PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Preston in October 2014

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 in HMP Preston in October 2014. He was 45 years old. I offer my condolences to his family and friends.

NHS England reviewed the man's clinical care at Preston. The prison cooperated fully with the investigation.

The man was remanded to HMP Preston on 25 September 2014, charged with malicious wounding of his wife and four counts of attempted murder. The man had tried to hang himself when he was in police custody for other charges the week before and arrived with a suicide and self-harm warning form indicating that he was at very high risk of suicide. He had been constantly watched for five days at the police station. Despite this background, the reception senior officer did not immediately identify the man as at risk of suicide and begin suicide and self-harm prevention procedures. A reception nurse and a duty governor recognised his risk, but, even then, prison staff assessed the man as at low risk of suicide or self-harm and checked him only once an hour during the night.

When an officer checked the man in the early hours on the day of his death, she could not see him properly because he had draped a towel across the end of the bunk bed, although she could see his arm on the floor. She called for help and officers went into the cell and found he had hanged himself by a sheet attached to the bed. Officers and nurses tried to resuscitate him but without success.

It was evident from events in the man's recent past that he was at high risk of suicide and self-harm. Although this was quickly rectified, I am concerned that this was not identified immediately when he arrived at the prison. The man seems to have engaged well with staff and he repeatedly said that he did not intend to harm himself again. However, as I have found all too often, prison staff relied too much on the man's assurance that he did not intend to harm himself, rather than his known risk factors. This led to them underestimating his level of risk and setting observations too infrequently.

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 **June 2015**

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SUMMARY

1. On 20 September 2014, the police charged the man with the malicious wounding of his wife, four counts of attempted murder and two counts of attempting to cause grievous bodily harm. He was held in police custody for five days until 25 September, when he was remanded to HMP Preston. This was his first time in prison for almost 15 years.

2. The man arrived in Preston with a warning form from the police indicating that he was at very high risk of suicide and had been constantly watched by the police. His escort document recorded that he had tried to kill himself at the police station on 17 September, when he had been arrested for other offences.

3. The man told a senior officer in reception that he had no thoughts of suicide or self-harm and the senior officer did not think he was at risk. However, a reception nurse and the duty governor asked officers to start Prison Service suicide prevention procedures, known as ACCT. Staff assessed the man as high risk for cell sharing and allocated him a single cell.

4. At an ACCT assessment interview on 26 September, the man said that he had not intended to kill himself in police custody and would not harm himself again. An ACCT review that afternoon, assessed the man as at low risk of suicide and self-harm and required officers to check him only once an hour. Operational problems meant a nurse could not attend the review that day, so staff arranged a further review the next day. The review panel did not complete a caremap setting out actions to reduce the man's risk.

5. The ACCT case review the next day again assessed the man as low risk and reduced observations to three during the day and hourly checks at night. Again, staff did not complete a caremap.

6. One of the man's alleged victims died on 27 September and the man heard this news two days later. Although the case had attracted a lot of local publicity, there is no formal record that staff knew about this and noted it.

7. At a check shortly after 2.00am on 2 October, the man appeared to be asleep. When the officer next checked him an hour later, she could see his arm on the floor, but he was mostly concealed by a towel draped across the end of the bed frame. The officer called for help. Other officers arrived and they went into the cell and found the man had hanged himself by a sheet attached to the bed. Officers and nurses attempted to resuscitate him. Paramedics arrived soon after. The paramedics checked the man and confirmed that he had died.

8. Although quickly rectified, we are concerned that staff did not open an ACCT as soon as the man arrived at Preston. We consider that staff underestimated his risk of suicide by placing too much emphasis on his apparent positive presentation rather than his evident risk factors. They should have completed a caremap to identify actions to reduce his risk. We make one recommendation about ACCT procedures.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Preston, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

10. On 13 September 2014, the investigator visited Preston and obtained copies of the man's prison and healthcare records. He later interviewed 15 members of staff and three prisoners at Preston.

