

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Coombes a prisoner at HMP Forest Bank on 28 September 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Adam Coombes was found hanged in his cell at HMP Forest Bank on 28 September 2015. He was 23 years old. I offer my condolences to Mr Coombes' family and friends.

Mr Coombes had been in prison previously, and had no history of suicide attempts or self-harm. On 11 August, he was remanded to HMP Manchester and, on 14 September, was sent to HMP Forest Bank. No one identified any concerns about Mr Coombes state of mind, either at Manchester or Forest Bank. Although it appears that Mr Coombes had some relationship difficulties, prison staff were unaware of this. I do not consider they could have predicted or prevented his actions.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2016

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Summary

Events

1. On 11 August 2015, Mr Adam Coombes was remanded to HMP Manchester, charged with serious, violent offences. He had been in prison before. There was no indication that he was at risk of suicide or self-harm.
2. Mr Coombes was initially regarded as a potential category A prisoner who would need the highest levels of security and was held in the segregation unit. On 15 August, he moved to a standard prison wing when it was decided he would not be regarded as category A.
3. On 14 September, about 100 prisoners were moved to other prisons after a disturbance at Manchester the day before. Mr Coombes was moved to HMP Forest Bank. On 15 September, a mental health nurse assessed him and had no concerns about him.
4. Mr Coombes phoned his girlfriend frequently and their calls were often heated as he accused her of seeing someone else. Other prisoners said that Mr Coombes talked about his forthcoming court case but did not appear upset about it and did not say anything that indicated he was suicidal. While he was at Manchester and Forest Bank he had access to an illicit mobile phone and often texted his girlfriend. Some of his texts indicated suicidal thoughts but no one else was aware of this.
5. On 27 September, Mr Coombes tried to call his girlfriend nearly two hundred times during the day from the prison phone in his cell but her phone was switched off. They argued about this when he eventually spoke to her that evening. On the morning of 28 September, Mr Coombes spoke to his girlfriend twice and said he could not do it anymore and that she should say that the last time she spoke to him, he was happy. She told him not to do anything stupid. At 10.19am, a prisoner who was delivering bedding to other prisoners saw Mr Coombes, who was locked in his cell, sitting on the bed and smoking a cigarette.
6. At 11.35am, an officer checked Mr Coombes as part of a routine roll check. He found Mr Coombes slumped under the sink with a ligature made out of material around his neck, attached to the mirror above. He went into the cell immediately, cut the ligature, and radioed an emergency medical code. Nurses and a GP came to the cell and tried to resuscitate Mr Coombes until paramedics arrived at 11.43am. The paramedics assessed Mr Coombes but at 11.53am, pronounced him dead.

Findings

7. There was little to indicate that Mr Coombes was at raised risk of suicide and he had never told anyone in prison that he had suicidal thoughts. No one was aware of his texts from an illicit mobile and, although he had a number of difficult phone calls with his girlfriend, these were from a phone in his single cell. We do not consider that staff at Forest Bank could have predicted or prevented Mr Coombes' death.

8. There was an appropriate emergency response when the officer found Mr Coombes had hanged himself. He quickly radioed an emergency, control room staff called an ambulance immediately and staff promptly began to attempt cardiopulmonary resuscitation.

The Investigation Process

9. The investigator issued notices to staff and prisoners at Forest Bank, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. NHS England commissioned a clinical reviewer to review Mr Coombes' clinical care at the prison.
11. The investigator visited Forest Bank and obtained copies of relevant extracts from Mr Coombes' prison and medical records. He interviewed five members of staff at Forest Bank. He liaised with the police and had access to police statements during the investigation.
12. We informed HM Coroner for Bolton about the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Coombes' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Coombes' mother was concerned about how his family had been informed of his death.
14. Mr Coombes' family received a copy of the initial report. They highlighted a point for clarification. This report has been amended accordingly.
15. Greater Manchester Police also raised a query with regards to Mr Coombes being seen on CCTV leaving his cell at unlock on 28 September. The investigator reviewed the CCTV and on further investigation concluded that the person seen on CCTV was not Mr Coombes. The report has been amended for factual accuracy.

