



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

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

May 2012

This is the report of the investigation into the apparently self-inflicted death of a man. He was found by prison staff during a routine check just before 7.00am in June in his single cell on B wing at HMP Preston. He had a ligature around his neck attached to the bed frame. Despite the efforts of prison staff, nurses and paramedics, he could not be resuscitated. He was 45 years old when he died. I offer my sincere condolences to his family.

The investigation was conducted by one of my senior investigators. In addition, a clinical reviewer carried out a review of the clinical care the man received. I am grateful to the Governor of HMP Preston and his staff for co-operating with the investigation. I apologise that the report has been delayed.

This is a lengthy and detailed report, reflecting the complexities of both the man's character and the events leading to his death. He had been in prison since 2004 and had been diagnosed with mental health problems. He also had a long history of both prescription and illegal drug use. It is clear that, at times, he was difficult to manage. He could be aggressive, unpredictable and, by his own admission, manipulative.

In March 2011, as he approached his release, he was charged with assaulting prison staff. As a result, he was not released but transferred to Preston awaiting trial. It seems that in mid-June, the man's mental health began to decline. He complained of hearing voices and made bizarre statements. Although he was seen by mental health practitioners, the care he received was not consistent. We make a number of recommendations to the Head of Healthcare as a result. We also make recommendations concerning the provision of drug treatment. There are 13 recommendations in total. This is a high number and reflects my concerns about aspects of the care provided to him.

However, that said, the man did not have a history of harming himself and throughout his years in prison had, apparently, never attempted to take his life before. I do not think that, on the evidence available, either prison or healthcare staff could reasonably have foreseen his actions.

This final version of the report reflects the National Offender Management Service's (NOMS) response to the recommendations made. I would also like to thank the man's parents for taking the time to consider the report at the draft stage.

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

May 2012

CONTENTS

Summary

The investigation process

HMP Preston

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was sentenced to nine years in prison in 2004 for an offence of violence. It was not his first time in prison. From the early days of his sentence, he displayed difficult and unpredictable behaviour. In 2004, he was diagnosed with mental health problems.
2. In 2007, the man revealed a long history of substantial drug misuse. He said that he was still using illicit drugs in prison but refused to engage with drug workers. Healthcare staff noted that he was addicted to a number of different drugs. They recorded that he sometimes tried to persuade doctors to prescribe medication to meet his addiction needs rather than because of a clinical need.
3. The man was assessed by a psychiatrist in 2009. He admitted to being manipulative and lying to people. He also said that, about ten years previously, he had suffered hallucinations and heard voices and been treated as an inpatient in hospital. He denied any history of serious depression and said he had not harmed himself since he was young. That year, he was prescribed antidepressants.
4. In June 2010, the man was prescribed methadone (a heroin substitute) and diazepam (a sedative medication) to try to help him reduce his use of illegal drugs.
5. The man was due for release in May 2011 and so, in February, he was transferred to HMP Garth, a prison nearer his home town. The following month, he allegedly assaulted two members of prison staff. As a result, he was transferred to HMP Preston on 8 April. The night before he moved to Preston, he said that he was thinking of harming himself and so he was monitored under suicide prevention measures. A few days later, he told staff that he had not felt suicidal but had threatened self-harm to manipulate staff. The suicide monitoring was ended on 10 April.
6. In early May, staff thought that the man was intimidating other prisoners and so he was monitored under the prison's violence reduction measures. On several occasions during his time at Preston, staff thought that he might be bullying other prisoners. However, he also made claims that he was the victim of intimidation by both staff and prisoners. When staff tried to investigate his claims he sometimes refused to give any further information about the nature of the victimisation.
7. The man pleaded not guilty to the charges of assault but he was refused bail and was remanded into custody. As his original sentence ended on 9 May, he became a remand prisoner (in custody awaiting trial) from that date.
8. Specialists from a local mental health unit tried to carry out an assessment of the man's mental health needs, however, he refused to co-operate. As a result, staff from the prison mental health teams tried to work with him whenever he complained of mental health problems or wing staff became concerned.

9. The man moved to the prison's vulnerable prisoner unit on 15 May (this unit is explained in detail later in the report). He requested the move because he said he felt threatened by other prisoners. In mid-June, his behaviour became more erratic and staff began to have concerns about his mental health. He complained of hearing voices and was seen by mental health practitioners. However, he had also broken various prison rules and so prison and healthcare staff thought that he was trying to manipulate them.
10. In June, the man asked to move from the vulnerable prisoner unit to a normal prison wing. He said that he did not like mixing with sex offenders and was bored by the unit regime. That day, staff arranged for him to move to B wing. At just before 7.00am the following morning, staff carrying out a routine check found him with a ligature around his neck. Officers and prison nurses attempted to resuscitate him until the paramedics arrived. Unfortunately, the attempts were unsuccessful and his death was pronounced at 7.44am.
11. The man was a complicated character who posed many challenges to those working with him. He had mental health problems made worse by the fact that he also misused drugs. This investigation has highlighted a number of failings in his care, particularly concerning the mental health care he received. We have made 13 recommendations to address them. However, he was not considered to be a risk to himself and we do not think that, on the basis of the evidence available, staff could reasonably have anticipated his actions.

THE INVESTIGATION PROCESS

12. The Ombudsman's office was notified of the man's death on 23 June and the investigation was allocated to a senior investigator. She visited Preston on 7 July to open the investigation. During her visit, she met the Governor and a number of other members of staff. She also met a representative of the Independent Monitoring Board (IMB – explained in more detail in paragraph 19) and the Prison Officers' Association (the staff trade union). She was provided with copies of all relevant paperwork relating to the man's time at Preston prison. In addition, she had access to paperwork covering the entirety of his most recent prison sentence. She was also given a copy of his medical record.
13. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and inviting them to contact her with relevant information. Four prisoners responded. Two were interviewed in person and one by telephone. One no longer wished to take part in the investigation (we cannot compel a prisoner to take part).
14. The local PCT appointed a clinical reviewer to undertake a review of the clinical care the man received at Preston. She had access to his full medical record and other documents as relevant.
15. In August, the investigator and clinical reviewer returned to Preston and carried out interviews with staff and prisoners. Following interviews, the investigator provided both verbal and written feedback to the Governor.
16. The Coroner for Preston and West Lancashire was informed of the nature and scope of the Ombudsman's investigation. He provided a copy of the post mortem report and some documents prepared by Lancashire Police. We are grateful for his assistance. The Coroner will be sent a copy of this report to assist with his enquiries.
17. The investigator contacted the Chair of the man's Multi Agency Public Protection panel (MAPPP – explained later in the report). He provided copies of the minutes of the last four meetings held prior to the man's death. The clinical reviewer sought further information regarding the man's mental health history from Guild Lodge, a secure mental health service in Preston. We are grateful for the assistance of both the local probation trust and Lancashire Care NHS Foundation Trust.
18. One of the Ombudsman's family liaison officers contacted the man's mother outlining the purpose of the investigation and inviting her to raise any concerns. She thought that her son had been verbally abused by other prisoners. She wanted to know whether this had been documented anywhere and what action the prison had taken as a result. She also said that, while her son was on remand at Preston, she had tried to take new clothes to him during a visit. She was told that this was not allowed. She thought that the decision not to allow him the clothes would have affected his self esteem and mood.

19. While the investigator was reviewing the man's file, she found the name and address of his father. The prison confirmed that they had not contacted him following his son's death. The investigator passed the contact information to the Coroner's officer who arranged for the local police to visit and break the news of his son's death. The family liaison officer then made contact with the father. He asked why he had not been told of his son's death earlier. He also wanted to know how long his son had been at Preston.
20. The man's father considered the draft report but did not feel able to provide feedback within the given timeframe. The man's mother sought legal representation. She remains concerned that her son was being bullied by staff before his death.
21. We are very sorry that the report has not been issued on time. The delay was caused by workload pressures in our office.

HMP PRESTON

22. HMP Preston is a Victorian prison in the centre of the city. It holds up to 842 adult male prisoners from courts in Lancashire and Cumbria. The prison can accommodate around 80 vulnerable prisoners (VPs). Prisoners may be deemed to be vulnerable because of the nature of their offence. Generally, those accused of sexual offences will be given VP status. Alternatively, prisoners may be given VP status because they are less well able to cope on normal prison wings, for example because they are in debt to other prisoners.
23. VPs are kept separate from the rest of the prison population. At Preston, they are normally housed on C2, the dedicated VP unit on the first floor landing of C wing. When the number of VPs at Preston exceeds the number of cells on C2, VPs will be placed on the “overspill” on the landing above, C3, which is otherwise a normal prison landing. VPs on C3 are kept separate, as far as possible, from other prisoners on the landing and are brought to C2 to collect their food and for periods of association (when prisoners are let out of their cells to mix with others and use the showers and telephones). Prisoners may ask to be given VP status and, if they sign a disclaimer, can ask to be removed from the VP unit and return to a normal wing.

HM Chief Inspector of Prisons

24. The prison was last inspected by HM Chief Inspector of Prisons (HMCIP) in August 2009. The report of that inspection described Preston as “overcrowded”, with a high turnover of “needy and sometimes challenging” prisoners. Despite these challenges, HMCIP found Preston to be a generally safe and well run prison.
25. Relationships between staff and prisoners were found to be good. Most staff treated prisoners with respect and offered support to them. There was a comprehensive violence reduction strategy in place, which included the strategy for dealing with antisocial behaviour. However, while a formal system was in place for dealing with the victims and perpetrators of antisocial behaviour, few perpetrators were moved to the higher levels of monitoring (the system is explained in more detail later). The support offered to the victims of bullying was “limited” and, generally, prisoners surveyed had little faith in the system. The quality of recording information about antisocial behaviour was also criticised.
26. HMCIP noted that a comprehensive suicide prevention and self harm management strategy was in place, which “reflected the establishment’s holistic approach” to supporting at risk prisoners.
27. The inspection report highlighted that the combination of prisoners held on C2 made it difficult to manage. Prisoners who were vulnerable because of the nature of their offence were living alongside those who could not live on other wings because they were in debt. The inspectorate wrote that, as a result, there was evidence of bullying by the latter group. The use of the vulnerable prisoner overspill on C3 landing added to the complications.

28. At the time of the inspection, Preston was in the process of introducing the integrated drug treatment system (IDTS - explained in paragraph 35). The inspectorate noted that prisoners with substance misuse and mental health problems (known as dual diagnosis) could access the mental health services but that none of the mental health staff had expertise in dual diagnosis. The IDTS nurses did not attend multi-disciplinary meetings to coordinate care. (Multi disciplinary meetings involve individuals from a range of services and teams. This might include general healthcare staff, mental health specialists, drugs services and community services.)

Independent Monitoring Board (IMB)

29. Each prison in England and Wales is monitored by a board of unpaid members of the local community, appointed by the Secretary of State for Justice, known as the IMB. The role of board members is to monitor the conditions prisoners are held in and submit an annual report to the Secretary of State. The most recent IMB report for Preston covers April 2009 to March 2010.

30. The Board described the prison as “a decent, caring and well managed institution”. They highlighted the increasing numbers of vulnerable prisoners having to be housed separately from the main population, and the strains that this caused. In conversation with the investigator, the IMB representative confirmed that the Board had no major concerns about the care and support provided to prisoners. The positive relationships between staff and prisoners were mentioned.