11. We informed HM Coroner for Preston and West Lancashire of the investigation and we have sent him a copy of this investigation report.

12. NHS England commissioned a review of the man's clinical care at the prison.

13. One of the Ombudsman's family liaison officers contacted the man's wife and sister and explained the investigation process. The man's sister said her brother had set fire to his house and attempted to take his life on 16 September, before being arrested on 20 September in connection with other offences. The police had recognised he was vulnerable and kept him on constant watch. She wanted to know why prison staff had not taken into account all her brother's risk factors; why he had not been constantly watched in prison, particularly when he was likely to be charged with murder; and why he had not been held in the prison's healthcare centre. The man's family received a copy of the draft report. They did not make any comments.

HMP PRESTON

14. HMP Preston is a local prison holding up to 842 adult men. Lancashire Care Foundation Trust provides health services at the prison. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility.

HM Inspectorate of Prisons

15. The Inspectorate of Prisons last inspected Preston in April 2014. Inspectors found that Assessment, Care in Custody and Teamwork (ACCT) documents for supporting prisoners at risk of suicide and self-harm were mostly of reasonable quality with thorough assessments. Reviews were generally multidisciplinary and very well supported by the chaplaincy and mental health teams. ACCT caremaps were generally reviewed and updated at each review. Many ACCTs provided evidence of good staff interactions with prisoners, but some comments were observational and did not demonstrate that staff had spoken to prisoners.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its 2013/14 annual report, the Board noted that Preston was a commendable prison where prisoners were cared for humanely and decently. The Board said Preston was striving to provide a safe and secure environment for prisoners.

Previous deaths at Preston

17. The man's death was the fourth apparent self-inflicted death at Preston since September 2011. In two of the three other cases, we were critical of the way the prison managed ACCT procedures. In the other case, we found that not all risk factors were taken into account when assessing the prisoner's risk.

Assessment, care in custody and teamwork (ACCT) procedures

18. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves 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 of the actions on the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

19. On 20 September 2014, the police charged the man with the malicious wounding of his wife, four counts of attempted murder and of causing grievous bodily harm. The victims involved in the further charges had been injured when the man allegedly drove his car into them and a number of other cars. The man had tried to hang himself three days before, on 17 September, when he was in police custody for alleged arson, for which he had been bailed. Because of this and the nature of the further charges, the police constantly watched the man while he was in their custody.

20. The man remained in police custody until 25 September when he was remanded to HMP Preston. He had been in prison custody before, but not for almost 15 years. Police completed a Person Escort Record (PER, a document that accompanies all prisoners when they move between police stations, courts and prisons) and identified the man as at very high risk of suicide. They also recorded that he had attempted to hang himself on 17 September. As well as the information on the escort record, the man arrived at Preston with a suicide and self-harm warning form stating that he had been on constant watch since his arrest, as the police considered him at very high risk of suicide. Court staff also recorded that the man's solicitor had said that the man would attempt suicide at the first opportunity.

21. A reception supervising officer (SO) saw the man in reception and completed a local form, used when the prison receives information from court that a prisoner might be at risk of suicide or self-harm. The reception SO noted:

> "… PER states very high risk suicide. Been on constant watch since arrest … Information from solicitor first chance [the man] gets … he will further attempt suicide."

22. The reception SO told the investigator that he saw from the man's papers that he had been charged with serious offences and had tied clothing around his neck while in police custody. He spoke to the man for around 15 minutes and said the man was open and lucid. The man told him that he had no thoughts of suicide or self-harm and he had tied clothing around his neck to cause difficulty for the police. Based on his presentation, the reception SO decided that he did not need to open an ACCT. He did not consider that the man's risk factors, based on the charges he was facing, outweighed how he appeared. The reception SO said that a reception nurse had been due to see the man after him and would explore mental health issues and make her own decision about opening an ACCT.

