

**Investigation into the circumstances surrounding the
death of a man
at HMP Preston in January 2007**

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

January 2008

This is the report of an investigation into the apparently self-inflicted death a man at HMP Preston on Monday 29 January 2007. I pass on my sincere sympathies to his family and friends both in the UK and overseas for their loss.

I appointed a colleague from my team to investigate the circumstances surrounding the man's death on my behalf. She received excellent and timely support from the prison's Deputy Head of Reducing Reoffending. I would also like to thank the Governor for the support and time that he and his staff gave to the investigation process.

Despite repeated attempts to contact the man's family, my office only communicated with them at the beginning of the investigation process. Regrettably, they have not had the opportunity to comment on the draft report before its finalisation.

I am also grateful to the clinical reviewer for his examination of the man's medical care while in prison. The clinical review was commissioned by Central Lancashire Primary Care Trust (PCT) and makes five recommendations.

The man had lived illegally in the UK for two years with friends and his brothers. Following a police raid on his home, he was arrested and questioned for a number of days. The man appeared in court and was remanded to Preston on Thursday 25 January. During his five days at Preston, he appeared to suffer from anxiety and was found in a state of panic on three occasions. He seemed confused as to why he was in custody. Staff submitted two referrals to the mental health team for an assessment, but he was not seen by a member of the mental health team before he died.

I was pleased to find staff so keen to settle prisoners into HMP Preston, and identifying their needs at an early stage to see if they could be addressed. However, as in many prisons, I am concerned at the level of primary care mental health resources available. Although I recognise that this is an area that is currently being developed as a matter of priority, I have made a recommendation to reinforce this.

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SUMMARY

The man was arrested suddenly following a police raid on his home. He was questioned by the police and immigration services for several days, before being remanded to HMP Preston on the evening of Thursday 25 January.

Throughout the reception and induction process, the man appeared to be confused by his situation and concerned about the charges he was facing. He told staff that it was his first time in prison and he appeared apprehensive.

Staff made efforts to explain his position to him, to put him in touch with his family and to make him feel more comfortable. On three occasions, he was found in an anxious state under his bed. Healthcare staff attended his cell promptly and succeeded in calming him down by talking with him about his problems. A mental health referral was made. Arrangements were made for him to speak with the imam and attend Muslim prayers on the Friday afternoon.

The man displayed "bizarre behaviour" and his cellmate raised concerns about him with the officers on duty. In his heightened state of anxiety, the man stood in his cell shaking or pacing. An officer took him to one side to see if he was okay and the man said that he was concerned about his legal representation. The officer explained that nothing could be done over the weekend but that he could contact his solicitor on Monday morning. The officer made a further mental health referral.

The weekly referral meeting was held by the mental health team on the afternoon of Monday 29 January. They discussed both of the man's referrals and agreed that the problems with which he was presenting were anxiety related. With that in mind, they referred him to the Primary Care Mental Health Worker who was on leave at the time of the referral.

The man moved to the induction wing. His new cellmate raised concerns about sharing a cell with the man after spending less than an hour with him at lunch time. The cellmate was moved and he was left in the cell by himself. Prisoners complained about him after they returned from their afternoon exercise period. They reported to staff that he was making threatening comments. Officers on the wing tried to get someone from the mental health team to see the man urgently. Eventually, the medical response nurse, who was not mental health trained, agreed to go to his cell after he had finished dispensing treatments. The man was discovered hanging in his cell before the nurse attended.

When the man was found hanging, staff acted promptly. With the help of a prisoner, they entered the cell and untied the ligature knot to lower him to the ground. At that point, the nurses arrived, found no signs of life and commenced cardio-pulmonary resuscitation (CPR). No one had brought a defibrillator to his cell, although it would probably have been of limited use in any case. The man was pronounced dead by the prison doctor at 4:55pm.

Although we had contact with the man's family at the beginning of the investigation process at the beginning of our investigation, my Family Liaison Officer has been

unable to contact his family or their representative since. Therefore, the man's family has not seen the draft report in order to make their comments.

I found evidence that staff had tried to engage and find ways to calm the man's state of unease. Two members of staff were sufficiently worried about his mental state to submit mental health referrals. However, I am concerned about the primary care mental health resources available at Preston and this report includes two related recommendations. Of the eight recommendations in total, five derive from the clinical review. Three are my own.

THE INVESTIGATION PROCESS

1. This investigation was conducted by my colleague, on my behalf. Notices were issued to staff and prisoners offering them the opportunity to contact the investigator with any information they thought relevant. No staff or prisoners responded to these notices.
2. On 7 February 2007, the investigator visited Preston to collect copies of the man's prison records. During this visit, my investigator met with the Chair of the Independent Monitoring Board. She also met with a member of the Prison Officers' Association (POA) and the Head of Healthcare to explain the purposes of the investigation and give them the opportunity to raise any concerns about the investigation process. At the end of her visit, the investigator had a brief meeting with the Governor who undertook to co-operate fully.
3. I would like to thank the Governor and his appointed investigation liaison officer for their assistance during this investigation. The investigator returned to Preston several times to interview staff and prisoners. She also contacted the Border and Immigration Agency and the man's solicitor.
4. I am grateful to the clinical reviewer for conducting a thorough examination of the man's medical care.
5. The man's elder brother spoke to my Senior Family Liaison Officer on a number of occasions. My Senior Family Liaison Officer, accompanied by the investigator, met with the man's other brother on 13 March 2007 to explain the investigation process and to give him the opportunity to raise any concerns. I hope that this report goes some way to answering the questions that the man's family might have about his death.

HMP PRESTON

6. As a local prison, HMP Preston faces the pressures of overcrowding on a daily basis. The population is always close to the prison's operational capacity of 690 prisoners. Preston is expected to increase its operational capacity over the next year.
7. In her most recent inspection, Her Majesty's Chief Inspector of Prisons found that, despite the threat of overcrowding to a healthy regime, Preston managed to operate "impressive first night arrangements", although reception procedures were not as good. The inspection team found that there was "evident mutual respect between many staff and prisoners". However, minority ethnic prisoners did not feel that they were effectively looked after, despite an improvement in the race relations policy. That said, the prison imam spoke highly of management at the prison and said that there were no difficulties that he was aware with Muslim prisoners integrating with other prisoners on the wings.
8. There is a mental health inreach team at Preston and an inpatient mental health facility for prisoners with acute mental health needs within the North West Prison Service Area. However, there is only one primary care mental health worker dealing with day to day mental health needs such as depression or anxiety. (I am pleased that this appointment has been made since a previous investigation in which I criticised the lack of primary care mental health resources at the prison. I understand that further work is ongoing, in partnership with Central Lancashire PCT, to address this important area of healthcare.)
9. The man's death was the first of two apparently self-inflicted deaths in 2007 at HMP Preston.

