Investigation into the death of a man at Royal Preston Infirmary while a prisoner at HMP Preston in August 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the circumstances surrounding the death of a man, who died after inflicting fatal injuries to himself. The man was a newly sentenced prisoner who had arrived at HMP Preston from court the day before his death. He used a wheelchair as a result of a stroke and was depressed by his physical limitations and very keen to improve his mobility. At the time he was sentenced, he was about to undergo three months intensive physical therapy. His prison sentence meant that he had to forego this.

The man appeared to be in relatively good spirits during his brief time in Preston but at the earliest opportunity he obtained a razor from staff and made four deep and fatal lacerations to his neck and groin. I offer my condolences to his family and I hope that this report answers their questions regarding his death.

The investigation was led by one of my senior investigator and my family liaison officer. The clinical reviewer provided a clinical review of the healthcare offered to the man in Preston. Her report is at Annex 1. I am grateful to the Governor and staff at Preston and Preston Crown Court for their co-operation with this investigation. I am also grateful to Preston CID for sharing important information with my investigator.

This is a particularly tragic story. The man was depressed about his physical condition. A pre-sentence report and psychiatric report told of his frequent thoughts of suicide and that he had taken an overdose in the months before his sentence. On the basis of these reports, probation staff at Preston Crown Court assessed him as being at high risk of suicide or self-harm if sent to custody. A court probation officer sent a warning form by fax to the prison to alert staff to the man's state of mind. A police investigation was unable to determine conclusively what happened to this fax but the man was not made subject to self-harm monitoring.

It is essential to learn from this distressing case. I therefore make recommendations to address systemic weaknesses in sharing risk information between agencies. I recognise the difficulty of making risk assessments in busy prison receptions, but I recommend greater focus on the use of documentary evidence. I also call for an improvement in the use of emergency codes at Preston. Notwithstanding the need for thoroughgoing changes as a consequence of the man's tragic death, I join the clinical reviewer in commending nursing staff for their attempt to save his life.

A copy of this report has been sent to Her Majesty's Courts and Tribunals Service and the Chief Executive of the Lancashire Probation Trust

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2012**

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SUMMARY

1. In January 2010, the man was charged with arson with intent to endanger life after a fire at a flat used by his previous girlfriend. In June 2010, he suffered a stroke due to a spinal abscess and became paralysed from the chest down. He spent over a year in hospital and rehabilitation units. By July 2011, he had regained some limited mobility and moved to special living accommodation. He remained dependant on a wheelchair, was doubly incontinent and received a daily care package and physiotherapy.

2. The man‘s physical limitations affected him profoundly. He was treated for depression and, in 2010, took a non-accidental overdose of heroin after being admitted to hospital because of concerns about his mental state. In August 2011, he was offered three months intensive residential physiotherapy at Rakehead Rehabilitation Unit.

3. The man appeared at Preston Crown Court on 25 August to be sentenced for the offence of arson. A pre-sentence report and a psychiatric report prepared for the court warned that he would be at high risk of suicide or self harm if he received a custodial sentence, he would lose his place at Rakehead. This was described as the only thing that gave him hope for his future.

4. He was sentenced to two years imprisonment and taken to HMP Preston at about 2.00pm. At 4.40pm, a court probation officer faxed, to two different numbers at the prison, a warning form highlighting concerns that the man was at risk of suicide or self-harm in prison. A police investigation did not establish exactly what happened to these faxes and did not result in any criminal charges being brought. The man was not made subject to self-harm monitoring at Preston. The staff who assessed him and who came into contact with him did not believe he appeared at risk.

5. The man was allocated to a cell designed for disabled prisoners on H2 landing in Preston’s healthcare centre. All of the staff who spoke to him on the afternoon and evening of 25 August and the morning he died described him as calm and in relatively good spirits. The man was offered a shower at about 10.00am the day he died. He was given permission to take a razor blade with him because he was unable to see into the mirror in his cell.

6. He was found some ten minutes later in a collapsed state having made severe lacerations to his neck and groin. Nursing staff and paramedics worked very hard to save his life and he was taken by ambulance to Preston Royal Infirmary. Paramedics managed to restart his heart but he died of his injuries in the operating theatre some 45 minutes after arriving at the hospital.

7. This investigation raises concerns about the communication of risk between the court and the prison and the process of risk assessment at Preston. We make ten recommendations.

THE INVESTIGATION PROCESS

8. This office was notified of the man's death the day he died. The investigation was allocated to one of my investigators on Monday 29 August. My investigator spoke to the Governor of Preston, on the telephone the next day. Notices were issued to staff and prisoners at Preston telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator did not receive any response to these notices.

9. My investigator visited Preston to open the investigation on 6 September. She met the Governor of Preston, visited the healthcare centre, spoke informally to staff and collected copies of the man's prison record and other relevant paperwork. She also spoke to representatives from the Independent Monitoring Board and the Prison Officers' Association. She met with Detective Inspector from Preston CID the same day. Because of the police investigation into the two faxes sent from Preston Crown Court to the prison on 25 August, my investigator did not address this issue in her interviews. She liaised with the police throughout their investigation and information was shared between the two investigations. The HM coroner provided her with a copy of the police investigation files.

10. A clinical review of the man's medical care in Preston was commissioned from Lancashire Care Foundation Trust. A clinical reviewer was appointed to undertake the review. We received her report on 24 October and it appears at annex one.

