

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in  
September 2013 while a prisoner at HMP Preston**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanging in his cell at HMP Preston in September 2013. He was 45 years old. I offer my condolences to his friends and family.

A clinical reviewer assessed the clinical care and treatment the man received at the prison. Preston cooperated fully with this investigation.

The man was remanded to HMP Preston on 28 September 2013, charged with assault and threats to kill his partner. At a reception health screen, he said that he did not have any thoughts of suicide or self-harm or suicide. A more detailed health screen and a routine mental health assessment the next day identified no concerns.

A few days later an officer found the man hanging in his cell. Officers cut him down and began cardiopulmonary resuscitation until nurses arrived and took over. Paramedics arrived quickly and took him to hospital, but he was pronounced dead shortly after arrival.

I am satisfied that the man had generally appropriate assessments when he arrived at the prison to help identify whether he was at risk of suicide and self-harm. On the basis of those assessments, it would have been difficult for staff at the prison to have predicted his actions. However, he was charged with a violent offence against a family member, a factor known to increase the risk of suicide. While in other respects his assessments appear to have been comprehensive, I am concerned that there is no evidence that this was taken into account. It is important that prison staff identify and consider all relevant risk factors when assessing a prisoner's risk of suicide and self-harm.

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**

**April 2014**

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## SUMMARY

1. The man was remanded to HMP Preston on Saturday 28 September 2013, charged with threats to kill and assault against his then partner. He was 45 years old. This was not his first time in custody. He told a nurse in the prison reception that he had no current thoughts of suicide or self-harm and had never had any. He said he had no mental or physical health problems. The nurse recorded that he engaged well and gave no cause for concern.
2. On Sunday, the man had a more detailed health assessment and no problems were noted. In common with all new arrivals at Preston he had a mental health assessment, which found no mental health problems. Also on Sunday, he had an induction interview with an officer from the safer custody team. He told the officer that he had no thoughts of suicide or self-harm. The officer considered that he had engaged well and he had no concerns about him. There is nothing to indicate that the assessments took into account the fact that he was charged with violent offences against a family member, a factor known to increase risk of suicide.
3. During a routine roll check a few days later, at approximately 5.40am, a night officer saw the man in bed in his cell. At 9.26am, an officer began unlocking prisoners on his landing so they could go outside to the exercise yard. When the officer reached his cell he got no reply from him. He went into the cell and found him hanging by a torn bed sheet attached to a pipe. The officer immediately called out for help and radioed an emergency code for urgent medical assistance. When the call was received the control room called an ambulance immediately.
4. Nurses and other officers arrived quickly and attempted to resuscitate the man. Paramedics arrived at 9.34am and continued to treat him. The paramedics were unable to find or establish a pulse and took him to hospital where he was pronounced dead at 10.17am.
5. In the short time he was at Preston, we are satisfied that the man's risk of suicide and self-harm was assessed on several occasions. The staff saw no reason to monitor him as a risk of suicide or self-harm. While that might have been a reasonable conclusion, based on what was known about him, there is no record that the assessments took into account the nature of the charges he was facing. It is possible, even probable, that had this been done the same conclusion would have been reached, but it is important that all risk factors are fully considered and weighed against other factors such as how a person presents. We make one recommendation about this.

## THE INVESTIGATION PROCESS

6. On 1 October 2013, the investigator issued notices to HMP Preston informing them of the investigation and inviting anyone with relevant information to contact him. No-one responded.
7. An assistant ombudsman was at the prison on 4 October in relation to another investigation and made some preliminary enquires. He met the Governor and visited the first night wing where the man had been based. He spoke briefly with staff who had been involved in the incident and collected all relevant documentation.
8. The investigator interviewed four members of staff at Preston on 25 and 26 November. Three further members of staff provided written statements.
9. The investigator informed the local Coroner of the investigation who provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.
10. NHS England, Lancashire Area Team, appointed a clinical reviewer to assess the man's medical care at the prison.
11. One of the Ombudsman's family liaison officers contacted members of the man's family. His father referred to a letter his son had left in his cell and was satisfied with the actions of the prison. He said that he might have been worried about losing a job he had recently obtained. His aunt raised some issues which were outside the remit of this investigation.
12. The man's family received a copy of the draft report. They indicated that it was the man's aunt that gave the contact details to the prison for his father and the report has been amended accordingly. The man's father said that while he had no comments to make on the content of the report, he was upset to read that the pipe work in his son's cell had been exposed.