KEY EVENTS

10. The man appeared at a local Magistrates' Court on 24 January, facing five counts of possession of a document with intent to deceive. He was refused bail and remanded into custody. His younger brother also appeared in court with him and was facing the same charges. Both were remanded to prison until their next court appearance, which was yet to be scheduled.
11. At the time that the man was remanded, the prison system was struggling with significant overcrowding issues. As a result, he was not remanded to the closest prison, but instead transferred to Preston after spending a night in court cells. His younger brother was under 21. Prisoners under the age of 21 are kept separately from the adult population in Young Offender Institutions (YOIs), with additional facilities for young people. He was therefore transferred to a nearby YOI.
12. On arrival at Preston, the senior officer in reception checked that the man had all of the appropriate paperwork. The senior officer completed section one of the cell sharing risk assessment (CSRA) and passed the part completed risk assessment and paperwork to the duty reception officer. (The cell sharing risk assessment is used to determine whether it is safe for a prisoner to share a cell with another prisoner, or if it would place the prisoner or his cellmate at risk.) That officer interviewed the man and asked him if he should have any concerns about locating him in a cell with another prisoner. The man said that he was not aggressive, had no thoughts or history of self-harm and no history of substance misuse. The duty reception officer concluded that the man could safely share a cell with another prisoner. The officer particularly remembered that the man asked whether he could be deported, rather than serve a custodial sentence in the United Kingdom. The duty reception officer advised the man to speak to his solicitor about deportation and his sentence, because he was not qualified to help him. The officer said that it was unusual for a prisoner to ask to be deported. In his experience, prisoners are usually anxious not to be deported.
13. The nurse on duty in reception on 25 January found that the man had a partially completed first reception healthscreen with him from his overnight stay in the court cells. (The first reception healthscreen is an interview by healthcare staff that takes place when a prisoner arrives at the prison. It should determine any physical or mental health conditions that require treatment, any substance misuse matters that need to be addressed and any risk that the prisoner may pose of harming himself or attempting suicide.) The nurse told my investigator that, instead of starting a new healthscreen, she checked the details on the existing form were correct and added to it. She asked the man a series of questions about his physical and mental health. She also assessed his behaviour and considered his likely risk to himself and others. The man told the nurse that he had never tried to harm himself before. Nonetheless, she noted:

“feeling anxious about first time in prison, confused over what he is charged with but stated he had no plans to harm himself at present.”

14. When the nurse asked the man whether he had any specific questions for reception staff, he asked about his sentence. She recorded the following in his medical record:

“worried about sentence has 10 yrs in head, advised to speak to officer on wing, try to contact solicitor.”

15. The man described how the police had found lots of identification with his details on them in his flat, but said that he was not involved in any deception. The nurse told my investigator that she knew the nature of the charges that he was facing but was not in a position to give him legal advice. She made a record of the man's confused presentation. She said that, although he was confused about being in prison, he was fully aware of what had happened to him in the previous few days. He told her that he had never received psychiatric treatment outside of prison, had never taken medication for psychiatric problems and had never self-harmed. He said that he had no thoughts of self-harm at that time. The nurse did not think that he was at risk of self-harm and therefore did not open an ACCT document. (ACCT - Assessment, Care in Custody and Teamwork - is the system used to monitor and support prisoners considered to be at risk of suicide or self-harm.) Based on her findings, she did not make a referral for a mental health assessment. During her interview, the nurse made it clear that the man was not having a panic attack in its truest sense, because he was in control of his breathing. She completed the medical section of the cell sharing risk assessment, indicating his confusion, before giving it to the officers to ensure that it accompanied the man to the wing.
16. During the healthscreen, the nurse asked another reception officer to speak to the man about his charges. The second reception officer took the man to one side of the reception area after his healthscreen and went through his court documentation with him. During interview, the officer remembered that the man was anxious to contact his friend and get his flat sorted out. He reassured him that staff on the first night centre would help him to get in touch with his solicitor and contact his friend. The man was given some food and was later escorted to the first night centre.
17. He was located in a shared cell on the first night centre with another prisoner. The first night officer then took him to a small interview room on the wing to complete the 'Immediate Needs' checklist, a form designed by staff at Preston to highlight any matters that are particularly troubling a prisoner who has just arrived. Some prisoners may not have been expecting to go to prison and officers help them put their affairs in order. The man initially indicated that he could not speak English at all. As the interview progressed, he began to understand what was being said to him and spoke to the first night officer. He said that he was “frustrated” because his mobile telephone had been confiscated by police so he had no contact numbers and he wanted to speak to his friends. In particular, he wanted to call someone abroad but the first night officer said that he could not authorise an international telephone call. The officer explained that prisoners have to make an application for an international call to the Governor.

18. The first night officer suggested that he write to his friends, but the man said that he had no addresses with him. When the officer suggested that his friends would visit him in due course, the man said that they were unlikely to because they would be fearful of arrest. He told the first night officer that he had never been depressed or treated as such. The officer did not think that the man was at risk of self harm. He described him as being "angry" during the interview because he could not understand why he was in prison. The officer again explained the charges that he was facing but the man still seemed to be confused. As an experienced officer on the first night centre, the officer said that a lot of prisoners are confused and angry when they first come into custody and the man did not give him any particular cause for concern.
19. At 7.30am the following morning, the man was seen lying on the floor under his bed, apparently having a panic attack. The officer covering the early morning shift before prisoners were unlocked radioed for assistance from healthcare staff. He handed over to another first night officer who arrived for the main shift and explained that he was waiting for healthcare to visit the man.
20. The nurse who had assessed the man on reception was on duty again that morning. When she arrived on the wing, she found the man in his cell under the bed breathing rapidly. After speaking to him, the nurse discovered that he was "very anxious about being in prison and stated he had never been in this situation before". She spoke with him for some time. After a short while, she asked the prisoner who shared the cell to leave them alone for some privacy. The nurse asked the man what was wrong and he said he did not know why he was in prison. She reminded him that she had spoken with him the previous day and what he had told her about the circumstances of his arrest. The nurse thought it was "bizarre" that he appeared to have completely forgotten their previous conversation. It was at this point that she decided that she would "definitely have to refer him to mental health inreach". As the conversation progressed, his breathing became normal. The nurse suggested that officers contact the chaplaincy team to see if the imam could encourage the man to settle into the prison routine. Following this episode, she also asked the doctor to visit the man's cell. The nurse thought that the man was particularly worried about being locked in the cell and speculated as to whether he had suffered a previous traumatic experience that had made him claustrophobic. Staff agreed to keep his cell door open as much as possible, security permitting.
21. The first night and induction wing principal officer wrote in the observation book that the man was "having a possible panic attack, although I do believe he was exaggerating a little". Nevertheless, a message was left at the gate so that the imam, who was due that morning, would make his way to see the man as soon as he arrived in the prison.
22. When the imam in Preston's chaplaincy team arrived at the prison at 9.00am that day, he immediately received a message at the gate to come to the first night centre and see a prisoner. The imam said that he thought it must have been urgent for a note to be left at the gate. Normally it would just be left in the chaplaincy office. The imam made his way to the first night centre where an officer directed him to the man's cell. He found the cell door open. The man

was standing in his cell and shaking, as if he had just had a panic attack. The imam took him to a glass-walled room just behind the wing office so that they could talk privately. The man said that he had come from a nearby city and had no family members in England but lived with a friend. The man asked if he had contacted his friend, but the man said that he could not because his friend had also been arrested. He asked the imam where his friend was. The imam told him that he did not know but that, due to overcrowding, there was a chance that his friend had not been brought to Preston. (The imam asked an officer on the wing to find out what had happened to the man's friend after he finished talking with him. The officer said that they were already in touch with the police about his whereabouts.)

