



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in August 2012
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 hanged in his cell at HMP Preston in August 2012. He was 33 years old. I offer my condolences to the man's family and friends and I apologise for the delay in issuing this report.

Two investigators were appointed. A clinical reviewer reviewed the clinical care the man received at the prison. HMP Preston cooperated fully with this investigation.

In April 2012, the man was remanded to HMP Liverpool charged with intimidating a witness, just three days after he had been released from prison. Shortly afterwards, staff became concerned about his mental state and began to monitor him under suicide and self-harm prevention procedures. Two days later, the man harmed himself by cutting his arm. The man moved to HMP Preston on 20 June and monitoring ended just over a week later.

On 13 July, the man was convicted and returned to the prison to await sentencing. He had been expecting to be released from custody when he was sentenced, but on 30 July the court imposed a sentence of two years' imprisonment. Reception staff noted that he said he had felt suicidal at court and was shocked at his sentence, but suicide and self-harm monitoring did not begin again until three days later after he said he was desperate to see someone from the mental health team. He cut himself later that day. The man shared a cell, but was alone in the cell on the morning of 6 August as there were insufficient activity places for all prisoners. Shortly after 10.00am, he was found hanged. Sadly, prison staff and paramedics were unable to revive him.

The investigation found that while the man received satisfactory support for his mental health problems, there were some shortcomings at both Liverpool and Preston in the operation of suicide and self-harm prevention procedures. In particular, I am concerned that there was a lack of continuity of case management, that caremap actions to help reduce risk were not reviewed effectively and that observations were not meaningful. We do not know whether more effective interventions would have prevented the man's actions, but it is important that prison staff use suicide and self-harm procedures appropriately to support prisoners at risk.

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

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SUMMARY

1. The man was released from HMP Forest Bank on 20 April 2012. On 23 April, he appeared at Blackburn Magistrates' Court, charged with intimidating a witness (his mother) on the day he was released from Forest Bank. He was remanded to HMP Liverpool.
2. The man first asked for the support of the mental health team at Liverpool on 30 April. On 4 May, he saw a mental health worker and told him that he had tried to strangle himself while in police custody. The mental health worker began suicide and self-harm monitoring procedures. Although the man was assessed that day, a caremap was not completed for a further two days. Later on 4 May, the man made cuts to his arm.
3. The man continued to be monitored as at risk of suicide and self-harm at Liverpool, but asked to move to another prison. He moved to HMP Preston on 20 June where the monitoring ended just over a week later. It is not clear that the caremap actions had been completed appropriately and there is no indication that staff considered that the man was still to appear at court which was likely to have been unsettling for him.
4. The man returned to court on 13 July, when he was convicted of threatening behaviour. The next day, he asked to see the mental health team as he was remorseful about his offence. A member of the mental health team assessed him on 18 July. The man said that he was expecting to be released from prison when he was sentenced. However, on 30 July, he was sentenced to two years in prison and returned to Preston. Court staff had recorded that the man had had suicidal thoughts after he was sentenced, but he told reception staff that he was just shocked by the length of his sentence.
5. The next day, he asked to see a member of the mental health team as he was feeling anxious. On 2 August, he told an officer that he felt depressed and suicidal. He later told a nurse that he was aggrieved by the length of his sentence. Suicide and self-harm monitoring was started again. The man cut himself later that evening. On 5 August, the man asked to speak to a specific prisoner Listener, but this was not allowed as this was contrary to agreed arrangements for Listeners. He refused an offer to see the Listener who was on duty at the time.
6. On 6 August, the man asked to see a member of the mental health team. He then went to an education class, but had to return to his cell as the class was full. An officer said that he had declined the opportunity to go outside to the exercise yard at 9.35am, but she did not see him as he was locked in his cell. When she next checked on the man at 10.10am, she found him hanging from a light fitting in his cell. Members of staff and paramedics were unable to resuscitate him.
7. We are concerned about the way suicide and self-harm monitoring procedures were completed at both Liverpool and Preston prisons. In particular, we found that there was a lack of continuity in case management,

and that caremaps were poorly written and were not completed before monitoring ended. Officers at Preston did not take into account that an appearance at court might alter the man's risk of harm to himself. We consider that Preston should review the light fittings in cells to see whether they can be made safer and should ensure that staff who meet families of deceased prisoners are fully briefed about the circumstances and able to give families the information they need.

THE INVESTIGATION PROCESS

8. The original investigator and obtained documents from HMP Preston about the man's time in prison. NHS Central Lancashire commissioned a clinical reviewer to produce a clinical review into the care provided for the man while he was at HMP Preston. On 22 October 2012, the investigator visited Preston with the clinical reviewer and interviewed four members of staff. The investigator left the Prisons and Probation Ombudsman's office in 2013 before the investigation was completed. An assistant ombudsman subsequently took over the investigation in addition to other duties. The assistant ombudsman visited Preston on 4 October 2013 and interviewed three more members of staff. We are very sorry that this staffing difficulty has led to a delay in issuing this draft report.
9. On 11 October 2012, one of the Ombudsman's family liaison officers contacted the man's family who subsequently wrote through their solicitor to outline their concerns about the man's care and their involvement with the man while he was in custody. The investigator and another family liaison officer visited the man's family on 11 January 2013. His family said that they had felt let down by the criminal justice system from the time of his arrest to his time in prison. A number of the issues they raised relate to the police, court process and other matters that are outside the remit of the Prisons and Probation Ombudsman. The man's family had the following concerns relevant to our investigation:
 - They did not consider that the prison staff they spoke to after the man's death knew enough about him. They believed the staff did not deal with them sensitively and were more concerned about protecting themselves.
 - They were concerned that the man had been able to hang himself from a light fitting.
 - They were concerned that the man had asked to see someone from the mental health crisis team on the morning of his death and did not get sufficient support.
 - They considered that the frequency of required monitoring and observations was insufficient.
 - They believed that the Imam had failed to identify and assess the man's risk.
 - One of the man's sisters had contacted the prison to express her concerns about him, but this was not acted on.
 - The man's cell mate had told them about several previous incidents of self-harm and that he had informed staff of these.
10. The man's family's solicitor gave us contact details for the man's cellmate, who had subsequently been released from prison. One of our investigators contacted him and invited him to be interviewed as part of this investigation. He asked for time to consider, but did not reply when we contacted him again.
11. HM Coroner sent us a copy of the post-mortem report. We have sent the Coroner a copy of this report.