## **HMP PRESTON**

13. HMP Preston is a local prison holding up to 842 adult male prisoners. Health services are provided by Lancashire Care Foundation Trust.

### **HM Inspectorate of Prisons**

14. HM Inspectorate of Prisons made an unannounced short follow up inspection of Preston in April 2012. Inspectors noted that a recommendation that all staff engaging with prisoners should receive ACCT (suicide and self-harm) training had not been achieved. Only 67% of uniformed staff had been trained which inspectors described as concerning when there had been three self-inflicted deaths at Preston in the previous year.
15. Since the previous inspection, inspectors said that the reception area had improved but was still cramped and inadequate for the large throughput of prisoners. Two interview rooms had been created and were used for private reception interviews which had previously been carried out at the desk.

### **Independent Monitoring Board**

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In their latest annual report, the IMB commented that the 'Safer Preston Team' continued to work to make Preston a safer place to live and work. They said that a total of 494 Assessment, Care in Custody and Teamwork (ACCT) documents had been opened and that, overall, the standard of these and anti-bullying procedures was good. The IMB considered that safer custody matters were well managed at the prison.

### **Previous deaths at HMP Preston**

17. There were seven deaths at Preston during 2013, including that of the man's. The other six were due to natural causes. There were no significant similarities with the circumstances of the four previous self-inflicted deaths at the prison in 2011 and 2012.

## KEY EVENTS

18. The man was remanded to HMP Preston on Saturday 28 September 2013. He had been charged with threats to kill and common assault against his partner. This was not his first time in custody. He was 45 years old.
19. When he arrived at Preston, a nurse carried out an initial reception health screen. She told the investigator that it was obvious that he was not happy to be in custody, but he seemed to be coping. She said that he was talkative, did not try to avoid any questions, and responded appropriately. He told her that he drank alcohol occasionally and had not used illicit drugs recently. She completed the medical section of a cell sharing risk assessment (CSRA - to determine whether a prisoner will be a risk of violence towards another prisoner). She said that he told her that he was happy to share a cell if required, but would prefer to be on his own. He was regarded as standard risk and able to share cell.
20. A registered mental health nurse checked to ensure that the man was not under the care of community mental health services and he was then taken to cell A2-15 in the first night centre the only available cell on the wing when he arrived. This was a double cell but he occupied the cell on his own.
21. The next morning Sunday 29 September, at around 10.00am, an officer saw the man as part of his induction. The officer said that he spent around 20 minutes with him, going through various documents and explaining the prison regime. He told the investigator that in addition to his duties as a wing officer, he was also part of the safer custody team and had a lot of experience of dealing with prisoners at risk of suicide or self-harm or who were experiencing periods of crisis. He said that the man gave no indication that he was at risk of suicide or self-harm and he appeared upbeat and 'normal.'
22. The officer said that the only issue that the man raised was that he had been cold the previous night so he arranged for him to have another blanket. The officer remained on A2 landing until around lunchtime, when his shift ended. He said that he did not see him interacting with any other prisoners during this time, although prisoners were unlocked and he had the opportunity to do so.
23. A nurse and a primary care mental health practitioner then saw the man. The nurse carried out a secondary health screen and recorded nothing significant in addition to the first assessment. The mental health practitioner conducted a well-man mental health assessment which is routinely completed for new arrivals at Preston the day after their reception. He said that he worked as part of the integrated mental health team, which covers both the primary and secondary aspects of mental health care. The team had decided to see all new arrivals to identify prisoners with mental health problems at an early stage.
24. The mental health practitioner said that he spent around 10 to 15 minutes with the man and did not identify any mental health issues. He told him that he had no history of mental health problems and had never been prescribed medication for his mental health. The mental health practitioner said that he explained to him that the mental health team were available for support if he needed it. He said that he presented as 'just a normal man' and he did not appear distressed or upset.