23. The man asked the imam where he was. The imam was surprised that he did not know but explained that he was in prison in Preston. He then asked why he had been arrested and the imam said that the police should have told him this. The man finally said that he was charged with five counts of deception. The imam told him that he needed to calm down and wait for his solicitor who would be able to advise about the nature of the charges he was facing. The man said that his solicitor had scared him by suggesting that he was likely to get two years for each count of deception, and it was likely that he would serve a ten year prison sentence. The imam explained that solicitors are obliged to advise their clients as to the absolute maximum sentence they could receive and that the advice did not mean that he would necessarily be sentenced to ten years.
24. During this meeting, the imam asked the man if he had any thoughts of self-harming. He told my investigator that he asks every prisoner, especially those who are in prison for the first time, whether they feel at risk of self-harm. The man said that he had no such thoughts and the imam was satisfied with this answer. The imam said that if the man had said he was thinking of self-harming, or if he had thought that he might be at risk, he would have opened an ACCT document. At the end of their discussion, which lasted around thirty minutes, the man asked the imam to say a short prayer for him, which he did. The imam invited the man to attend the weekly Muslim service that was taking place that afternoon and he agreed. The imam escorted the man to his cell but left the door open, as he had found it, to avoid making him feel anxious or claustrophobic.
25. Shortly afterwards, the duty first night centre officer completed the follow-up assessment to the immediate needs checklist which had been completed by another first night officer the evening before. The duty first night centre officer told my investigators that the man spoke good English but would sometimes exaggerate his language difficulty to his advantage. The officer particularly remembered that the man was anxious about retrieving his telephone contacts from his mobile telephone. The officer told him that he would speak to the police to try to recover the telephone, but when he spoke to the police they said that the telephone had been confiscated by the immigration service. The duty first night officer spoke to the immigration service who said that they were not in possession of any of the man's personal property.

26. The man also asked the duty first night centre officer if arrangements could be made to telephone his father overseas. The officer explained that international telephone calls were allowed, but that an application had to be made to the Governor. The officer filled out the necessary application form on the man's behalf. Following the interview, the officer wrote that the man was still "very concerned" about being in prison and needed help with legal aid. However, according to the follow-up assessment checklist, the man did not ask for information about deportation, visits, letters or telephone calls.
27. During the morning of 26 January, the man approached the first night officer and said that he was unhappy with his solicitor and wanted details of another solicitor. That officer thought that the man approached him particularly because he was a familiar face from his first night in prison, he is also a trained legal aid officer. He suggested that the man contact the Immigration Advisory Service, who would be able to advise him about his immigration status. He wrote the address down and reassured him that, in his experience, they were quick to visit prisoners who contacted them. The officer also explained that it would be inappropriate for him to recommend a lawyer, but gave him a directory of solicitors. He said that the man should write to the solicitor that he wanted to represent him with the details of his case and see if they would take him on as a client. The man asked the officer how long his sentence was likely to be, given the nature of his charges. The officer told him that he could not advise about that because it depended on the circumstances of the offence and the judge's decision in court.
28. By coincidence, that day the imam was the member of the chaplaincy team detailed to work on the first night centre. This meant that he would speak to all of the new prisoners who had arrived the previous day. He said that, at some point later that morning, he walked past the man's cell and he was standing in the far left corner of the cell, shaking and looking out of the window. The imam said that the man appeared to be "internally not feeling well". The imam suggested that he calm himself down and sit on his bed, but the man insisted that he was okay standing.
29. At 12.45pm, healthcare staff were called to the man's cell again after he was found collapsed on the floor of his cell. The same nurse as had seen the man in reception attended his cell and found him under his bed, breathing heavily. He began breathing normally again when he sat up and spoke to her about his anxiety. He told the nurse that he was having problems coming to terms with being in prison and was troubled by the effect that it would have on his mother's health. He told her that speaking with the imam had helped him calm down. The nurse explained to the man that he had to be locked into his cell over the lunchtime period, but that this would be an opportunity for him to calm down and rest. Two senior officers were waiting outside in case the nurse needed assistance. The nurse locked the door when she was finished and was accompanied by the senior officers as they made their way off the wing together. Before they had left the wing, an officer on the wing called for assistance because the man had again got under his bed and was shaking. One of the senior officers unlocked the door and both resumed their position outside the cell. The nurse calmed the man down again and explained that he had to be

locked in his cell over the lunchtime period. He was in the cell on his own at the time, but the senior officers explained that new prisoners would arrive before the end of the day and he would have someone else in the cell later on. She advised the man to see the imam again because it seemed to have helped him before. The man asked her to find him a copy of the Quran. Officers told her that this would be arranged. Eventually, he calmed down and the nurse was able to leave him.

30. The nurse described the man as suffering from “genuine panic”. She said he was in control of his breathing and therefore was not having a panic attack. However, he was not in full control of himself and, in his anxious state, fell off his chair. She made the mental health referral at this time. After seeing him that afternoon, she spoke to the doctor and the doctor agreed to go and see him in his cell in order to give him something to help him sleep over the weekend.
31. The mental health team meets every week, on a Monday, to discuss all of the mental health referrals and decide whether the prisoner should be seen by the in-reach team or the primary care mental health worker. The nurse said that she was concerned that the man would have to wait over the weekend, but she did not know what else to do for him. There are no primary care mental health services available at Preston over the weekend period.
32. At some point during the afternoon of the 26 January the doctor on duty that day, went to see the man. She remembered him being particularly anxious about his family and his mother’s health. Following her visit, the doctor made the following entry in his medical record:

“Not sleeping. Coping poorly with incarceration. Needs MHT (Mental Health Team) referral. Review after he has had a few nights rest. Prescribed Zopiclone in possession for five days.” [Zopiclone is a drug commonly used to treat sleeplessness.]