12. The man's family received a copy of the draft report. The solicitor representing them wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. The man's family asked us to point out that there is a history of suicide in their family.

HMP PRESTON

13. HMP Preston is a local prison holding up to 842 men. Healthcare is provided by Lancashire Care Foundation Trust. The healthcare unit has inpatient facilities which are used as a regional facility. There is a full-time doctor between 9.00am and 5.00pm on weekdays and a doctor works in reception between 5.00pm and 8.00pm. At weekends there is on-call cover.

Previous deaths at Preston

14. There were three self-inflicted deaths at Preston from 2010 up to the time of the man's death. In one of these investigations we made a comprehensive recommendation about the need to improve suicide and self-harm monitoring processes at the prison which was accepted. The prison subsequently introduced refresher training for staff and other measures aimed at improving the quality of suicide and self-harm monitoring procedures. However, some of the same issues were identified during this investigation.

Her Majesty's Inspectorate of Prisons

15. 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.

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.

HMP LIVERPOOL

17. HMP Liverpool is a local prison which serves the courts in Merseyside. It holds up to approximately 1,400 men. The prison has eight residential wings and a purpose-built healthcare unit, which opened in 2007. Liverpool Community Health Trust is commissioned to provide healthcare. The prison healthcare centre provides outpatient services, as well as 24-hour inpatient care.

HM Inspectorate of Prisons

18. In its most recently published report of an inspection of Liverpool in December 2011, the Inspectorate found some progress had been made at the prison since the previous inspection, but it had been very slow. Inspectors noted that healthcare was well managed with a good range of nurse-led and specialist clinics. In relation to suicide and self-harm procedures inspectors were concerned that not all vulnerabilities were identified and acted on and many staff were out of date with ACCT training. Most reviews had multi-disciplinary presence but few care plans identified individual members of staff to support prisoners. Reviews were rarely chaired by the same manager. A crisis intervention team, the chaplaincy and Listeners provided good support.

Independent Monitoring Board

19. In the most recent annual report for 2012, the Independent Monitoring Board (IMB) noted that recommendations from a health service review held in 2009/10 were still being implemented, including increasing the number of GPs and the development of a day centre for prisoners with complex needs. The IMB noted that there had been four deaths at the prison in 2012, two of which were self-inflicted. The IMB was satisfied that the prison took safer custody and suicide prevention work very seriously and that staff were vigilant and professional.

Assessment Care in Custody and Teamwork (ACCT)

20. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

21. On 20 April 2012, the man was released from HMP Forest Bank after serving a 12 week sentence for battery. The victims were his wife and mother. On 23 April, he appeared at Blackburn Magistrates' Court, charged with intimidating a witness (his mother) on the day he was released from Forest Bank. He was remanded to HMP Liverpool.

HMP Liverpool

22. When he arrived at Liverpool, a nurse noted at the reception health screen that the man appeared calm and rational. He had said that he did not have any thoughts of suicide or self-harm and had not tried to harm himself in the community. The man said that he had been prescribed citalopram, an antidepressant.
23. On 30 April, a member of staff from the prison's mental health team, saw the man after he had asked for support. The member of staff from the mental health team noted that the man's symptoms were vague and included getting lost when he went out, poor memory and hearing voices. The man would not say if he had had any thoughts of harming himself and the member of staff from the mental health team thought that he was confused by the question. The man said that he had used cannabis since the age of 13, but did not use alcohol or other drugs. He told the member of staff from the mental health team that he was incontinent of both urine and faeces and soiled his clothes. He also said that he had asthma, pains in his feet and back, blurred vision and migraines. The member of staff from the mental health team referred him for further assessment by the mental health team and also requested a GP appointment to review his physical health problems.
24. The man did not attend a GP appointment on 2 May. No reason is recorded. That afternoon, another member of staff from the mental health inreach team, began a full mental health assessment with the man which continued the next day. They also met again on 4 May, when the man told the member of staff that he had attempted suicide three times in the previous week while he was in police custody. He said that he had tried to strangle himself with a T-shirt. The member of staff noted that he could not provide specific details about these incidents. The man said that he did not feel suicidal any more, but the member of staff decided to open an ACCT because of what he had told him. The member of staff from the mental health team noted that the man seemed to be low in mood and unstable emotionally, and to have some learning difficulties. He had several physical problems caused by accidents and assaults which had been exacerbated by the effects of homelessness and self-neglect. The member of staff arranged for the member of staff from the mental health team to monitor the man over the forthcoming bank holiday weekend. They discussed whether the man should move to the healthcare unit as an inpatient, but agreed that they needed more information before making a decision.

25. A Senior Officer (SO) completed an immediate action plan. He recorded that the man should share a cell with a friend, be supported by the mental health team, and be observed by staff three times during the night. Staff were also instructed to record three conversations with the man during the day.
26. At 3.00pm, on 4 May, an officer interviewed the man for an ACCT assessment. The man said that he was unhappy at being in jail and had had some tobacco stolen from his back pocket. The officer noted that the man claimed to have tried to strangle himself the week before, but said he did not have any current thoughts of harming himself. He said he was having trouble sleeping and felt depressed. He asked for medication, and also for tobacco, which he said helped with his distress. The officer recorded the summary of the assessment as "treatment for depression".
27. The SO conducted the first case ACCT review with the man at 3.15pm. No other member of staff attended. He allowed the man to call his solicitor. The man asked the SO for tobacco and the SO was not convinced that the man was at risk of suicide and self-harm. He noted that he thought this was a "try on" and that the man had not mentioned the information about harming himself before. The SO assessed the man's risk of harm to himself as low.
28. At 6.55pm on 4 May, the man pressed his cell bell and showed the officer who responded, a cut on his forearm. The officer called the duty healthcare officer and the mental health team. The man said that he had cut his wife's name into his arm, but was otherwise reluctant to discuss what had happened. An ACCT review was not held. The nurse moved the man to a gated cell in the healthcare centre so that he could be observed easily. The nurse noted that the man was settled for the next two nights. It is not clear when the man moved out of the gated cell.
29. A caremap, which is expected to be agreed at the first ACCT review, was not completed until 6 May by a case manager whose name is illegible on the document. The case manager noted two issues in the caremap; self-harm ideation and possible learning difficulties. Six actions were identified to address these issues.
30. The member of staff from the mental health team saw the man on 7 May. He told the member of staff from the mental health team that he missed his wife, although she had beaten him with a cricket bat. He said his family were justified in hating him because he had had a relationship with another woman. He said that he had been having problems sleeping for years. He did not hear voices in his head, but said he heard mobile telephones and trains.
31. The next day, the member of staff from the mental health team and a nurse saw the man, who said he was very low, in pain and suffering from incontinence. The member of staff from the mental health team told him that he had referred him to a psychiatrist. The nurse gave him some pain relief and asked for a GP to see him the next day. The man did not attend the appointment and no reason is recorded.