Background Information

HMP Forest Bank

16. Forest Bank is a local prison in Salford, serving courts in the North West. It holds 1,460 remanded and sentenced men. The prison is privately managed by Sodexo Justice Services. Sodexo provides primary health care services. There is a 20-bed inpatient unit with 24-hour nursing cover. An agency provides GP services with doctors available from 9.00am to 9.00pm Monday to Friday, 1.00pm to 5.00pm Saturday and 9.00am to 12.00pm Sunday. There is out of hours cover at other times.

HM Inspectorate of Prisons

19. The report of the most recent inspection of Forest Bank in February 2016 has yet to be published. At the previous inspection in 2012, inspectors said that Forest Bank was a good prison, which had improved. They said that, although it operated in a challenging, inner city environment, staff attached great importance to keeping people safe. Reception processes were appropriate and first night arrangements were good. The suicide and self-harm policy was well-publicised. Inspectors said that the prison had reasonably good arrangements to support and help those in self-harm crisis. Inspectors' main concern was that prisoners did not have enough activity.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisons treat prisoners fairly and decently. In its most recent annual report for the year to November 2014, the IMB noted that Forest Bank had a whole prison approach to the prevention of suicide and self-harm, led by the safer custody team. New arrivals were housed in a dedicated wing and given an induction programme about the prison regimes and procedures, including details of support services.

Previous deaths at HMP Forest Bank

18. Mr Coombes' death was the first self-inflicted death at Forest Bank since 2014. There were no significant similarities between this and the previous two self-inflicted deaths at the prison.

Key Events

19. On 8 May 2015, Mr Adam Coombes was released from HMP Risley on licence. On 8 June, Greater Manchester Police served Mr Coombes with a “threat to life disruption notice”. This said that the police had intelligence to suggest that Mr Coombes had threatened someone’s life.
20. On 10 August, Mr Coombes was arrested on suspicion of attempted murder, possession of offensive weapons and grievous bodily harm. On the same day, the police served him with another notice, called a threat to life warning. This said that police intelligence suggested that Mr Coombes was at medium risk of harm from another person. This was allegedly linked to gang-related offences Mr Coombes had committed. Mr Coombes told police that he was not concerned about any threats against him. On 11 August, Mr Coombes appeared at court and was remanded to HMP Manchester.
21. When Mr Coombes arrived at the prison a reception officer noted that during previous prison sentences, Mr Coombes had been considered as high risk for sharing a cell, because he had threatened to take a hostage. He did not consider that Mr Coombes was at risk of suicide or self-harm.
22. At an initial health screen, Mr Coombes said he had no concerns about his health and was not taking any medication. A healthcare assistant recorded that Mr Coombes had no history of self-harm and did not need to see the GP.
23. That evening, an offender supervisor completed a basic custody screen and referred to the police notice that someone had threatened his life. Mr Coombes said that he had no concerns about his safety.
24. Because of the serious nature of his charges, the prison security department reported Mr Coombes to Prison Service Headquarters to consider whether Mr Coombes should be regarded as a category A prisoner, the highest level of security. In the meantime, Mr Coombes was held in the segregation unit, the standard procedure for potential Category A prisoners.
25. On 12 August, a member of the chaplaincy team spoke to Mr Coombes in the segregation unit. He said that Mr Coombes told him he had no concerns or thoughts of suicide or self-harm. He said he was aware of the support available, and that his family and friends would visit him.
26. That day, a mental health nurse went to see Mr Coombes in the segregation unit for a mental health assessment, as a standard procedure for prisoners charged with murder or attempted murder. She said that Mr Coombes was relaxed and did not appear distressed. She did not consider that he was at risk of suicide or self-harm and discussed her assessment with her managers. They decided that the daily routine segregation healthcare checks were sufficient to ensure his welfare. On 15 August, Mr Coombes moved to a single cell on A Wing, after it was decided he would not be a category A.
27. On 18 August, there was an altercation on A Wing between Mr Coombes and another prisoner. Mr Coombes was restrained and taken to the segregation unit

to cool off before returning to A Wing. There was no indication of any a link to his outstanding charges. The next day, he was moved to a single cell on E Wing.