During interview, the doctor said that she was concerned about the man’s anxiety. She said that it was not unusual for someone who has not been in prison before to suffer from such reactive anxiety. The doctor said that the prescription was written on the inside of the prescription chart, which meant that nurses would give him the sleeping tablets daily on the wing. In January 2007, there was no policy at Preston for risk assessing new prisoners on arrival at the prison as to whether they should have medication in possession in their cell. (Since that time, a policy has been introduced to manage this risk and encourage an individual to manage their own clinical condition.) The doctor agreed with the nurse’s decision to make a referral for a mental health assessment. The man did not seem to be reacting well to custody and staff at the prison did not have access to his past mental health history.

33. The Muslim service took place at about 1.30pm. The imam remembered that the man attended and was supplicating and crying throughout the service. After the service, prisoners have the opportunity to chat to each other before returning to their wings. After the service on Friday 26 January, the imam was speaking with several prisoners when the man approached him. The imam immediately

stopped talking to the others and asked him if he was okay. He asked the imam what was going to happen to him. The imam reassured him that someone would come and see him to explain what was likely to happen. The prisoners nearby overheard this conversation and asked the man why he was in prison. He told them that he was worried about his charges and concerned about his sentence. The other prisoners reassured him that he was unlikely to receive as long a sentence as he expected. The imam said the man appeared to be comforted by the conversation. Since their morning meeting, the imam had learned that the man's friend (who he has since discovered was his brother) had been taken to a nearby YOI. He reassured the man that he would have the same access to an imam and the same support structure that he had at Preston. The imam promised to come and see the man on Tuesday morning.

34. At 7.15am on Saturday 27 January, the man rang his cell bell and told an officer that he was suffering from a headache. The healthcare centre was contacted but no note was made on the man's medical file as to whether he received any treatment. Ten minutes later, the officer noticed the man lying on the floor, positioned half way under his bed. After two or three minutes, the man got up and started walking around his cell looking agitated. At this time, he was sharing a cell with another remand prisoner. Staff were aware of the man's anxiety and the difficulty that some prisoners might have had sharing with someone who was distressed. Staff told my investigator that they were pleased at the calming effect that the man's new cellmate appeared to have on him.
35. When he learned of the investigation process, the man's cellmate contacted my office to speak to the investigator. He wanted to express his concern at the treatment that the man received when he was at Preston. The cellmate told the investigator that the man had a good grasp of English but that staff would not take the time needed to understand him. He said that officers in the first night centre told the man that he would get around 20 years in prison for the charges that he was facing. The cellmate said the man was particularly worried about his sentence and the impact that it would have on his family. The cellmate said he repeatedly asked staff for more information about the man's legal case, but staff ignored his many requests. The cellmate also asked about the man's younger brother in the YOI, but again he said that staff were not responsive.
36. The cellmate described the man as "decent", but that staff and prisoners were intimidated by him and did not treat him respectfully. The cellmate particularly remembers an occasion on Saturday 27 January when a male and a female officer were on duty. He found the man with a razor blade in an anxious state. The cellmate persuaded the man to give him the razor blade and then handed it to staff. The cellmate said that he made it clear to staff that the man was at risk of attempting suicide. He said that he told staff repeatedly that the man should be put on a 'suicide watch'.
37. The investigator spoke to the officers who were working on the first night centre over the weekend of 27 and 28 January. Neither officer recalled a prisoner giving them a razor blade. However, the female officer remembered the man's cellmate approaching her on 28 January with concerns about his "bizarre" behaviour. She passed on the concerns to the male officer who agreed to speak

to the man. The male officer took the man into the small interview room on the wing and asked him what was wrong. The man appeared angry in their exchange and the male officer said that he felt intimidated at times, but established that the man's main problem was with his solicitor. The male officer explained that it was not possible to sort out his solicitor on a Sunday, but that it could be dealt with the next day with the help of a legal aid adviser. The officer was worried about the man because he seemed confused and kept repeating the same question. He was also aware of the cellmate's concerns. With this in mind, the officer made a second referral to the mental health team. During interview, he could not remember if he took it to the mental health team that night or the following day and it was undated. He said that he took it to the healthcare centre and handed it to a nurse, explaining his worry. He made the following entry on the form:

"[The man] appears to be very distant and struggles to understand and take in what is said to him. He has displayed odd behaviour, lying under his bed awake! Sometimes he appears very agitated and ready to 'blow'."

38. The two officers said that they did not consider that the man was a risk to himself that weekend. Both officers are trained in ACCT procedures which enable staff to identify and support prisoners who are at risk of self-harm. They said that they would have opened an ACCT document if they had been worried about him.

39. On Monday 29 January, the male officer who was on duty over the weekend made the following entry in the man's wing history sheet:

"[The man] can be a drain on staff. He is consistently asking for something and if he can't get what he wants he will wait and ask another officer ... it appears he is very agitated about being in prison ... he is in need of a solicitor and I will try to sort this out tomorrow. Although he says he doesn't understand he still displays some strange behaviour."

40. The man's cellmate left Preston on the 29 January. He said that he spent all night on 28 January awake with the man. The man was particularly worried about his cellmate leaving. The cellmate said that he looked after the man. Other prisoners could be intimidated by the man's "larger than life" appearance, but when the cellmate was with him, they did not feel threatened. The cellmate said that they both cried when he left Preston.
41. Every Monday, the mental health team hold their weekly referral meeting, attended by all of the inreach team, the primary care mental health worker, and the team secretary. The aim of the meeting is to discuss every referral and decide the most appropriate course of action for the prisoner. On 29 January, they considered two referrals relating to the man, one made by the nurse and one by the male officer. The team reviewed the man's clinical record and decided that his problems were, as described by a mental health inreach nurse, "mainly anxiety related and may therefore be best met at this stage by a Primary Care Mental Health Nurse". The primary care mental health worker was on leave on 29 January, so the inreach nurse emailed her at around 3:30pm after

the meeting had finished. During interview, the primary care mental health nurse said that it takes an average of two weeks between her receiving a referral and her meeting the prisoner to assess their needs. In January 2007, she was the only primary care mental health worker at Preston.

42. Just before lunch at 12.00 noon, the man was moved from the first night centre to the induction unit. (In fact, the first night centre is located on the same wing as the induction wing and he just moved down one floor of the same wing.) He was put in with another prisoner just before the lunch period. Within ten minutes, the new cellmate had rung the cell bell requesting to be moved out of the cell. He told staff that the man was threatening him and acting bizarrely. The officer covering the lunch period attended and spoke to the cellmate. She persuaded him to give the man a chance to settle down. The cellmate reluctantly agreed to stay in the cell until after the lunch period to see how it went.
43. At lunchtime, the prisoners collect their meals and return to their cells to eat them. The cell doors are then locked to enable officers to go for their lunch. This means that the prison is in what is known as a 'patrol state'. Only one officer is required to stay on the wing to patrol, respond to cell bells and check at-risk prisoners. The officer can only enter the cell in an emergency and no prisoners are allowed out of their cells. The officer on duty over the lunchtime period on 29 January made the following entry in the staff observation block for the induction wing:

"These two prisoners constantly on the cell bell over dinner patrol. [The man] appears to have mental issues. Hotel 2 informed and will come and see him after dinner." [Hotel 2 is the member of healthcare staff who responds to requests from officers on the wing and emergencies.]