32. The member of staff from the mental health team saw the man again on 9 May. They discussed the man's episode of self-harm on 4 May. He said that he was feeling angry with himself at the time and that he was very unhappy about his current relationship with his family. He said he was still in pain and the member of staff from the mental health team asked nurse to give the man some more pain relief.
33. The next ACCT case review took place at 4.30pm on 9 May. The name of the case manager is not clear, but another member of staff from the mental health inreach team was present. At the review, the man's recent act of self-harm on 4 May was discussed with him. The man said that he became frustrated easily and needed to address his mental health issues. He said that he saw the healthcare unit as a place of safety. The ACCT remained open and the level of observations remained the same as previously. His risk was still assessed as low, although he had actively self-harmed since the previous assessment.
34. The man remained living in the healthcare centre as an inpatient. Staff noted on several occasions that he still appeared unsettled. On 14 May, a GP prescribed mirtazapine, an antidepressant. The same day, the mental health team discussed the man and booked an appointment for him to see a psychiatrist on 30 May.
35. The member of staff from the mental health team saw the man on 16 May to complete what his medical record described as an initial mental health assessment. The member of staff from the mental health team noted that the man's mood had improved, as had his sleep patterns and levels of pain. Another manager held a third ACCT case review. The man said that he did not have any thoughts of self-harm and said that he would approach staff if he had any such thoughts. The member of staff from the mental health team saw the man again on 18 May and noted that he was calm and talkative, but was worried about his physical health. The member of staff from the mental health team assured him that staff were conducting tests that should help identify the cause of his pain.
36. The GP saw the man on 21 May and noted that the man was clean and well-groomed, but complained of joint pain and was generally unwell. He examined him more fully the next day. Blood test results were abnormal for his liver function and the GP requested an ultrasound test at hospital. He also requested a podiatry review as the man had problems with his feet.
37. On 29 May, the man provided urine and faeces samples. Later that day, he spent some time with the nurse, to discuss his thoughts and feelings. They talked about goals, which included the man occupying himself on the healthcare unit and participating in association, and to understand and comply with his medication regime.
38. The next ACCT review was held later on 29 May, chaired by the fourth different case manager in four reviews. The man reported being low in mood. He said that he did not have anything outside prison, except he was well

supported by his siblings. He said that he was getting racially abused in the healthcare unit, but declined to discuss this further. He said that he would speak to staff if he felt low or agitated. The ACCT remained open.

39. The next day, the psychiatrist, saw the man and set out a management plan in the medical record. He advised that the man should remain on mirtazapine and that the ACCT should remain open. The psychiatrist did not think that the man required the input of any specialist services at that time. He suggested that the man should be referred to the primary care psychology team to discuss anger management and should see his community GP when he was released to assess his ongoing medication. On 31 May, the psychiatrist wrote a letter about this meeting. He said that he did not intend to see the man again, and that the man had become more irritable and aggressive towards during the interview. The psychiatrist said that he had terminated the interview after the man became threatening.
40. Another ACCT review took place on 3 June, this time chaired by the nominated case manager. The man said that he was anxious about returning to a normal wing and was worried about getting racial abuse. The case manager said that she would talk to staff on I wing so that they were aware. She noted that his main concerns seemed to be family issues outside prison. The man moved to I wing later that day.
41. On 11 June, wing staff called the mental health team as the man was expecting to see the original member of staff from the mental health team who was on leave. Another member of staff from the mental health team established that there was no crisis and went to see him the next day. The man told her he had problems with his mood, anger management and anxiety. He said his medication was helping and that staff had helped him with a telephone call.
42. The next evening, 12 June, the man made several cuts to his forearm and was observed banging his head against the cell wall. He said that he wanted to kill himself. He was moved back to the healthcare unit to be observed overnight.
43. On 13 June, the case manager chaired a further ACCT review. The man said that he had harmed himself out of frustration. He said that he wanted to return to the wing and go to work. His level of risk was recorded as raised but no change was made to the frequency of his observations. The man went back to I wing.
44. On 14 June, the man told the member of staff from the mental health team that he had been unhappy with how the consultation with the psychiatrist had progressed, but was sorry for his outburst. He told the member of staff from the mental health team that some of his family wanted to visit him and this had helped to improve his mood.
45. At some point between 13 and 20 June, the wing manager chaired another ACCT review. The man told him that he was worried about his safety on the

wing and that two Asian men had racially abused him. He added that he had been assaulted at Liverpool the previous year. (There is no record of this in the man's medical record.) He said that he wanted to move to Preston. The wing manager agreed to pursue this.

46. Further blood tests were taken on 19 June, which showed that the man's liver function was normal. The next day, he transferred to HMP Preston. The ACCT case file went with the man.

HMP Preston

47. The SO chaired an ACCT review at Preston shortly after the man arrived. The duty governor and an officer from the first night centre attended. The man said that he was happy to be at Preston and had no thoughts of self-harm. He said he would let staff know if this changed. His primary concern was getting his medication and he was told that this would be resolved. (His medication was issued the next day). He said that he wanted the ACCT to be closed. He was told that this would probably happen at the next review. The level of review was set at two observations an hour throughout the day. His level of risk was not recorded. He was referred to the mental health team.
48. The next ACCT review took place on 23 June, chaired by the SO and attended by the man, another officer, a nurse from the mental health inreach team and a member of staff from the safer custody team. The man said that he did not have any thoughts of suicide or self-harm and felt fine at Preston, except he was not getting the pain relief he needed. The level of observations was reduced to one each hour and the mental health team agreed to do a full assessment.
49. On 27 June, the man forgot to collect his medication in the afternoon and rang his cell bell to inform an officer. An officer spoke to a nurse who gave the medication to a colleague to issue. The nurse asked the officer to tell the man that missing his medication would not harm him. On 1 July, the man again forgot to collect his medication and the nurse said that they would not give him the medication that night. The man was upset and rang his cell bell several times. He asked to see a Listener (a prisoner trained by the Samaritans to support other prisoners in distress) which was arranged. He later asked to see a Listener again and said he felt unwell because he had no medication. A Listener could not be arranged immediately and officers explained to the man that he would see one as soon as possible. The man became argumentative and the officer suggested he put in a complaint to healthcare if he was not happy with the decision about his medication. The man was given the Samaritans phone and he said that he would try to sleep when he had finished. (The Samaritans phone is a cordless phone which prisoners can use in their cells.)
50. At the next ACCT review, chaired by the SO on 28 June and attended by members of the mental health, safer custody and chaplaincy teams, the man said that he was keen to enrol on an anger management course. He said that

he had had good support from Listeners. He said that he did not have any suicidal thoughts and would like the monitoring to end. The review agreed and the ACCT was closed. There was no mention of the events of the previous night in the case review. The SO ticked the box to say that the caremap had been reviewed. Although the caremap was amended to show that the actions had been completed, the status of action boxes had last been updated on 9 May and there was no indication who had completed the actions and when. The ACCT review did not refer to the man's forthcoming court appearance and what effect this might have on him.