Previous deaths at Preston

31. The man is the eighth prisoner to apparently take his own life at Preston since the Ombudsman began investigating all deaths in prison custody in 2004. His was the second of three apparently self inflicted deaths to occur at Preston in the space of four months. The circumstances of the deaths are not similar. However, this office recommended that defibrillators (which can help to restart the heart in certain circumstances) be taken to all medical emergencies in relation to a death that occurred in 2007.

Assessment, Care in Custody and Teamwork (ACCT)

32. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where

the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

Counselling, Assessment, Referral, Advice and Throughcare service (CARATs)

33. CARATs teams operate in every prison in England and Wales. They provide low intensity, non-clinical interventions to prisoners with substance misuse problems. They work primarily with those who use drugs, but can also work with prisoners who use both drugs and alcohol. (The service is not available to prisoners who only misuse alcohol.)
34. Prisoners may refer themselves to the service or be referred by staff. A CARATs worker will assess the prisoner's history of substance misuse and establish their support needs. Interventions on offer might include one to one counselling sessions, group work or specially designed programmes.

Integrated Drugs Treatment System (IDTS)

35. IDTS is a Prison Service scheme which aims to increase the amount and quality of substance misuse treatment available to prisoners, with particular emphasis on the early days in custody. It is intended to improve the links between clinical and non-clinical services and reinforce continuity of care from the community into prison, between prisons, and on release into the community. As part of the IDTS programme, prisoners can be prescribed methadone (a heroin substitute). At Preston, the IDTS team is nurse led, with input from a substance misuse specialist doctor.

Segregation unit

36. The segregation unit is a small, discrete unit in the prison where prisoners who cannot be managed on the normal wings may be located, usually for a relatively short amount of time. Sometimes, prisoners are moved to the segregation unit when they behave badly on the wings or break prison rules as a form of punishment. They may also be housed in the unit for their own protection. The regime in the segregation unit is generally more restricted and prisoners have less time out of their cells.

Tackling Antisocial Behaviour (TAB) plans

37. At Preston, prisoners who are considered to be the perpetrators or victims of antisocial behaviour may be placed on a TAB plan. For perpetrators, the TAB process has three stages. In the first stage, staff monitor the prisoner's behaviour for seven days. The prisoner is not made aware that the TAB plan is open or that they are being monitored. In stage two, the monitoring continues but the prisoner is made aware of the TAB. The perpetrator may lose certain privileges if there is evidence of bullying or antisocial behaviour. In stage three, the perpetrator is placed on report and may receive a punishment. If a prisoner is the victim of antisocial behaviour, they will be offered staff support.

Multi Agency Public Protection Arrangements (MAPPA)

38. Multi-Agency Public Protection Arrangements (MAPPA) is the name given to arrangements in England and Wales for the responsible authorities tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. Offenders who come within the MAPPA remit are classified according to the type of offence they committed, the nature of the risk they pose and how the risk should be managed. The higher the risk, the higher the level at which the individual is managed. Level 1 offenders are managed by one agency, usually the police or probation service. Level 2 offenders are managed jointly by all the MAPPA agencies (including housing), and level 3 offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) which is made up of senior managers from the MAPPA agencies. The man was a level 3 offender.

Personality disorder

39. A personality disorder is a mental health condition, which affects how the individual thinks and feels. There are many different types of personality disorders, each with different symptoms. However, some of the more common symptoms include anxiety, depression, being emotionally “disconnected” and having difficulty maintaining close relationships. It is quite common for people with personality disorders to misuse substances.
40. Personality disorders are usually treated with long term psychological therapies (normally based around talking therapies). There is no licensed medication to treat personality disorders although some patients find medication such as antidepressants helpful in managing some of their symptoms.

Mental healthcare provision at Preston

41. At Preston, prisoners with mental health problems may be treated by either the Primary Care Mental Health Team (PCMHT) or the Mental Health Inreach Team (MHIT). Both are staffed by Registered Mental Health Nurses (RMNs). The PCMHT generally care for those prisoners with treatable mental health problems such as depression and anxiety. These prisoners may be prescribed medication by the general prison doctors.
42. The MHIT cares for those prisoners diagnosed with a mental illness which is chronic and enduring, such as schizophrenia. The MHIT works alongside a psychiatrist. Individual prisoners may receive treatment and interventions from both teams, depending on their specific mental health problems.

KEY EVENTS

43. In May 2004, the man was convicted of violence against a child and was sentenced to nine years in prison. It was not his first time in prison. He was diagnosed with a dissociative personality disorder in 2004. (People with this disorder tend to act impulsively, be reckless and irresponsible. They may try to exploit others and have little regard for other people's feelings.)
44. In August 2007, the man was released on licence, having served half of his sentence. (Most prisoners are automatically released when they have served half of their prison sentence. They may be released on licence with a number of conditions they must abide by. If they break any of the conditions of their licence, they can be recalled to prison. If recalled, they must serve the remainder of their sentence.) Within two days of his release, he was recalled to prison when he broke the terms of his licence.
45. Throughout his time in prison, the man was a difficult and unpredictable prisoner to manage. He spent periods of time in the segregation units of the various prisons he was held in. He often carried out "dirty protests" (smearing excrement around his cell). Staff found his behaviour to be "odd" and described him as manipulative.
46. In November 2007, while at HMP Parkhurst, the man was seen by a CARATs worker. He told the drugs worker that prior to prison he had regularly injected heroin and amphetamines. He described a history of using a "cocktail" of drugs "all the time". He also said that he had drunk between 16 and 24 units of alcohol every day since he was 16 years old. (According to current guidelines, men should not consume more than three or four units of alcohol per day.) He told the CARATs worker that he had used illicit drugs while in prison. He admitted that, in the preceding month, he had used heroin, methadone (a heroin substitute), amphetamines and benzodiazepines (a drug with sedative properties) every day. He used ecstasy, subutex (another heroin substitute) and methamphetamines (a stimulant drug) about once a week and crack cocaine once a month. However, he said that he had no concerns about his current substance misuse and did not want any help from CARATs (prisoners must voluntarily engage with the service).
47. The man underwent a mental health assessment in June 2009 with Consultant Psychiatrist A. During the review the man admitted to being manipulative and lying to people. He said that he "could not stand" being with other people, which was why he preferred to be held in the segregation unit. He said that he did not want to participate in any offending behaviour or substance misuse courses in prison. He told the psychiatrist that he had been admitted to hospital in 1994 and 1998 when he experienced visual hallucinations and heard voices. He said that he was diagnosed with drug induced psychosis and having a "paranoid disposition". (Drug induced psychosis is the term used to describe mental health problems brought about by drug use. Individuals with a paranoid disposition may be more likely to feel victimised or persecuted.)

48. The man denied any significant periods of depression. He said that when he was young he had made superficial cuts to his arms but that he had not done this for some time. (According to his prison medical record, he was admitted to hospital in 1998 having made superficial cuts to his arms.) The psychiatrist noted that he did not appear to be suffering from any mental illness, but that his problems were compatible with a personality disorder. (Some mental health specialists do not consider people with personality disorders to be mentally ill. They sometimes regard the behaviours present as a result of a personality disorder as manipulative and within the individual's control.) The psychiatrist concluded that the way in which the man related to other people was "dysfunctional" but that he was not suitable for transfer to a secure psychiatric facility. The psychiatrist recorded that the man did not currently need to be prescribed medication for his mental health.
49. In September 2009, the man told healthcare staff that he was hearing voices telling him to harm members of the public on his release. He said that he felt depressed and asked to be prescribed medication. However, staff recorded that he had asked for medication in the past, possibly because of his substance misuse problems. They concluded that, in the absence of symptoms of depression, they would not prescribe antidepressant medication. The man continued to ask for medication to treat his mental health conditions and so Consultant Psychiatrist A assessed him again in October. The psychiatrist recorded that the man was focused on being prescribed medication and would not accept that he might feel better if he made changes to his lifestyle. However, the psychiatrist decided to prescribe mirtazepine (an antidepressant) in case it made a difference to his mood.
50. Over the following months, the man moved in and out of the segregation unit, sometimes because he asked to and sometimes because he had broken prison rules. He also asked to be prescribed a number of different medications. His mental health was reviewed again in April 2010. On this occasion, Consultant Psychiatrist A found no evidence of depression, low mood or psychosis. Although the man said that the mirtazepine had helped, he asked to be prescribed benzodiazepines (sedative medication) because he suffered with anxiety and agoraphobia (an irrational fear of leaving familiar environments). Healthcare staff again concluded that his requests for further medication were linked to his substance misuse problems, rather than his health, and so did not prescribe them.
51. The man was referred to the CARATs team in May 2010, to see if he was suitable to be prescribed methadone given his continued use of drugs in prison. (In some prisons, prisoners are prescribed the heroin substitute, methadone, to help them to stop taking other illegal drugs.) The man said that he was currently using 30 milligrams (mg) of diazepam (a type of benzodiazepine) and 800mg of tramadol (a pain relief medication) each day. He was prescribed 400mg of tramadol a day, but was taking twice his prescribed dose, presumably by buying it from or trading items with other prisoners. (He had been shot in the neck some years previously and had lead shot still embedded in his neck, which he said caused him pain.) He asked to start a methadone prescription as soon as

possible and was referred to the IDTS nurse. He said that he would be interested in undertaking group work.

52. On 27 May, the man was assessed by the IDTS nurse. He told the nurse that he was prescribed 90 millilitres (ml) of methadone a day before coming to prison. The nurse noted that he said he was using heroin on an almost daily basis, as well as up to 30mg of benzodiazepines. He said that he wanted to be prescribed methadone so that he could stop using heroin. The nurse recorded that he had not harmed himself for many years and was not thinking of harming himself now. Six days later, on 2 June, he began the methadone maintenance programme, starting with a prescription of 20ml a day. By 11 June, this had increased to 30ml. He was told not to buy or trade for any other drugs as well. (Taking other drugs or medications, especially opiate based ones, while on a methadone prescription can be very dangerous and lead to overdose. In addition, one of the purposes of being on methadone is to reduce the use of illicit drugs.)
53. The man told staff that he wanted to continue to take methadone until he was released in May 2011. On 16 June, he asked for the methadone dose to be increased, he said that he was still taking up to 30mg of unprescribed benzodiazepines every day. As a result, healthcare staff agreed to prescribe diazepam because he had “no intention” of stopping using them. (Presumably, staff thought it preferable that he be prescribed the medication rather than obtain it illicitly in the prison. This is not specifically explained in the medical record.)
54. Over the following weeks, the man continued to ask for his methadone and diazepam doses to be raised, saying that he was still using illicit drugs. It is clear from the entries made in his medical record that he continued to claim that he was using a variety of drugs that were not prescribed to him. At times he complained that staff were not giving him the correct doses of his prescribed medication, suggesting that they were doing this on purpose. Staff found him to be paranoid and he was referred to the mental health team. However, in discussion with a doctor in September, he admitted that his drug habit was more problematic than he had realised. He accepted that he was getting his full doses but that they were not enough to prevent him from suffering withdrawal symptoms and buying more on the wings. The doctor agreed to increase the methadone dose again.
55. In October, the man again complained that he was not getting the correct methadone dose. He described suffering leg and stomach cramps in the mornings and getting anxious while waiting for his medication. Staff noted his increasing paranoia, which continued into December. In January 2011, the doctor raised the methadone dose to 60ml. That month, healthcare staff noted his “odd behaviour” and episodes of paranoia. They concluded that he might either be using drugs to alleviate the symptoms of mental ill health, or that his mental health worsened when he used drugs.