The cellmate had rung the cell bell many times over the lunchtime period. He used the in-cell furniture to trap the man at the far end of the cell in order to keep him away because he felt threatened. The officer on duty over the lunchtime period was so concerned by the situation that she contacted the orderly officer, who was in charge of the operations throughout the prison over the lunchtime period. The officer asked whether cellmate could move cells despite the patrol state because of the apparently deteriorating situation. The orderly officer agreed and the officer recorded that the cellmate was moved "because he was frightened of what [the man] was going to do to him".

44. In line with national procedures, officers revisited the man's cell sharing risk assessment and raised his level to high. As a consequence, he was left in the cell on his own. The revised risk assessment noted that he "has displayed an inconsiderate and threatening attitude towards cell mates. Bizarre behaviour leaves cell mates feeling vulnerable." At this time, the orderly officer also checked the progress of the mental health referral and discovered that the man was to be seen by the primary care mental health worker.
45. At around 1.00pm, three induction wing officers resumed their duties on the wing, receiving a verbal briefing from the officer covering the lunchtime period

about what had happened over lunch. The afternoon proceeded as normal and no officer recalled the man causing them any concern.

46. At 3.45pm, all prisoners were taken out to the exercise yard for their daily hour of exercise. Prisoners reported to staff that they overheard heard the man talking about “killing the infidels”. Prisoners told staff that they found his behaviour threatening. Even though staff knew about the mental health referrals, one of the induction officers said that it was agreed by staff in the wing office “collectively” to contact the mental health team for someone to see the man urgently in light of his “strange” comments on the exercise yard. The officer contacted the medical response nurse for the main shift on 29 January. A male agency nurse was the medical response nurse that day. He was dispensing treatments with his female colleague, who answered the officer’s first call. She took the details of the man’s presentation and said that she would contact the inreach team. When the female nurse called the inreach team, she was told that the man’s case had been reviewed at the earlier referral meeting and had been allocated to the primary care mental health worker. The female nurse relayed that news to the induction officer. The induction officer said that the man needed to be seen there and then and he was advised to call the mental health team directly. The officer tried to speak to the inreach team and was referred back to the emergency response nurse. Eventually, the nurse agreed to see the man after he had finished dispensing his treatments, but he made it clear to the officer that he was not trained in mental health. He would be seeing him in the capacity of a general nurse. In the man’s medical record, the emergency response nurse wrote:

“I re-stated to staff that [the man] had been referred to the Inreach team and that they were aware of the situation. The member of staff I spoke to re-stated that he would like a member of healthcare to see [the man]. I said that a psychiatric nurse would be required to make a psychiatric assessment but that I would come and see [the man] after issuing C/D wing treatments.”

47. Earlier in the day, the man’s new cellmate had borrowed a newspaper from a prisoner who worked as a cleaner on the wing. When the cleaner had asked the man’s cellmate for his newspaper during the exercise period, the cellmate said that he had left it in his cell. Prisoners were returned to their cells from the exercise yard and locked up at 4.30pm.
48. Around 4.35pm, the cleaner went to collect his newspaper from cell D3-13 where he expected to find the cellmate who he thought was still located with the man. He opened the observation panel. He thought he saw the man sitting by his bed, cleaning his teeth. He described the man as being in a seated position with what appeared to be foam down his left side. The cleaner said that he could not see very clearly because it was late on a winter afternoon and the cell was quite dark. He said that the cellmate was always in bed so he turned the night light on from outside the cell to see more clearly. It was at this point that he saw the man hanging from the end of his bed.
49. The wing office was located just near the cell. The induction officer had just finished speaking with the emergency response nurse and was making his way

out of the office. The cleaner ran towards the induction officer in a state of distress. He told the officer that he thought that the man was hanging. The officer, followed by a second induction officer, who was in the wing office, ran to the man's cell. On his way, the first induction officer shouted "Code One" (this is the radio code used for medical emergencies at Preston). The principal officer radioed the communications department to tell them that there was a code one emergency and that healthcare was needed. Two minutes later when the principal officer had reached the cell, she requested an emergency ambulance.

50. When he reached the cell, the first induction officer unlocked the cell door. Due to the position of the man's legs across the entrance, staff could not open the cell door to get to him. By this time, he had been joined by two more induction officers. The first induction officer used his shoulder to try and force the door open and managed to open it a small way. There was only room for a small individual to get into the cell and all of the officers were too big. The cleaner volunteered to enter the cell and move the man's legs so that officers could gain entry and start resuscitation efforts. This was agreed and the cleaner went into the cell. The first induction officer estimated that it took around three minutes before the cleaner entered the cell.
51. The cleaner moved the man's legs so that staff could enter. He immediately tried to undo the ligature but he was struggling because his hands were shaking. The first induction officer undid the ligature and two officers worked with the cleaner to lower the man gently to the floor and put him in the recovery position, on his side. During interview, the first induction officer said that he thought about using a ligature knife but the knot was loose and he thought it would be quicker to undo it. The other officer thought that he could feel a pulse. He said the following during interview:

"Now I felt, I thought I could feel a very faint pulse, that's what – like I said I've not had first aid training since 1988, that was just I'd got a reaction at the time."

52. The emergency response nurse was in the treatment room on C-wing, still dispensing medication to prisoners, when he heard "Code One" being called over the radio. The nurse told my investigator that a "Code One" radio call meant that there had been a hanging or an attempted hanging. He took the emergency response bag from the treatment room and made his way immediately to the man's cell. He thought it took no more than thirty seconds to reach the cell. While he was on the way, another nurse caught up with him. Although the defibrillator was also located in the treatment room, neither nurse brought it with them. When they arrived at the cell, they saw the man lying on his left side on the floor with the ligature removed and officers surrounding him. Both nurses checked for a pulse but could not find one. The second nurse inserted an airway to administer oxygen and the emergency response nurse started chest compressions.
53. At around 4.50pm, the prison doctor was walking to the ground floor ward of the healthcare centre to do a final round before she left the prison for the day. A nurse told her that another nurse was looking for her and that she thought that

there had been a “Code One” on the induction wing. The doctor does not carry a radio and, if she is not with the designated medical response nurse, she is not aware of emergencies until a member of staff tells her. She said that she went to the induction wing but did not know what she was attending. She does not take equipment with her because it is expected that the nurse attending the emergency will bring all of the necessary kit.

54. When the doctor got to the cell she saw that nurses were attending the man. The doctor said that she was advised by the emergency response nurse that there had been no sign of life on the nurses’ arrival, five to ten minutes before the doctor had got to the cell. The doctor examined the man herself and also found no signs of life. Before the doctor had completed her examination, the paramedics arrived. The paramedics placed ECG leads onto the man’s chest and told her that the machine showed complete asystole. (‘Asystole’ is the absolute standstill of the heart muscle.) The doctor and the paramedics agreed that the man was clinically dead and at 4.55pm life was pronounced extinct.