51. On 3 July, the member of staff from the mental health team faxed his notes to Preston.
52. In July, the man saw a number of different Listeners from different wings on six different occasions.
53. An ACCT post-closure review was held on 5 July. The man said that his sister and father had visited him and forgiven him. He was happy with his medication, was working full time and was planning to go to the gym. He said that he had the support of his family, who were writing to the Judge and planned to help him get released, and he would live with his mother and father when he was released. He said that he did not have any other issues, but it was noted on the form that he would be in court for sentencing on 11 July.
54. The man attended court on 13 July (not 11 July) and was convicted of threatening behaviour. He was remanded in custody to await sentencing on 30 July. When the man arrived back at Preston, the nurse saw him and noted in his medical record that he did not have any concerns.
55. The next day, 14 July, the nurse, from the primary mental health team, was called to the wing to see the man for a crisis call. The man told her that he was remorseful because of the effect that his drug taking and gambling had had on his family. He wanted to engage with staff to show how much he had changed. The nurse told him that he would have a mental health assessment and suggested he would benefit from support from the primary mental health team. The man said that his current dose of mirtazapine (30mg) was not having the required effect and the nurse referred him to the GP to review his medication.
56. A member of staff from the mental health inreach team, saw the man on 18 July for a primary mental health assessment. They discussed the member of staff from the mental health team the member of staff from the mental health team's earlier assessment and the man agreed that it was fair. He said that his mental state was now stable and that he was looking forward to being sentenced on 30 July as he thought he would be released because of the time he had already spent in prison on remand. If not, he did not think that he would have much more time to serve. He said that he had been referred to the psychological wellbeing practitioner and the member of staff from the mental health team urged him to keep the appointment. The member of staff from the mental health team noted that the man tended to look on the dark

side of life. The man said that he regretted his previous self-harm. The member of staff from the mental health team the member of staff from the mental health team agreed to take him onto the primary care mental health caseload, so he would continue to be treated by them.

57. The member of staff from the mental health team told the investigator that he had not been aware of the crisis call of 14 July. He said he would normally check the prisoner's medical record before an assessment but, because he had the assessment from the member of staff from the mental health team and the psychiatrist, he did not do so on this occasion. He said that even if he had seen the note about the crisis call, it would not have changed his decision to take the man on to the caseload. The member of staff from the mental health team told the investigator that the man appeared relatively happy during the assessment.
58. On 27 July, a probation officer faxed a notice of the risk of possible self-harm or suicide to Preston. This was scanned on to the man's medical record but it is not clear whether any action was taken.
59. The man appeared at Preston Crown Court on 30 July 2012 and was sentenced to two years in prison. When the man returned from court, staff in reception noted that it was recorded that he had had suicidal thoughts while at court. The nurse spoke to the man and he told her that he did not have any thoughts of suicide or self-harm, but was shocked at the length of his sentence. An ACCT was not opened.
60. The next afternoon, officers asked the nurse to come to the wing to see the man as he was anxious after his sentence. The man said that he had not expected his two year sentence as it was all a misunderstanding. He was hoping to move to HMP Haverigg, where he had friends. He said he had no thoughts of suicide or self-harm. He asked for an increase in his medication and the nurse thought that the man appeared flat in mood.
61. That evening, the man went to collect his medication, but refused to take it as it was Ramadan. The GP agreed to issue the medication for him to take in his cell outside fasting times.
62. On 2 August, the man spoke to the officer and said that he was depressed and was feeling suicidal. He said that he was desperate to speak to someone from the mental health team. The officer was concerned and opened an ACCT. The wing manager completed an immediate action plan and set the level of observations at three an hour until the man was further assessed and reviewed. He also noted that the man should remain in the same cell that day, but should then be moved to share with another prisoner.
63. A nurse saw the man at 4.20pm. The man said that he felt ill and needed help. He said that he felt aggrieved about his sentence and had suicidal thoughts.

64. The man was checked as required over the next two hours. However, at 6.55pm, the man's cell mate told an officer that the man had cut his wrists and neck. The nurse dressed the wounds, which she described as being mainly superficial. A Principal Officer (PO) chaired an ACCT case review at 7.15pm, which the nurse and the duty governor attended. The man said that he found the wing too noisy and boisterous. The PO agreed to move the man to the care suite on C wing overnight and to look for a quieter location to give him some respite. A further review was arranged for the next day. The level of observations was increased to four an hour until the next review.
65. The next morning, on 3 August, the man moved cell to share with the other prisoner. Later, the nurse conducted an ACCT assessment. The man told him that he was finding it very difficult to cope and that he had expected to be released from prison when he went to court for sentencing. He said that, when he had cut himself, he had wanted to sleep and not wake up. However, he said that he was now glad he was alive, did not have any current thoughts of harming himself and had support from his family, who he wanted to speak to. He also thought that a move from Preston would help him.
66. After the assessment, the man spoke to the officer about obtaining enhanced level on the prison's incentives and earned privileges scheme, but the officer noted that he still seemed low. At 11.35am, the officer spoke to the man, who told him that he "could not do it" behind his door (meaning he could not cope with being locked in his cell) which was why he asked to speak to a Listener so often. The officer explained that this was the reality of life in prison, but noted that the man was not very happy about this. The man was taken to speak to a Listener.
67. At 2.45pm, the SO chaired another ACCT review, which two members of staff (from the safer custody team) and a chaplain attended. The man said that he felt a bit better, but needed to contact his family. The SO noted that telephone credit was being arranged to allow this. The man said that he wanted to move from Preston, but the SO noted that he would need to be more stable in mood before a transfer could take place. There is no record that they discussed the man's comment to the officer earlier that morning about not being able to cope with being locked in his cell. The level of observations was reduced to one observation per hour (although this was written on the front sheet of the ACCT document as "1x documented observation day and night"). The SO arranged the next review meeting for 9 August but did not record a level of risk for the man.
68. A nurse noted in the man's medical record that day that, after discussion with the mental health team, a GP and the Imam, the man was no longer to be given his medication to keep in his cell. The man was concerned that this would mean he would break his fast if he took medication during the day, but the Imam assured him that this was allowed. He told the nurse that he understood when to collect his medication.
69. On 4 August, the man made several telephone calls. Because an ACCT had been opened, these calls were monitored, but most were not in English and