Events at HMP Garth

56. On 4 February 2011, the man transferred to HMP Garth because it was closer to his home town and he was approaching release. On his arrival, a member of

healthcare staff assessed his mental and physical health. The man said that he suffered with asthma, was a smoker and used drugs. The nurse recorded that the man had harmed himself in the past and that he needed to be referred to the mental health team. He was assessed as being unsuitable for sharing a cell because he was deemed to pose a high risk to fellow prisoners. He was given a cell in the segregation unit until a suitable cell on one of the wings became available.

57. The man met a CARATs worker on 10 February and said that he was interested in one to one support from CARATs prior to his release. He acknowledged that he would also need support on his release from prison and said that he would like to work with community drugs services.
58. Dr A, the prison's substance misuse specialist doctor, assessed the man on 14 February. She noted that he was prescribed 60ml of methadone and 20mg of diazepam as well as carbamazepine (normally used to treat epilepsy and depression), cyclizine (to treat nausea), salbutamol and fluticasone (for asthma) and ibuprofen gel (to relieve pain). He told the doctor that he had suffered anxiety since he was 15 years old and that he had been shot in the neck in 1994. He also said that he had been prescribed mirtazepine until 2010.
59. The doctor wrote that the diazepam prescription needed to be reviewed. She noted that she was only happy for the prescription to continue if it was agreed by a consultant psychiatrist, otherwise, the man would need to begin a diazepam detoxification programme. (On a detoxification programme, the patient is prescribed a slowly decreasing dose until they no longer experience any withdrawal symptoms and are not physically reliant on the drug.) She also recorded that the man needed to be seen by a general doctor about the nausea he said he suffered and the cyclizine prescription.
60. Dr A, who is also the substance misuse specialist doctor at Preston, was interviewed as part of the investigation. She explained that she was surprised to find the man was being prescribed cyclizine. She said that when taken with opiate based medications or drugs it can increase the effects of the opiate. Because of this, it is sometimes misused and should not be prescribed to those receiving opiate based medication such as methadone. However, she said that the man told her he was Hepatitis C positive and suffered nausea as a result. (Hepatitis C is a viral infection which affects the liver. In the early stages of the infection – normally within the first six months, the patient may feel sick. However, those who remain untreated and continue to experience symptoms beyond six months normally complain of more serious symptoms, not including nausea.) It is not clear whether the man was, in fact, Hepatitis C positive. Tests carried out at Parkhurst in January 2011 indicate that he was infected with the virus, however, when he arrived at Garth, he said that he was Hepatitis C negative. Certainly, there is no clear evidence that he received any treatment for the virus while in prison.
61. The man denied any knowledge of the effect of cyclizine on opiates. Dr A reduced his dose and told him to see the general doctor to discuss the prescription. (In interview, she explained that, as the IDTS doctor, she was only

able to deal with substance misuse related issues and that general health matters had to be dealt with by the non-specialist prison doctors.)

62. On 14 February, the man submitted a complaint form, in which he wrote that two prisoners had made threats against him. He said that staff had assured him that he would be kept separate from the two men, but that this was not happening, which meant that he was not able to use the exercise yard. The issue was also raised in a Security Information Report (SIR). (A SIR must be submitted by any one working in a prison who has information which might compromise the safety of the public, the prison staff or other prisoners, or the security of the prison. SIRs are dealt with by the prison's security department.)
63. A senior officer in the segregation unit confirmed that he had answered the man's complaint, which was "unfounded". Staff recorded on the SIR that the man did not come into contact with the named prisoners and that, in any case, all prisoners are escorted by staff when in the segregation unit making bullying and intimidation difficult. Staff also noted that one of the named prisoners had already moved to another prison and the other was due to move prison the following week.
64. On 24 February, the man had an appointment with Dr B. She discussed with him the disadvantages and risks of using cyclizine. (It is not clear if the doctor ceased the prescription that day, but certainly, on his arrival at Preston in April, he was no longer prescribed cyclizine.)
65. As the man's release drew closer, healthcare staff discussed his future plans with him. He was referred to the forensic personality disorder service at Guild Lodge, who agreed to visit him at Garth to assess his needs on release. (Guild Lodge is a secure mental health service in Lancashire.)
66. In early March 2011, healthcare staff recorded that the man seemed increasingly paranoid. They were instructed to continue to monitor his behaviour. An entry in his medical record notes that he was happy to stay in the segregation unit. However, on 12 March, he began a dirty protest which continued until 17 March.
67. Two members of staff (one of whom was Consultant Forensic Psychiatrist B) from Guild Lodge visited the man on 18 March. The psychiatrist provided notes of the meeting to the investigator and clinical reviewer. He recorded that, during the meeting, the man said he had no mental health problems but that staff wanted to "see him persecuted". The man said that he had been called a "nonce" (a commonly used derogatory term for prisoners thought to have committed sexual offences) over the last eight years and at different prisons. He believed he was being watched by hidden cameras (including ones hidden inside televisions) and that he could hear staff talking and laughing about him.
68. The man told the Guild Lodge staff that he liked "a laugh", was laid back and did not take life too seriously. He said that he ignored people that he did not like and that he made up his mind about people "within minutes of meeting them". He said that he did not like "arrogant, aggressive, bossy" people who order others around. He denied any problems controlling his mood or anger. The last line of

the psychiatrist's record notes that the man had no thoughts of self harm. The psychiatrist and his colleague made no formal assessment of his mental health at the meeting.

69. The psychiatrist told the investigator and clinical reviewer that he and his Guild Lodge colleague had not completed any further interviews with the man because he said that he wanted to consult his lawyer before agreeing (or not) to undergo a full personality disorder assessment. Details of the meeting between him and the Guild Lodge staff were not shared with healthcare staff at Garth (or later Preston), or entered onto his prison medical record or community mental health record (an electronic system known as eCPA). The Guild Lodge team did not, therefore, reach a conclusion as to whether or not the man had a personality disorder. Nor did they offer any advice to prison healthcare staff in dealing with or treating him.
70. On 23 March, the man allegedly assaulted two members of prison staff, punching one in the face and biting another on the hand. According to staff, the attack was unprovoked. The matter was referred to the police who charged him with assault occasioning actual bodily harm. Later that day, he was overheard shouting threats to one of the prisoners he claimed was bullying him. An officer completed an SIR in which she noted that he had made threats "in retaliation" after the prisoner and "the whole of the landing" called him a "nonce".
71. At 1.15am on 7 April, the man asked staff to check him during the night because he was thinking of harming himself. An officer opened an ACCT plan and wrote that the man was "very morose and subdued". The officer noted that the man had begun a dirty protest earlier that evening. Staff decided to check him at least hourly throughout the night, until he had been interviewed by an ACCT assessor the following day.
72. A member of staff gave the man his breakfast at 8.30am the following day. He said that he was "okay" but would not explain why he was still carrying out a dirty protest. Staff noted that the ACCT assessment interview could not be carried out until he stopped the dirty protest. (Dirty protests raise health and safety risks for those close to the prisoner and their cell. It is normal procedure to limit to the absolute minimum the number of staff who can enter the cell of or have close contact with a prisoner on a dirty protest. Staff who do need such contact may be required to wear protective clothing.)
73. A governor visited the segregation unit at 10.05am. The man told the governor that he was being bullied by "everyone" on the unit. He refused to give any more information about the bullying but agreed to end his dirty protest.
74. An officer carried out the ACCT assessment at 3.30pm that afternoon. She wrote that the man felt that he was "constantly being taunted by both staff and prisoners". He said that "someone had threatened to slash him" (cut him with a blade). He also complained about being in the camera cell. (Some cells in prison are fitted with closed circuit television (CCTV) meaning that they can be monitored by staff at any time.) He said that he felt "under duress" when in the camera cell.

75. The man told the officer that he had said he might harm himself during the night because he was bored and wanted staff's attention. Although he said that he had self-harmed in the past, he was reluctant to give any further information about this. He said that he was looking forward to his release and "was adamant" that he had no plans to harm himself. During the ACCT case review, held later that afternoon, the staff present agreed that he seemed a bit paranoid. However, they also agreed that he did not appear to have any thoughts of self harm. They decided to monitor him at regular intervals, and at least once every two hours.
76. The staff also completed the ACCT Caremap which details the prisoner's concerns or problems, what might be done to resolve the problems and who needs to take action. They noted that the man was bored and had been given a "distraction box" (which contains activities such as jigsaw puzzles and puzzle books which can be carried out in the cell). They also recorded that, because of his apparent paranoia, the mental health team should be contacted. Staff contacted the mental health team that day. The man was asked whether he would like any family or friends to be involved in the ACCT process but he said that he did not.
77. The following day, 8 April, the man appeared at a Police Station in relation to the assaults against staff. Later that day, he was transferred to Preston. It seems that the decision had been made that he should not remain at Garth because of the charges against him although there is no clear documentary evidence to explain the move.

Events at HMP Preston

78. Prior to his arrival, Preston staff completed a SIR, in which they noted that the man had been housed in the segregation unit at Garth and before that at Parkhurst. He had a history of carrying out dirty protests and was going to be charged with assaulting staff. As a result of the assault, Garth had decided that three members of staff should be present whenever his cell was unlocked. The SIR also noted that a bladed article had recently been found in his cell at Garth. On his arrival at Preston, the man was given a cell in the segregation unit. Information recorded on his electronic prison file noted that he posed a risk to children, to women and to prison staff.
79. On his arrival in the segregation unit the primary care mental health team (PCMHT) manager assessed his suitability to be segregated. This is a standard procedure, using an assessment tool which covers whether the prisoner is mentally well enough to be segregated. It is particularly important when the prisoner being segregated has mental health problems or is on an open ACCT plan. The PCMHT manager was interviewed as part of the investigation. She said that, on meeting the man, she found him to be pleasant and co-operative. He said that he was quite happy to be at Preston and described it as allowing him a "new start". He told her that he had no thoughts of self harm. She assessed him as being suitable for segregation.

