeated behaviour, unprovoked and intended to cause fear or harm to the victim."

143. Whilst there was clearly an altercation between the man and another prisoner over the pool table that should not have been left unsupervised by staff, my investigators found no evidence that this amounted to a systematic and repeated pattern of behaviour that would constitute bullying. An officer reprimanded the man about the pool ball and the man felt he had little chance to defend himself. The officer appears to have raised his voice in the earshot of other prisoners in the open part of the wing which might have upset the man.

The only reference in the wing record describes an argument and pool balls being removed from the table. It does not mention how or whether the other prisoner was dealt with (I think he should have been reprimanded too). Neither is the incident referred to on the man's wing history sheet.

The Governor should remind all wing staff to keep all areas for association properly supervised so that prisoners feel safe, and that all incidents are dealt with accordingly and properly recorded.

RECOMMENDATIONS AND GOOD PRACTICE

The following recommendations were made following the investigation and all have been accepted by the Prison Service. The response from the Prison Service has been included after the relevant recommendation.

1. **All Healthcare staff should be reminded to fully complete Reception Health Screening documents and refer prisoner patients to appropriate specialist services.**

   A Staff Information Notice is to be issued by Head of Healthcare and a system of management checks to be implemented to ensure compliance.

2. **The Governor and Head of Healthcare should ensure that both healthcare and discipline staff are made fully aware of and understand local policy on confidential health information sharing and remind all staff of the importance of information sharing, particularly in relation to ACCT.**

   Confidentiality and appropriate disclosure is covered in pages 21 & 22 of the ACCT pocket guide for staff and it is a national requirement that all staff in contact with prisoners/trainees are familiar with ACCT i.e. trained to at least ACCT Foundation level.

   Staff Information Notice to be issued which highlights the relevant section of the local ACCT protocol.

3. **The Governor and Head of Healthcare should develop a local policy dealing with advanced medical directives based on national policy and guidelines.**

   Policy to be developed and published as part of the local Caring for the Suicidal Policy.

4. **The Governor should clarify to all staff whether or not it is standard local policy for all prisoners on ACCT to be placed in camera cells if available, and, if not, provide guidance on the circumstances in which this might be appropriate.**

   Local Caring for the Suicidal Policy document to be amended to clarify the use of camera cells.

5. **The Head of Healthcare should consider making it local policy to take a defibrillator to a Code 1 emergency as a matter of course.**

   Policy to be developed and notified to staff

6. **The Head of Healthcare should remind managers of the importance of staff care and welfare in accordance with PSO 2710 and in accordance with local policy, particularly the importance of attending the staff de-brief following a death in custody.**

Staff Information Notice to be issued, reminding all staff of the role of Staff Care and Welfare services.

All managers to be reminded via e-mail of the importance of the Staff Care and Welfare services.

7. **The Governor should remind all wing staff to keep all areas for association properly supervised so that prisoners feel safe, and that all incidents are dealt with accordingly and properly recorded.**

   A Staff Information Notice to be published

Good Practice

8. **I commend the night duty officer's actions in entering the man's cell on his own without waiting for colleagues to arrive.**

9. **I commend the use of the feedback letter, updating ACCT teams on action taken by MHIT following a referral, and placed on the prisoner's ACCT folder, as a good example of information sharing.**

10. **I commend as good practice the 'Closed ACCT Quality Check Report' used and completed by the Safer Custody Team, to assess whether ACCTs have been opened appropriately at reception and the correct support put in place.**

Clinical Review Recommendations

The following learning has been identified by the clinical review. I endorse these learning opportunities and am pleased to report that the PCT / Prison partnership have accepted all the recommendations and drawn up an action plan to address them.

1. **A system needs to be established to ensure that prisoners moving from reception to the vulnerable prisoner wing have a second screen within five days of reception.**

   Nurses are checking the reception register to ensure that all well man assessments are completed. This will also be added to the primary care task list to ensure this is completed

2. **That clarity is achieved for the Mental Health Service within HMP Preston in terms of:**
   - **Provision, including quality of interventions**
   - **Roles and responsibilities**
   - **Referral criteria to in-reach and primary care**
   - **Unmet need.**

   This should be done by way of a comprehensive review with commissioner, provider and prison involvement.

   This was discussed at the Partnership Board meeting held in August 2006. The Commissioners have agreed to facilitate a review of the Mental Health In reach Services and ensure these dove tail with developing mental health provision. The prison mental health development group is also working on a document that describes the tiers of service and referral criteria for services provided and those under development. The consideration of implementing an unmet needs system as described in the Care Programme Approach will be considered as part of this development

3. **The prescription and administration record chart should be completed fully and the 'medication omission use codes' used appropriately. A note of refusal in the clinical record is useful. A frequent audit of these should be undertaken by the Healthcare Manager (or designate) to ensure the standard is maintained on no less than a six monthly basis.**

   Prescription cards are checked twice weekly to ensure compliance with medication and accuracy of information as part of an ongoing system of audit.
   A notice to staff will be reissued to ensure that they complete prescription cards and record any refusals in line with policy.

4. **That staff are re-educated and re-trained if necessary to the standards of record keeping set out by their appropriate professional body. The standard of record keeping should be audited by the Healthcare Manager or designate to ensure maintenance of the standard and should be no less than on a six monthly basis.**

Training to be sourced on record keeping and delivered to staff. This will reinforce requirements of NMC also audit to take place on recordkeeping as part of Healthcare Audit Calendar October 2006.

5. **Healthcare and discipline staff to receive awareness training and education regarding information sharing, use of existing guidelines/protocols and advanced medical directives. The aim of which should be to enable confident disclosure of information between professionals and clarity of the legal processes needed to ensure directives are used appropriately, for the prisoner, their families/carers and staff.**

   Relevant training to be sourced and a session to be delivered

6. **That the partnership board review the [emergency response code] system with the aim to ensure it remains 'fit for purpose' for the needs of prisoners within HMP Preston and this should be done no less than annually.**

   To be placed on Agenda for Partnership Board meeting planned for October 2006. Presentation will take place on current system and discussion to ensure it is 'fit for purpose.'