



**Investigation into the circumstances surrounding the
death of a man at HMP Preston in April 2011**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

October 2012

This is the report of an investigation into the death of a man in April 2011, while in the custody of HMP Preston. He was 36 years old and had been remanded into prison less than two weeks before. At the time of his death, he was subject to monitoring under the suicide and self-harm prevention measures.

A senior investigator carried out the investigation. A clinical reviewer completed the review of the man's medical care, on behalf of the local Primary Care Trust (PCT). I am grateful to the Governor of Preston and his staff for their co-operation with my investigation.

I apologise for the delay in issuing this report, which was due a police investigation and subsequent court proceedings against two prison officers involved in the man's care. Despite the delay in issuing this draft report, the Governor was provided with the recommendations in January 2012, to enable the prison to address these.

The man had been remanded to prison charged with a breach of an earlier court order. Staff at the court had concerns about him, which were shared with reception staff at Preston. On his arrival at the prison, a mental health trained nurse assessed him and suicide and self-harm monitoring procedures were put in place. He moved to the mental health unit of the healthcare wing on his first day in custody for closer monitoring, remaining there until 18 April, when he was discharged to a residential wing.

Staff continued to monitor the man at intervals of every hour during the day and every 30 minutes during the night and the cell in which he resided had been fitted with a camera for closed circuit television (CCTV). A few days later at 9.22pm, an officer on night duty checked him and saw him sitting on his bed. CCTV footage shows that he went to his window immediately after being checked at 9.22pm, and he is not seen on the camera again. No further checks were made until 12.25am, when the officer found him suspended by a ligature. Despite the best efforts of the staff and paramedics, he did not respond and was pronounced dead at 12.55am.

It is worrying that the investigation has found a number of shortcomings in the handling and management of the suicide and self-harm prevention procedures at HMP Preston. These procedures require review and improvement. Most alarmingly, two staff faced criminal charges for failure to check the man during the night and for falsifying records. These charges were proven, and demonstrate appalling failures to discharge an appropriate duty of care to a vulnerable prisoner. In addition, the clinical reviewer has identified the need for a number of improvements in clinical processes.

In total, I make six recommendations in relation to the issues highlighted in this report and do so in the firm expectation that appropriate lessons will urgently be learned from this tragic case.

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.

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Prisons and Probation Ombudsman

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SUMMARY

1. The man arrived at HMP Preston on 9 April 2011. He was 36 years old and had been in prison several years before. At court, concerns were raised about his well-being and the risk he posed to himself, which were communicated to the prison before his arrival.
2. As part of the reception procedures, a nurse assessed him and it quickly became apparent that he required further assessment by a member of the prison Primary Care Mental Health Team (PCMHT.) A mental health nurse then assessed him in reception. He recorded that the man had been receiving care from Mental Health Services in Blackpool prior to custody, which was later confirmed and that he also had a history of harming himself. Due to immediate concerns about his welfare, he was placed under the suicide and self-harm monitoring procedures, which provide additional support for prisoners at risk of harming themselves.
3. Following completion of the reception procedures the man was given a cell on D wing, the first night centre. He had been assessed as being a high risk of harming a cellmate and therefore was on his own. He raised no immediate concerns. During the early evening, he asked to speak to a member of the mental health team. Wing staff contacted the healthcare wing to let them know that they were concerned about him. After speaking to him, a senior nurse arranged for him to move that evening for a period of assessment to the inpatients unit (H1) of the healthcare wing, which provides for mental health needs. He remained there until 18 April. Monitoring under the suicide and self-harm prevention procedures continued and case reviews were held as required. Whenever he was asked directly about harming himself, he denied such thoughts.
4. On 18 April, following an assessment by a visiting psychiatrist and a case review in which he made contradictory comments about his thoughts of self-harm, the man moved from the healthcare unit to a residential wing, C3. He again was in a cell on his own due to the initial cell sharing risk assessment that had been carried out on his reception. Staff recorded that he engaged with other prisoners and had raised no concerns. On 21 April, he told an officer that he had difficulty sleeping, as he was concerned about his legal team and his mortgage. The officer advised him to write down what he needed help with and offered to help him complete the necessary forms when she was next on duty. The same officer saw him later in the evening and he was smiling and seemed all right.
5. Staff responsible for monitoring the man were required to check him every 30 minutes during the night. The night officer checked him at around 9.22pm but made no further checks until around three hours later at 12.25am. ACCT documentation indicates that checks were made by the officer between these times, but a police investigation has found these to have been false entries.
6. When the officer looked into the cell via the observation panel he saw the man at the back of the cell with a ligature tied around his neck suspended from a

curtain rail. He immediately used his radio to call for emergency assistance other staff attended and went into the cell.

7. Staff released him from the curtain rail, laid him on the floor and removed the ligature from his neck. Nursing staff attempted to resuscitate him until the arrival of paramedics at 12.45am. The paramedics continued to treat him, but he failed to respond and was pronounced dead at 12.55am.
8. The prison put in place appropriate procedures to contact the man's next of kin and to staff support. A friend subsequently disclosed a letter, which implied that his actions had been planned.
9. Six recommendations were made, all of which were accepted and the Prison Service response has been added. These related to the operation of the suicide prevention procedures, a failure in the induction process and the need for improvements in healthcare and mental health provision at HMP Preston.

THE INVESTIGATION PROCESS

10. An investigator opened the investigation on behalf of appointed investigator on 5 May 2011. She met the Governor and collected all documentation relating to the man. Notices were issued informing both staff and prisoners of the investigation. They asked anyone who had information pertinent to the investigation to contact the investigator. One response was received from a prisoner at Preston. The appointed investigator assessed the information provided, by interviewing a Developing Prison Service Manager (DPSM).
11. The local Primary Care Trust (PCT) provided a review of the medical treatment the man received while in custody. This review was undertaken by a clinical reviewer. The investigator and clinical reviewer conducted joint interviews with eight members of staff on 14 and 15 July 2011. The investigator provided both verbal and written feedback upon conclusion of the investigation.
12. One of the Ombudsman's family liaison officers (FLOs) wrote to the man's wife on 27 May to explain the role of the Ombudsman and purpose of the investigation. The family raised no questions about his time at Preston. However, they would have the opportunity to receive a copy of the draft report and comment should they choose to do so.
13. In the interim period while police investigations have been ongoing, other members of the man's family, who had not previously been known, contacted the Governor at Preston. Their details were forwarded to the investigator and FLO, who made arrangements for a copy of the draft report to be made available to them. The family have provided a response to the draft report.
14. The investigator contacted the Coroner to inform him of the investigation and requested a copy of the post mortem report once available. The Coroner has received a copy of this report to assist with the inquest process.
15. The investigator had regular contact with the police who investigated and then charged two members of staff relating to the man's case, and information has been shared.