there is limited information about their content. At 6.30pm, he told an officer that he felt better after speaking to a Listener but, at 9.10pm, he told the officer that he was struggling to cope, had suicidal thoughts and was hearing voices. The officer reported this to a senior officer. A Listener came and spoke to the man and at 10.20pm. The man told the officer that he felt a lot better.

70. On 5 August, the man asked for a Listener and an officer took him to see the duty Listener. At 2.05pm, the man returned to the wing and told the officer that he wanted to see the mental health inreach team, as well as two specific Listeners he knew from C3 wing. The officer noted in the ACCT record that he thought that the man was abusing the facilities offered to him and that he had made a referral to the mental health inreach team and noted that the man had exercised in the yard for 30 minutes and collected his meal.
71. At 5.50pm, the man asked to see a specific Listener from C3 wing. The officer offered to take him to the Listeners' duty care suite, but the man declined. He asked to see Listeners again at 8.30pm (when he again specifically asked for the particular Listener from C3) and then again at 8.50pm. The officer reminded him that he had earlier refused the officer's offer to take him to the duty care suite so he did not allow him to see a Listener then. The officer informed the night orderly officer and observed the man at the appropriate times for the rest of the night and noted that he was mostly asleep.
72. The man's cell mate noted in a statement to the police that the man had told him that he was stressed because he did not always speak to the same Listeners. The cellmate thought that the officers did not believe that the man wanted to see a Listener because he was distressed, but thought he only used this as an opportunity to get out of his cell. He said that, when he was not allowed to see the Listener, the man put a black bag over his head.
73. On 6 August, an officer unlocked the man's cell at 8.25am. She remembered seeing him on the lower landing as he had later asked a cleaner to get his Ramadan box for him, which he had left in the cell. The cellmate brought the box down from the cell for him. At 8.45am, the SO spoke to the man, who said that he was not feeling well and wanted to see a member of the mental health crisis team. The SO contacted a mental health practitioner, who said that he would come and see the man.
74. The man then went to an education class but, according to an entry in the ACCT document, returned to his cell at 9.05am as there were too many prisoners attending. The cellmate said that he saw the man going back to his cell, but the cellmate remained at a different education class.
75. An officer was working on the man's wing that day. She had just returned from leave, but wrote in her police statement that she knew that the man was on an ACCT and understood that he should be observed hourly. She said that the officer told her that the man had returned from his class and was in his cell.

76. At 9.30am, the officer was asked to unlock the cells to allow prisoners out for an exercise period. She walked down the landing shouting "exercise". Prisoners who wanted to go outside to the exercise yard were expected to indicate by pressing their cell bell, which turned on a light outside their cells. Although the man's light was not on, the officer said she recalled calling to him through the cell door and said she was sure that he had replied to her indicating he did not want to go out.
77. The officer decided to check on the man at about 10.10am, before the other prisoners returned from the exercise yard. At first she went to the wrong cell and had to go back to the office to find out which cell he was in, which was number 27. She then went to cell 27 and opened the observation hatch. She saw the man standing in the cell. His eyes were closed and his head was tilted to the right. The officer then noticed that there was a ligature made of bed sheets around his neck. She had not realised immediately that he was hanging as his feet were on the floor.
78. The officer ran back to the office and shouted "code 1" (an emergency code which the officer told the investigator signified a hanging). She ran back to the cell, opened the door and supported the man's weight. She was joined by the SO and two officers, who helped cut the man down and lay him on the floor of the cell. The SO said in his police statement that the man had tied the ligature through a light fitting.
79. The SO said that he had radioed a code 1 emergency call, but when he got to the cell, he could still hear radio traffic and was unsure whether the message had got through. He then called another code 1 over the radio network and asked an officer to telephone the communications room to make sure that the message had got through. The communications log shows that a code 1 was recorded at 10.14am and an ambulance was called at 10.16am.
80. A nurse arrived at the cell and began cardiopulmonary resuscitation (CPR). Two more nurses arrived shortly afterwards and began to clear the man's airway. Two further nurses arrived and helped give CPR. The nurse attached a defibrillator which showed there was no shockable rhythm. (A defibrillator is a life-saving machine which analyses heart rhythm and delivers electric shocks to victims of cardiac arrest when it determines there is a rhythm that is likely to respond.) The doctor arrived at the cell at 10.22am.
81. An ambulance arrived at the prison at 10.26am and paramedics reached the cell at 10.29am. They inserted another airway and assisted with CPR. The defibrillator continued to advise not to administer a shock. The paramedics administered five lots of adrenaline, but were unable to resuscitate the man. At 11.11am, the paramedics and the doctor agreed that the man had died.
82. At 12.05pm, a hot debrief was held for staff who had attended the scene to provide reassurance and support.

83. Two managers at Preston went to the man's parents' home to inform them of his death. They arrived at 12.45pm and spoke to the man's father, mother and brother. They explained to the man's father what had happened and what investigations would there would be.
84. A family liaison officer was appointed. On 7 August, she spoke to the man's uncle, who his family had asked to be the main point of contact, and gave him some further information. The man's family agreed that they would like to visit the prison, but not until after the funeral. The family liaison officer explained that the prison would contribute towards the funeral expenses. Later that day, the family liaison officer spoke to the man's uncle to tell him about the post-mortem arrangements. The man's family went to see his body at the mortuary that afternoon.
85. The post-mortem examination on 8 August concluded that the cause of the man's death was hanging. The man's funeral took place later that day.
86. The family liaison officer recorded in the family liaison log that Preston's Imam returned to work on 10 August. She updated him and he told her that he planned to visit the man's family. There is no record in the log of when the Imam visited. The man's family noted in a statement provided for this investigation that the Imam had told them that he had visited the man in his cell after his act of self-harm on 2 August and that the man had said that he would not harm himself again. There is no record of this meeting in the ACCT ongoing record.
87. The man's family visited the prison on 15 August. They spoke to the Governor, the duty governor, the Imam and the family liaison officer. During the meeting, the man's family raised many concerns about how he was kept safe at Preston. They did not believe that he had been monitored frequently enough and did not accept that the light fitting from which he had been found hanging would have been able to take his weight. The family liaison officer noted in the family liaison log that the man's family clearly stated that the prison had failed.