25. No further information was recorded about the man on 29 September. He wrote a letter to his bank that day instructing them to make changes to his account and stop various standing orders. This was discovered in his cell after his death.
26. The officer on night duty over the weekend of 28 and 29 September in a statement for the investigator said that she had spoken to the man when she started her shift on the evening of 28 September. She said that she had introduced herself to him during her first roll check when he told her that he was okay. She said that she told him that she would be on duty all evening if he had any problems and that she would check on him every hour as it was his first night at the prison. (This is standard procedure for all new arrivals at Preston.) She recorded her hourly observations on a standard form.
27. The officer saw the man again the next evening. She completed a roll check when she arrived for duty and recalled seeing him in his cell, although she did not speak to him. At 5.40am the next morning, she conducted a further roll check and said that he was in bed at that time.
28. An officer arrived for duty at around 6.40am on Monday, although his shift did not formally begin until 7.30am. A further roll check is not required at that time but he said he usually went to every cell to check prisoners' welfare. However, that morning there were three prisoners subject to suicide and self-harm monitoring (known as ACCT) on the wing. He said that he went first to check on those prisoners and then went to the wing office to update their ACCT documents.
29. After he had completed the ACCT documents, the officer received a radio alert asking all available staff to attend an incident on C2 landing at approximately 7.15am. He went to C2 where the wing manager told him that a prisoner who prolifically harmed himself had broken cell furniture and was making threats to harm himself and staff. He said that he spent some time with other staff on C2 dealing with the situation before he returned to A wing. He then checked again the prisoners who were subject to ACCT monitoring.
30. The officer said that the wing manager briefed staff in the wing office between 8.15 – 8.30am. He then went to A2 landing. At 9.20am, he began unlocking prisoners to allow them to spend some time in the open air in the exercise yard. Some prisoners on the landing at the time were considered vulnerable and kept separate from others so unlocked at a different time. He said that he went to the cells of the other prisoners, unlocked the doors and asked them if they wanted to go out to the exercise yard. This meant he was able to engage with them appropriately rather than just asking through the observation hatch.
31. The officer arrived at the man's cell at about 9.26am. He said that he opened the door and, as he walked in, he noticed that the top mattress was folded in half, and the bottom bed was empty. At first he thought that either healthcare or induction staff had taken him to an appointment as this often happened. However, as he turned he saw him hanging from a pipe which ran across the top of the cell with a torn sheet tied around his neck.

32. The officer said that he immediately left the cell to call for assistance. As he came out of the cell, he dropped his key chain and the noise alerted another officer. He said that he could see that she could tell something was wrong from the look on his face. At that time the prison had recently introduced new procedures for medical emergencies. The new system used code red for emergencies involving bleeding and code blue (which had replaced code 1) for breathing or respiratory difficulties. In his haste, he radioed a code 1, although he said he knew about the new coding system.
33. Two more officers also on A wing went immediately went into the cell, cut the sheet and lowered the man to the cell floor. The communications room had received the initial call from the officer at 9.27am and then sent out a radio code blue. They called an ambulance at the same time.
34. A custodial manager and the orderly officer (in charge of the operation of the prison) heard the code blue call and went immediately to A2 landing. The orderly officer went into the cell to help the officers and the custodial manager contacted the communications room to check that an ambulance had been requested.
35. A nurse responded to the emergency call at 9.27am with three other nurses. They brought emergency equipment, including a defibrillator and oxygen, and arrived within a few minutes. She said that when she got there, the man was slumped in an upright position behind the cell door and was unresponsive. The officers had removed the sheet from around his neck. She moved him onto his back and, after establishing that he had no cardiac or respiratory output, she and her colleague began cardiopulmonary resuscitation (CPR).
36. The nurses continued CPR and the healthcare manager, the primary care deputy manager and the prison GP joined them. The defibrillator indicated that there was no shockable heart rhythm and that CPR should continue.
37. Paramedics arrived at 9.34am and the man was moved onto the landing to provide more room to administer treatment. Paramedics continued to treat him and then decided to take him to hospital. They did not manage to establish a pulse before they left. The ambulance left the prison at 9.57am. He was escorted by two officers and no restraints were used. Despite the efforts of all the staff involved in attempting to resuscitate him, he was pronounced dead at the hospital at 10.17am.

## Events following the man's death

38. A search of the man's cell found what appeared to be a letter written by him. A copy of this was given to the police and his father later on, but the investigator has not seen it, despite requesting a copy from the police. As described by his father, the letter was to his bank, cancelling a number of standing orders.
39. When he arrived at Preston, reception staff completed the standard procedures for new arrivals. They asked for contact details of someone he would wish to be contacted in an emergency, but the man did not give them any next-of-kin details. The Governor and the prison family liaison officer left the prison soon after the man had been taken to hospital to notify his ex-partner, whose address they had found on court documents. While they were on their way, the prison notified them that he had died at 10.17am. They went to the address, but, as no one was home, they contacted the prison and went to another address listed in the documentation. This was the address of his ex-partner's grandmother. They explained that he had died and she contacted her granddaughter, who arrived 20 minutes later. The Governor explained what had happened and his ex-partner told him that his father lived locally. She gave them the address of his aunt, and in turn she was able to provide the address for his father.
40. The Governor and prison family liaison officer went to see the man's father and his aunt, who, his ex-partner told them, had cared for him when he was a child and informed them both of his death. They explained what investigations would take place, the procedures that would follow and gave his family the contact details of the prison's family liaison officer. The Governor later wrote to offer a contribution towards funeral costs and help with arrangements if required.
41. A debrief was held at the prison for all the staff involved in the emergency incident with the man on 30 September. Healthcare staff also attended a separate meeting to discuss the medical intervention.