HMP PRESTON

16. HMP Preston is a category B local prison (holding prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult). Mainly Victorian, its wings were built between 1840 and 1895 on a site which had been occupied since 1790. The prison closed in 1931, reopened for military use in 1939 and as a civilian prison in 1948. It became a local prison in 1990, and now serves the courts in Lancashire and Cumbria by holding male offenders over the age of 20 who have been remanded in custody, are awaiting trial, or awaiting allocation to another prison after being sentenced.
17. Preston provides the in-patient facility for the north-west region, with health services provided by NHS Central Lancashire Provider Services. The in-patient facility holds prisoners who are too ill to remain on a residential wing but do not require admission to an outside hospital. Admission is arranged by referral from the original establishment, followed by an assessment by the team at Preston. There are separate landings for patients with mental and physical needs, with a total of 30 beds.
18. The man was the 12th prisoner to die in Preston since the Ombudsman's office became responsible for investigating deaths in custody in 2004. Five of these deaths were due to natural causes. In previous investigations, we have made recommendations regarding the healthcare department, and similar recommendations are made in this report.
19. The last inspection of Preston by Her Majesty's Chief Inspector of Prisons (HMCIP) took place in August 2009. The resulting report noted that the service provider had recently completely overhauled the healthcare department after a period of lack of investment. The department was showing signs of recovery, although this had yet to reach to prisoners.
20. The Prisons Act 1952 and Asylum Act 1999 require every prison to be monitored by an independent board, appointed by the Secretary of State, from the local community. The Independent Monitoring Board (IMB) at Preston published their last annual report in March 2010. They commented that it had been a particularly difficult year for Preston's healthcare services. There is nothing in the report that relates to the issues identified in this investigation.

Critical incident and hot debrief

21. A critical debrief takes place normally two weeks after a serious incident. It gives the staff the opportunity to understand the incident in greater detail identifying any learning points, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment. A 'hot debrief' takes place immediately after a serious incident allowing staff to receive immediate support.

Cut down tools

22. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons who have contact with prisoners must be provided with and carry, when on duty, their own cut down tool.

Emergency response codes

23. Emergency codes are used to summon staff to deal with a particular situation. In most prisons the common coding system is 'Blue' to indicate a prisoner with respiratory problems or who is unconscious, and 'Red' to indicate a prisoner who is bleeding. The benefit of such codes is to allow medical staff to attend the emergency with the correct equipment and to minimise delays to treatment.

Listeners

24. Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.

Reception and induction

25. A Cell Sharing Risk Assessment (CSRA) is completed for every prisoner on their reception into custody. The document has recently changed and now requires any decision to be evidence based. This requires staff to check prisoner's previous convictions to identify potential risks to a cellmate if they share a cell. A level of risk either low or high is then given to the prisoner. If high risk and considered to be unsuitable to share a cell then this must be frequently reviewed by a multi-disciplinary team.
26. Reception staff do not routinely have access to a prisoner's past records and so at this point the prisoner is the main source of information. All prisoners will also have a Person Escort Record (PER) (a document recording information about the prisoner when escorting him or her between prisons, court and police stations), which should include pertinent information such as the risk posed to others and self.
27. An initial healthcare screen is conducted and concentrates on the prisoner's immediate well-being, their mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.
28. All new prisoners are located on the induction wing. If a prisoner is considered vulnerable they should be located on other more appropriate wings and receive their induction there. Prisoners are asked about any immediate concerns, such as disability, their offence and general well being. The induction should include a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained.

Counselling Assessment Referral Advice and Throughcare service (CARATs)

29. The Counselling Assessment Referral Advice and Throughcare service team based in a prison essentially provide an assessment and sign-posting service for prisoners with drug and alcohol problems. The team work in partnership with the healthcare service and disciplined staff to provide a service within the prison and also as a referral agency for ongoing support to prisoners on their release.

Suicide and self-harm monitoring

30. Assessment Care in Custody and Teamwork (ACCT) has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

KEY EVENTS

28. The man was remanded into custody at Magistrates' Court on 9 April 2011. He was 36 years old. He had breached the conditions of a previous court order that prevented him from having contact with his ex-wife. While in the court cells, he was recorded as 'depressed and crying' and, as a precaution, court staff placed him under constant observation. This meant that a member of court staff would observe him from outside the door at all times. A self-harm warning form was completed, and a member of staff wrote:

"Bizarre behaviour seems very depressed, history of self-harm, head banging on cell walls. Started to bang head on cell wall after being on a legal visit. Says that someone is talking to him in his head."

The purpose of the self-harm warning form is to alert prison staff that an individual may need closer observations and also to provide some background information about their problems on arrival in custody. The court staff telephoned HMP Preston and told the reception staff that a self-harm warning had been raised and this was handed over to them on his arrival at the prison.

29. The man was interviewed by reception staff and asked to provide the name and address of his next of kin or other person he would like to be notified in an emergency. He told reception staff that he had been in custody previously in 2001. In addition to providing basic information to the reception staff as required, a cell sharing risk assessment (CSRA) was completed. The CSRA is completed on every prisoner when they arrive into custody, with the aim of identifying those that are unsuitable to share a cell, either because they pose a risk of harm to cell mates or for medical reasons. Part one of the man's CSRA recorded that a self-harm warning form had been received. The document was then passed to the reception nurse to complete section two.
30. A Registered General Nurse (RGN) assessed the man and completed the initial health screen. The healthscreen records the name and address of a prisoner's community doctor and any existing medical problems. The nurse recorded that he was taking medication for depression, but he was unable to remember the name of it. When asked about previous self-harm, he said that he had taken an overdose of prescribed medication a few months earlier. The nurse also recorded that he said that he was hearing voices and was suffering from depression, and prior to custody had been receiving treatment from the mental health services in Blackpool. It is a requirement when someone arrives into custody that their medical records are requested from their community doctor as soon as possible. There is no evidence that this was done for him, despite him providing information about his doctor.
31. The nurse completed section two of the CSRA and wrote 'hearing voices and crying a lot, known to mental health services in Blackpool'. He ticked the box to indicate that in his opinion the man would pose an increased risk if he shared a cell with another prisoner. Due to concerns about his presentation

and previous history, a Registered Mental Health Nurse (RMN) was asked to review him in reception.