11. My investigator visited Preston on 12 and 13 September and interviewed seven members of staff. Following the interviews she met with the Governor of Preston and gave him verbal feedback about the progress of the investigation and emerging issues. She followed this with an email to the Governor of Preston on 20 September. She spoke to a further member of staff by telephone on 20 September. On 4 October, my investigator and my assistant ombudsman interviewed a Senior Prisoner Custody Officer and a Crown Court Liaison Probation Officer at Preston Crown Court.

12. One of the Ombudsman's family liaison officers spoke to the man's father on 23 September. She explained the nature of this investigation and asked him if he had any questions or concerns about his son's treatment in prison and the circumstances surrounding his death. The man's father said he would like to meet and discuss the issues. The Ombudsman's family liaison officer and my investigator met him on 30 November together with his solicitor. The man's father raised the following points:

    - The man's father said that it took less that 24 hours for his son to be able to take his own life at Preston and he felt that a complacent approach by staff caring for him, given his obvious distress at his situation, was a matter of significant distress and concern to him.
    - He felt it was inappropriate, given the effect it had on his rehabilitation and the state of his physical and mental health, that he had received a custodial sentence

- He felt that it should be a high priority that prison staff with direct responsibility for prisoners deemed to be at risk are given the risk warning information.
- He felt that it was unlikely that anyone genuinely wanting to take their own life would admit this to staff and so it was important to take all relevant information into account when assessing risk.

13. The man's father and his solicitor received a copy of the report as part of the consultation period. The investigator responded outside of this report when additional clarity was requested by the solicitor about the identity of an officer and a matter relating to probation. No further issues were raised with regard to the investigation findings. I would like to thank the man's father for his consideration of the report.

14. A post mortem report gave the cause of death as "incised wounds to the neck and groin".

HMP PRESTON

15. HMP Preston accepts adult male prisoners over the age of 20 from the courts serving Lancashire and Cumbria. Mainly Victorian, its wings were built between 1840 and 1895 on a site which had been occupied since 1790. It became a local prison in 1990.

16. The purpose built healthcare centre opened in 2006. Health services are provided by Lancashire Care Foundation Trust. The centre has 30 beds and contains the in-patient facility for the north-west region which can also be accessed by HMP Wymott, HMP Risley and HMP Garth. There are 18 beds on the ground floor for mental health patients (known as H1 landing) and 12 beds on the first floor for patients with physical health problems (known as H2 landing). The in-patient facility holds prisoners who are too ill for normal location but do not require admission to an outside hospital. The beds are arranged in a mixture of single rooms and three bed dormitories. There is also a cell designed for use by a wheelchair user and a separate shower room for patients with mobility problems. There is no set number of beds for use by Preston or any of the other prisons in the region and they are allocated according to clinical need.

17. There are six staff on duty during the day covering H1 and H2, and two at night. This includes both healthcare officers and nurses. There is a full-time doctor between the hours of 9.00am to 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor available in the prison's reception area. At night, on-call cover was, at the time of this investigation, available through a contract with Care UK.

18. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Preston in a full announced inspection in August 2009. Despite the challenges posed by overcrowding, HMCIP found Preston to be a generally safe and well run prison. Relationships between staff and prisoners were found to be good. At the time of the inspection the health service provider had recently completely overhauled the healthcare department. HMIP noted that it was showing signs of recovery but this had not yet filtered through to the prisoners.

19. Every prison has an Independent Monitoring Board (IMB) made up of local independent volunteers whose job it is to monitor standards to make sure prisoners are being treated fairly and humanely. Each IMB is required to report every year on their findings. In the most recent available report on the period between April 2010 and March 2011. The Preston IMB described the prison as "a decent, caring and well managed institution" and remarked on the positive relationship between staff and prisoners.

20. The man is the ninth prisoner to apparently take his own life at Preston since the Ombudsman began investigating all deaths in prison custody in 2004. His was the third of three apparently self-inflicted deaths to occur at Preston in the space of four months. The investigations into the other two have not highlighted any similarities with this investigation.

KEY EVENTS

21. The man was born and brought up in the North West. In an interview with the man's probation officer, he described a supportive upbringing in a close family. He left school aged 16 and became a plasterer like his father. The man said he used illicit substances from the age of 13 and was involved in a number of incidents with the police. He settled into a relationship aged 18 and had two daughters. In his twenties he began to inject heroin and this habit led him into an increasing pattern of offending behaviour in order to support his addiction. The man had three short spells in prison in 1988, 1990 and 1997. In 2002, he was sentenced to 42 months for possession of heroin and failure to surrender to the police.

22. In January 2010, the man was charged with 'arson - being reckless as to whether life was endangered'. In June 2010, while on bail awaiting sentence, he suffered a stroke as a result of an abscess on his spine. He became numb from the chest down and had to use a wheelchair. He also suffered pain, nerve-damage, altered bowel and bladder function and depression as he struggled to cope with the damage to his body.

23. The man spent a considerable time in different hospitals and rehabilitation units after his stroke. He was admitted to a psychiatric unit for depression during the latter part of 2010 and was prescribed anti-depressants. He took a non-accidental overdose of heroin while a patient there. In June 2011, he moved to special Housing Association accommodation. In an interview for his pre-sentence report in early August, the man told the probation officer that he had frequent thoughts of suicide and had attempted to kill himself by taking an overdose. He said these thoughts prevailed despite the prescription of anti-depressants. Since his stroke the man said he lived an isolated existence because he did not want to be seen in public in his changed state. He found it hard being unable to work and his self-esteem was low as a result. The probation officer wrote in bold text in her report:

> "During the course of the assessment it has been identified that there are concerns about the man and him contemplating suicide, coping in custody and being vulnerable due to his mental and physical state. If he received an immediate custodial sentence, I would consider him to be at a very high suicide risk and this information would need to be conveyed to the appropriate people from the point of sentence."