ISSUES

Family Contact

55. Preston's Deputy Head of Reducing Reoffending made efforts to contact the man's family to notify them of his death. The prison contacted the Nigerian Embassy who managed to contact his family in Nigeria. Unfortunately, the prison did not establish direct contact with his family until the week after his death. My investigator was given details of the efforts made to contact his family and it is clear that the prison's efforts were frustrated, despite many attempts on their part. However, I was concerned that there were no trained Family Liaison Officers at the prison at the time that the man died. I am pleased to note that a senior member of staff has been trained in family since his death.
56. My office was contacted two days after the man died by an MP from Nigeria, acting on behalf of the family. The following day, the man's older brother called our office and told my senior family liaison officer, that he wanted to be the main point of contact for the family. He said he would liaise with the MP from Nigeria to keep his family there informed. My senior family liaison officer has spoken to the man's brother by telephone directly and through his solicitor, throughout the investigation process. In March, my investigator and my senior family liaison officer visited the man's younger brother in Lancaster Farms YOI to explain the investigation process and to give him the opportunity to raise his concerns.
57. The family has suspected that there was third party involvement in the man's death. However, the police visited the cell within hours and have ruled this out. While this is ultimately a matter for the inquest to determine, given that the man was located in a locked cell on his own at the time that he died, I too have concluded that his death was self-inflicted.
58. Another significant issue raised by the family was the time it took for the body to be released by the Coroner in order for them to proceed with the burial according to Islamic tradition. While any delay is regrettable, this matter is unfortunately outside of the remit of my investigation.
59. The man's brother was concerned that he might not have had access to an imam. In fact, as I have shown, the man spent some considerable time with the prison imam and attended weekly Muslim prayers. He was given the Holy Quran which was found in the cell after he had died.

Staff Support

60. The man was at Preston for less than five days. Staff had not had the opportunity to get to know him well. However, my investigator was struck by the number of staff who were affected by his loss and had become acquainted with him in the short period he was at the prison. All staff felt well supported following the man's death. At all levels, they reported good relationships with the management team at the prison and felt that the Governor was appreciative of the challenges of their roles. A debrief was held after the man died, which staff who attended found useful.

Clinical Review

61. Central Lancashire PCT commissioned the Healthcare Manager for Lancaster Prisons to review the clinical care that the man received while he was in custody. The clinical reviewer had access to the man's prison files and the transcripts and notes of the interviews carried out by my investigator.
62. The clinical reviewer concludes there was evidence of acceptable record-keeping standards. However, he judges that there was some delay in the mental health referral process which indicated a service gap in the local primary care mental health service. He also considers that, if the man had been put on an open ACCT document, he would have been subject to a more in-depth initial assessment and the outstanding mental health issue might have been dealt with more quickly.

Mental Health

63. In reception, the man underwent the first reception healthscreen. The nurse at reception recorded that he was feeling anxious but that "he had no plans to harm himself at present". He told her that he had no history of mental health problems but that was concerned about the charges he was facing. She arranged for an officer to talk him through his court documentation. The nurse did not make a referral for a mental health assessment following the healthscreen. In interview, the nurse said that a lot of prisoners who go through the reception process seem a bit "panicky". She thought that once the man had been settled on the first night centre, and had spoken with his solicitor, he would calm down. She also knew that he would have a medical check-up the next day, and therefore would be seen by a healthcare professional who would assess his condition if the anxiety persisted. She made a clear note on the cell sharing risk assessment which accompanied the man to the first night centre as follows:

"States he feels anxious about possible sentence and being in prison for first time but states he doesn't have any intentions to harm himself at current time."

64. The clinical reviewer expresses no concerns with the nurse's judgement throughout the screening process. However, he is concerned that she completed an unfinished form that accompanied the man from his night in court cells before he arrived at Preston. I agree that a new healthscreen form should be started for each prisoner on arrival at the prison.

A new first reception healthscreen should be completed for each prisoner arriving at Preston.

65. The duty first night centre officer said that he had no concerns about the man's mental state during the follow-up induction assessment the next morning. He said that the man was not settled during the interview but was mainly concerned about contacting his friends or family. The officer filled out an application for an international telephone call on the man's behalf, and tried to locate the man's

mobile telephone by contacting the police and the immigration service. Unfortunately, the mobile telephone had gone missing. The application for an international telephone call was found in the wrong pigeon hole after the man had died.

The Governor should consider streamlining the system for prisoners to apply for international telephone calls, including a fast track system to be used in an emergency situation.

66. When the man arrived on the first night centre, an officer completed an immediate needs assessment. The man told the officer that he had no history or thoughts of self-harm, no history of depression or any health problems that needed medical attention. The officer remembered that the man was confused and angry during the assessment. As an officer with a lot of experience on the first night centre, he said that a lot of prisoners who have just arrived in custody can present like this and he had no concerns about the man's mental state. He thought that his language difficulties might have been a defence mechanism, as his understanding improved during the course of assessment. The officer did not think that the man was at risk of self-harm.
67. The following morning, the same nurse that had seen the man on reception attended his cell to find him panicking on the floor of his cell under his bed. She said that he was not hyperventilating and that he was not having a panic attack. However, she was concerned about his mental state. He seemed confused why he was in prison despite their conversation the previous day. She also wondered if he was claustrophobic because he seemed most upset about being locked in his cell. She asked officers to arrange for the imam to visit him and explained to them that he did not like to be locked in his cell. Officers left the man's door open for most of the morning, security permitting. The imam visited the man as soon as he arrived at the prison. He spoke to him at length about what was bothering him and encouraged him to attend afternoon prayers. The nurse also spoke to the doctor about prescribing the man something to calm him down over the weekend.
68. However, the man was found in a similar state during the lunch hour that same day. Again, the same nurse attended the cell and again she found the man under the bed. She tried to calm him down and explained that the door had to be locked during the lunchtime period. Following this visit, she spoke again with the doctor and they agreed that the nurse should make a mental health referral. During interview, the nurse said that she was concerned that she knew the man would not be seen by the mental health team over the weekend. She thought that this time might give him to opportunity to settle down so he could be effectively assessed. However, she said, "there's no true way of getting somebody seen straight away if you're really worried here." The nurse expressed frustration that there was no mental health service available over the weekend.

There should be a review of the referral pathways to mental health services particularly around responsiveness to perceived crisis and the methods of communicating actions/decisions.

69. The man's cellmate in the first night centre raised concerns about him with the officers on duty at the weekend. He complained of "bizarre behaviour". The male officer took the man to a quiet office on Sunday afternoon and asked him what was bothering him. Following a long conversation about his legal representation, the officer was sufficiently concerned that he wrote a mental health referral, detailing the following:

"He has displayed odd behaviour, lying under the bed awake! Sometimes he appears very agitated and ready to 'blow'."