28. On 24 August, Mr Coombes' offender supervisor introduced herself and explained her role to him. She said that Mr Coombes did not appear to be fazed by anything. She said he kept winking at her and said he was not guilty. They did not discuss much about his charges, as Mr Coombes intended to plead not guilty.
29. The offender supervisor said that Mr Coombes spoke about the threat to life warning he received from the police. He told her that people in his local community thought that he was responsible for some offences but he was not concerned about this. She asked why he was considered a high risk for sharing a cell and Mr Coombes admitted that he had threatened to take a hostage during a previous sentence at HMYOI Lancaster Farms.
30. Mr Coombes asked whether the offender supervisor worked for social services, as they had advised his girlfriend not to have any contact with him because of risk to her and her child. She told Mr Coombes that she would not contact social services about him. She said that there was nothing about him or what he said that gave her any concern about his well-being.
31. Mr Coombes stayed on E Wing at Manchester. After his death, Mr Coombes' girlfriend told the police that he had had a mobile phone. (Mobile phones are illegal in prisons.) She said that he rang her from the prison phones during the day, but they texted each other at night.
32. On 13 September, a prisoner climbed on the prison roof and a major disturbance damaged a wing. Mr Coombes' girlfriend said that he had texted her on 13 September and said, 'You're all alone and it's just going to get harder. It's my fault. Maybe you need to forget about me. To be honest I wake up everyday wishing I was dead. Find someone who will make you happy.'
33. Mr Coombes' girlfriend told the police that at 10.56am on 14 September, Mr Coombes had texted her. He said, 'I'm not gonna lie. I tried kilin myself the other day that's how much my heads gone xx [sic].' Mr Coombes' girlfriend said that she was shocked and begged him not to do anything stupid. After this, she said his messages went back to normal. There is no evidence that Mr Coombes had mentioned any suicidal thoughts to staff while he was at Manchester and they knew nothing about the texts.
34. Because of the damage to the wing, Manchester had to transfer some prisoners. Mr Coombes was moved to Forest Bank at 11.00pm on 14 September. As they arrived late, Mr Coombes and other prisoners spent only a short time in the reception area. Basic information was recorded and Mr Coombes was asked about his well-being and any thoughts of self-harm or suicide and paperwork completed. He did not raise any concerns.
35. On 15 September, a mental health nurse saw Mr Coombes for an initial health screen. He noted that Mr Coombes was not taking any prescribed medications and reported no concerns. He recorded in Mr Coombes' medical record that he

had no concerns about Mr Coombes' well-being and there was no indication that Mr Coombes was at risk of suicide or self-harm.

36. An officer told Mr Coombes and other prisoners who had arrived from Manchester the night before, about the facilities, support networks and daily routines at Forest Bank. The officer said that the prisoners were also seen individually by staff from other departments, such as chaplaincy, drug rehabilitation agency etc. He said that during the induction no immediate concerns were raised, but the prisoners were not particularly happy about being moved from Manchester.
37. Mr Coombes did not have a job at Forest Bank so spent each day on the wing. A prisoner at Forest Bank told the police that he moved to D1 Wing, the same wing as Mr Coombes, around 20 September. He said that he often spoke to Mr Coombes during weekday evening association periods between 5.30pm and 8.00pm when prisoners are unlocked from their cells and can mix with each other. He said Mr Coombes usually talked about people outside prison and never appeared worried about anything.
38. Another prisoner on Mr Coombes' landing said that Mr Coombes talked a lot about how his trial would go, but did not seem very worried about it. He said that Mr Coombes seemed convinced that he would be found not guilty and wanted to be out before Christmas to see his girlfriend's baby. He said that he was not aware of Mr Coombes having any trouble with other prisoners. Mr Coombes did not mention any health problems or threats to his life.
39. On 21 September, a senior prison custody officer searched Mr Coombes' cell because there was information that he had a mobile phone. He did not find a mobile phone but said he found some wire which prisoners use to charge electric equipment. No action was taken against Mr Coombes. He said that Mr Coombes' behaviour on the wing was very good. (Mr Coombes had concealed a mobile phone internally and this was found at the post-mortem examination.)
40. On 25 September, Mr Coombes made a complaint that money was missing from his prison account. He did not receive a reply before he died but there was no money missing. When the prisoners had transferred at short notice from Manchester, Forest Bank had advanced them money to allow them to buy tobacco, phone credit and other goods from the prison shop. The prison had automatically recovered the advance of money Mr Coombes had received when he first arrived, once his accounts were transferred from Manchester.
41. Each cell at Forest Bank has its own phone and prisoners can phone family and friends once the prison approves their numbers, if they have enough credit. At night, the prison switches off the phones, but prisoners can still use them to contact the Samaritans.
42. On Sunday 27 September, Mr Coombes tried to ring his girlfriend 192 times from the phone in his cell but did not get through. Mr Coombes' girlfriend said that she had switched her phone off. She said that she had been feeling under pressure and had told Mr Coombes how difficult things were for her.