ISSUES

Clinical and mental health care

88. The clinical reviewer completed a review of the man's clinical care while he was at HMP Preston. The clinical reviewer found that, overall, the care the man received was at least as good as that he could have expected in the community.
89. The clinical reviewer considered that the initial healthscreen at Preston had been conducted appropriately. The man told the nurse that he had a history of depression, but did not mention that he had previously harmed himself in prison (as he had done in Liverpool in May.) However, the nurse appropriately made a referral to the mental health team. (The information would have been available in the ACCT documents which accompanied the man and in his medical records.)
90. The clinical reviewer found that the man had been appropriately assessed by the mental health team at Preston and Liverpool. He was prescribed appropriate medication for depression and had received input from the mental health team and a visiting psychiatrist. The primary mental health team at Preston followed the advice given by specialists and we are satisfied that he received appropriate care for his mental health problems.

Management of risk of self-harm and suicide

ACCT case reviews

91. The man was monitored under ACCT procedures, the Prison Service process for monitoring and supporting prisoners at risk of suicide and self-harm, for much of his time in custody. He was being monitored under the ACCT process at the time he transferred to Preston from Liverpool.
92. While at Liverpool, the man had seven case reviews. It appears from the case records that these were chaired by six different managers. At Preston, there were three chairs for the three case reviews held before the ACCT was closed. After the second ACCT was opened on 3 August, there were two reviews, chaired by different people. Prison Service Instruction 64/2011 sets out the process for the management of the ACCT process. There is a mandatory action that a case manager should be appointed and a further instruction that, where possible, the same people should attend case reviews. There is an obvious risk that a lack of continuity in the management of a case will reduce the level of knowledge that those present have of the prisoner. Frequent changes of case managers mean they will not be able to identify any changes in demeanour and presentation at reviews which might indicate a change in the level of risk. We make the following recommendation:

The Governors of HMP Liverpool and HMP Preston should ensure that there is continuity of case management in ACCT case reviews.

93. The man had four case reviews while he was at Preston. A member of the mental health team and the safer custody team attended three of the reviews, the exception being the review held immediately after the man arrived at Preston. A member of the chaplaincy attended a review on one occasion, and a member of the Offender Management Unit attended another one. We are therefore satisfied that the reviews were attended by an appropriate range of members of staff.

Caremaps

94. A caremap was drawn up when the ACCT was opened at Liverpool on 6 May 2012. It is not clear why this was not done at the first case review, held two days earlier. Although the caremap highlighted two issues, there were six corresponding actions. The actions listed to address the issue of self-harm ideation included “maintain safe environment”, “provide 1:1 support when required” and “reduce recurrence of self-harm episodes”. These actions were all allocated to healthcare staff, the mental health team and the man himself.
95. The second issue was listed as “possible learning difficulties”. Two actions were listed, for the man to be supported to understand the prison regime and to encourage him to participate in wing activities to encourage social inclusion. These actions were also allocated to the healthcare and mental health teams. There was no action to identify whether the man had learning difficulties and what further support might be needed.
96. An ACCT should not be closed until an ACCT case review is satisfied that all the caremap actions have been appropriately achieved. This caremap was particularly unhelpful, as it contained vague actions that were not attributed to anyone, or a team, but to several groups of people, and which were not linked directly to the ACCT assessment. There is a need to ensure that caremap actions have detailed time-bound actions aimed at reducing risk which are appropriately targeted and we are not satisfied that those set at Liverpool were sufficiently specific. The case reviews at Preston did not refer to the caremap although Prison Service instructions require reviews to consider and record progress against the caremap and to consider whether the prisoner has any additional needs which require the caremap to be updated. The instructions require that ACCT plans should not be closed until all the caremap actions have been completed. While the caremap actions were too vague we are concerned that there was no reference at all to them at Preston before the ACCT was closed on 28 June 2012. Nor is there any evidence that staff at Preston considered whether new caremap actions were required. We make the following recommendation:

The Governors of HMP Liverpool and HMP Preston should ensure that:

- **ACCT caremaps have meaningful time-bound actions aimed at reducing prisoners’ risks to themselves,**
- **That progress against caremaps is considered at each review and that caremaps are updated if additional needs are identified and**

- **ACCTs are not closed until all identified actions of caremaps have been completed.**

Assessment of risk

97. When the ACCT was closed on 28 June, The man said that he had no suicidal thoughts and was happy for the ACCT to be closed. He had asked for the ACCT to be closed when he first arrived at Preston. At the previous review on 23 June, the SO had noted that the mental health team had yet to assess the man. This assessment did not take place until 18 July. The SO also noted that the man was due back in court for sentencing and that he was planning to plead not guilty. This does not appear to have been taken into account when the ACCT was closed.
98. The man believed that he was likely to be released when he appeared at court for sentencing. There was a clear risk that the man's mental health would have been affected if the court's decision was contrary to what he was expecting. We consider that the ACCT case review should have discussed this risk before closing the ACCT. At minimum, a plan should have been in place to monitor him if he came back from court to serve a longer sentence than he had expected but ideally, the ACCT should have remained open until the man had been sentenced and his reaction to that sentence monitored. Changes in status and receiving a longer sentence than expected are identified as triggers and risk factors for suicide and self-harm. We make the following recommendation:

The Governor of HMP Preston should ensure that ACCT reviews consider all forthcoming events which might affect a prisoner's risk and that ACCTs are not closed shortly before potential trigger points for suicide or self-harm.

99. When the man returned from court on 30 July, staff noted that he had had suicidal thoughts. He then maintained that he had just been shocked by the length of his sentence. However, at this point staff should have supported the man using ACCT procedures. He had been given an unexpectedly long sentence, had a history of self-harm and mental health problems and his offence was against his mother. All of these are known risk factors for suicide and should have been considered when assessing the man's risk to himself when he returned from court. We make the following recommendation:

The Governor of HMP Preston should ensure that staff take full account of all known risk factors of prisoners returning from court when determining their risk of suicide or self-harm

Level of observations

100. When the ACCT of 2 August was first opened, the man was observed three times an hour. This was raised to four times each hour at the first case review later that day. The ACCT assessment on 3 August, noted that the man was severely depressed. Just hours later, at the next case review, the case

manager, a different one from the manager who had set the observations at four times an hour the day before, reduced the level of observations to one each hour. We believe that there was little evidence at that stage to indicate that the man's level of risk had decreased sufficiently to warrant such a drop.