24. The probation officer wrote in her conclusion:

> "The man is aware that an immediate custodial sentence will be under consideration and due to his medical situation, his mental health, his need for a wheelchair and his previous suicide attempt, he has already stated to me that he would attempt to kill himself if sentenced in this way. He is especially fearful of losing access to his daily rehabilitation sessions as the slight mobility he has gained is his sole focus and his sole hope that his life will improve in the future."

25. A consultant psychiatrist also prepared a report for the court on the man. He interviewed the man at his home on 4 August. The man told the consultant psychiatrist that over the last 15 years he had a history of cutting his arms deeply. He was seen by psychiatrists in relation to this but was not given medication. He told the consultant psychiatrist that he had last cut himself about three years previously with a Stanley knife. It was a deep cut requiring stitches.

26. The man also told the consultant psychiatrist that he was worried if he went to prison he would lose the limited mobility he had gained through daily physiotherapy. The man described feeling low and depressed all the time. He had constant thoughts of self-harm and said he would have killed himself but for his two adult daughters. He said he cried at night and had trouble sleeping. He was not eating enough because he did not feel hungry and was losing weight. The consultant psychiatrist reported that the man appeared stressed and worried about his future and his health. His presentation was consistent with depression and also in keeping with mental and behavioural disorders due to multiple drug use.

27. The consultant psychiatrist concluded:

> "If the man was imprisoned the chances of deterioration of his mental state will be significantly high. I have no doubt his depression will get worse and he will be unable to deal with the stress any more and will break down, necessitating a transfer to a psychiatric unit. Chances of making a serious attempt on his life will also be high, particularly because he has self-harm thoughts present all the time."

Later in the opinion section of his report, the consultant psychiatrist wrote, "He will be at risk of making a serious attempt on his life if in prison."

28. The man's pre-sentence report was sent to the court probation team at Preston Crown Court on 24 August. The report was read by a member of the probation team and the man was highlighted as being at risk of suicide or self-harm if given a custodial sentence. Accordingly an entry to this effect was made next to the man's name on the white board in the probation office listing those persons due to appear in court on 25 August.

29. The man attended Preston Crown Court on 25 August and was sentenced to two years in prison. The man's father told the investigator that the judge commented that she could have given a four year sentence but had reduced it to two on account of the man's physical condition. The man's father said the judge had told the man that he would receive the same health care in prison that he would have received in the community.

30. The man was taken to the custody area of the court and GEO Amey prisoner custody staff completed a Person Escort Record (PER – a document that travels with the prisoner between court and prison that contains information about the person's charge, identifies risks and lists property and valuables). Because the man had been on bail before he was sentenced, the custody

officers had no paperwork associated with him and the PER was completed using information gained only from interviewing him. (Court papers, including warrants are not sent down to the custody area until later. Pre-sentence reports and other reports written for court arrive in a sealed envelope and are not read by custody staff.) A senior custody officer completed the first two pages of the PER. In the health risks section on the second page, she noted that the man had suffered a stroke and used a catheter, and that he suffered from depression. The section relating to indications of self-harm/suicide was left blank.

31. The man arrived in Reception at Preston at about 2.00pm. Nurse A, the Primary Care Manager on H2 (the landing in the healthcare centre where prisoners with physical health problems are located), said she became aware just after lunchtime that a prisoner in a wheelchair was arriving from court. She asked Nurse B, who was working in Reception, to assess the man's healthcare needs to see whether he could be located on a normal wing rather than take a healthcare bed.

32. As the nurse in Reception, Nurse B's main role was to complete a first reception health screen for all prisoners arriving at Preston. The first reception health screen is part of the prisoner's electronic medical record and consists of a number of set questions about mental and physical health. The nurse interviews prisoners in a separate room in Reception in a one to one capacity. Nurse B saw the man at about 2.10pm. She remembered him maintaining good eye contact with her and being "interactive and smiley". She said she spent about 30 minutes with the man because his needs were quite complex and there was an issue about where he would be located. She said the prison's disability officer joined them for the discussion about location and the completion of the health screen. While the health screen took place the Duty Governor established which cell was suitable for the man.

33. Nurse B said she asked the man how long he had been in a wheelchair and he told her about his stroke and rehabilitation programme. She asked him if he had come to terms with his disability to try to establish whether it had affected his mental state. She also questioned him about how he managed and what he was able to do for himself. Nurse B said that the man's main concern appeared to be that, if he were located on a normal wing, he would be bullied. He told her about his incontinence and that he self-catheterised. He said he had been in prison before and knew how things worked. He said no one would want to share a cell with him. The nurse said she told him she understood and that they would try to put him in a single cell.

34. During the healthscreen, Nurse B asked him whether he had any thoughts of suicide or self-harm. He told her that, if he did not get a single cell, he would cut himself. At that point the nurse said she was told by discipline staff that the only cell that would accommodate his wheelchair was one on H2 landing in the healthcare centre. She immediately reassured him that he would be in a single cell there rather than on a normal wing. The nurse described him as "really chuffed" and "really pleased" with this location. She said she was not

worried about him hurting himself once she knew, and he knew, that he would be in a single cell.