80. A second ACCT case review was held at 6.55pm on 8 April. The review was well attended, with the man, a governor, the PCMHT manager, the prison's decency manager, a member of the induction team and one of the segregation managers present. The man told the review team that he was not feeling suicidal or like harming himself. He said that he was happier now he had moved from Garth. Staff noted that because of the "exceptional" reasons for his transfer he should remain segregated and the ACCT be reviewed again the following day. In the meantime, staff were instructed to check him five times an hour.
81. The man's ACCT plan was reviewed again on 9 April. Again, the review was well attended. The man was there, as well as a governor, the PCMHT manager, a senior officer (SO) from the segregation unit and a member of the chaplaincy team. During the review, the man repeated that he was pleased to have transferred from Garth. He was asked if he had any thoughts of harming himself. He told the review group that the ACCT had originally been opened because he had threatened to hang himself to manipulate the staff. He asked for some in-cell activities (such as puzzles), which staff agreed to find for him. His risk to himself was considered to be low, but he was to be checked five times an hour whilst segregated. The SO updated the man's ACCT Caremap, noting that his property had not yet arrived from Garth. The SO noted that he would contact Garth to check. He made another entry later confirming that all of the property had arrived at Preston on 8 April.
82. Healthcare staff confirmed the man's prescribed medication on 9 April. The man said that he wanted to change the time that his medication was given to him. He also wanted to change from liquid diazepam to tablet form. Healthcare staff told him that his medication would not be altered until or unless it had had been reviewed by a doctor. During interviews, healthcare staff were asked why he might have wanted to change from liquid diazepam to tablets. Dr A said that medicines given in tablet form are easier for prisoners to sell or pass to other prisoners. She thought it possible that he wanted to sell or trade his diazepam.
83. At 10.10pm on 9 April, the man told an Operational Support Grade (OSG), the member of staff on duty overnight, that he was hearing voices. Although the OSG recorded this in the ACCT plan, no further mention is made of it and there is nothing to suggest that staff took any further action to explore it or refer him to the mental health services.
84. The man, a governor, the PCMHT manager, a SO and a segregation officer met for a further ACCT case review at 10.00am on 10 April. The man said that he was feeling fine and had no thoughts of harming himself. According to the record of the review, he said that he was "not one for self harming". The staff told him that he would be referred to A2 wing, the reintegration unit. (When prisoners leave the segregation unit at Preston, they move to the reintegration unit for a period of time. The unit provides additional support to prisoners to help them readjust to life on the normal wings. It also allows for staff to assess the prisoner's behaviour.) He seemed pleased with the news. All present at the review agreed that the ACCT plan could be closed. However, the man was reminded of the support available to him and was encouraged to seek help if he needed it.

85. According to a SIR completed on 10 April, during the ACCT review, the man threatened to harm himself in ten days time, on 20 April, to “get back” at his ex-partner. No record of this claim was made in the ACCT plan itself. Staff completing the SIR noted that another ACCT plan should be opened a few days before that date. Staff also noted that counselling had been arranged for him via healthcare. (No further ACCT plans were opened for him prior to his death in June. However, there is no evidence to indicate that he did harm himself on or around 20 April, as he had threatened, or that there was any noticeable increase in his vulnerability at that time.)
86. The man’s personal officer made an entry in his electronic prison file later that day. (The personal officer scheme is in place in many prisons in England and Wales. Under the scheme, officers are allocated to work with certain prisoners. The personal officer is expected to be the first port of call for the prisoners they have under their care, although prisoners are encouraged to approach any member of staff if they have a problem. Personal officers are expected to make regular entries in their prisoners’ files.) The personal officer noted that the man seemed to be “testing the system”, for example by covering the camera in his cell. However, he wrote that the man could be polite and present well at times. The personal officer continued that the man needed to engage with and conform to the regime more.
87. The man moved from the segregation unit to A2 wing on 12 April. The next day, the man’s offender supervisor met him for the first time. (Offender supervisors are based in prisons and serve as a link between the prisoner and the probation service in the community. They help prisoners to complete the targets set as part of their sentence plan. The sentence plan outlines the work needed to ensure that the risk of reoffending has been reduced and the prisoner is safe to be released.) The offender supervisor recorded notes of the meeting. He wrote that the man had not worked prior to prison and was unlikely to find work on release because of his substance misuse and mental health problems and his “lack of inclination”. He had not worked while in prison, largely because he had spent so much time in segregation. The man said that he planned to live with his father on his release, which the offender supervisor said needed to be checked. He said that the man “denies or minimises” his unpredictable and violent behaviour.
88. The offender supervisor was interviewed as part of the investigation. He said that he knew the man was transferring to Preston from Garth before he arrived and he was discussed at an inter-departmental risk management meeting. The offender supervisor was also given information about him by probation staff at Garth. He was a MAPPA level three prisoner, meaning that significant work and resources would be directed at reducing his risk of reoffending on release.
89. At his first meeting with the man, the offender supervisor said that he was surprised to find the man to be “amiable” and friendly. He thought that the man seemed confident and not at all vulnerable. However, he knew that he could present in a variety of ways and that his character often changed quickly. He told the investigator that he realised:

“... this is a side of somebody, you know, and there are many more that I've probably yet to discover and over the following weeks I was to discover, either through what was recorded on the information system in the prison or from when I saw him that, you know, he was a very different person in different situations.”

90. The following day, the man met a CARATs worker. The CARATs worker noted that they had discussed overdose awareness, using drugs safely and dose tolerance. The man also had an appointment with Dr A to review his IDTS progress. The doctor noted that the man was prescribed 60ml of methadone, 400mg of ibuprofen, 10mg of diazepam and 100mg of carbamazepine. He asked to be prescribed cyclizine but Dr A refused on the basis that he had no visible symptoms requiring the prescription. He also asked for his methadone dose to be increased, but the doctor refused this for the same reason.
91. An officer from the Safer Custody team carried out an ACCT post-closure review on 15 April. (The purpose of the post-closure review is to ensure that any issues identified during the ACCT process have been resolved and that the ACCT does not need to be re-opened.) The man said that he was “feeling ok” and had no thoughts of self harm. He was now living on A2 reintegration unit and healthcare staff had reviewed his medication. He told the officer that he received letters from his mother and visits from his family. The officer reminded him of the support networks available and the man said that he would tell staff if he felt vulnerable in future. The officer noted that the man was “positive about his future”.
92. On 20 April, the man pleaded not guilty to the two counts of assault he was charged with. This meant that he would be facing trial in due course. Also that day, a MAPPP meeting was held, attended by a variety of individuals from key agencies in Lancashire. Also present were the offender supervisor and a worker from Preston’s MHIT. The panel discussed the man’s possible upcoming release. However, they also noted that, due to the ongoing assault charges, he might not be released as anticipated on 9 May. The worker from MHIT was tasked with trying to persuade the man to co-operate with the Guild Lodge personality disorder assessment.
93. On 3 May, an officer made the man subject to a stage one Tackling Antisocial Behaviour (TAB) plan because he had intimidated several of the more vulnerable prisoners on the unit. One prisoner told staff that the man had shown him a “shiny object”, which he perceived to be a weapon. In line with the prison’s violence reduction policy, the man was not told that the TAB had been opened. Later that day his cell was searched and two litres of fermenting liquid was found in his locker. (Although it is illegal to consume or make alcohol in prison, prisoners sometimes brew “hooch” using fruit and food items.) The man denied any knowledge of the liquid, but he was placed on report. (When a prisoner is placed on report, they must appear before a governor who decides whether the prisoner is guilty of breaking prison rules. This process is known as adjudication. If found guilty, the prisoner may receive a punishment such as loss of earnings or time out of cell.) Staff did not find any weapons in the man’s cell.

94. The officer who became the man's personal officer when he moved to A2 made an entry in the electronic prison file that day. He noted that he did not need to be housed on A2 because he was a "strong individual" who intimidated other prisoners. The officer wrote that he needed to be moved to one of the normal prison wings "for the good of the unit".
95. The following day, the worker from MHIT visited the man and asked him to consent to a full assessment by the Forensic Personality Disorder service at Guild Lodge. He refused because he did not think that he had a personality disorder. He also refused to an appointment with a psychiatrist. The MHIT worker was present during an interview with a colleague from the MHIT. She said that nothing more was done to try and persuade him to co-operate with the assessment.
96. On 6 May, the man appeared by video link at Crown Court in relation to the charges of assaulting staff at Garth. He applied for bail but the Judge refused, remanding him in custody. His original sentence expired on 9 May and after that date he became a remand prisoner awaiting trial.
97. The man applied for vulnerable prisoner status on 12 May. Vulnerable prisoner status can be granted to a prisoner due to the nature of their offence or because they need to be separated from the general prison population for another reason. It is often given to prisoners charged with sexual offences. The man's application was not related to the nature of his offence. He wrote that he wanted vulnerable prisoner status because he had been threatened by prisoners on other wings who had information about his previous offence (which although against a child, was not of a sexual nature). He had been at Preston about seven years previously. In his application, he suggested that the prisoners now making threats had also been at the prison then. He said that he could not name any of them. A governor agreed the man's application that day and he was given a cell on C3, the VP unit overspill, because C2 was full.
98. The TAB plan was reviewed on 17 May and staff decided it should stay open until the man had been on C wing for a while and staff had been able to monitor his behaviour. It was closed on 23 May, when staff noted that there was no further evidence that he was involved in bullying.
99. On 24 May, the man complained that, despite being a remand prisoner, his mother had not been allowed to deliver three sets of new clothes to him. He argued that the way he was being treated amounted to bullying. Staff responded to his complaint on 26 May, noting that because he had been a sentenced prisoner on basic regime, he would not be allowed his own clothes unless or until he reached enhanced status. (Prisons in England and Wales operate the Incentives and Earned Privileges (IEP) scheme. Good behaviour is awarded with extra privileges, such as televisions in cells and extra association time. Poor behaviour is punished by privileges being taken away. There are three levels, enhanced, which is the highest level and awards the most privileges, standard and basic.)

100. The investigator sought additional information about the decision not to allow the man's mother to deliver clothes to her son. She spoke to the Reception senior officer. He explained that remand prisoners have 42 days in which to arrange for three sets of their own clothes to be brought in by family or friends. Sentenced prisoners may only access new clothes by purchasing them from the prison catalogue. The SO explained that when a prisoner reverts from sentenced to remand (as the man did after 9 May), they are not given the same 42 day opportunity. The SO was not certain whether prisoners received written information about the clothing policy but did say that it caused some confusion with prisoners.
101. Over the next few days, the man completed two applications for work and education. He said that he wanted to have some constructive time out of his cell and that he was prepared to do any job suitable for him. He indicated that he would be interested in completing the two week drug and alcohol awareness course, an art class, victim awareness and stress management.
102. The man was assessed by one of the prison doctors on 2 June after he complained of permanent nausea. He was re-prescribed cyclizine as a result and the doctor ordered blood tests, presumably to establish the cause of his nausea (which the man said was either due to him being Hepatitis C positive or because he was suffering lead poisoning from the lead shot in his neck).
103. At 7.40pm on 3 June, the man was placed on report having been found drunk in his cell. He was examined by a nurse who described him as slurring his speech, unsteady on his feet and abusive. A bottle of orange fermenting liquid was found in his cell. The matter was adjourned while he sought legal advice.
104. The following day, a second level one TAB plan was opened when staff suspected that the man had bullied another prisoner for his medication. Again, in line with the policy, he was not told that the plan had been opened.
105. The man spoke to his mother by telephone in the evening on 6 June. The prison provided the investigator with a summary of the contents of the call. (In prison, all prisoners' telephone calls are recorded and may be listened to by staff. Monitoring of telephone calls takes place on a random basis, or if there is intelligence to suggest such monitoring is necessary. There is no evidence to suggest that staff listened to all of the man's telephone calls or that this particular call had been listened to prior to his death.) During their conversation, he told his mother that he "could not stand" living on the vulnerable prisoner unit because it was small and claustrophobic (he was still housed on the overspill). He complained that he had nothing to do. He said that he needed to motivate himself and his mother encouraged him to stay positive and focused. They discussed whether his mother could bring clothes in to him and he said he would ask staff.
106. The following day, the man was placed on report once more for refusing to submit to a mandatory drugs test. (Prisoners can be asked to undergo a drugs test at any time, if there is any suspicion that they are using drugs. Refusing the test results in the prisoner being placed on report and facing adjudication.)