43. At 9.07am on 27 September, Mr Coombes spoke to his mother for two minutes. They talked about family matters and Mr Coombes did not say anything that caused her to be concerned about him. At 3.18pm, Mr Coombes briefly called his mother again and asked if she had heard from his girlfriend, but she had not. Between 3.59pm and 4.47pm, Mr Coombes spoke to his girlfriend four times and they argued about why she had not answered her phone earlier. Mr Coombes accused her of seeing someone else. At the end of the last call, Mr Coombes told her to remember that he loved her.
44. A prisoner said that he spoke to Mr Coombes at 4.50pm on 27 September, just before they were locked in their cells for the night. He said that Mr Coombes told him he had been thinking of how to get off the charges he was facing. He said that they talked for only a few minutes before they had to go back to their cells. He said Mr Coombes appeared no different from usual.
45. On Monday 28 September, officers unlocked prisoners just after 7.00am to collect their breakfast. CCTV was viewed by the investigator but Mr Coombes was not seen to leave his cell. Officers locked prisoners back in their cells at 8.00am. Officers then unlocked the prisoners who needed to go to work and did a roll count of the prisoners left on the wing. There was a problem with the count that morning and an officer counted the cells that another officer had done earlier. Neither officer reported anything unusual about Mr Coombes.
46. Between 7.05am and 9.13am, Mr Coombes tried to call his girlfriend 14 times from the phone in his cell. He got through at 9.17am and 9.26am and said, "It's all messed up, I cannot do it anymore...Don't hate me...Just say the last time you spoke to me, he was happy.' Mr Coombes' girlfriend asked him what he meant but he said it did not matter. He said, 'I just can't do it anymore. It's all too much. There are easier ways.' Mr Coombes' girlfriend told him not to do anything stupid but he said it did not matter and that he had to go. The last call lasted around four minutes.
47. At 10.19am on 28 September, a prisoner was checking whether other prisoners needed new bedding, which would be delivered late. He stopped outside Mr Coombes' cell and looked into the cell through the observation panel. He said that Mr Coombes was sitting on his bed, smoking at the time. He said that he had asked Mr Coombes if he needed clean bedding and thought he had said he did.
48. At 11.30am, an officer began another roll check of prisoners on the wing before the other prisoners returned from work. He arrived at Mr Coombes' cell, at 11.35am. He said he could not immediately see Mr Coombes when he looked through the observation panel but then saw him slumped on the floor, with material around his neck which was tied to the mirror above the sink. He immediately unlocked the door but could not get a response from Mr Coombes. He radioed a code blue medical emergency (which indicates situations such as when a prisoner is unconscious or not breathing) and cut the ligature from Mr Coombes' neck. A prisoner who was on the wing, responded immediately and helped the officer place Mr Coombes in the recovery position.
49. A nurse said he heard the code blue call at 11.38am and went immediately to Mr Coombes' cell, which he thought took about 30 seconds. He said that, when he

reached the cell, he noted that Mr Coombes had swelling and bruising around his neck. He thought his neck looked slightly deformed. Mr Coombes was not breathing and had no pulse so he began cardiopulmonary resuscitation (CPR).