35. Nurse B wrote on the man's electronic medical record that he was able to mobilise and transfer himself independently, could wash himself but needed a shower chair and could not stand unaided. She added that the man said that he had no concerns about his health while in prison. In the section on her impressions of his behaviour and mental state, she wrote "mixed emotions, appears calm and collected". In the section on emotional state observations she wrote, "appears calm and collected, pt [patient] denies any thoughts of self-harm or suicide. States he will manage while he is in here." She recorded the man's answer to her question of whether he had ever tried to harm himself in prison as, "pt states he has no thoughts of self-harm unless he shares a cell, then he stated he would self-harm, to get what he wants. Discussed with officers, not for ACCT at present but for monitoring." (ACCT – Assessment Care in Custody and Teamwork – is the formal monitoring system used in prison for prisoner's thought to be at risk of suicide or self-harm.) According to the electronic medical record he told the nurse that he had not tried to self-harm outside prison.

36. A Healthcare Support Worker (HCSW) told the investigator that she remembered the man arriving on H2. She escorted him to the day room while another prisoner was moved out of the cell allocated to the man. The HCSW said he asked her about the daily routine and when he would receive his medication. She said he seemed "quite sound in mood" and was chatty. She answered his questions and then went to tidy the disabled prisoner's cell in preparation for the man moving in.

37. Nurse C introduced herself to the man while he was waiting in the day room. She apologised for the fact he had to wait to get into his cell. She told the investigator that the man replied "oh that's alright" and then asked her if he could use a walking frame that was in the day room. The nurse told him that it had been measured for someone else. They discussed the possibility of the man having his own walking frame sent in and the nurse obtained confirmation from the head of healthcare that this was possible. The man told her that he had been using a walking frame as part of his rehabilitation and he did not want to "set himself back" in prison. The nurse said she would start the process for getting his walking frame the next day and made an entry in the H2 diary about it. (Staff write any jobs in the diary so that whoever is on duty the following day can take them forward.)

38. Nurse C said the man appeared pleasant and talkative. She asked him about his stroke and he explained how it had happened and said he was able to move himself from the wheelchair to the toilet and the bed. She said the man appeared pleased that he could have his walking frame sent in.

39. The healthcare support worker took the man to his cell at about 4.30pm. The man told her he did not want the teatime meal because he was not hungry and could not taste much since his stroke. He asked to see the doctor about his medication and the HCSW told him she would arrange that for him.

40. At about the same time in Preston Crown Court, a court probation officer became aware that the man had received a custodial sentence that morning. He was aware that the man had been flagged as at risk of suicide or self harm in custody and accordingly he completed a National Probation Service Warning Notice of Self-harm or Suicide form (referred to as the SSHWF). A standard sentence pre-printed on the form in the information section reads, "The pre-sentence report indicates that the above named is deemed to pose a risk of self harm/suicide." He made a handwritten amendment to include the word "high" before the word "risk". He also wrote underneath, "Reports to frequent suicidal ideation and previous attempts via overdose (no dates provided in report)." In the medical section he wrote, "PSR [pre sentence report] indicates that def [defendant] is in receipt of anti-depressants." He then faxed the form to both Reception and to H1 landing (the mental health in-patient landing) at Preston. The time on the fax received in Reception shows 5.39pm. The time on the fax received on H1 shows 5.40pm. The police investigation established that the clock on the fax machine was incorrect and the faxes were sent at 4.39pm and 4.40pm respectively.

41. According to police interview transcripts, Officer A found the fax sent to Reception on the back desk. He said at interview that he only saw the front sheet of the fax, not the SSHWF. He walked to the nurse's station in Reception with documents for another prisoner and handed the fax front sheet to Nurse B. He did not specifically tell Nurse B that the fax was among the other papers he gave her. Nurse B told police that she was not handed documents by Officer A and did not have any conversation with him.

42. Nurse D was on duty on H1 landing on 25 August. When interviewed by the police, he said that he was asked to send a fax to the Ministry of Justice and while at the fax machine he found a fax on the nurse's station that referred to a SSHWF. He rang Nurse B in Reception and told her about the SSHWF. Nurse B told him that the man had been processed and taken to H2. Nurse D said she told him that no concerns had been raised in Reception and the man was not on an ACCT. Nurse D said he took the fax to H2 landing and handed it to Nurse E. Nurse E told the police that he was not given a fax by Nurse D on 25 August. CCTV shows Nurse D walking onto H2 landing at 4.45pm holding an A4 piece of paper and leaving a minute later. The police found no other evidence to support Nurse D's statement that the fax was handed directly to Nurse E.

43. Later that evening, the man asked the healthcare support worker about his catheters, which were still in Reception. The healthcare support worker found him some similar ones from the H2 store and stayed with him to make sure they were suitable for him. She said that they shared a joke and the man appeared to be fine. She saw him one last time before going off duty at about 8.15pm when the nurse from Reception brought the man's own catheters up to the landing. The healthcare support worker passed them to the man. She said he was on his bed watching TV and smiled at her and said "thank you".

The events on the day the man died

44. Nurse F started her duty at 7.45am on the day the man died. She was assigned to H2 and her first duty was to make sure the patients there received their morning medication. She was also required to make fabric checks of each of the cells to make sure that the locks and windows were secure and the lights, toilets and taps were working. The nurse said she combined the two duties and began them at about 9.00am. She first met the man when she checked his cell. She thought he appeared "relatively upbeat" and did not appear to be depressed or distressed. He did appear to be anxious that he had not received any medication. He told her that he had last taken it before he went to court the previous day. The man also explained that one of his symptoms was muscle spasms in his lower limbs. The nurse said she noticed that the man's legs were shaking and he appeared to find this painful.

45. Nurse F went to the nurse's station and told Nurse C that the man was anxious about his medication. Nurse C asked Nurse F to contact the man's GP as a matter of priority. (If prisoners come into prison on prescribed medication the prison first confirms this with their community GP before issuing them with medication.) Nurse C went to see the man and apologised that he had not had any medication. She explained that they needed to get confirmation of the prescription from his GP first. She said the man was lying on his bed and appeared to be fine.