32. The RMN works at Preston as part of the Primary Care Mental Health Team (PCMHT), but also has a dual role as part of the 'Crisis' team whose role is to respond to problems on the wings with people in crisis and deliver intervention as appropriate. He also explained that the PCMHT have a caseload of up to 30 people who they see as primary care patients. In addition to this, there is also a Mental Health In-Reach Team (MHIRT) which provides care for prisoners with severe and enduring mental health problems. Mental health patients who are deemed to be unmanageable on the normal wings are housed on the healthcare wing (H1) where there is an inpatient facility.
33. He told the investigator that the man was tearful and said that he had been under the care of mental health services in Blackpool. He explained that in such cases he obtains a patient's community records or history. When he spoke with him it was 'out of hours' for the MHIRT whom he would normally approach for this information. Therefore, he telephoned the community mental health team at Guild Lodge and the staff there were able to confirm the care he had been receiving via e-CPA (the electronic clinical recording system for mental health services within Lancashire Care Foundation Trust.) He decided that the man should be monitored under the suicide prevention and self-harm management procedures and he therefore opened an Assessment, Care, Custody and Teamwork (ACCT) document
34. The ACCT process requires an assessment to be carried out by a trained assessor to try and talk through and record the individual's problems and identify the level of risk of the person harming themselves. As a trained ACCT assessor, the nurse completed the assessment with the man. During the assessment, he told the nurse he heard voices in his head that told him to harm himself or others. He said that as a consequence he had harmed himself on several occasions by overdose of prescription medication and attempted to jump off a bridge in Blackpool. He added that he was stopped by the police who took no further action other than to tell him to go home. The nurse asked about his previous custodial history, and he replied that he had been given a previous custodial sentence for attacking a stranger in a pub, in response to a voice inside his head. As part of the assessment, the nurse asked him about his family and what support he had. He said that he had recently had some problems with his ex-wife and, apart from a friend with whom he had been living prior to custody, he had no other family.
35. Throughout his assessment the man repeated that he had nothing to live for, but had no immediate plans to harm himself. Although he felt he had nothing to live for, the nurse said that he had identified he had a young daughter and tried to get him to focus on this as a possible reason for living. He told the nurse that he needed help from the mental health team.
36. The nurse recorded that the man had an existing prescription of sertraline, an anti-depressant and arranged for this to be re-prescribed. The prescription was written by a nurse practitioner, but the name on the prescription chart is

unreadable (Nurse Practitioners are RGNs who have completed advanced training, sometimes in a specialist field, and are qualified to prescribe medication in the absence of a doctor). In addition to the assessment, the nurse referred him to A2 landing, which he considered to be a quieter wing. Although he could not be sure, he thought that A2 had no more than 40 prisoners and was quieter. It is referred to as the re-integration unit. He said that its primary role was for those individuals who do not cope well on the main wings. In addition to this referral, he also referred him to the PCMHT, as part of the pathway for mental health care.

37. The ACCT procedures require a case review to be held immediately after the assessment with the prisoner, assessor and wing manager, normally a senior officer (SO). The man's review is recorded as having taken place at 3.35pm, with a SO, who was the manager on D wing, the first night centre, where he had been given a cell.
38. The SO noted that the man had been told about the various avenues of support available to him on the wing, including Samaritans, Listeners and staff. He said that he was expecting to have money sent in to him from friends, and was told that he would receive further information as part of his induction. He told the SO that he was due back in court in June, so he would be with them for a while. He was asked directly about any immediate plans to harm himself. He replied that he had none and expressed no immediate concerns. A further case review was planned for 14 April and the SO wrote that the D wing manager should attend along with a member of the chaplaincy.
39. The man was in a single cell on D wing, which was equipped with in-cell close circuit television (CCTV). Not all the cells on D wing are fitted with CCTV and the SO was asked by the investigator, whether he had been given this cell by chance or as a precautionary measure. The SO explained that it is normal procedure on D wing and there was a tendency to accommodate prisoners in these cells when they first arrive in custody.
40. The investigator asked the SO how the CCTV is monitored and whether this forms part of the ACCT monitoring at Preston. She said that she does not work regularly on D wing. However, as part of the safer custody team, she was aware that if a member of staff was in the office they would glance at the monitors, but prisoners in those cells are not constantly monitored. In relation to ACCT, the SO said that if a prisoner in a camera cell is subject to ACCT monitoring then the requirement is for physical checks i.e. going to the cell to observe the individual and not completing checks via the CCTV. She added that the CCTV was to be used as an aid and not in place of staff completing physical checks.
41. Preston has a protocol for the use of CCTV which was published in June 2010, along with a staff notice, advising them of the importance of reading the protocol. The protocol describes the intended use of CCTV and, guidance for staff in relation to prisoners on ACCT monitoring. The protocol highlights to

all staff the fact that the use of CCTV is not a replacement for physical checks to be conducted on those prisoners who are deemed to be at risk.