23. The reception SO said that shortly after he had seen the man, the duty governor came to the reception area. When she looked at the man's cell sharing risk assessment, she asked if the reception SO had opened an ACCT. He said he had not, but the man was waiting to see the nurse. The duty governor said that she wanted the staff to open an ACCT, regardless of the nurse's assessment. The reception SO's shift was ending at that time so he passed the message to the next reception SO on duty.

24. A reception nurse saw the man for a reception health screen. She told the investigator that she was already aware of the charges against him from the local newspapers. Based on that background and the suicide and self-harm warning form she had no doubt that he was at risk of suicide and self-harm. She asked an officer to open an ACCT document, while she continued the health screen.

25. The reception nurse said that the man spoke about his attempt to harm himself when he was in police custody and referred to problems with his marriage. He said that he had previously taken an overdose of drugs and had seen his doctor in the previous few months for depression. She said he did not appear to be in a particularly low mood. The reception nurse noted that the man had a fractured shoulder, which happened during the incident that had led to his arrest. A prison doctor had examined the injury and found that the man was fit to be detained in prison. The man said that he had used drugs in the last month and drank alcohol four to five days per week. The reception nurse did not refer the man to the substance misuse team as he had been in police custody for a number of days and she did not consider he was at any acute risk from withdrawal symptoms.

26. As the man was on bail for arson, staff assessed the man as high risk for cell sharing and allocated him a single cell. (The man's sister told one of our family liaison officers that her brother had set fire to his home on 16 September and had attempted to take his life the same day.)

27. Another reception SO went to see the man at 7.00pm, by which time he was in the prison's first night centre. He spoke to the man for a few minutes and noted on his ACCT concern and keep safe form that he had no thoughts of suicide or self-harm but an ACCT was being opened as a precaution. The SO said that the man seemed in good spirits.

28. The safer custody custodial manager (CM) saw the man at 9.00pm to complete an ACCT immediate action plan (to help keep the man safe overnight). The safer custody CM said that the man was a bit emotional when he spoke about the breakdown of his marriage and about the events that had led to him coming to prison. He said that when he had tied clothing around his neck in police custody, it was because he thought he was not being treated well and wanted to draw attention to this. The safer custody CM said that the man had told him that he had no intention of killing himself. The safer custody CM did not think that the man was at particular risk of suicide but, as he was in a single cell, decided that he should be observed three times an hour during the night.

29. The next morning, 26 September, a mental health nurse assessed the man's mental health using standard assessment templates. The man scored mild for anxiety and moderate to severe for depression. The mental health nurse said that despite his high score for depression, the man did not seem distressed. He said that he had threatened to kill himself when he was in police custody, as he had been detained for several days and did not think anything was happening. The mental health nurse noted on the man's clinical records that he was a high

suicide risk. She said that the assessment template gave only "high" and "low" as options for recording suicide risk and she marked him high because of the risks identified on his suicide and self-harm warning form. She noted on the man's ACCT document that he was a little low, but said he had no thoughts or plans of self-harm. She referred the man to the mental health team.

30. An officer spoke to the man that afternoon to complete an ACCT assessment. The man said that his offences were linked to the breakdown of his marriage and he was tearful when he spoke about that. He said that he had tried to strangle himself with his clothing while in police custody but had done it to get attention rather than to kill himself. He said that he had never harmed himself before (which does not appear to have been the case) and he had no current suicidal thoughts. The ACCT assessor told the investigator that the man engaged well in the interview, spoke about his sons, made good eye contact and even laughed and joked. The man said he would not harm himself again. During the assessment, the man identified a number of people he wanted put on his telephone contact list. The ACCT assessor noted that this was a positive sign and she had no concerns about his wellbeing.

31. The first SO held the man's first ACCT case review later in the afternoon of 26 September. The first SO told the investigator that staff had opened seven ACCTs the previous day, all of which needed first case reviews that day. There were also 18 prisoners already subject to ACCT procedures, who were scheduled to have case reviews that day. A second CM decided that another SO with a multi-disciplinary team would review the prisoners already on ACCTs and that the first SO should do the first case reviews for the seven men who had just had ACCTs opened. The second CM told him that there were no healthcare or chaplaincy staff available to join him, so he should use officers from the first night centre and schedule the next ACCT reviews for 27 September, when it would be possible to hold multidisciplinary reviews. The first SO said that the second CM had told him that there was no need to complete caremaps, as these would be done the next day at the follow-up reviews.