## ISSUES

### Medical Care

42. The clinical reviewer assessed the medical care provided to the man while he was at Preston. As he was at the prison for such a short time he had had only limited contact with the healthcare team.
43. The clinical reviewer commented that, although the man arrived at the prison at the weekend, he was given a thorough assessment of both his physical and mental health needs. He said that there was no evidence in the completed assessments that the man had any mental illness or history of self-harm. He also noted that the mental health team had searched an electronic database to check whether the man had received any mental health input in the community, which he thought was an example of good practice.
44. The clinical reviewer considered that the emergency response was prompt and thorough. We are satisfied that despite the initial confusion about the appropriate emergency code to use, there was no delay. In summary, he was satisfied that the medical care the man received was in line with prison policies and the equivalent of that which he would have received in the community.

### Management of risk of suicide and self-harm

45. The man was assessed several times in the three days that he was at Preston. He had a reception health screen interview with a nurse, an induction interview with an officer and then a second health screen and a compulsory mental health assessment. We believe that this level of engagement, especially at a weekend, was good. As with all new arrivals at Preston, he was monitored hourly on his first night. In the circumstances it is unfortunate that routine monitoring of new arrivals does not extend beyond the first night, but none of the staff who saw him assessed him as at risk of suicide or self-harm so no additional monitoring was implemented.
46. Prison Service Instruction 64/2011 which governs safer custody procedures indicates that relationship instability, early days in custody and charges of offences of violence, particularly against family members or partners are risk factors for suicide. The man had been charged with threatening behaviour and common assault against his then partner. This and the other factors known to increase the risk of suicide should have been identified and considered as part of an assessment of his risk of suicide but there is no indication that he was asked about the circumstances of his alleged offence or that these factors were taken into account by those assessing his risk.
47. While the man had a commendable number of assessments when he arrived at the prison, including a mental health assessment, it does not appear that there is an assessment process at Preston that prompts staff to consider and assess all the known risk factors for a newly-arrived prisoner. It would not have been immediately apparent from the court papers that his charges related to alleged offences against his partner, but it would have been helpful if the circumstances of his offence had been explored with him, particularly as any charges of violence against another person raises the risk of suicide.

48. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors should be collated and considered to ensure that a prisoner's level of risk is holistically judged.
49. We do not necessarily conclude that a full assessment of all the risk factors would have resulted in staff deciding that the man needed to be monitored under suicide and self-harm prevention procedures or that the outcome for him would have been any different. The assessment of risk has to be a matter of staff judgement, but it needs to be properly informed by an assessment of all the known risks. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm.**

## **RECOMMENDATION**

1. The Governor and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm.	Accepted	<p>A Staff Information Notice - Management of prisoners at risk of harm, to self, to others and from others – has been issued to remind all staff of potential triggers which may increase risk of harm to self or others.</p> <p>All reception officers have been reminded that if a PSR (pre-sentence report) is received the section on impact of custody / risk of harm to self (section 6) must be read and any issues noted and investigated further. They have also been reminded that the PER, CSRA, risk of harm form must be checked and acted upon in relation to risk or harm.</p> <p>On arrival all prisoners are risk assessed from a healthcare perspective, all of which form part of a national reception screening tool. Self harm / Risk of Suicide is always explored and if a prisoner states that they are a risk then it is explored further with the MH team &amp; via the ACCT process.</p> <p>There is now a quarterly management checks by the Head of Safer Prisons and Equality to provide assurance to the Governor that the</p>	<p>Completed</p> <p>Governor Actioned</p> <p>Completed</p> <p>Head of Operations Actioned</p> <p>Completed</p> <p>Head of Healthcare Actioned</p>	

			relevant systems are operating effectively.	Completed Head of Safer Prisons and Equality Quarterly	
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