42. After attending his ACCT review, wing staff completed initial induction paperwork with the man. The prison regime, visits, letters, canteen, fire awareness and how to access support from Listeners were all explained to him. He said that, while he had not expected to be in custody, he was alright and that healthcare staff were sorting out his medication. It was recorded that he would require a full induction which would provide more in-depth information and assistance on issues such as housing and legal aid.
43. At 5.20pm on 9 April, the man asked a member of wing staff if he could speak to someone from the mental health team. Staff initially contacted the healthcare unit to ask if someone would be able to see him and were told that a message would be passed on. At 5.40pm, the nurse who was covering reception was contacted and told the wing that she would go across to the healthcare unit and see if anyone was available. She made the following entry at 5.52pm on his medical record:

"Hotel 2 call received. Wing staff becoming increasingly concerned about his mental well-being. Officers state he appears very anxious and is going to the back of his cell as he fears someone is going to get him. Senior nurse on Healthcare informed."
44. Just before 7.00pm, a RMN, the senior nurse, went to D wing and spoke with the man, as requested by wing staff. She recorded that it was difficult to fully assess him as he was tearful throughout the assessment. He again said that he had been under the care of the Blackpool Crisis Team, and talked about someone who he could see and who laughs at him. The nurse also recorded that he had only been taking sertraline for a few weeks and had previously been prescribed citalopram, also an anti-depressant, which had not been effective. She decided that he should be admitted to H1 for a period of assessment, and the Crisis Team in Blackpool should be contacted the following day for more information.
45. After the man moved to H1, an ACCT review was conducted. The senior nurse chaired the review, which was also attended by a SO and the man. It is a requirement of the ACCT policy that a review is held whenever a move to another wing takes place. The reasons for him being admitted were recorded and indicated that he was happy with this decision, and that he was willing to get help for his 'voices' and low mood. He said that he had no current thoughts of harming himself. The level of risk on the ACCT was reduced from 'raised' to 'low' and observations required every 30 minutes both during the day and at night.
46. The investigator asked the nurse to explain the reason for reducing the man's level of risk. She said that he was in a period of crisis, but she did not feel that he was at risk of harming himself. She also explained that he was experiencing stress due to his location on the residential wing, and by moving him to H1 this had been reduced. She confirmed that he had said that he had

no thoughts of harming himself at that time, and she also noted that appeared to be more positive after moving.

47. As part of the admission procedures on H1, a risk assessment of the man was completed. The assessment was to ascertain what his immediate needs were and to provide a plan of care. However, this did not form part of his clinical record which was accessible by all healthcare staff, and instead was stored on a separate computer drive. This information was only highlighted during the investigation. The initial health screen completed on reception by the nurse should have been followed up with a secondary health screen, sometimes referred to as a 'well-man assessment' within 72 hours. This assessment was not completed, but it is unclear whether this was because he had moved to H1.
48. The man continued to be monitored under the ACCT procedures. The prescribed level of observations and conversations when he was admitted to H1 was every 30 minutes, both during the day and at night. Entries were made in the ACCT document following these instructions; however, they were made on the half hour, and provided little evidence of interaction with him.
49. On 11 April, a member of staff spoke to the man in order to provide him with some induction information. A full induction should be available to all prisoners when they first arrive in custody, regardless of their location. This should provide information on all aspects of the prison regime, as well as an opportunity for prisoners to ask questions or share their concerns. There is no evidence that he was given a full induction programme. The same day, he received a letter from the PCMHT advising him that he had been placed on their waiting list. This seems odd, given that he was already resident on the mental health section of the healthcare wing. The explanation was that he had to be assessed. Over the next couple of days, he was recorded as accepting food and cleaning his cell, but still complaining of feeling agitated and hearing voices.
50. The ACCT monitoring was reviewed on 13 April. The review was chaired by the ACCT manager and attended by a member of the chaplaincy team and an officer, one of the safer custody team. It was recorded that during the review the man appeared low in mood and avoided eye contact. When he was asked what was wrong, he was unwilling to elaborate on his problems but he did tell the review panel that he was keen to see a psychiatrist. He also said that he felt able to approach staff if he needed to. It was recorded that he expressed no suicidal thoughts during the review and the panel reduced his level of observations to hourly during the day, remaining half hourly at night.
51. Comments on the man's medical record mirror those that were written on the ACCT document, and provide little further insight into how he progressed while on H1. However, on 14 April a comment on the ACCT document indicated that he appeared very agitated, and had been observed banging his head on the window in his cell. As a result, his observations were increased from hourly to half hourly. It was not possible from the documentation to identify the member of staff who had made this entry. Any significant event,

such as a change in the level of observations should prompt a case review to be held, and a senior nurse manager chaired a review of his ACCT monitoring that afternoon. He attended the review along with a SO, who represented the safer custody team. During the review, he said that he had not been banging his head and had actually been feeling around for where the heating was coming from. It was recorded that he appeared calm and relaxed and, when asked, denied any thoughts of self-harm.

52. The SO had completed the man's first case review when he arrived at Preston. The investigator asked her whether she had seen a change in him when she attended the review on H1. She replied that, in her view, he was looking better and she had thought to herself that maybe they were making some progress. The RMN wrote that all present at the review were in agreement that the level of observations could be returned to hourly.
53. As a manager on H1, the senior nurse was responsible for carrying out management checks on the ACCT documents open on the unit. She was asked by the investigator to explain the purpose of the checks. She said that the checks were to make sure that the level of observations on the front of the ACCT document had been met, for example, if a prisoner was on hourly observations, there are hourly entries and, if not, she would raise it as a concern. Another reason was to make sure that the entries are legible, and there is evidence of interactions. The investigator pointed out that the entries in the ACCT were very regimented and consistently made on the hour or half hour. She said she had mentioned this issue to the staff and it was also fed back by the safer custody team that observations should be unpredictable.
54. Over the next few days the man was recorded as participating in activities on H1 and interacting with staff and other prisoners. On 16 April, the chaplaincy assistant spoke to him while visiting prisoners on H1. She recorded on his ACCT document that he had told her he had not seen anyone since arriving at Preston. She told him that he needed to be patient and he replied "I will be dead by then". The investigator asked her about this entry.
55. The chaplaincy assistant said she had seen him during association and there were other prisoners around when she was speaking to him. She could not recall how the conversation had started, but remembered that he had complained about not seeing a psychiatrist, and he had been in Preston for about a week. She had told him he would need to be patient and he had then made a comment like "I'll be dead by then". She said that she felt that it was a 'throw away' comment, but was aware that she should record it on the ACCT. When asked whether she had spoken to anyone on H1 about the comment before leaving, she said that she had spoken to someone, but it was more about whether he would be seeing a psychiatrist rather than the comment he had made.
56. On 18 April, the man was assessed by the prison's visiting psychiatrist, who spoke to the man for some time. The psychiatrist made hand written notes of his assessment, which detailed his history. He told the psychiatrist that he continued to have thoughts of harming himself, but he had no means of doing

so in prison. He recorded that the man was prescribed 5mg olanzapine, would require a blood test and be reviewed in his next clinic. He also indicated that he had no objection to him returning to a residential wing. Olanzapine is used to treat schizophrenia, bi-polar disorder and depression.