46. Nurse F contacted the man's GP and received confirmation by fax of his prescription. She completed a prescription sheet and took it to a prison doctor on H1 landing for signature. She then returned to the man's cell at about 9.45am and found him sitting with another member of staff completing what she thought was a Well Man Assessment (A secondary health screen - in fact The man's electronic prison record shows this was a personal emergency evacuation procedure assessment). She told him that his prescription had been confirmed and he would receive his medication as soon as it was sent up from the pharmacy.

47. A short while afterwards, Nurse A said she saw the man talking to the wing cleaner (another prisoner) outside the disabled shower room. The nurse told the man she would unlock the shower room for him. She said he asked her if he could have a razor and she agreed. The nurse showed the man the shower area and how the shower worked. She explained he would need to transfer himself on to the seat. He told her he could manage on his own and she told him to collect his washing kit from his cell while she found him a razor. The nurse collected a razor from the treatment area and asked the healthcare support worker to take it to the man. The HCSW said she asked the man if he needed to take the razor with him into the shower and he replied, "Yes Miss, because I can't reach the mirror in the cell". The man asked her to get him a towel, which she did. She said he had all his soaps with him and a change of clothes. She returned with the towel and he was partially undressed. She put the board up in the shower and asked him if he was alright and then left him to have his shower.

48. Nurse G told the police at interview that she was at the nurse's station on H2 and found the faxed SSHWF, without the front sheet, amongst another prisoner's file. She read it and noted that it referred to a previous attempted suicide by overdose by the man. She said the man was already in the shower when she found the fax. She asked administrative staff if they knew about the SSHWF. The nurse said she put the fax aside with the intention of dealing with it when the man finished his shower. An administrative support worker from H2 landing told the police that she remembered Nurse G "going mad" and talking about a fax that had been sent in on 25 August that had only just been found.

49. Officer B was on duty as allocations officer on the morning the man died. His duties involved completing categorisation algorithms for newly sentenced prisoners (to determine their security category) and interviewing them to determine which prison they would serve their sentence at. The man was on Officer B's list and he went over to H2 to interview him at about 10.00am. Officer B said when he arrived he asked a nurse whether the man was fit to be interviewed. The nurse replied that he was, but he was in the shower and had been in there about five minutes. The officer decided to wait for the man to come out. After about five – eight minutes the officer decided to open the shower door to see how long the man would be.

50. Officer B said he noticed the empty wheelchair and then saw the man lying on the floor. His initial reaction was that the man must have fallen over. He then pulled the shower curtain back and saw that the man had cut his throat. He then noticed wounds to the man's groin and a considerable amount of fresh and congealed blood in the shower area. The officer said he shouted for a nurse, grabbed some clothing and put it to the man's neck. He let the nurses through the gate and then went to lock the rest of the patients in their cells.

51. Nurse F heard Officer B say that someone was on the floor in the shower. She said she did not register any urgency and so went into the shower thinking someone had simply fallen over. She immediately saw a considerable amount of blood. The man was however conscious and able to speak to her. Nurse F shouted for assistance and Nurses C and Nurse A arrived within seconds. Nurse F said the man turned to her and told her to leave him alone. Nurse C said she heard the panic in Nurse F's voice and ran into the shower room. When she saw the blood she went straight to a nearby treatment room for some gloves and an apron. On the way she passed the pharmacist and asked her to call for a blue light ambulance and to call for the prison emergency response nurses using 'code 4' to indicate severe bleeding (in fact the call put out was for 'code 2' indicating 'shortness of breath'). Nurse C said she went back into the shower and noticed faeces as well as blood. She picked the man's arms up thinking he had cut his wrists but couldn't see any injuries.

52. Nurse F said she and Nurses C and A tried to turn the man in order to locate and assess his wounds. The man tried to push them away. Nurse F said once the man had been turned she saw a severe laceration to his left jugular and two further lacerations in his left and right groins. Another deep

laceration to his right jugular became apparent when they started first aid. Nurse A went to get some swabs and pressure dressings were applied to the man's wounds. Oxygen and other emergency equipment were brought in by Nurse B and Nurse H. Oxygen was given to the man via a bag and mask (an Ambubag). They raised his legs to try to stop the bleeding. Nurses F and Nurse C said the man continued to struggle and resist treatment but suddenly he changed colour and he stopped fighting. Nurse F said she lost the pulse in his left wrist and the nurses then started cardio-pulmonary resuscitation (CPR) in the form of chest compressions in a ratio of 30 compressions to two breaths (The man was already receiving oxygen). A defibrillator (a portable electronic device that reads heart rhythm and advises whether to administer an electric shock or to continue CPR) was attached to the man. Paramedics arrived and began to help. CPR continued to be given to the man while he was placed on a stretcher and taken to the ambulance.

53. Nurse H travelled with the man in the ambulance to the Royal Preston Infirmary (RPI). She said that the man's heart stopped twice in the ambulance but just as they arrived at RPI they got some cardiac output. The nurse said hospital staff worked on the man for about 45 minutes. It was the first time she was able to see the nature of his wounds because he had been covered in blood and faeces in the prison. She said that the cuts to the man's neck and groin were such that he had severed all of his major arteries. She last saw the man when they took him to the operating theatre to try to repair his arteries. The man's wounds proved to be too catastrophic to be repaired and he was pronounced dead.