Again, the hearing was adjourned so that the man could seek legal advice. That morning he was downgraded to the basic regime as a result of his “persistent poor behaviour” and for being disrespectful to healthcare staff.

107. The VPU manager at the time was interviewed during the investigation. He said that, once on the unit, the man “bucked against the system” and seemed not to want to fit in. He described him as seeming cocky and different from other prisoners. The manager said that the man could be “quite challenging” and that staff thought he was responsible for intimidating other prisoners on the unit. The manager also mentioned that, at times, staff thought the man had bullied other prisoners for their medication, or had persuaded them to sell it to him. He thought that the man might have been using other prisoners’ medication himself and also passing it on to others. The manager said that he had submitted an SIR noting that the man might be a danger to others on the unit.
108. The investigator asked the manager if, to his knowledge, the man was the victim of bullying. The manager said that, to his knowledge, the man was not bullied. He acknowledged, however, that vulnerable prisoners are sometimes bullied because of their status.
109. On 8 June, the man appeared in court by video link. He was told that his trial would begin on 26 July.
110. The man completed a racist incident form on 9 June. In it, he complained that an officer and prisoners on C3 landing had been racist towards him. He said that he was of mixed race and that people were insulting him and his family. The Race Equality Officer conducted an enquiry into his claims, the notes of which were made available to the investigator. As part of the investigation, the officer spoke to him and asked him if he could name any of the staff or prisoners using abusive language. The man said he did not know who they were but that he heard them saying things as they passed his cell door. The officer also asked if the man could remember any of the abusive language that had been used. He said that he could not recall anything that had been said but that he was “sure they were offensive” and aimed at him. He then suggested that people might have been saying offensive things about his tattoos.
111. The officer told the man that he could not investigate his claims of racism as he could not identify either the individuals or the offensive language they had used. On that basis, the officer said that he had to close the investigation. The man apparently agreed and said “well, I am White British”. The officer told him that he should speak to staff if he was unhappy living on C3 landing. He also reminded the man of the complaints process and the availability of the IMB. The officer asked the man why he was on the basic regime. The man said it was a “conspiracy against him as nobody likes him”. The officer said that he knew the man had received several IEP warnings for poor behaviour and that he needed to “knuckle down” and behave himself. He said that he would try.
112. As part of the investigation into the man’s complaint, the officer spoke to the VPU manager who said that the man had never mentioned being the subject of racist

- abuse. Another senior officer working on the unit said the same. Given the lack of evidence to support the claim, the officer found the complaint to be not proved.
113. On 10 June, the VPU manager asked the mental health team to see the man after he reported hearing voices. The manager told the investigator that the man made an “off the cuff remark” that he was “not feeling right” and was hearing voices in his head. The manager asked the man whether he wanted the manager to contact the mental health team and the man said that he did. The manager described the man as “adamant” that he had a problem.
 114. A member of the mental health inreach team (MHIT) came to see the man shortly after the manager’s call. He told the MHIT nurse that his primary concern was not having a television (because he was on the basic IEP level). He said that he had only heard voices since his television had been removed. He told her that he felt he might be at risk from staff because of the assault charges. He said that the voices were not telling him to harm either himself or anyone else and denied any such thoughts. The nurse reminded him of the support available. She recorded the details of their meeting in his electronic medical record. She noted that he did not seem distressed or psychotic and that his main focus had been getting a television. She concluded that she would discuss him with the rest of the mental health team the following Monday.
 115. She was also interviewed during the investigation. She said that she spoke to the man through his cell door because no staff were available to unlock him and take him down to C2. She said that she tried to get the man to talk about the voices he was hearing but that he would not elaborate very much. She explained that people who are hearing voices are usually able to tell others where the voices seem to be coming from (for example, inside or outside the head) and what they are saying. He appeared not to want to talk about the voices he said he could hear, nor did he seem agitated or distressed (possible signs of psychosis). Instead he seemed focused on his television having been removed and how he might be able to get it back. She said that she told the man that only prison staff could decide to return the television to him.
 116. The following morning, the MHIT nurse telephoned the personality disorder team at Guild Lodge. They explained that until the man agreed to co-operate with assessments, they could do nothing further. According to her colleague the personality disorder team advised that he could be managed on a crisis basis. This meant that there was no specific care plan for how his mental health or personality disorder needs would be met. It also meant that he was not managed by either the PCMHT or MHIT, but that someone from either team would see him as and when he needed support (when he was in “crisis”).
 117. At 9.59am on 11 June, the man rang the prison’s anti-bullying telephone line. (The telephone line number is displayed around the prison. Prisoners are encouraged to use the line to report instances of bullying if they do not want to approach staff in person.) He said that he had not slept for four days and thought there was a “dangerous element” in the prison that was “out to seriously harm him”. As a result, the investigator spoke to an officer, the prison’s violence reduction co-ordinator. The officer explained that the prisoners who call the anti-

bullying line leave messages on an answer machine that is checked at least once a day. Providing the prisoner leaves their name and prison number, the officer will go and speak to them.

118. The officer went to see the man later on 11 June. He told the investigator that the man said a senior officer from Garth was speaking to him through the door. The officer said that he reassured the man that this could not be the case as the senior officer had not been at Preston. He told the investigator that he found the man's claims to be "bizarre". The officer said that he knew the man had recently been seen by the MHIT nurse and the man confirmed that he was working with mental health staff. On that basis, the officer did not report his concerns to C wing staff or to either the PCMHT or MHIT. The officer told the man to contact him again if he felt he was being bullied. The man apparently did not leave any further messages on the anti-bullying answer machine.
119. The VPU manager reviewed the open TAB plan later that day. He noted that staff should continue to monitor the man, paying particular attention to the items he ordered in his canteen (where prisoners can buy additional food and other items). The manager instructed staff to check the man's cell before and after canteen was issued in case there was any evidence that he was taking items from other prisoners.
120. At 3.30pm that day, the man asked to see someone from the mental health team because his "head was going". He was told that the mental health nurse had gone home for the day.
121. On 13 June, staff had further reasons to be concerned about the man's behaviour. A note in the wing observation book (where staff record important information about any incidents on the wing) detailed that staff had received information that the man and another prisoner were planning to take a female member of staff hostage. All staff were instructed to be vigilant. Later that day, the man's TAB plan was upgraded to level two after staff witnessed him making threats to two other prisoners. The man was told and he apologised and said he would also apologise to the two prisoners he had threatened. As a result of being on a level two TAB, the man was told he would be served his meals and given his methadone on his own. He was told that, if his behaviour did not improve, he might lose his place on the vulnerable prisoner unit.
122. The VPU manager asked the man if he objected to him referring the man to the mental health team and he said he did not. The manager completed the referral that day, noting that the man was not sleeping, hearing voices, being confrontational and threatening other prisoners. (The mental health team recorded that they received the referral on 15 June.) In interview, the manager said that he could not remember what had prompted him to contact the mental health team that day. However, he said that from mid-June, the man seemed "out of sorts" and unsettled. The manager said that the man began falling out with prisoners he had previously got on with. However, the manager said that he considered the man to be a "strong" individual and he was not concerned that he might harm himself. He explained that had he any concerns about the man's risk to himself, he would have opened an ACCT plan.

123. During the investigation, two prisoners contacted our office to contribute to the investigation. Prisoner A was transferred to HMP Forest Bank shortly after the man's death and so was interviewed by another investigator. He said that he had been on the VP unit at Preston with the man. He got to know him a little and said that the two of them used to chat. He told the investigator that, at times, he had concerns about the man's mental health. He said that the man said "mad things like he was getting watched with cameras in his TV and stuff like that". He said that he felt that the man "wasn't altogether there". He described an episode when the man thought that an individual had been placed on the unit to spy and gather information and was not actually a prisoner.
124. According to prisoner A, the man was also using other prisoners' medication and possibly selling medication to other VPs. On one occasion, he and a couple of other prisoners took medication prescribed to another prisoner. Prisoner A said that the other prisoners were made unwell by the medication and that some prisoners on the unit had blamed the man and "got on his case all the time". Prisoner A did not think that the man had bullied any other prisoners on the unit. He said that he often "stuck up" for him. Prisoner B said that he was not aware of the man being involved in taking or trading drugs on the unit. However, he was under the impression that he had stopped taking his methadone recently. (There is nothing in the medical records to suggest that this was the case.)
125. Prisoner B said that, to his knowledge, the man had not been the subject of any bullying by prisoners. However, he thought that staff on the wing had given him a "hard time", perhaps because of the alleged assault against staff at Garth.
126. Prisoner A also said that the man had talked of suicide on occasion. He described him as "sick" of being a VP but said that he thought he would suffer repercussions if he moved to a normal wing. When asked what the man had said about suicide, the prisoner explained that he had talked of hanging himself. He said that he and other prisoners had "laughed it off" and not taken it seriously. He said that he told an officer about what the man had said. The officer apparently agreed to keep an eye on him as a result.
127. Prisoner B said that he had attempted suicide in the past and that, one day, the man asked him about his attempt. He asked prisoner B what method he had used, but he refused to tell him. However, prisoner B said that the man had never given any indication that he was thinking of suicide.
128. The man's personal officer on the VPU was interviewed as part of the investigation. (His interview took place before that of Prisoner A's.) The officer explained that he had met the man a couple of times but had not had much contact with him while he was a VP. The officer said that the man tended to stay in his cell and during association, would mix with those prisoners who were not sex offenders.
129. The officer was asked whether he was aware of the man being bullied. He said that he was not and did not think it seemed likely. He was also asked whether he had ever had any concerns about the man's vulnerability or risk to self. The

officer said that the man always gave the impression that he was fine and never complained of any problems.

130. At 7.30pm on 13 June, the man set fire to some paper in his cell. The fire was extinguished and he was moved to the segregation unit to await adjudication. While segregated, he was assessed by an MHIT nurse. The nurse recorded that he was physically and mentally well enough to be segregated. He returned to C3 landing two days later, on 15 June. The VPU manager was asked whether, in his opinion, he had set fire to items in his cell in an attempt to harm himself. The manager said that he did not think so.

131. The man smashed his television set at approximately 2.35am on 16 June (there is no record of when the television was returned to him, or for what reason, given that he was still on the basic regime). The man said that he wanted to move to the segregation unit but was told that this was not possible. He was moved to a different cell and he said that he would not cause any more problems. He was placed on report awaiting adjudication. An officer was on duty at the time and was interviewed as part of the investigation. He described his interaction with him that night:

“He could be demanding, yes, he could be demanding. There was no aggression with it. I remember him throwing it against the door. He said it fell. I told him straight, you and I both know it didn’t fall, you threw it against the back of the door, and he just laughed at that point.”

132. The mental health team wrote to the man on 16 May, noting that he had been referred for assessment (by the VPU manager) but that there was a waiting list. The letter instructed him to tell staff if his problems worsened.