57. It is difficult to understand the psychiatrist's rationale for advising that he be discharged to a residential wing at that point and the clinical reviewer comments on the potential missed opportunity to improve the man's outlook while he was resident in H1. There is no indication that staff knew that he had admitted thoughts of self-harm to the psychiatrist.
58. The man attended an ACCT review prior to his discharge from H1 on the afternoon of 18 April. The review was attended by a SO from C wing - where he would be moving to, a nurse from PCMHT and chaired by the senior nurse manager. It was recorded that he appeared settled and fit to go to C3. All support had been explained and he had no current thoughts of self-harm. (His statement about self-harm contradicted what he had told the psychiatrist that morning but there is no indication that staff were aware of this.) It was planned that he would be followed up after a week by the PCMHT. As well as the ACCT review, a care plan was completed and placed in the ACCT document. There is no care plan recorded on his medical record. However, the senior nurse told the investigator that at the time care plans and any assessments completed on him would have been stored on the separate drive mentioned earlier in this report and therefore not available on his main medical notes. He moved to C3 landing later in the afternoon.
59. When the man had first arrived at Preston and was assessed by a nurse, a referral had been made for him to be located on the re-integration unit, as this was considered to be a better place for him to adjust to being in custody. The investigator asked the senior nurse whether this had been considered as an alternative to him being moved straight to C3. She responded that the psychiatrist had no objections to him moving to a residential wing and, as the psychiatrist, his advice would be taken as to where a discharged patient should go.
60. She explained that there is a referral process for the re-integration unit (A2). In the past, psychiatrists discharging patients from H1, wrote in their clinical notes 'discharged to A2'. However, the SO on A2 raised concerns that patients were only being discharged to A2, with no plan for them to move on. She said that the staff on A2 were happy to accept referrals but she was of the view that the psychiatrists now needed to authorise patients for normal location, with a view to going on A2 as an interim measure.
61. Again, as the man had changed location an ACCT review was held on 19 April. This was attended by a SO, who chaired the review, an officer, a nurse from PCMHT and one of the chaplaincy team. During the review, he said that he was still hearing voices which were mainly at night. He said that he was keen to get a job as this would help him cope and take his mind off the voices. The SO wrote:

"He needs to come to terms that he has come to jail as he has broken the non-molestation order. Has been advised to speak to legal and bail staff to contact his solicitor."

It was also recorded that he told the review panel that he would not tell staff if he was going to kill himself. The panel agreed that the level of risk should remain 'low'.

62. Following the ACCT review, the mental health nurse recorded on the man's medical notes, 'seen for ACCT review, no concerns voiced or raised about self-harm ...' The SO also completed a security information report (SIR) following the review. (An SIR is a document that can be completed by any person working in a prison to highlight something that they have seen or heard that may have an impact on the security of the prison.) He wrote:

"Whilst on ACCT review the man stated that one of the reasons that he was in jail was that he had breached a non-molestation order six times, he stated that when he gets out he will probably do it until he does what he has planned. However, when asked to expand on this he would not say."

63. The SO told the investigator that, prior to 19 April, he had no knowledge of the man. On the day of the review, he was working on C wing to cover for a regular senior officer. He was asked whether the comments made by the man, about not telling staff if he was going to harm himself and still hearing voices, had made the review panel consider raising his level of risk. He said that his perception of his comments was that the focus was directed more at harming his ex-partner, and that was why he had submitted the SIR. The investigator pointed out to the SO that this is not what he wrote during the review. He also asked him whether anyone else present had raised any concerns that he had made the statement about harming himself. The SO replied that he could not recall anyone raising concerns and all agreed that he was a low risk.
64. There is little documented about the man over the next couple of days. He was given a cell near the landing office when he had arrived onto C3 and this again was equipped with CCTV. An officer, a regular member of staff on C wing, told the investigator that it is likely he was given this cell as he was on his own and it was nearer to the wing office, which meant staff could keep a closer eye on him. His level of observations was hourly during the day and every half hour during the night.
65. On the afternoon of 21 April, during a conversation with the officer, the man told her that he was concerned about his legal team as well as his mortgage and business. The officer recorded in the ACCT that he appeared quite anxious, and told her that he had not been sleeping well, due to his worries. She advised him that there were people who he could speak to who would be able to assist him and give him advice. She advised him to write down a list of the issues he needed help with, and when she was next on duty she would help him complete the relevant forms.

66. The officer recorded on the ACCT that the man seemed better after their conversation. He told her that he had been trying to fix everything, and she told him that he should not try to achieve too much or set himself unrealistic goals. That evening, prisoners on C3 were unlocked after the evening meal for one hour of association. During that time she saw him and he appeared alright, talking to other prisoners and smiling. Just before the prisoners returned to their cells at 8.00pm, she passed him and told him not to forget to write the list. She said that he smiled and said that he would.
67. Prison staff who work during the evening usually finish their shifts around 9.00pm, when the night staff take over. However, in some cases night staff arrive earlier to begin their duty. On the night of the incident, Officer A was the night officer, and arrived for duty at around 8.00pm. He counted all the prisoners on C3 and C4 landing and made his first observation on the prisoners who were subject to ACCT monitoring. That day there were four such prisoners on C3 and C4, including the man. The officer made an entry in his ACCT at 8.15pm, which said 'sat at table watching TV'; another entry timed at 8.45pm reads the same.
68. As previously mentioned, the man was in a cell with CCTV. As part of the investigation, the investigator viewed the CCTV recordings. At 9.22pm, the officer can be seen to go to the man's cell and look in via the observation panel. The in-cell CCTV shows the man look towards the door from his bed where he was sitting, before moving across to the window once the officer had moved away. He then did something at the window before disappearing from view. The officer made an entry on the ACCT timed at 9.15pm which said 'laid on bed watching TV', he continued to make entries every 30 minutes stating the same, and that the man had replied 'ok' on one occasion during a check. However, the wing CCTV footage shows that the officer made no further checks on him until approximately 12.25am.
69. At 12.25am, the officer went to the man's cell. He looked in through the observation panel and saw him at the back of the cell with a ligature around his neck. The officer immediately used his radio to call for assistance. Officer B, who was the assistant orderly officer that night, heard the call over his radio. (An orderly officer is responsible for the prison during the night, including dealing with any emergency situations that arise, and is supported by an assistant who will respond to problems if the orderly officer is unable to do so.) Officer B said that on hearing the emergency call he immediately went to C3 with a Operational Support Grade (OSG). As they arrived, he saw the officer standing outside cell 29, the one occupied by the man. During the night only the orderly officer carries a set of keys. All other staff who patrol residential areas are provided with a sealed emergency pouch containing a single cell key. The seal can be broken when access to a cell is required in an emergency.
70. Officer A had broken the seal on his pouch and, as Officer B and the OSG approached, he unlocked the door. All three members of staff went into the cell and Officer B saw the man hanging from the plastic curtain rail, by

shoelaces that were tied around his neck. Officer A and the OSG lifted him up to release the pressure on the ligature and Officer B cut it from the curtain rail using his cut-down tool. He made a second cut to remove the ligature from his neck.