Care for staff after the man's death

54. After the man was taken to hospital, the staff involved in trying to save his life were gathered together and given clean uniforms and hot drinks. Members of the Staff Care and Welfare Team came to talk to them and Governor B conducted a hot debrief (a meeting for the staff involved to share their experiences and receive support). She asked all the staff who they were and what role they had played. The staff were offered the opportunity to go home and taxis were provided for those who accepted this offer. In the days following the staff were offered the opportunity to have counselling and to talk to the post-traumatic shock team from the PCT.

55. All the staff interviewed were very satisfied with the level of support they were given and offered by management and colleagues.

Family liaison

56. Governor C was appointed as family liaison officer (FLO) for Preston. A family liaison officer at HMP Kirkham (the closest prison to the man's father's home) was asked to visit the man's father in person to break the sad news. The man's father was not at home so the Kirkham FLO rang him on his mobile phone. The man's father wanted to go to Preston immediately and was advised to take a taxi paid for by the prison, which he did. Governor C subsequently visited the man's father and returned his son's property to him in

person. The prison offered the man's father a financial contribution to the funeral costs and Governor C and another member of staff attended.

ISSUES

The assessment of the man's risk

57. Prison Service Order (PSO) 2700 Suicide Prevention and Self-Harm Management paragraph 3.2.1 states:

> *"Establishments must have a local policy for sharing prisoner risk of self-harm information with other agencies* …To achieve such a cross-agency strategy, establishments will find it helpful to seek Area and Regional advice and support, e.g. from Area and ROMs offices, Health and Social Care in Criminal Justice Programme Leads within the CSIP Regional Development Centres or NIMHE Lead, PECS Area Contract Manager, National Probation Service Chief Officers and Regional Managers Probation and YJB Leads and through Area/Regional PECS Boards and Reducing Re-Offending Action Teams."

Paragraph 4.17.1 says:

> "Agencies and individuals outside of prison can help with warnings, assessment and referral. *Establishments must have in place robust systems for receiving and recording, and passing to the area of the prison where the prisoner resides, information coming into the establishment from families, agencies, Offender Managers/Supervisors and other parties outside the establishment who have concern for a prisoner who may be at risk of self-harm or suicide.*"

The passages in italics indicate that the instruction is mandatory.

58. The warnings of the man's risk of suicide/self-harm contained in the pre-sentence report and the psychiatric report were identified appropriately by court probation staff. The man was also listed on the white board used to keep track of prisoners who presented a risk. The court probation officer explained at interview that there are not sufficient numbers of probation staff at Preston Crown Court to allow someone to be present at each court hearing. Therefore, probation staff only find out towards the end of the business day what has happened to the people listed on their board. He explained that the accepted practice in August 2011 was that, when people identified as posing a risk of suicide or self-harm in prison were sentenced, probation staff completed a SSHWF and faxed it to Reception and H1 landing at the prison. He told the investigators that he had also assumed that prison staff would read the pre-sentence report and other reports when the prisoner arrived at prison.

59. When the man was taken from the court to the custody area at Preston Crown Court his pre-sentence report and other reports were placed in a sealed envelope. The SPCO said at interview that custody staff do not open this envelope and read the reports. Custody staff see little paperwork, especially for a prisoner who has been sentenced from bail, and the information needed

to complete the PER form and the associated risk assessment is gathered almost solely from an interview with the prisoner.

60. The man arrived in Reception at Preston shortly before 2.00pm. The documents available to Reception staff were the PER form completed at Preston Crown Court, the Warrant and the other court papers including the pre-sentence report and psychologist's report. In practice the only documents read in Reception are the PER and the Warrant. The reports prepared for court placed in the prisoner's custodial documents file are eventually passed to prison probation staff. They may not be read for some weeks. (We recognise that it is not realistic or practical to expect Reception staff to read pre-sentence reports in every case.) In this case there was no record on The man's PER that he had a history of attempted suicide and self-harm and therefore no immediate reason for staff to look further into the documents from court. Like the court custody staff, in order to assess a prisoner's risk, Reception staff rely heavily on the interview by discipline staff and the interview by the nurse for the first reception health screen.

61. The investigator asked all the healthcare staff at interview for their views on the practice of receiving warning forms by fax. The overwhelming opinion was that the practice was unreliable. The faxes often went missing or became caught up in other paperwork. If a prisoner had already passed through Reception the likelihood of the warning form arriving at his location diminished significantly. The investigator established that the practice had been in place for at least some seven years. (In fact the police investigation gave the length of time as 10-15 years.)

62. The matter of what happened to the faxes sent by the court probation officer on 25 August has been investigated extensively by Preston CID Force Major Incident Team. The exact chain of custody of the fax has not been conclusively established. The only member of staff who has said that he read the SSHWF on 25 August is Nurse D. He told police that he realised that staff with direct responsibility for the man needed to be aware of it and he found out where the man was located. CCTV shows that he took the fax to H2 at 4.45pm. There is no evidence that he handed it to the person he said he did or told anyone verbally about the information it contained. We do not know what happened to the fax once Nurse D brought it to H2. The Crown Prosecution Service did conclude, however, that there were no grounds for criminal charges to be brought against any staff at Preston. The fact remains that, for whatever reason, the faxed SSHWF did not find its way to a member of staff working on H2 until the morning of the man's death by which time it was too late to act on it. The system, widely regarded by staff as flawed and unreliable, failed with fatal consequences.

63. We understand from the court probation officer and the SPCO that the system in operation at Preston Crown Court has changed as a consequence of the man's death. The court probation officers now send information about risk by fax to the custody area at the court as well as to the prison. We welcome prompt change in response to fatal incidents where systemic failings have been identified. While changes have already been made, we believe the

process needs to be tightened further in order to ensure that this vital information gets to the right people as reliably as possible.