133. The PCMHT manager explained in interview that the PCMHT has a waiting list of approximately three weeks. She said that, following referral, the prisoner undergoes a full assessment, which takes about 45 minutes, and then a care plan is devised. She explained that, on receiving the referral, the MHIT administrator checks the eCPA for further information. On the basis of any information recorded there, the administrator can prioritise the prisoner and arrange for him to be seen sooner. Equally, depending on the information contained on the eCPA, the MHIT (who work with those prisoners with more severe mental health problems) might decide that they will take the prisoner on their caseload.

134. The PCMHT manager was asked whether, in her view, the man should have been prioritised. She said that he was a MAPPA prisoner whose mental health care was apparently being co-ordinated by someone from the MHIT. On that basis, she thought that he was already on the MHIT caseload. In interview, the MHIT nurse explained that she was not his care co-ordinator and that her name had been wrongly entered onto the eCPA. As noted earlier, the MHIT believed that he could be managed on a crisis basis, by members of staff from both the PCMHT and MHIT.

135. The VPU manager reviewed the TAB plan on 19 June. He wrote that the man was “still pushing boundaries” and protesting at being on the basic regime. The manager wrote that the man had “multiple” adjudications outstanding and that there was SIR information about him. He decided that the TAB should remain open for further monitoring.
136. At about 10.45pm that evening, the man asked to use the Samaritans’ telephone, which staff arranged. (The Samaritans’ telephone is normally a cordless telephone, which prisoners can use in their cell. The telephone can only be used to call the Samaritans.) An officer was on duty that night and in interview remembered that he rang his cell bell to ask for the telephone. The officer did not ask him why he wanted to speak to the Samaritans (he explained that this was confidential between the prisoner and the Samaritans). However, he said that he saw no obvious signs that he was in distress. The officer described him as seeming the same as any other occasion the two had met.
137. The following day, the man told staff that he was hearing voices saying that someone was “going to get him”. The mental health team was contacted and asked to examine him. It is not clear whether he was seen by a mental health nurse that day.
138. On 22 June at 9.50am, the man was placed on report after urinating through the gap in his door onto the wing landing. He said that he wanted to move to the segregation unit. That day he spoke to Developing Prison Service Manager (DPSM) A and said that he wanted to move off the vulnerable prisoners unit and onto a normal wing.
139. DPSM A was interviewed as part of the investigation. She explained that, as the overall C wing manager (therefore also responsible for the VP unit), she had some prior knowledge of the man. She had also met him on his previous stay at Preston when he had been housed on a normal wing. She described him as having been “challenging” in the past, but that he was more “problematic” during his most recent period at the prison.
140. The man joined the DPSM and a SO in the wing office to discuss his issues. The DPSM said that the man told the staff that he wanted his television back. She said that she told him his behaviour was not acceptable and that he would need to co-operate with staff in order to come off the basic regime. He told her that the VP wing was “not for him” as he did not like associating with vulnerable prisoners. He also complained of being bored with the VP unit regime. (The DPSM explained that, because they have to be kept separate from other prisoners, VPs have less access to education, work and the gym.) The SO asked him why he was a VP given that he had lived on the normal wings during his sentence. The man said that he did not know why he was a VP and wanted to move to a normal wing. The DPSM said that she asked him if he wanted her to arrange a move to a normal wing and he said that he did.
141. Because the man had previously applied for VP status, he was asked to sign a disclaimer that he was now prepared to be housed on a non-VP wing. Having completed the paperwork, the DPSM returned to see the man in his cell and told

him that he could move to B wing. He seemed happy with the news. In interview, the DPSM said that he was happy and smiling during her contact with him that day and she had no reason to worry about him. She also confirmed that the levels of observation on B wing were no different to those he was subject to on C wing (for example, the frequency of checks carried out overnight).

142. The VPU manager was asked whether he knew that the man wanted to move to a different wing. He said that he was not aware and that the man had not spoken to him about being unhappy on the VP unit. The manager was not at work on 22 June and so did not know that the man had moved until the following day. However, an officer told the investigator that the man had been asking to move from the VP unit for “a couple of weeks”, because, he thought, the man did not like mixing with sex offenders.
143. At 11.20am, an officer escorted the man to cell B3-18 on B wing. The cell contained a bunk bed, but because he was considered unsuitable for sharing a cell with another prisoner, he was the sole occupant. The television was removed from the cell as he was still on basic level. The officer made a statement following his death. He said that the man seemed happy to move to B wing.
144. Prisoner A told the investigator who interviewed him that he did not believe that the man had voluntarily moved from the VP unit. He suggested that officers on C wing were laughing at him and other prisoners were intimidating him and so he might have felt pressured to move. He did not talk to the man prior to his move to B wing.
145. Prisoner B also said that he did not think the man would have chosen to move off the VP unit. He told the investigator that he thought he had been “forced off” the unit.
146. A nurse was dispensing medication on B wing at about 4.45pm that day. The man came for his medication and she asked him to wait while his prescription was brought over from C wing. While waiting, he commented that there was no CCTV in place on B wing. She replied that CCTV was installed on the wing and when he asked where the cameras were, shrugged her shoulders and did not answer. (There is no CCTV in place on B wing, although it is installed across much of the prison.) In interview, she said she found the conversation worrying because she thought he might be a risk to staff. She did not think that anything he said that afternoon suggested he was planning to harm himself. (After she had finished dispensing medication that afternoon, she completed an SIR recording her conversation with him.)
147. When his prescription arrived, he refused to take his diazepam because it was in liquid form not tablet. The pharmacy technician was also present. She confirmed in a written statement that he had been prescribed liquid diazepam “for months”. He continued to refuse the medication and walked away from the hatch. The nurse informed the nurse on duty that evening. He dispensed medication on B wing at 7.30pm. He made a written statement confirming that the man did not collect his medication that evening.

148. Officer A was on duty on B wing from 8.00pm until early the following morning. She provided a written statement to the investigator. She wrote that she carried out a wing roll check sometime between 8.00pm and 9.00pm. (During a roll check all of the prisoners must be counted. This is done by the member of staff looking through the observation panel in the cell door. Staff conducting roll checks at night or in the early hours of the morning do not need to get a response from each prisoner, merely assure themselves that the right number of prisoners are on the wing.) Because the man was not on an ACCT plan at the time, she had no reason to check him again until the early morning roll check at about 5.30am on 23 June. In her statement, the officer wrote that she could not remember any specific details about her check on him that morning. There is nothing to indicate that the man raised any concerns with the officer that night or used his emergency cell bell.
149. Officer B arrived at the prison at 6.30am to begin his shift. He received a verbal handover from Officer A and then began a roll check of the prisoners on B wing. When he reached the man's cell (B3-18) he looked through the observation panel. He saw that the man's bed was empty. He could see a leg at the far end of the bunk bed, but could not see the rest of the man's body. He banged on the cell door a couple of times, but got no response. He became concerned and so used his radio to ask for staff assistance. The emergency control room at the prison logs the use of radios. According to that log, he asked for assistance at 6.58am.
150. Within a few seconds, Officer B saw other staff arriving on the landing and so he tried to open the cell door. The door had been wedged shut and so he used his shoulder to force it open. As he went into the cell, the officer saw the man slumped at the end of the bed, with a ligature made from a bedsheet around his neck attached to the frame of the bunk bed. Officer B took hold of the man's body to support the weight. Officer C, who had arrived at the cell, helped Officer B to do so while another officer cut the ligature. The orderly officer in charge of the prison at the time followed the officers into the cell. On seeing the nature of the emergency, he used his radio to alert the prison to a code 1 emergency. (At Preston, staff use radio codes 1 and 2 to alert colleagues and healthcare staff to medical emergencies. A code 1 indicates that someone is not breathing. The use of codes helps to ensure that healthcare staff bring the right medical equipment to the scene.) Healthcare staff responded to the radio call at 6.59am. Staff in the control room telephoned 999 for an ambulance at 7.01am.
151. The man was placed on the cell floor and the ligature was removed. Staff began cardiopulmonary resuscitation (CPR – when chest compressions and rescue breaths are delivered). Two nurses arrived at the cell at 7.03am, bringing some emergency equipment with them. One nurse recorded details of the response in the man's medical record. She noted that, on their arrival, the man was not breathing and had no pulse. She recorded that staff had already begun CPR at a rate of 30 compressions to two rescue breaths (in line with current national guidelines).

152. Both nurses used some of their equipment to try to deliver oxygen to the man's lungs. The automated external defibrillator (AED) was collected from the healthcare department and the pads were applied to his chest. (An AED is a machine which reads whether the patient's heart is beating and, in some circumstances, delivers a shock which can help to establish a normal heart rhythm.) The AED instructed that the man should not be shocked and that CPR should continue.
153. The ambulance arrived at the prison at 7.10am. On arrival the two paramedics' mobile telephones were removed (because, generally, mobile telephones are not allowed into prisons). They parked the ambulance and began following a member of staff to the scene. However, the paramedics were then asked to move the ambulance, which was blocking other vehicles. Having done so, they made their way straight to the cell. However, there is no evidence to suggest that this caused a significant delay to paramedics reaching the man. One of the paramedics made a statement to the police, which was shared with the investigator. She noted that the man felt warm and his skin was pink, which, she said, indicated that the CPR efforts had been efficient.
154. Despite further attempts to revive the man, he was pronounced dead at 7.44am.

Information received following the man's death

155. On 25 June, another prisoner told staff that the man had given away some of his belongings to two prisoners the night before his death. The investigator spoke by telephone to the prisoner, who said that he had been in the shower on the evening of 22 June, which is almost opposite the man's cell. He said that he saw the man giving away tobacco and shower gel to other prisoners. He did not know the names of the prisoners who received his property. He said that he knew this was unusual behaviour but did not mention it to staff on the wing that evening.

Contact with the man's family

156. Following the man's death, staff checked his file for details of his next of kin. The emergency contact details he had provided were those of his mother. On 23 June, the Governor and Chaplain visited her at her home address and broke the news of her son's death. Following the visit, a governor was appointed as the family liaison officer. The family were offered financial assistance with the cost of the funeral. This is in line with Prison Service Order (PSO) 2710, Follow up to a death in prison. On 28 June, the man's mother and brother visited the prison.
157. During the investigation, the investigator noticed in the records that the man had also provided contact information for his father. His father's information was listed under next of kin, but not in the emergency contact section. The investigator asked prison staff whether any contact had been made with him since his son's death. Staff confirmed that they had only had contact with his mother. The investigator also spoke to the Coroner's officer who arranged for local police to visit the father's address. The police broke the news of his son's death on 2 August.

Support for staff and prisoners

158. Following the man's death, the prison held a hot debrief at 9.00am, for those staff involved in the emergency response. (A hot debrief is a meeting, which should be held very shortly following a serious incident such as a death in custody. The purpose of the hot debrief is to allow those involved to discuss the events and for support and reassurance to be offered. Holding a hot debrief is a requirement of PSO 2710.)
159. All of the staff interviewed who knew the man were very shocked to hear that he had died. None thought that he had showed any signs of being a risk to himself. All of the interviewed staff said that they knew how to access support if they needed it.
160. Prisoners at Preston were informed of the man's death by way of a notice from the Governor. Case reviews were held with all prisoners on ACCT plans.