71. Other staff went to C3 and a third officer entered the cell and performed cardio pulmonary resuscitation (CPR) on the man. The officer continued CPR until healthcare staff arrived. Two nurses arrived at the cell with emergency equipment and took over CPR. An ambulance had been requested as soon as staff had first entered the cell and paramedics arrived at 12.45am. The paramedics continued treatment but the man did not respond and at 12.55am CPR was stopped and he was pronounced dead.

Events following the man's death

72. Immediately after the man's death, the prison gathered all the information held on him and identified his next of kin. The police attended the prison, as is the normal course in all deaths in custody. The cell was checked to see if a note had been left, but none was found.
73. It is usual for the prison to notify the next of kin, in person and as soon as is practicably possible. However, the investigator was told that the man's next of kin were two friends and the address was in an unknown area of Blackpool. As it was late and to ensure the safety of staff was not compromised, the prison asked the police to make contact. The police contacted the prison at 6.10am to say that this had been done. Later that morning, staff found the address of his estranged wife and the Governor and Prison Chaplain visited her home. The Governor explained what was known at that time about the death and the process that would take place, including the PPO investigation.
74. A hot-debrief was held and all staff who had been involved that morning attended. Staff were asked whether they had any immediate concerns or issues arising from the man's death, but none were reported. They were told about the services of the staff care team who were available to offer emotional support if it was required. All staff said they felt adequately supported.
75. The Governor asked a member of his management team to review the CCTV footage from C3 and the man's cell, which is done routinely after a death in custody. The CCTV footage identified that Officer A had not completed the necessary suicide and self-harm monitoring checks in accordance with the ACCT document as he said he had. All the information was passed to the police whose investigation resulted in charges being laid on 2 November against the officer and his wife, who had been the night orderly officer. Both were suspended from duty after the death. Both members of staff pleaded guilty to misconduct in public office at a later court hearing.
76. During the investigation, it became apparent that the man had written to his friend, whom he had named as next of kin, a couple of days before his death. After his death, his friend spoke with a nurse from the mental health team in Blackpool who had worked with him and showed him the letter he had

received. The letter made reference to arrangements he wanted his friend to make. He told his friend that he wanted him to sell his van and use the money for his new garden.

77. HMP Preston covered the full cost of the funeral and the prison chaplain delivered the service, which was attended by two Governors.

ISSUES

Management of the suicide prevention and self-harm management procedures

78. When the man arrived at Preston, the need for him to be placed under the suicide and self-harm measures was correctly identified by a nurse and an assessment of his immediate needs completed. The assessment was also followed by a case review involving a nurse, a SO and the man, following ACCT guidelines and a care plan completed.
79. Prison Service Order (PSO) 2700 provides a guide to staff on what 'observations' and 'conversations' entail and how these should be recorded. The PSO says:
- "...Conversations must be interactive, with staff actively engaging with the prisoner, encouraging him/her to talk and participate in activities where appropriate. The quality of conversations will be reflected in the quality of entries in the on-going record ..."
- "... Significant events, conversations with and observations of the at-risk prisoner must be recorded in the on-going record, and accompanied by the recording member of staff's printed name and signature. The minimum required frequency of recording such conversations and observations is stated in the 'required frequency of conversations and observations and required frequency of recording' box on the front cover. The purpose of recording observations is to help form a picture of the individual's state of mind and so contribute to care. A good-quality, meaningful entry once an hour or at the end of the night shift can communicate more than pages of meaningless comments, such as 'correct when checked,' written at intervals of a few minutes. The requirement to record should not be so onerous that it reduces the care that staff are able to offer prisoners ..."
80. The majority of entries made in the man's ACCT record did not follow these guidelines. There were very few that were meaningful and which demonstrated that staff had actively engaged with him. Most were observations or comments that were written without any explanation of why the individual had written it, such as 'no current concern'. This may have been the case, but does not explain why. In addition to the limited information recorded, staff did not follow the guidelines in writing their names clearly after making an entry.
81. The comments and entries in the man's ACCT document were mostly made within the timescales prescribed on the front cover. The PSO is not prescriptive regarding the frequency of observations, other than that they should be at a level which meets the needs of the individual. However, completing a check on either the hour or half hour is predictable. It is therefore good practice for staff to be encouraged to conduct their observations at unpredictable intervals, which still allows for the required number of checks to be made. The entries on his ACCT, particularly by night

staff, were formulaic and repetitive, with an entry every thirty minutes, and the same thing written each time. The clinical reviewer has also criticised the frequency of ACCT observations in her report.