As a matter of urgency the Governor of Preston, the North West Area National Offender Management Service Safer Custody Manager, the Prisoner Escort Custody Services Area Contract Manager and the Chief Executive of the Lancashire Probation Trust should meet and ensure that there is an effective local policy for sharing prisoner risk of self-harm information with and within HMP Preston in accordance with PSO 2700 (paragraph 3.2.1). This policy should be cascaded to relevant staff at the courts and the prison.

In the meantime we recommend that:

Court Probation and custody staff should fax warning forms to HMP Preston and follow these up with a telephone call to ensure receipt.

We also recommend that:

The Governor of Preston should ensure that the prison has a robust system for receiving and recording information coming into the establishment in accordance with PSO 2700 (paragraph 4.17.1) and chapter two of PSI 64/2012 which replaces it from 1 April 2012.

The Head of Healthcare should ensure that a record is kept of all documents that arrive by fax in the healthcare centre (H1 and H2) and that there is an auditable trail.

The first reception health screen

64. Nurse B had worked at Preston for some six weeks and this was the first time she had undertaken this role unsupervised. The clinical reviewer examined the first reception health screen as part of her clinical review. She noted that Nurse B screened and assessed the man in accordance with the prison's protocols. Nurse B did not have sight of the pre-sentence report, psychiatric report or SSHWF when assessing the man. The clinical reviewer found that the nurse showed sensitivity to the man's physical needs and awareness that his change in condition might have affected his mental state. The nurse spent some 30 minutes with the man and gave him an opportunity to express any emotional difficulties.

65. The clinical reviewer concluded that there was nothing in the man's demeanour during the first reception health screen to indicate to Nurse B that he was suffering any behavioural, mental health problems or suicidal ideation. She found that, on the information available to her at the time, Nurse B had dealt appropriately with the man's anxiety about sharing a cell and it was reasonable to judge that the man's stated intention to cut himself was not a significant issue once she had reassured him he would be in a cell on his own in the healthcare centre rather than on a normal wing. In any event both the

man's use of a wheelchair and his offence of arson meant that he could only be located in a single cell.

66. We note that Nurse B asked other staff present in Reception for their advice about whether she should open an ACCT form in response to the man's statement that he would cut himself if he had to share a cell. Nurse B wrote on the record, "Discussed with officers, not for ACCT at present but for monitoring." From the report of the exchange with the man, we consider that it was reasonable to take the view that he was making a clear threat in order to ensure he got the outcome he wanted, rather than indicating he was at risk of self-harm generally. In answer to all other direct questions during the reception process (and indeed also at court) about his history of self-harm and future intentions the man firmly denied any intention to harm himself or that he had done so previously. However, it is not clear from the record what form the intended monitoring was to take and who would have onward responsibility for making it happen.

67. There is little point in noting that someone requires monitoring but then not alerting colleagues that this is the case. While not opening an ACCT was not an unreasonable decision, had an ACCT been opened it would have presented a reliable mechanism for the monitoring to have taken place. Other than the ACCT process, we are not sure that there is any other reliable method for a prisoner to be monitored. We therefore make the following recommendation:

The Governor should ensure that the ACCT process is used to monitor prisoners in accordance with PSO 2700.

Other risk assessment issues

68. The investigator asked all the nursing staff interviewed about their approach to risk assessment and what tools they used. She also asked them how they weighted warning forms completed by other agencies outside the prison. The overwhelming response was that the best tool for assessing someone's risk was a face to face interview where the nurse could observe body language and ask probing questions. Staff acknowledged that risk warning forms could be important in highlighting previous risk but that they may refer to risks present some time before. The nurses said that the presence of a risk form would not automatically lead them to open an ACCT form whatever information it contained. In his interview with the police, Nurse D was asked if he thought an ACCT document should have been opened on the man in the light of the SSHWF. He replied that he did not think so because a mental health nurse bases their assessment on their opinion of how the person presents and what they say and not on documents. This view was also expressed by other staff in police interviews even after being shown the man's SSHWF.

69. We addressed the issue of staff basing assessments purely on what the prisoner told them in our Annual Report 2009-2010. We said:

> "Not for the first time the Ombudsman's report emphasised that, while what prisoners say is important, they can not be relied upon to declare when they intend to harm themselves. Calm assurances from the prisoner that they are not contemplating suicide may be misleading, indeed deliberately so. Staff should be guided in their decision-making not simply by what the prisoner says but by the documented information supplied by police, escort staff and medical professionals."

70. The assessment of risk is complex. Suicide is by nature often an impulsive act and predicting who presents a real risk is hugely difficult. It is therefore vital that staff make use of as many tools and as much information as is available to them. Professional judgement and the experience gained by working with prisoners is invaluable. But there are certain things that automatically place a person at high risk of attempting suicide and these must not be ignored. Perhaps the greatest indication that a person will seek to take their own life is if they have tried to do so before. Another indication of high risk is if the offence relates to domestic murder or other serious crimes against a family member. Arson too (The man's offence) is strongly linked to self-harm.

71. In The man's case the staff who came into contact with him did not have the benefit of knowing of his previous attempt to kill himself or about the high risk identified in the PSR and psychiatric report. We do not criticise them for the assessment carried out on the man in the absence of this. Nevertheless we are concerned about a perceived over-reliance on the prisoner's words and presentation despite staff acknowledging to the investigator that someone who intends to take their own life is unlikely to admit it. The investigator was also concerned that some staff interviewed were not aware of the high risk indicators listed above. We therefore recommend that:

    The Head of Healthcare in conjunction with the PCT should ensure that all healthcare staff receive appropriate awareness training in factors that indicate a person is at high risk of attempting suicide. Guidance is already contained in PSO 2700 (and in chapter three of PSI 64/2011 which replaces it after 1 April 2012).