Results from the post mortem

161. The post mortem, carried out on behalf of the Coroner, concluded that the man died as a result of hanging. An examination was also conducted to determine whether he had any drugs or alcohol in his system when he died. The examination concluded that he had not consumed any alcohol or drugs that were not prescribed to him. The levels of medication in his body were consistent with his prescribed doses.

ISSUES

Clinical care

162. A clinical reviewer carried out a clinical review of the healthcare offered to the man while at Preston. Because the man had been in prison for several years, but at Preston for only a relatively short time before he died, her review also considers some of the care provided at other prisons. It is a lengthy and detailed review, which makes a number of recommendations. Some are particularly pertinent to this investigation and are included in the discussion that follows, others relate to wider healthcare issues at Preston. As a matter of course, we expect the Governor and Head of Healthcare to act on all of the recommendations she makes.
163. The man had been in prison since 2004 and, throughout his most recent sentence, had displayed difficult and manipulative behaviour. He spent a great deal of time in the segregation units of the prisons he was held in. He often engaged in dirty protests. A review of his file suggests that he was unpredictable. Staff at Preston who were interviewed as part of the investigation described him having “different sides”. Sometimes he was polite and co-operative, but he could also be abusive, violent and difficult to manage.

Mental healthcare

164. The man spent several years at HMP Parkhurst at the beginning of his sentence. The clinical reviewer finds that he received a good standard of mental healthcare while there. He was reviewed on several occasions by a psychiatrist who concluded that the man did not suffer from any mental health problem. His problems were identified as being the result of a personality disorder. On that basis, he was deemed not to be suitable for transfer to a secure psychiatric facility. Although the psychiatrist found no evidence of depression, anxiety or psychosis, he prescribed an antidepressant medication in October 2009. The man continued to be prescribed antidepressants until 2010.
165. In December 2010, the man was referred to the personality disorder team at Guild Lodge, a secure facility near Preston. He was due for release in May 2011. Entries on his medical record indicate that he had continued to present with symptoms of a personality disorder, rather than a treatable mental health condition.
166. Two members of staff from Guild Lodge visited the man at Garth in March 2011. At that meeting, he was asked to consent to a full assessment to determine his mental health needs. He refused to co-operate further with the team. On this basis, the Guild Lodge specialists were unable to form an opinion of how prison healthcare staff might best work with him. Staff from both the PCMHT and MHIT at Preston said that they were waiting for guidance from Guild Lodge. The MHIT nurse said that she was told that he should be dealt with on a “crisis” basis. This meant that no one team took responsibility for his mental health care and he was seen on an ad hoc basis when he experienced mental health problems.

167. The investigation and clinical review revealed that the Guild Lodge specialists did not make a full entry on eCPA (the computer system used by mental health providers in Lancashire and available to some staff at Preston) or provide written feedback to prison mental healthcare staff. It is clear that this communication breakdown impacted on the care offered by the PCMHT, the MHIT and the IDTS team, all of whom appear to have struggled to know how to work with the man.

The Head of Healthcare should liaise with managers at Guild Lodge to ensure that appropriate mechanisms for sharing information, care plans and guidance between Guild Lodge and prison healthcare staff are in place.

168. It is also of concern that, in any case, staff on the PCMHT at Preston do not currently have access to eCPA, despite working with prisoners who have information recorded there.

The Head of Healthcare should arrange for all registered mental health nurses working at HMP Preston to have access to eCPA as a matter of priority.

169. As briefly noted above, it has been difficult to establish which mental health service was taking responsibility for the man's care. On his arrival in the segregation unit at Preston on 8 April, the PCMHT leader was involved in his care. She assessed his suitability for segregation and attended his ACCT case reviews. However, staff from the MHIT were attending his MAPPA meetings and taking forward actions from those meetings.

170. The VPU manager referred the man to the mental health services on 13 June. The referral was processed by the PCMHT administrator (as is normal practice). The clinical reviewer and investigator were told that, on receipt of a referral, the administrator of the MHIT provides details of any relevant eCPA information to the PCMHT administrator. The PCMHT administrator reviews other available information and decides whether the prisoner should be referred to the MHIT or placed on the PCMHT waiting list. The man was indeed placed on the PCMHT waiting list.

171. The clinical reviewer notes that, in her opinion, the allocation of complex cases should not be an administrative task. She also highlights that the prison's Mental Health Interagency Working Protocol states that "if a prisoner is an actively registered patient on the eCPA, the MHIT will automatically assume responsibility for the referral". The man was indeed registered on the eCPA, however, the MHIT did not apparently take overall responsibility for his care.

172. The man's complex mental health issues clearly caused problems for the two mental health teams at Preston, with neither being certain about who was responsible for him. The resulting confusion may well have affected the quality of mental health treatment he received. To further complicate the matter, it seems that Preston does not currently have any clear and agreed guidance for working with prisoners with personality disorders. The clinical reviewer makes

several recommendations aimed at clarifying the referral and treatment processes for prisoners with mental health problems.

The Head of Healthcare should review the Mental Health Interagency Working Protocol to ensure that both the PCMHT and MHIT are clear about their roles and responsibilities.

The Head of Healthcare should ensure that mental health referrals are discussed at a single point of allocation meeting and that subsequent decisions are logged in the prisoners' medical records.

The Head of Healthcare should devise a care pathway for prisoners with personality disorders.

Substance misuse

173. It seems that the man's mental health problems were closely linked with his substance misuse. In November 2007, he told a CARATs worker that he had a history of extensive drug use prior to coming to prison and had continued to use a number of illicit drugs in prison. In addition, he admitted to misusing prescribed medication (both that prescribed to him and that bought from or traded for with other prisoners). Entries in his medical record show that, at times, it was difficult for staff to determine whether he had a mental or physical clinical need to be prescribed medication or was requesting the medication in order to satisfy his addictions.
174. On his arrival in prison in 2004, staff noted that he was dependent on heroin. However, it quickly became apparent that he was misusing a number of substances, including prescribed medication such as sedatives and pain relief tablets. In 2007, he was referred to CARATs but despite acknowledging his substantial drug problem, he refused any further drug treatment.
175. In May 2010, the man was referred to CARATs and the IDTS team and was assessed as suitable for beginning the methadone maintenance programme, which he did in June of that year. The aim of prescribing methadone was to reduce his dependence on other substances and to encourage a more stable lifestyle. However, he continued to use heroin and other substances despite the methadone dose being increased.
176. The man was also prescribed diazepam in June 2011 having been assessed as diazepam dependent in 2009. He was prescribed the medication having made it clear that, otherwise, he would continue to take numerous other medications (including that prescribed to other prisoners). It was considered safer to prescribe diazepam than to allow him to continue to misuse unknown substances in unknown quantities.
177. Garth and Preston share the same substance misuse specialist doctor, Dr A, who was responsible for the man's methadone prescription. The clinical reviewer notes that the doctor's entries in his medical record were "clear, concise and provided an account of the clinical history, assessment of him, with rationale

and guidance". In interview, Dr A was asked about the man's substance misuse care plan. She explained that, until staff knew the outcome of the charges of assaulting staff, the plan was to maintain him on a consistent dose of methadone. This was in line with his wishes and was sensible given that he had been due for release in May, was now on remand and therefore, might be released at any time.

178. Dr A also explained that the long term plan was to reduce the man's dose of diazepam until he no longer needed the medication. However, he was very resistant to this idea. To avoid any possibility that he was selling his diazepam, or trading it with other prisoners, he was prescribed liquid diazepam.
179. However, aside from entries in the medical record by Dr A, there is little documentary evidence of the IDTS team's involvement with the man. The clinical reviewer notes that there was no written care plan in his medical record, nor was there any recording of one to one meetings between IDTS nurses and him. Although he had previously expressed an interest in substance misuse related group work, there is no evidence that he was offered or attended any. The clinical reviewer also writes that methadone prescriptions are not recorded on SystmOne (the medical computer system) at Preston. In fact, the IDTS manager could not locate a current methadone prescription chart for him.

The Head of Healthcare should review the working practices of the IDTS team and assure herself that contact with clients is of sufficient regularity and quality.

The Head of Healthcare should ensure that IDTS record keeping practice complies with the standards required by the National Nursing and Midwifery Council and the Manchester Record Keeping Policy, including:

- **ensuring that all IDTS clients have completed and regularly reviewed care plans which are reflected on SystmOne, and**
- **ensuring that IDTS prescribers record all prescribed medication on SystmOne.**

Links between the man's physical health complaints and his substance misuse

180. The man complained of several physical health problems, for which he frequently requested medication. As noted above, these health problems made it much more difficult for healthcare staff to distinguish between his drug dependency and legitimate medical complaints. He was prescribed a number of different medications over the course of his prison sentence, many of which are known to have addictive qualities or be popular with prisoners with substance misuse problems.
181. The man told healthcare staff that he had been shot in the neck some time ago. He said that some of the lead shot was still embedded in his neck (which was confirmed in an x-ray). He complained of nerve pain due to the shooting. He also complained of permanent nausea, which he sometimes said was a result of lead poisoning (from the lead shot) and sometimes a result of being Hepatitis C positive.

182. The man was prescribed cyclizine while a prisoner at Parkhurst. Cyclizine (generally prescribed to treat nausea) is said to enhance the effects of opiates, and as a result it is often abused by opiate users. While at Garth, Dr A questioned whether the man should be prescribed cyclizine and referred him for review by one of the prison's general doctors. The prescription was stopped at some point prior to him arriving at Preston. However, he continued to complain of nausea. In April and May 2011, Dr A refused to prescribe cyclizine because, in her opinion, the man had no medical need for it. She recorded her decision in his medical record. In June 2011, he was examined by a locum doctor (who are usually employed by an agency and do not regularly work in the prison) who prescribed cyclizine once more.
183. The clinical reviewer notes that the man complained of almost permanent nausea and said he had trouble eating properly as a result. She writes that healthcare staff could have monitored his weight over time as weight loss is an appropriate monitor for patients complaining of nausea. She found three entries recording the man's weight in his medical record, dated August 2010, January 2011 and February 2011. In isolation, those three measures would not have allowed clinicians to challenge his claims.
184. In 2009, the man underwent a blood test, which showed that the lead levels in his blood were within the normal range. In December that year, surgical specialists advised that the lead shot was safe to leave in his neck. Once at Preston, he was due to undergo another blood test (possibly to test for lead levels). This had not occurred prior to his death. The clinical reviewer notes that lead poisoning is extremely rare and concludes that, on the evidence available, it is "improbable" that he was suffering with lead poisoning.
185. Dr A told the investigation team that she is not involved in prescribing decisions that relate to prisoners' general health complaints, because her role is to be the substance misuse specialist. Clearly, the man's case demonstrates how some prisoners' treatment needs cut across both substance misuse and general health. It seems the man's prescription for cyclizine was re-started because he demanded it, rather than on the basis of clear medical evidence. This emphasises the need for regular communication between the substance misuse specialist doctor and the general prison doctors. Dr A described good informal communication between herself and the general doctors but it appears that there are no formal meetings. The clinical reviewer suggests that general prison doctors, particularly those who are new or locums, spend time shadowing the substance misuse specialist as part of their professional development.

The Head of Healthcare should introduce a regular meeting to discuss complex cases or issues of concern. The meeting should be attended by a full range of healthcare staff representing MHIT, PCMHT, IDTS and primary care general health.