70. During interview, the officer told my investigator that he took the mental health referral form down to the healthcare centre himself but not until Monday morning. He said that he was a little more concerned about him than other prisoners. He told healthcare staff that he thought the man needed a "quite a quick" referral.

71. After the man's cellmate on the induction wing had moved cells during the lunchtime period, the man's cell sharing risk was reviewed. He was assessed as a high risk to others because of his "inconsiderate and threatening behaviour" to the cellmate and his "bizarre behaviour". The principal officer contacted the mental healthcare team to check that a mental health referral had been made. She was told that he had been referred onward to the primary care mental health team.

72. Once prisoners had returned from afternoon exercise, concerns were raised with staff that the man had been making strange comments in the exercise yard about how he had been sent from God to kill people. The first induction officer said that the matter was discussed in the staff office among officers and it was decided that the mental health team needed to see the man urgently. That officer told my investigator that when he tried to arrange this he felt he was "being passed around". The emergency response nurse on duty at the time eventually agreed to see the man. During interview, the nurse expressed frustration that he was not clear about the systems in place at Preston to deal with mental health emergencies. He said he was told after the man's death that the inreach team was able to respond to mental health emergencies when required. He made the following comment:

"... my understanding was the mental health in-reach team was for the mental health care of people in the main part of the prison and if that is not the case then I think it needs to be made clearer."

73. In fact, when the first induction officer called the inreach team, they referred him back to the emergency response nurse. So it appears that many staff, including members of the inreach team themselves, are unclear of the process and support available. If this had been clear, perhaps the man would have been assessed more urgently.

The Governor and the Head of Healthcare should ensure that staff are clear about who to access in the event of a prisoner requiring urgent access to the mental health team.

74. At the weekly mental health meeting at 3.00pm on Monday 29 January, the referrals made by the officer and the reception nurse were discussed. The inreach nurse explained to my investigator that it was decided that the man's problems were anxiety related. As he seemed to be suffering from anxiety, which is a primary care mental health problem, he was referred to the primary care mental health care worker. Unfortunately, the primary care mental health worker was not at the meeting as she was on annual leave. The inreach nurse emailed the referral for action on her return from leave. During interview with my investigator, the primary care mental health worker said that from April 2006 to April 2007 the average length of time between a routine referral being made and her seeing the prisoner was 11 days. She said that this compares very favourably with the service in the community.
75. The clinical reviewer judges that the referral meeting was insufficiently recorded, and it was not clear what the decision making process has been. I agree that it would be helpful to keep a clear record of the discussions held at this meeting.

It is recommended that the referral meetings are more comprehensively recorded so that healthcare staff subsequently attending to the patient have a clear indication in the clinical record of considerations made and decisions taken at a referral meeting.

76. The service manager of prison healthcare at Central Lancashire PCT wrote to my investigator with details of the methods used to respond to mental health crises at Preston. She explained that:
- “... whilst there is currently no dedicated crisis intervention service at HMP Preston as you would expect to find in a community NHS model, we still as a Healthcare Team respond to mental health crisis in a number of ways. This could be either via Hotel 2, attending Special Sick [a system whereby a prisoner can request an emergency appointment with a doctor for the same day], requests to the Inpatient Team on Healthcare, a member of Primary Care assessing or the Primary Care Mental Health Worker.”
77. There is currently only one primary care mental health worker in employment at Preston. She did not meet the man because she was not working on the few days that he was in the prison. The service manager of prison healthcare explained to my investigator that the primary care mental health team at Preston is currently under development. As part of the expansion, there are plans to introduce a crisis intervention tool so that prisoners with low level mental health needs will have access to appropriate support urgently, if required. A paper was presented to the prison's senior management team with the following priority outlined:
- “Additional staff working in primary care mental health would enable a crisis response to be developed in order to respond to actual or perceived mental

health crisis amongst prisoners in the prison. This would also seek to improve joint working with healthcare and prison staff especially in relation to ACCT and other areas of need. This area of development has been discussed with the commissioners at the PCT and is seen as priority dependent upon available funding.”

78. I have commented in past investigations on the level of primary care mental health provision at Preston. (I acknowledge that this a problem that affects virtually all prisons.) I am pleased that some progress has been made since then with the appointment of the primary care mental health worker. The work outlined above was underway prior to the man’s death. Unfortunately, at the time of his death, there was not a co-ordinated approach to crisis intervention and this is echoed in the nurse’s frustration that the man could not been seen by a mental health professional over the weekend.
79. However, staff took steps to address the problems the man was anxious about - for example, his claustrophobia, his family contact and his legal representation. Given the resources available to them at the prison, I judge that staff tried their very best to help him.

Suicide Awareness

80. The clinical reviewer makes the following comment in the conclusion of his review:

“It is noted that an ACCT was not opened for [the man] – this would have provided a greater level of initial assessment by an ACCT assessor and may have sped up or forced the issue of Mental Health Assessment.”

81. The man told staff that he did not feel suicidal at the first reception healthscreen, the immediate needs assessment, the follow up assessment and when the imam spoke at length with him about how he was feeling. Staff assessed his risk of suicide on all of these occasions. At no time did staff identify him as a risk to himself. All staff my investigator spoke to were ACCT trained. The nurse, who assessed the man on reception and visited him in his cell on two occasions, felt that she had not received full ACCT training, but according to her training records she had received the training albeit at the basic level. Despite their repeated concerns about his mental state, all staff were surprised that the man apparently took his own life. I do not agree that this was due to the lack of assessment. Furthermore, the weekly meeting remains the single pathway, through which all mental health referrals are processed. Therefore, I do not agree that the man’s mental health referral would have been “sped up” as the clinical reviewer suggests in his review. There was no fast-track procedure at Preston for mental health referrals. I have commented on how a crisis intervention process would have helped in this instance.
82. When the man’s cellmate from the first night centre contacted my investigator, he said that he had told staff he was concerned that the man was a risk to himself. He said that he had taken a razor blade from him and handed it to staff on duty at the weekend. My investigator spoke to the two members of staff who

were on duty on the weekend of 27 and 28 January. They recalled the cellmate raising concerns about the man's behaviour, but neither officer remembered being handed a razor. There is no surveillance footage to establish if a razor was handed to officers that weekend. Following the cellmate drawing his concerns to staff's attention, the male officer on duty spoke at length with the man. He was sufficiently concerned about his mental state to make a mental health referral but did not think that the man posed a risk to himself.