82. There was evidence that a system was in place for managers to conduct quality checks on ACCT documents. However, the effectiveness of these checks was questionable with no evidence that the points made above were ever highlighted by managers. During the investigation, staff said that they were aware of that some observations were predictable and entries meaningless. Management checks need to be robust and, where problems are identified, there should be clear evidence that they have been addressed.
83. There are a number of reasons for regular case reviews when a prisoner is subject to suicide and self-harm monitoring. These include to review the prisoner's initial problems, any suicidal or self-harm intent and the level of risk.
84. Case reviews were held regularly for the man on the specified dates, and he always participated. Attendance at these reviews was, in the view of staff, multi-disciplinary and it can be seen from the record that chaplaincy, safer custody and mental health staff were frequently in attendance. However, it should be borne in mind that not only persons who have engaged with the prisoner should be invited to attend, but any person who it is considered may be able to offer a positive contribution.
85. When the man was discharged from H1 there was a case review, attended by the manager from wing C3, where he was due to move. The Caremap was updated and an additional care plan placed inside the ACCT. Once he moved to C3 a further case review was held, again in line with the requirements of the ACCT procedures.
86. The SO who chaired the review on 19 April, was covering a shift on C wing and said that he had no previous knowledge of the man prior to the review. It is unfortunate that the review on C3 was not chaired by either the same SO who had attended H1 on the day the man moved or a regular C wing SO.
87. As mentioned earlier, one of the purposes of a case review is to review risk and suicidal or self-harm intent. During case reviews on 13 and 19 April, the man raised a number of significant issues, presented as depressed and made clear he would not tell staff if he was going to harm himself. This information, in conjunction with his demeanour should have prompted discussion about increasing the level of risk or observations which, in turn, should have been documented in the review notes.
88. The SO did not know him and had no interaction with him prior to the review on 19 April. He said that no one present at the case review had mentioned increasing the level of risk or observations. After the review, the mental health nurse, who had attended on behalf of the PCMHT, recorded on his medical record "seen for ACCT review, no concerns voiced or raised regarding self-harm".

89. The SO said that following the review he was more concerned about comments the man had made about his partner, and this had prompted him to submit an SIR. This conversation was not recorded as part of the case review.
90. Despite some positive practices some procedural weaknesses have been identified in the handling of the suicide and self-harm prevention procedures, we make the following recommendation:

The Governor should conduct a comprehensive review of the operation of ACCT procedures at HMP Preston and ensure that:

- **staff engage and interact positively with prisoners subject to ACCT monitoring;**
 - **staff complete ACCT observations at unpredictable intervals;**
 - **staff complete ACCT records in accordance with PSO 2700, including always making meaningful entries and writing their names clearly in the correct column;**
 - **the current system for quality assurance of completed ACCT records is improved and robustly managed.**
 - **case managers are reminded of the purpose of case reviews and that all relevant points and decisions arising from the discussions are be recorded.**
91. The man should have been checked every 30 minutes during the night. However, the evidence shows that the officer responsible for doing so on the night of his death did not check him between 9.22pm and 12.25am, although he completed the records indicating that he had conducted the required checks. These matters were subject to criminal charges and both members of staff pleaded guilty. They are no longer employed by the Prison Service.

Access to induction

92. When the man first arrived at Preston he was on D wing, where he was due to be given a full induction, as indicated on the completed first night paperwork. However, he moved to H1 within a few hours of arrival. Despite this, he should have had a full induction as he had not been in custody for over ten years and therefore would have been unfamiliar with current rules and regimes.
93. The investigator asked the senior nurse manager whether prisoners who go to the healthcare wing shortly after arriving at Preston still have access to an induction programme. She said that it was a problem for prisoners to return to D wing when they are discharged from the healthcare department and, although staff will attend H1 to complete some aspects of the induction, she was not sure what this involved.

94. When the man returned to C wing he had a lengthy talk with an officer, in which he told her that, amongst other things, he was concerned about his legal team and mortgage. If he had been provided with the full induction to which he was entitled to when he first arrived, he might have had the opportunity to discuss his concerns and receive advice and support. Discussion of possible solutions might have helped to allay some of his worries.
95. Prison Service Instruction (PSI) 52/2010 Early days in custody – reception in, first night in custody and induction to custody provides specifications and guidance on what should be provided during an induction, who should receive it and how it should be delivered. The PSI says:

“Prisoners must be placed on an appropriate induction programme... as soon as they are able to benefit from it ... Arrangements must be made for those whose induction is delayed to be able to obtain information in the interim.

96. The clinical reviewer also criticised the induction process in her report. We make the following recommendation:

The Governor should ensure that the induction process is delivered in line with PSI 52/2010 and that prisoners are not disadvantaged due to their location.

Clinical care

97. In the report by the clinical reviewer, she makes a number of recommendations for the Head of Healthcare at Preston. Some of these recommendations are reflected in this report.
98. During the man’s reception health screen he said that he had been receiving care from the mental health team in Blackpool. This was confirmed by a nurse, who telephoned the crisis team in Blackpool to try to obtain background information. The clinical reviewer refers to the importance of nursing staff being able to access a patient’s history and makes the following recommendation which we endorse and slightly recast:

The Head of Healthcare should ensure that Registered Mental Health Nurses working within HMP Preston are given access to the electronic clinical recording system (eCPA) as a matter of priority. This will enable them to access the full mental health history to assist in making informed decisions about care planning and risk assessment.

99. Following the assessment by a nurse, the man was referred to the PCMHT in line with Mental Health Care Pathway protocols. A letter informing him that he was on the waiting list for mental health services was sent to him while he was a patient on H1 mental health ward. The clinical reviewer comments on this:

“... This does not promote the vision of effective interagency working or a positive experience for him of the mental health services in custody.

Evidence available demonstrated a lack of clarity around roles and responsibilities for mental health service on H1 ...”

100. During the investigation the clinical reviewer was told that this is an area that is currently being reviewed. The following recommendation is made by the clinical reviewer, which we have slightly reworded and endorse:

The Head of Healthcare should ensure there is clarity on the roles of staff on H1 and their responsibilities as part of the delivery of mental health services at HMP Preston.

101. PSO 3050 Continuity of healthcare for prisoners, says that every effort should be made to retrieve any information required from the prisoner’s general practitioner (GP) or other relevant service with which they have had recent contact. The clinical reviewer comments on this further in her report and makes the following recommendation which we endorse:

The Head of Healthcare should put in place a robust process to request and review past medical history from a prisoner’s community GP.

102. The guidance in PSO 3050 indicates that in the week following first reception, every prisoner must be offered a general health assessment. At Preston, this is known as a ‘well man assessment’. As he transferred to H1, the man did not have such an assessment. The clinical reviewer points out that regardless of a prisoner’s location they must be offered a second assessment. Therefore prisoners located on H1 from reception or the first night centre should complete the secondary screen with an appropriately trained nurse. We endorse the following recommendation:

The Head of Healthcare should ensure that all prisoners are offered a second health screening in the week following first reception.

103. The man was admitted to H1 for a mental health assessment. HMP Preston’s Mental Health Care Pathway states that the criteria for admission to H1 should include an initial consultation with either the PCMHT or MHIRT as well as an assessment within 72 hours. Following a full review of the clinical entries on SystemOne, the clinical reviewer concluded that no assessment had been completed for him.