50. More nurses arrived with emergency medical equipment, including a defibrillator. A prison GP reached the wing about a minute after the code blue. He said that nurses were performing CPR when he arrived, giving oxygen to Mr Coombes and had attached the defibrillator. He examined Mr Coombes but could not detect a pulse and his temperature was low.
51. The defibrillator found no shockable heart rhythm and the GP inserted a cannula into Mr Coombes' throat to try to increase the airflow. He noted that Mr Coombes' pupils were fixed. A paramedic arrived at Forest Bank about three minutes after receiving an emergency call at 11.39am. His initial assessment was that Mr Coombes' neck was severely damaged and he asked the healthcare staff to continue CPR. A nurse contacted the ambulance trauma cell for advice, as he thought the injury to Mr Coombes was so severe that continuing CPR might be futile. Another ambulance crew arrived shortly afterwards and the paramedics agreed that they should stop CPR. Mr Coombes' death was recorded at 11.53am.

Contact with Mr Coombes' family

52. A prison chaplain was the prison family liaison officer. He and a prison manager arrived at Mr Coombes' mother's house at 1.55pm to inform her of his death. His mother was not there but his brother gave them a telephone number for her but they could not contact her. The chaplain established that Mr Coombes' brother was over 18 years old and, after taking advice from the duty director, told him what had happened. Mr Coombes' brother contacted his stepfather, told him what had happened and his mother returned home. Although Mr Coombes' mother was unhappy about how they had learnt of his death, we are satisfied this was appropriate.
53. The chaplain offered condolences and support, including helping organise the funeral. Mr Coombes' funeral was held on 16 October 2015. The prison paid funeral costs in line with national policy.

Support for prisoners and staff

54. The prison posted notices informing other prisoners about Mr Coombes' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Coombes' death. The duty manager debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

Post-mortem report

55. A post-mortem examination concluded that the cause of death was hanging. Toxicology tests did not show that Mr Coombes had taken any illicit drugs or medication before he died.

Findings

Assessment of risk of suicide and self-harm

56. Prison staff interview new prisoners in reception to assess their risk of suicide and self-harm. They should begin Prison Service suicide and self-harm prevention procedures if they assess that prisoners are at raised risk of suicide and self-harm because of identified risk factors. Prison Service Instruction (PSI) 64/2011 lists a number of factors and potential triggers, which increase the risk of suicide and self-harm. Although Mr Coombes had some evident risk factors, such as his age, being on remand, charged with a violent offence and possibly facing a long sentence, there was little to indicate he was at heightened risk of suicide and needed monitoring.
57. Mr Coombes had been in prison a number of times. There was no record of any previous suicide attempts or self-harm and he had no history of mental health problems. He never told anyone in Manchester or Forest Bank that he had suicidal thoughts and he gave staff no reason to consider that they should monitor him under the ACCT procedures. When Mr Coombes arrived at Manchester, as well as the standard reception assessment, he had a mental health assessment, which identified no concerns about his risk of suicide or self-harm.
58. When he arrived at Forest Bank, a mental health nurse assessed him on 15 September and found no evidence that Mr Coombes was at risk of suicide or self-harm. Although it appears that Mr Coombes had relationship difficulties, which can be a risk factor for suicide, particularly for young men, none of the staff at Manchester or Forest Bank were aware of this. Other prisoners did not consider he appeared distressed or suicidal. We consider it would have been very difficult for staff to have identified that Mr Coombes was at high and imminent risk of suicide, or prevent his actions, which appear to have been sudden and unexpected.

Emergency response

59. Prison Service Instruction 3/2013 says that governors and directors must have a medical emergency response code protocol. This is to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. Forest Bank has an appropriate emergency protocol. The PSI also says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. During interviews, prison staff demonstrated that they were aware of the local policy and its requirements.
60. The officer used an appropriate medical emergency code when he radioed the control room for help after he found Mr Coombes hanging. The control room contacted the ambulance service immediately they received the code blue call and the first responder paramedic very quickly afterwards. We are satisfied that there were no unnecessary delays in the emergency response which was fast and effective.

Clinical care

61. The clinical reviewer identified no concerns about Mr Coombes' clinical care at Forest Bank.

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