186. The clinical reviewer also comments on the man's Hepatitis C status and treatment. She concludes that, following the review of his medical record, it is unclear whether he was indeed Hepatitis C positive. There is no record of him

having undergone the recognised test used to establish presence of the virus. In January 2011, staff at Parkhurst recorded that he was Hepatitis C positive. However, when he reached Garth in February, he said he was Hepatitis C negative. It seems that he never received any treatment for the virus – at least, none is recorded in his medical record. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with relevant risk factors are appropriately screened for Hepatitis C on their arrival at Preston.

The man's mental state prior to his death

187. Having had the benefit of reviewing all of the available documentation and interviewing both healthcare and discipline staff, it is our view that the man showed signs of worsening mental health from mid-June until his death. On 10 June, he complained of hearing voices and was assessed by the MHIT nurse. She concluded that he was claiming to hear voices because he wanted his television returned to him. However, he had apparently been treated as an inpatient in 1994 and 1998 having complained of hearing voices and suffering visual hallucinations.
188. On 11 June, the man left a message on the prison's anti-bullying line. When the officer went to investigate his concerns, the man claimed that a senior officer at Garth had been making abusive comments through his door. The officer told the investigator that the officer had not been at Preston and so could not have done so. He found the man's claims to be "bizarre" but took no further action. Later that day, the man complained that his "head was going" and asked to see a mental health nurse. Over the next few days, his erratic behaviour continued. He set fire to paper in his cell, was confrontational and aggressive with other prisoners and again complained of hearing voices. In interview, one of the VP unit managers said that he thought he seemed unsettled and "out of sorts" in the weeks before his death. As noted above, neither the PCMHT nor MHIT took overall responsibility for his care.
189. However, in considering whether healthcare or discipline staff missed signs that the man was beginning to struggle or pose a greater risk to himself, we must bear in mind his history of unpredictable behaviour. Throughout his time in prison, he had displayed a range of unusual behaviours. When staff tried to discuss his behaviour with him, he would often claim that he only said or did things in order to manipulate staff. We think it clear that he would have benefited from a more coherent approach to his mental health. However, it is not possible to say with any certainty whether, even had this been the case, mental health trained staff would have been able to differentiate between serious mental health concerns and his persistent unusual behaviours.

Whether the man was the subject of abuse or victimisation

190. The man's mother was concerned that her son had been the victim of verbal abuse from other prisoners. As with other aspects of this investigation, this has been difficult to establish. At various points during his sentence, he complained

of being verbally abused and singled out by other prisoners. Indeed, at times he complained that he had been bullied by members of staff.

191. He complained that he had been called a “nonce” because other prisoners thought he had committed a sexual offence against a child (he had not). He also said that he had encountered racism. However, on more than one occasion, when staff tried to investigate his claims, he refused to provide names or any other information about the nature of the abuse he received. This made it difficult for staff to take action. On other occasions, staff felt that his claims were unfounded for other reasons, such as because the prisoner he accused had already left the prison. In addition, some of his complaints were made in the context of increasing periods of paranoia.
192. Once at Preston, the man was twice monitored on a TAB plan because staff thought that he was bullying and intimidating other prisoners. Prisoners A and B did not think that the man had been responsible for bullying others. Prisoner B was not aware of the man having been bullied himself, although Prisoner A said that he had been bullied.
193. The man’s disruptive and unpredictable behaviour in prison may not have endeared him either to staff or prisoners. However, we have found no clear and direct evidence to either support or refute the possibility that he was victimised. Therefore, we are unable to draw a conclusion.

The man’s access to his own clothes

194. On 9 May, the man’s original sentence ended and, had it not been for the outstanding assault charges, he would have been released. Instead, he became a remand status prisoner. His mother was concerned that her son’s mental wellbeing suffered when, as a remand prisoner, he was not allowed to receive three sets of clothes from her.
195. Preston’s current policy was explained to the investigator, and is set out earlier in the report. Under the policy, the man was not entitled to receive clothes from his mother and he was told this when he made a written complaint. He was told that he would not be allowed access to new clothes unless or until he reached enhanced level on the IEP scheme (he was on basic level at the time). The Reception SO told the investigator that prisoners whose status reverts from sentenced to remand are not given the opportunity to have clothes brought in for them. The SO acknowledged that prisoners found the policy confusing. HMCIP, reporting in August 2009, highlighted that the “mechanics for [prisoners accessing their own clothes] were so restrictive that most chose to wear prison clothing”. The Inspectorate recommended that the current clothing system be relaxed. We have also found the system in place for remand prisoners to be confusing and overly complex and make the following recommendation:

The Governor should relax the current restrictions on remand prisoners receiving clothes and allow replacement clothing to be received from families, as well as purchased.

The man's move from C wing to B wing

196. During the investigation, two prisoners said that they could not believe that the man would have chosen to move from C wing to B wing. They thought that he had been forced to move wings.
197. The DPSM told the investigator that on 22 June, the man had been difficult to manage. When challenged, he said that he did not want to live on the VP unit because he did not like mixing with other vulnerable prisoners and was bored with the regime. He had expressed similar sentiments to his mother in a telephone call some days earlier. In order to arrange the move, he was required to sign a disclaimer, expressing his wish to move from the VP unit. He did so and, according to staff interviews and statements, was pleased to move to B wing.
198. We have found no evidence to suggest that any undue pressure to move was placed on the man. We conclude that the move was arranged at his request. Furthermore, we have seen no evidence to suggest that staff should have been suspicious or concerned about his wish to move from the VP unit.

Emergency response

199. Officer B began carrying out a roll check on B wing shortly after 6.30am. When he reached the man's cell, he realised that something was wrong and raised the alarm at 6.58am. In line with the prison's local policy, the officer waited until he was certain other staff were approaching before unlocking and going into the cell. Once inside, he found the man at the rear of the cell, with a ligature around his neck. Staff present began CPR and nursing staff were in the cell within five minutes of the alarm being raised.
200. The two emergency response nurses brought some of their medical equipment with them, but did not initially bring the defibrillator. This was collected separately. When the defibrillator was used, it instructed that the man's heart had no shockable rhythm and that CPR should be continued. While the defibrillator was not required on this occasion, it should form a standard part of the emergency equipment and be taken to any code 1 call.

The Head of Healthcare should ensure that the defibrillator is kept with or in the emergency bag and is taken to all code 1 emergencies.

201. The ambulance arrived at Preston at 7.10am. The paramedics had their mobile telephones taken away on their arrival. The Governor is already aware of this issue and has taken steps to remind staff that emergency ambulance staff are not subject to the same security procedures as other visitors.
202. One of the paramedics made a statement to the police. She explained that the crew parked the ambulance inside the prison gates and had got out of the vehicle. They were then asked to move the ambulance as it was blocking an access route. Whilst we appreciate the importance of vehicle access, it was unfortunate that the ambulance crew were delayed in reaching the man. Given

that two issues concerning the paramedics' arrival have been identified, we make the following recommendation:

The Governor must remind all staff of the procedures for allowing ambulances and their crews rapid access into the prison in an emergency.

203. We are pleased to reflect the paramedic's view that prison and healthcare staff had performed CPR in accordance with current guidance.

Contact with the man's family

204. The man's prison file contained contact information for both his mother and his father. However, when asked who he wanted to be contacted in an emergency, he had given only his mother's details. On that basis, the Governor and chaplain visited her home address on 23 June to break the news of her son's death.

205. During the course of the investigation, it transpired that neither the prison nor the Coroner's office had made contact with the man's father. When he was eventually informed in August, he had missed the funeral and was understandably upset. We appreciate that, by breaking the news to the mother, the prison had acted in accordance with the PSO. We also understand that contact with bereaved families can be a very sensitive area, particularly when different branches of the family are no longer in contact. However, the father's details were available in the file. We think it would have been prudent for the prison to have discussed the issue with the Coroner, who could have arranged for him to have been informed at an earlier stage.

The Governor should ensure that, following a death in prison, the Coroner is informed of any additional next of kin who have not been informed of the death, but for whom contact details are available.

CONCLUSION

206. The man had been in prison since 2004 and was a complex and difficult man to manage. He had some identified mental health problems which were complicated by his misuse of prescribed and illegal drugs. He was due for release in May 2011 but, in March, was charged with assaulting prison staff and so was remanded into custody awaiting trial. In April, he transferred to Preston. He was found with a ligature around his neck on the morning of 23 June and could not be resuscitated.
207. In mid-June, prison staff began to have concerns about the man's mental health. This investigation has highlighted a number of problems with the mental healthcare he received at Preston. However, it seems that his strange behaviour did not cause staff to worry that he might harm himself and so he was not being monitored under suicide prevention measures. As a result of this investigation, we have made 13 recommendations, highlighting our various concerns about his care. However, we do not believe that staff could reasonably have foreseen his actions.

RECOMMENDATIONS

The NOMS response is reflected in italics below each recommendation.

1. The Head of Healthcare should liaise with managers at Guild Lodge to ensure that appropriate mechanisms for sharing information, care plans and guidance between Guild Lodge and prison healthcare staff are in place.

The recommendation has been accepted.

2. The Head of Healthcare should arrange for all registered mental health nurses working at HMP Preston to have access to eCPA as a matter of priority.

The recommendation has been accepted.

3. The Head of Healthcare should review the Mental Health Interagency Working Protocol to ensure that both the PCMHT and MHIT are clear about their roles and responsibilities.

The recommendation has been accepted.

4. The Head of Healthcare should ensure that mental health referrals are discussed at a single point of allocation meeting and that subsequent decisions are logged in the prisoners' medical records.

The recommendation has been accepted.

5. The Head of Healthcare should devise a care pathway for prisoners with personality disorders.

The recommendation has been accepted.

6. The Head of Healthcare should review the working practices of the IDTS team and assure herself that contact with clients is of sufficient regularity and quality.

The recommendation has been accepted.

7. The Head of Healthcare should ensure that IDTS record keeping practice complies with the standards required by the National Nursing and Midwifery Council and the Manchester Record Keeping Policy, including:

- ensuring that all IDTS clients have completed and regularly reviewed care plans which are reflected on SystemOne, and
- ensuring that IDTS prescribers record all prescribed medication on SystemOne.

The recommendation has been accepted.

8. The Head of Healthcare should introduce a regular meeting to discuss complex cases or issues of concern. The meeting should be attended by a

full range of healthcare staff representing MHIT, PCMHT, IDTS and primary care general health.

The recommendation has been accepted.

9. The Head of Healthcare should ensure that prisoners with relevant risk factors are appropriately screened for Hepatitis C on their arrival at Preston.

The recommendation has been accepted.

10. The Governor should relax the current restrictions on remand prisoners receiving clothes and allow replacement clothing to be received from families, as well as purchased.

This recommendation has not been accepted.

11. The Head of Healthcare should ensure that the defibrillator is kept with or in the emergency bag and is taken to all code 1 emergencies.

The recommendation has been accepted.

12. The Governor must remind all staff of the procedures for allowing ambulances and their crews rapid access into the prison in an emergency.

The recommendation has been accepted.

13. The Governor should ensure that, following a death in prison, the Coroner is informed of any additional next of kin who have not been informed of the death, but for whom contact details are available.

The recommendation has been accepted.