101. This meant that the man was being observed once an hour on the morning of 6 August. He had asked to see the mental health crisis team on the morning he died and the mental health practitioner said that he would come and see him. The man was then taken to an education class, where he would have been in a group and less likely to harm himself. Unfortunately, because there were too many people at the class, he was returned to his cell while his cell mate remained at his class. He was thus left in his cell alone and the protective factor of having a cellmate was lost. PSI 64/2011 recognises that participation in regime activities can significantly reduce a prisoner's risk of harm to themselves and should be encouraged. It is therefore unfortunate that no one appears to have considered prioritising prisoners on open ACCTs when the available activity places were over-subscribed that morning.
102. Staff on the wing were aware that the man had returned. It is regrettable that this meant that the man was left alone in his cell, but we accept that this in itself would not have been regarded as sufficient to have triggered a review of his level of observations, unless the ACCT had specified they should be higher when he was alone. However, there is a question whether the man was appropriately monitored that morning.
103. The level of observations was recorded on the front of the ACCT document as "1x documented observation day and night" which is misleading. As the staff recorded an observation every hour in the ongoing record, it is apparent that they understood that the level of observation was to be at least once an hour. On the morning of 6 August, wing staff saw the man at 9.05am when he was locked in his cell and this is recorded in his ACCT document. The officer then recorded at 9.35am that he had declined exercise. She did not see him at the time but believed she has heard him. As, shortly after this, she was unsure about which cell he was in, we cannot be sure that she did not hear someone else saying that he did not want to be unlocked for exercise and she mistakenly thought that this was the man.
104. When carrying out ACCT checks, PSI 64/2011 indicates that staff should actively engage with the prisoner, encouraging him to talk and participate in activities where appropriate. We do not believe that the entry at 9.35am, when the man was recorded as declining exercise from behind his cell door, met this standard and therefore do not regard this as fulfilling the observation requirement. The officer did not check the man again until approximately 10.10am. As the last time he had been seen was 9.05 this was a little outside the hourly requirement.
105. While it might have been prudent to consider whether the man's level of risk and observations needed to be reviewed after he had asked to see someone from the mental health team that morning or when he was came back from his activity and was left alone in his cell, our main concern is that the expected

level of observations had been reduced on 3 August, without evidence of a reduction in risk. There was little to indicate at the ACCT case review on 3 August that the man's risk of suicide and self-harm had reduced sufficiently to reduce the level of observations from four times an hour to once. We make the following recommendation:

The Governor of HMP Preston should ensure that the level of observations for prisoners on ACCTs properly reflects their level of risk, that reasons for reducing observations are fully recorded and that meaningful observations are conducted at the required frequency.

Light fittings

106. There are many ligature points in most prison standard prison cells which would be very difficult to eradicate. Someone determined to hang themselves will usually be able to do so. However, the man's family was surprised, as people often are, that light fittings can support the weight of an adult male. We do not know the man's motives for tying the ligature on 6 August, or why he chose to use the light fitting, but sometimes prisoners attempt to hang themselves as "a cry for help" and might use the light fittings for that purpose. We are concerned that such prisoners might choose to use a light fitting in the belief that it will not support their weight. Following similar deaths at another prison in the North West, we recommended that the prison should review their light fittings to make them safer. We believe that Preston should do the same, to reduce the possibility of them supporting the weight of a body and being used as a potential ligature point. We make the following recommendation:

The Governor of HMP Preston should ensure that light fittings in cells are assessed to identify whether any modifications can be made to make them safer.

Availability of Listeners

107. The man asked to speak to a specific Listener on the evening of 5 August. The officer offered to contact the duty Listener for the man, but he was adamant that he would only speak to one Listener from C3 landing. The man asked several times that evening for a Listener (and, on one occasion, the same Listener as earlier), but another officer told him that, as he had refused to see the duty Listener earlier that evening, he could not do so. The man's cell mate told the police that the man became stressed when he could not see the same Listener. He thought that officers did not really believe that the man needed to see a Listener, but just used this as an opportunity to get time out of his cell.
108. The policy on Listeners is contained in a local instruction entitled "Caring for the suicidal and those at risk of self-harm". The section on Listeners states that a rota for the duty care suite is published on a monthly basis and "must be strictly adhered to. This is to ensure that the same Listeners are not being utilised all the time, which could cause burn-out."

109. Although we understand why the man might have wanted to see the same Listener, we believe that the two officers were acting in accordance with the published policy, which is in place to protect the Listener service for all prisoners. We are satisfied that the man had appropriate access to Listeners.

Family liaison

110. It is clear from the man's family's account of their interaction with Preston that they have concerns not only about how the man was cared for, but also about the information they were given, both in meetings at their home and at the prison. We have two accounts – from the man's family and from the family liaison log – and both parties have acknowledged that the meeting at the prison on 15 August was challenging.
111. We believe that the initial contact with the man's family was of a good standard. We consider that it was thoughtful to ask the Imam from another nearby prison to join them at the man's family's home in the absence of the Imam from Preston. However, subsequent contact was marred by a level of mistrust, seemingly caused by the lack of information that the prison were able (or willing) to provide. As an example, in the family liaison log, the family liaison officer recorded that when she spoke to the man's uncle on 7 August, she gave them "as much information as permitted". The family liaison officer also noted that the man's family repeatedly said at the meeting on 15 August that prison staff were not giving them the answers they needed and, at one point, they said that the meeting was a waste of time.
112. The man's family said that a visit from Preston's Imam was not useful, and that he gave them some false information. They also said that during the meeting at the prison on 15 August, several members of the prison staff did not know the full circumstances of the man's death. They said that they had to ask questions continually to try to establish the full facts about what happened on the man's last morning. They were told they would get some of the answers at the inquest, which they perceived as an unwillingness to disclose information to them. For example, the man's family said in their statement that they were told that a member of the Crisis team was on his way to see the man when he was found. However, we have found no evidence to suggest this was the case, either in the medical record or from our interview with the mental health practitioner, who had told the SO that he would send someone to see the man.
113. It is unfortunate that the man's family lost confidence in the prison. The family liaison officer made a comprehensive note of the meeting of 15 August. As the account is broadly similar to that of the man's family we are satisfied that the prison has acknowledged the difficulties of the relationship. It is clear from both accounts that the man's family did not feel that they were given answers to their questions. PSI 64/2011 sets out the guidance for family liaison after a death in custody. Although it does not set out specifically the types of information that should or should not be given, it advises that if there is any information that cannot be released, for example because the police have

asked for some information to be kept back, the prison should explain why this is necessary. If prisons do not know the answers to questions that should give a commitment to provide the information at a later date.