The response to finding the man in the shower

72. The medical emergency response is covered in detail by the clinical reviewer in her clinical review at annex one. She concludes that, once the emergency was discovered, the nurses acted quickly and worked efficiently as a team to try to save the man's life. CPR was administered in line with current Resuscitation Council guidance. The clinical reviewer comments that, given the nature of the man's injuries, it was surprising that staff were able to keep him alive as long as they did.

73. We agree that the nurses at Preston worked hard, efficiently and with determination to try to save the man's life. Unfortunately, the severity of the man's injuries, and the fact that he had already lost a significant amount of blood before he was found, prevented them from being able to save him. The

man’s subsequent resuscitation in the ambulance is testament to the praiseworthy efforts of staff and paramedics. We agree with the clinical reviewer’s recommendation that:

The Governor should commend the nursing team for their efforts in the emergency response to the man.

74. The clinical reviewer notes that the radio call for emergency assistance was recorded as a Code 2, indicating shortness of breath, instead of as a Code 4 (severe bleeding). She concludes that this made no difference to the response and outcome in this case. In The man’s case he was found in the healthcare centre and everything needed was to hand but this will not always be the case. The use of codes is important because it alerts medical staff to the nature of an emergency, allows them to bring the right medical equipment with them and therefore gives staff a better chance of being able to preserve life. In the light of this we make the following recommendation:

The Governor should ensure staff are aware of and appropriately use the different emergency codes at Preston.

75. The control room log shows the request for emergency assistance to H2 was made via telephone at 10.17am. Three minutes later another telephone call was received asking for a blue light ambulance. An ambulance arrived at the gate at 10.24am, and the paramedics arrived on H2 a minute later. A further two ambulance cars arrived at 10.37am. Documentation from the North West Ambulance Service shows that the second ambulance team was called by the first in order to assist with a “traumatic cardiac arrest”. The ambulance left the prison with the man on board at 10.54am.

76. Logs were kept at the scene and a hot debrief was held appropriately. The local death in custody contingency plans were followed and all relevant parties were informed of events in a timely manner.

CONCLUSION

77. This is a particularly tragic story. The man's case serves to highlight the difficulty of risk assessment and the importance of making judgements based on all available information. Sadly it is also a tale of systemic failure in communication of risk between agencies. Neither of these themes are new to this office. We hope that some positive learning results from this sad story.

RECOMMENDATIONS

1. As a matter of urgency the Governor of Preston, the North West Area National Offender Management Service Safer Custody Manager, the Prisoner Escort Custody Services Area Contract Manager and the Chief Executive of the Lancashire Probation Trust should meet and ensure that there is an effective local policy for sharing prisoner risk of self-harm information with and within HMP Preston in accordance with PSO 2700 (paragraph 3.2.1). This policy should be cascaded to relevant staff at the courts and the prison.

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   "Meetings have taken place between the Governor of HMP Preston and the Deputy chief Executive of Lancashire Probation with regards to ensuring that relevant information is correctly shared with the prison. A new system of alert notices has been developed and is in use. A full protocol involving all relevant parties as described in the recommendation is being developed and will be in place by the end of April 2012."

2. Court Probation and custody staff should fax warning forms to HMP Preston and follow these up with a telephone call to ensure receipt.

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   "This is in place, and relates to the recommendation above."

3. The Governor of Preston should ensure that the prison has a robust system for receiving and recording information coming into the establishment in accordance with PSO 2700 (paragraph 4.17.1) and chapter two of PSI 64/2012 which replaces it from 1 April 2012.

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   "The full provisions of PSI 64/2012 will be in place at the implementation date of 1 April 2012."

4. The Governor should ensure that the ACCT process is used to monitor prisoners in accordance with PSO 2700.

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   "PSO 2700 is replaced by PSI 64/2012 on 1 April 2012. The requirements of PSI 64/2012 are being implemented and will be in place by the required date. This will include version 5 of the ACCT document as published in March 2012."

5. The Head of Healthcare should ensure that a record is kept of all documents that arrive by fax in the healthcare centre (H1 and H2) and that there is an auditable trail.

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   “A system for ensuring this recommendation is met and has been published and is in operation.”

6. The Head of Healthcare in conjunction with the PCT should ensure that all healthcare staff receive appropriate awareness training in factors that indicate a person is at high risk of attempting suicide. Guidance is already contained in PSO 2700 (and in chapter three of PSI 64/2011 which replaces it after 1 April 2012).

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   “All staff with prisoner/patient contact are required to be trained in ACCT awareness, and to have refresher training every three years. This applies to healthcare staff working within HMP Preston.”

   We were not satisfied that this response met the requirements of the recommendation. We put this to NOMS who replied:

   “The recommendation has been accepted and the prison have said in the current response that this training (about factors that indicate that a person is at high risk of attempting suicide) is provided to all staff who come into contact with prisoners as part of the prison’s ACCT awareness training programme.”

7. The Governor should commend the nursing team for their efforts in the emergency response to the man.

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   “The Governor fully accepts this recommendation to commend those staff involved in the emergency response.”

8. The Governor should ensure staff are aware of and appropriately use the different emergency codes at Preston.

   The National Offender Management Service (NOMS) accepted this recommendation at draft report stage and commented:

   “A Staff Information Notice clearly illustrating each Code and its meaning will be published, and this information will be displayed on all appropriate staff offices for reference.”