32. In the summary of the case review, the first SO noted that the man was very relaxed and said he had no thoughts of suicide or self-harm. He said he knew what to do if he needed support. The first SO assessed the man as being at low risk of suicide and self-harm (from three options of low, raised or high) and reduced the man's supervision to one written observation an hour, day and night. He set the next review for 27 September, the next day, and noted that this would be a multidisciplinary review.

33. The ACCT assessor and another officer were also at the review on 26 September. The ACCT assessor said that she had briefed the first SO beforehand about her assessment and had agreed at the review that the man seemed at low risk. The other officer said that he had had no concerns about the man's presentation.

34. The second CM told the investigator that the first SO's evidence was not entirely accurate. He said that he had asked the first SO to ask someone from

the healthcare team to attend the ACCT review if that were possible, but the priority was to get the reviews done that day. He did not agree that he had told the first SO that there was no need to complete a caremap.

35. On the afternoon of 27 September, the second SO held an ACCT case review with a mental health nurse, and a prison chaplain. The second SO said that she understood that she needed to hold a multidisciplinary review, as there had been no mental health or chaplaincy representatives at the man's review the previous day. Before the review, she read the ACCT assessment interview, the concern and keep safe form and the summary of the first review. The second SO said that the man was very relaxed at the review and said he had no thoughts of suicide or self-harm and would speak to staff if he had any such thoughts. He spoke about how much he loved his children and said that he would not harm himself for their sake. He said his act of self-harm in police custody had been in the hope he would be allowed out of the cell for a cigarette.

36. The second SO noted that the ACCT should remain open, as the man had been in prison for only a short time. She recorded that his level of risk was low and she reduced his observations to three times during the day with hourly observations at night. She set the next review for 6 October. The second SO could not recall what contribution the mental health nurse made at the review, but said he did not mention that the mental health nurse had noted in the man's clinical records that he was at high risk of suicide. She believed that if he had passed on that information, she would have set a higher frequency of observations. The second SO said that she did not write a caremap for the man as they had all agreed that he had no issues to put on a caremap.

37. The chaplain told the investigator that the man had seemed very controlled at the review. She said she had asked him what support he was expecting from his family and he said his marriage was over. He said he knew what to do if he felt he needed support and that he had no thoughts of suicide or self-harm. The chaplain said that after the man had left the room the panel discussed his presentation and considered that he had come across as too controlled given the charges he was facing. However, this was not recorded in the record of the case review.

38. On 27 September, a pedestrian who had been hit by a car the man was driving when he was arrested died of his injuries. The man had previously been charged with his attempted murder. The man heard the news from his brother in a telephone conversation on the afternoon of 29 September. The man swore several times and was clearly upset about this. There is no record that prison staff were aware of the pedestrian's death or considered how it might affect the man's risk if they were aware.

39. The ACCT assessor made a number of entries in the man's ACCT document over the next few days. Most entries just noted that he was reading or watching television in his cell. The ACCT assessor said that when she unlocked the man on a morning in October she told him that he was due to go to the gym for an induction session. He laughed and said that he could not go because of his broken shoulder. She told him the gym staff might be able to offer him

physiotherapy and so he went. The ACCT assessor said that the man also went to the library that afternoon.

40. In the early afternoon of the same day, a mental health review team agreed that the man should be referred for an urgent mental health assessment due to his possible risk of self-harm.

41. A library orderly and trained Listener, said that the man joined the library that day and they spoke for about five or ten minutes. He gave the man a tour of the library. The library orderly said that the man borrowed six books and seemed in good spirits.