104. The clinical reviewer also found no evidence of assessment tools being available or used and advised that mental health assessment tools should be introduced and placed on SystemOne as templates, supported by appropriate training.

105. She also referred to the expectations of HM Chief Inspector of Prisons (HMCIP) that a prisoner who is deemed to require assessment by specialist mental health services are seen within seven days and that every prisoner will have a clinical record containing an up to date assessment and care plan which should include medical history. However, the man was admitted on 9 April and not seen by a psychiatrist until 18 April and no comprehensive assessment, care

plan or social history was identified for him. Recommendations on mental health assessments are made by the clinical reviewer in her report.

Method of the man's self-harm

106. The man used his own shoelaces to self-harm, and it would be understandable for people to question why a person who had been considered to be of risk of harming himself would be allowed to have such items in his possession.

107. Prison staff must make decisions based on the evidence that they have before them at the time, taking into account previous methods that a prisoner may have used to self-harm. He had not previously used a ligature or indeed made reference to doing so. It is also important that any restrictions placed on an individual, such as removing items from them, do not add to the despair that they are feeling. The PSO 2700 says:

'...removing personal belongings from a person who is feeling hopeless and depressed (especially items of clothing, belts or shoelaces) can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Fear of losing their normal possessions can discourage prisoners from disclosing suicidal feelings. And removal of some items in possession (such as pens) can deprive the individual of access to creative activities which might distract them from their painful feelings. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so ...'

108. There is no evidence to suggest that prison staff should have removed any items, in particular shoelaces from the man when he was located onto the residential wing.

FAMILY RESPONSE TO REPORT

109. The man's family were provided with the draft report and the opportunity to give feedback.
110. The family told us that they would like to clarify in the final report that the man did not spend part of his childhood in a care home or reside with other relatives; he lived with his mother until he left home.
111. The family continue to be upset by the perceived lack of effort by HMP Preston in tracing them after his death and the delays, which took place in informing them.
112. The family have concerns that the comment he made to the member of chaplaincy staff, 'I will be dead by then' was treated as 'a throw away comment'. They feel that he had been placed in a cell and treated as a normal prisoner, when he clearly was not. He was depressed and needed help. The family believe that if staff had listened to him and provided the help he required, then he would still be alive.

RECOMMENDATIONS

1. The Governor should conduct a comprehensive review of the operation of ACCT procedures at HMP Preston, and ensure that:
 - staff engage and interact positively with prisoners subject to ACCT monitoring;
 - staff complete ACCT observations at unpredictable intervals;
 - staff complete ACCT records in accordance with PSO 2700, including always making meaningful entries and writing their names clearly in the correct column;
 - the current system for quality assurance of completed ACCT records is improved and robustly managed.
 - case managers are reminded of the purpose of case reviews and that all relevant points and decisions arising from the discussions are be recorded.

The Prison Service accepted these recommendations and said:

A universal e-mail to all staff was sent by the Deputy Head of Residential – Safeguards on 8 March 2012. In this e-mail, staff were reminded of the requirements to make clear, concise and informative/meaningful ACCT entries, and to keep within prescribed time limits whilst also making unpredictable observations. These requirements are re-enforced as part of the ACCT refresher training that all staff are required to complete on a three yearly cycle, and which forms part of the Induction training that all new staff do upon arrival at HMP Preston.

At the Safer Preston meeting, which takes place monthly, a sample of completed ACCT records is now examined and further quality checks are carried out by the multi-disciplinary panel. Any issues or concerns that are noted are minuted, and actions to remedy these concerns are allocated to a named individual(s). This is a standing agenda item and the minutes of all meetings are published on the Intranet for the availability of all staff.

Prior to the publication of PSI 64/2011, HMP Preston carried out a number of measures to ensure that all staff were aware of the requirements within this policy. A number of briefings and presentations took place, and the presentation was published to all staff and can be accessed via a public folder.

On 1 May 2012, version 5 of the ACCT document was published and training for trainers became available for two of HMP Preston's staff to deliver ACCT refresher training, and Case Manager training at the prison.

A programme of Case Manager training has now been put into place and has been published. This will be delivered throughout the business year.

2. The Governor should ensure that the induction process is being delivered in line with PSI 52/2010 and that prisoners are not being disadvantaged due to their location.

The Prison Service accepted this recommendation and said:

All prisoners coming into HMP Preston, including those going into units such as Segregation, the Drug Dependency Unit and Healthcare, receive the same first night induction procedures, the same Healthcare assessment and the same access to partner agencies involved in the Induction process. All new receptions are communicated to the First Night Centre (FNC) and all new prisoners, with the occasional exception of those prisoners going directly to Healthcare or to Segregation, go to the FNC itself. The record of all prisoners received into the prison is held on the FNC to ensure that no prisoner is missed from the process. The location of the FNC itself has changed, and it is now at ground level, meaning that access to the unit for disabled and mobility-impaired prisoners is greatly improved.

Recommendations for healthcare

3. The Head of Healthcare should ensure that Registered Mental Health Nurses working within HMP Preston are given access to the electronic clinical recording system (eCPA) as a matter of priority. This will enable them to access the full mental health history to assist in making informed decisions about care planning and risk assessment.

Healthcare at Preston accepted this recommendation and said:

All Mental Health staff now have access to eCPA and are utilising this in conjunction with SystemOne.

4. The Head of Healthcare should ensure there is clarity on the roles of staff on H1 and their responsibilities as part of the delivery of mental health services at HMP Preston.

Healthcare at Preston accepted this recommendation and said:

All staff are aware of their role and have clear Job Descriptions. They are expected to support the main prison at the weekend when the IMHT are working with reduced staffing. All staff have been advised of the importance of admission/Well Man/care planning.

5. The Head of Healthcare should put in place a robust process to request and review past medical history from a prisoner's community GP.

Healthcare at Preston accepted this recommendation and said:

All patients' medical records are now requested the day following admission. There is a robust system in place to request these records and pass on to the GP.

6. The Head of Healthcare should ensure that all prisoners are offered a second health screening in the week following first reception.

Healthcare at Preston accepted this recommendation and said:

All prisoners regardless of location receive a Well Man assessment within 24 hours of arrival.