114. Grieving families will understandably be very distressed after the death of a loved one and we appreciate that at an early stage it may be very difficult for prisons to provide all the answers to their questions. Some questions might need to wait for the PPO investigation and then the inquest process before they are answered. Even when prisons have the answers, bereaved families might find them difficult to accept, so good communication is essential. However, it is clear that the man's family do not feel that they were given answers to questions which the prison should have been able to provide and that they gained the impression that some information was being deliberately withheld. We make the following recommendation:

The Governor of HMP Preston should ensure that prison staff who meet the families of deceased prisoners are fully aware of the circumstances of the death and are able to provide families with accurate answers to their questions.

RECOMMENDATIONS

1. The Governors of HMP Liverpool and HMP Preston should ensure that there is continuity of case management in ACCT case reviews.
2. The Governors of HMP Liverpool and Preston should ensure that:
 - ACCT caremaps have meaningful time-bound actions aimed at reducing prisoners' risks to themselves,
 - That progress against caremaps is considered at each review and that caremaps are updated if additional needs are identified and
 - ACCTs are not closed until all identified actions of caremaps have been completed.
3. The Governor of HMP Preston should ensure that ACCT reviews consider all forthcoming events which might affect a prisoner's risk and that ACCTs are not closed shortly before potential trigger points for suicide or self-harm.
4. The Governor of HMP Preston should ensure that staff take full account of all known risk factors of prisoners returning from court when determining their risk of suicide or self-harm
5. The Governor of HMP Preston should ensure that the level of observations for prisoners on ACCTs properly reflects their level of risk, that reasons for reducing observations are fully recorded and that meaningful observations are conducted at the required frequency.
6. The Governor of HMP Preston should ensure that light fittings in cells are assessed to identify whether any modifications can be made to make them safer.
7. The Governor of HMP Preston should ensure that prison staff who meet the families of deceased prisoners are fully aware of the circumstances of the death and are able to provide families with accurate answers to their questions.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p><u>HMP Liverpool and HMP Preston</u></p> <p>The Governors of HMP Liverpool and HMP Preston should ensure that there is continuity of case management in ACCT case reviews.</p>	Accepted	<p><u>HMP Liverpool</u></p> <p>HMP Liverpool has introduced an improved Case Manager system to address the issue of continuity. All ACCT plans open for one month are now Case Managed by the respective wing CM.</p> <p><u>HMP Preston</u></p> <p>We plan to introduce one of two systems where by either the Offender Supervisor or a dedicated supervising officer from the safer custody team will be the case manager.</p>	October 2014	
2	<p><u>HMP Liverpool and HMP Preston</u></p> <p>The Governors of HMP Liverpool and Preston should ensure that:</p> <p>a)ACCT caremaps have meaningful time-bound actions aimed at reducing prisoners' risks to themselves,</p> <p>b)That progress against caremaps is considered at</p>	Accepted	<p><u>HMP Liverpool</u></p> <p>The Care map process and the requirements of this recommendation will form part of a revised Quality Assurance process in order to address this concern.</p> <p>In addition to Case Manager training. All Case Mangers will be briefed as part of the continuous improvement process to raise awareness and adherence to these issues. Records of the briefing will be maintained and repeated annually.</p> <p><u>HMP Preston</u></p> <p>A bid to increase resource in our safer custody team has been submitted. This increased</p>	October 2014	

	<p>each review and that caremaps are updated if additional needs are identified and</p> <p>c)ACCTs are not closed until all identified actions of caremaps have been completed</p>		<p>resource will be responsible for quality assurance of A, Band C</p> <p>In terms of C each case will be managed on a case by case basis. There will be times when some care map actions are ongoing and can be managed outside of the ACCT process but only if the prisoner is no longer a risk of suicide or self-harm and no longer needs the support of the ACCT processes. In these cases the actions will be updated as to how it will be progressed outside of the ACCT process or if not to be progressed why the action is no longer a risk factor.</p>		
3	<p><u>HMP Preston</u></p> <p>The Governor of HMP Preston should ensure that ACCT reviews consider all forthcoming events which might affect a prisoner's risk and that ACCTs are not closed shortly before potential trigger points for suicide or self-harm.</p>	Accepted	<p>The commitment to having continuity of case management will enable completion of this recommendation. Case Manager will also be reminded of this responsibility.</p>	October 2014	
4	<p><u>HMP Preston</u></p> <p>The Governor of HMP Preston should ensure that staff take full account of all known risk factors of prisoners returning from</p>	Accepted	<p>This forms part of the ACCT training session that is delivered via an establishment training plan over 3 year cycle to staff. Periodic notices will be issued to remind and refresh staff.</p>	December 2014	

	court when determining their risk of suicide or self-harm.				
5	<p><u>HMP Preston</u></p> <p>The Governor of HMP Preston should ensure that the level of observations for prisoners on ACCTs properly reflects their level of risk, that reasons for reducing observations are fully recorded and that meaningful observations are conducted at the required frequency.</p>	Accepted	All planned case reviews are conducted by a multi-disciplinary team with at least one Health professional within the team. The team decides the levels of observation and interactions based on the information available. A reminder notice will be issued to case managers to documents reasons for alterations observations.	September 2014	
6	<p><u>HMP Preston</u></p> <p>The Governor of HMP Preston should ensure that light fittings in cells are assessed to identify whether any modifications can be made to make them safer.</p>	Accepted	A review will be conducted by the estates manager to identify if any modifications can be implemented to make light fittings safer.	December 2014	
7	<p><u>HMP Preston</u></p>	Accepted	We will ensure that there are a reasonable	April 2015	

<p>The Governor of HMP Preston should ensure that prison staff who meet the families of deceased prisoners are fully aware of the circumstances of the death and are able to provide families with accurate answers to their questions.</p>		<p>number of fully trained Family Liaison Officers who are briefed prior to visiting the deceased family.</p>		
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