83. The short period in custody was the man's first time in prison and he was a foreign national prisoner. He suffered from anxiety and was found on three occasions in a panicked state in his cell. Irrational behaviour and feelings of anger or being disconnected are risk factors listed in *The ACCT Approach*, a guide for prison officers about caring for prisoners at risk. The guide encourages staff to consider both what the prisoner says and his behaviour when deciding whether to open an ACCT document.
84. The man was described as "bizarre" by several staff during interviews. He would repeatedly ask staff why he was in prison, despite their attempts to explain his charges. He was frustrated and confused about being in custody. His main concerns were related to tangible issues, for example legal representation and international telephone calls. Attempts were made to resolve these issues for him, and to try and calm him down. The imam spent time with the man, who assured him he was not thinking of self-harm. He seemed "angry" to officers who spoke to him about his behaviour. He said that he had not considered suicide or self-harm in the past. In the final hours of his life, the man was threatening to a new cellmate and made menacing comments to other prisoners during the exercise yard.
85. It is easy to say with hindsight that the man's "bizarre" behaviour was connected to a risk of self harm. However, at the time staff interpreted his behaviour as symptomatic of a mental health issue not associated with feelings of suicide. Staff all assured my investigator that they considered whether the man was at risk of self harm or suicide, but decided that he was not. In the hours before he died, staff on the wing collectively talked about the man and decided that he needed to be seen urgently by the mental health team because of his threatening behaviour and the risk that he presented to others. They did not open an ACCT document. I am satisfied that staff took the man's behaviour seriously and that action was taken to support him. While others might have taken the view that an ACCT document should have been opened, I do not think it was unreasonable for Preston's staff not to have done so.
86. I have no criticism to make of the care and support that staff offered to the man. Indeed, had he been on an ACCT document, I do not think that the care plan that would have been developed would have differed significantly from the care and support he actually received. An ACCT might have ensured that he was more regularly observed. However, the man was found by the cleaner within five minutes of returning from exercise. Even if he had have been on an ACCT document, it was unlikely that he would have been checked between his return from the exercise yard, when he was locked in his cell, and when the cleaner

found him. Sadly, I do not think that the opening of an ACCT document would necessarily have changed the outcome.

Emergency Response

87. The man was not subject to ACCT and staff were not, therefore, carrying out regular checks on him. He was discovered by another prisoner. It would have been best practice for that prisoner to have been guided away from the cell at the time staff responded to the emergency call. Indeed, it is surprising that the prisoner had to be involved for officers to gain entry to the cell because of his smaller physical size. However, preservation of life took precedence over procedure and I do not think that officers had any viable alternative. The prisoner told my investigator that he had been well-supported since the man's death. He said the Governor had recognised his efforts and that staff had gone out of their way to check his welfare. In particular, he commented on the support that he received from the officer who broke the news of the man's death to him in a timely and sensitive manner.
88. I have been pleased to learn that the Governor recognised the prisoner's efforts. However, in light of this investigation, I wonder if more formal recognition is required. For that reason, I make the following recommendation:

The Area Manager should formally commend the prisoner for his actions in assisting staff when the man was found.

89. When the first induction officer gained entry to the cell, he untied the ligature from around the man's neck. In Prison Service Order 2700 (the national instruction that governs the management of suicide and self harm prevention across the Prison Service), staff are encouraged to "preserve the knot if possible". If the knot is preserved, it can provide useful evidence if there is any doubt whether the ligature was made by the prisoner's own hand. However, the officer described the knot as "loose" and decided that it would be the quickest way to remove the ligature and bring the man to the floor to commence emergency first aid. I think the officer's judgement rightly put the preservation of life over the preservation of evidence.
90. I agree with the clinical reviewer that a defibrillator is a vital piece of resuscitation equipment. In fact, I made this recommendation to the Head of Healthcare at Preston in an earlier investigation. The radio sign "Code One" meant "hanging or attempted hanging" to all staff asked by my investigator. The two nurses who attended said that they understood that they were coming to an attempted hanging. I am therefore concerned that a defibrillator was not taken as a matter of course. Early application of a defibrillator can be crucial. The emergency response nurse and the doctor both thought that in this case a defibrillator would have made no difference because the man showed no signs of life upon examination by healthcare staff. I am satisfied that, in this case, a defibrillator would not have changed the outcome. However, I endorse the clinical reviewer's recommendation regarding resuscitation and draw it to the attention of the Governor and the Head of Healthcare.

There should be a review of how nurses respond to emergencies and what equipment they take – a defibrillator should be seen as an integral part of the resuscitation equipment.

All healthcare staff must be adequately trained and regularly updated in Basic Life Support and trained to use whatever resuscitation equipment exists within the prison which includes advisory defibrillators.

91. I am pleased to report that, since my investigator drew this point to the service manager for prison healthcare and the Governor attention, all healthcare staff have undergone refresher training in resuscitation and reminded of the importance of taking a defibrillator to any life-threatening situation.

RECOMMENDATIONS

The clinical reviewer identifies five areas of learning and service development for Preston. One of these has already been acted upon and I hope that the remaining four will be given swift and due consideration:

A new first reception healthscreen should be completed for each prisoner entering HMP Preston on every occasion.

There should be a review of the referral pathways to mental health services particularly around responsiveness to perceived crisis and the methods of communicating actions/decisions.

It is recommended that the referral meetings are more comprehensively recorded so that healthcare staff subsequently attending to the patient have a clear indication in the clinical record of considerations made and decisions taken at a referral meeting.

There should be a review of how nurses respond to emergencies and what equipment they take – a defibrillator should be seen as an integral part of the resuscitation equipment.

All healthcare staff must be adequately trained and regularly updated in Basic Life Support and trained to use whatever resuscitation equipment exists within the prison which includes advisory defibrillators.

I have made a further three recommendations:

The Governor should consider streamlining the system for prisoners to apply for international telephone calls, including a fast track system to be used in an emergency situation.

The Governor and the Head of Healthcare should ensure that staff are clear about who to access in the event of a prisoner requiring urgent access to the mental health team.

The Area Manager should formally commend the prisoner for his actions in assisting staff when the man was found.

During the consultation process, following the issue of the draft report, the prison responded with the actions that have been taken in light of these recommendations. Their response was as follows:

- In terms of mental health provision, the primary care mental health team is currently under development and additional staff are being recruited to form a crisis intervention response team. This team will be available 7 days a week, should staff have concerns about particular prisoners.
- With regards to the recommendation that healthcare staff be adequately and regularly updated on the basic life support, all healthcare staff have since

undergone refresher training in resuscitation and reminded of the importance of taking a defibrillator to any life threatening situation.

- Processes have also been put into place with regards to International Calls, in that all Foreign National prisoners are automatically given five pounds worth of pin phone credit on. On reception subsequent months, Foreign Nationals will be allowed a free five minute telephone call.

ANNEX 1

Documents considered during the investigation

Death in custody documentation
Prisoner Core Record
Custodial Documents File
Immigration documentation
Wing history
Staff observation book from first night centre
Staff observation book from induction wing
Citizenship Programme
Application form regarding international telephone call
Paramedic Record
First reception healthscreen
Prescription chart
Continuous Clinical Record
Mental Health In-reach file
Interview notes/transcripts