42. A prisoner in a cell at one side of the man's cell was close in age to the man and had most interaction with him among other prisoners. He told the investigator that had he arrived at the prison on the same day as the man and they had spoken a little during periods when they were unlocked. He remembered the man coming back from the library with a lot of books and said he had seemed happy. They spoke again before evening lock-up at around 5.30pm to 6.00pm and the man had said he would see him the next day.

43. There were two prisoners in the cell the other side of the man's cell. One said that he had spoken to the man a little in the days they were on the wing together. He said the man seemed no different from usual on the day before his death and had said he would see him the next day when they were locked up for the evening. The other prisoner who lived in this cell said he had never had any conversation with the man.

44. A night officer made an ACCT check at 8.00pm that evening and noted that the man was watching television. She continued to check him at irregular hourly intervals. The man spent the early part of the evening watching television before reading a book for a few hours. When the night officer checked him at just after 2.00am, she noted that he appeared to be asleep.

45. When the night officer next checked the man at 3.10am she saw that his bed was empty. She switched on the nightlight and saw a towel draped across the end of the bunk bed. The man's arm was on the floor, but the towel concealed the rest of his body. The night officer did not know what was happening and she kicked the door to attract his attention, but he did not respond. The night officer tried to radio the night orderly officer (NOO – the person in operational charge of a prison at night). She could not get a radio signal so she ran to the landing office a few yards away, phoned the NOO and told him that she could not get a response from the man.

46. An operational support grade officer (OSG) was on the third landing when he heard the night officer running along the landing above and using her radio. He called to ask if she needed help and she asked him to come up. The OSG said that as he reached the man's cell, the NOO was right behind him.

47. The NOO told the investigator that when the night officer called him it was clear from her voice that she was very concerned. He said it took him around 20 to

30 seconds to reach the man's cell. When he arrived, the night officer was standing at the cell with a key ready and the OSG was with her. The night officer unlocked the door and he and the OSG went into the cell. They found the man in a seated position on the floor with a bed sheet tied around his neck and to the top of the bed frame. They cut the sheet and moved the man to the side of the bed where there was more room. The NOO radioed a code blue alarm. (This indicates a medical emergency requiring immediate medical assistance and which should alert the control room to call an ambulance immediately.) The man was not breathing so the NOO and the OSG began cardiopulmonary resuscitation.

48. Two nurses in the healthcare centre responded to the request for immediate assistance. They collected emergency equipment and went to the wing. It took around one to two minutes to reach the cell and when they arrived, two officers were carrying out cardiopulmonary resuscitation well. The nurses asked the officer to continue while they got the defibrillator ready. They tried to get a heart reading, but could not as the man had a hairy chest. They asked an officer to get a razor and in the meantime, they continued cardiopulmonary resuscitation. Once they had shaved some hair, they applied the defibrillator pads. The defibrillator found no shockable heart rhythm, so they continued the resuscitation attempt until paramedics arrived at 3.28am. The paramedics assessed the man and quickly decided that he could not be resuscitated. At 3.30am, the paramedics pronounced that he had died.

49. When he began resuscitation, the NOO had found a letter tucked into the waistband of the man's trousers, which he passed to another officer to read, in case the man had mentioned taking an overdose of medication, in addition to hanging himself. The officer told the NOO that it was a goodbye letter from the man to his wife.

50. One of the prisoners in a next door cell told the investigator that he had heard the man's bed squeaking in the early hours as if the man was getting in and out of bed. Fifteen minutes later, he heard the night officer radioing to say she could not see the man in his cell and then he heard the staff trying to resuscitate the man.

51. The man had named his wife as his next of kin. In line with standard procedure, the prison contacted the police for advice about security concerns before visiting the man's wife at her home. The police advised that it should be a joint visit. Prison staff arrived near to the man's wife's home at 8.00am but had to wait until the police arrived at 9.30am, before informing her that her husband had died. The prison contributed to funeral costs in line with Prison Service national policy.

52. The prison held a debrief with the staff involved in the emergency response and informed them of the support available from the care team. Staff reviewed all prisoners being managed under ACCT procedures in case they had been affected by the man's death.

53. The man's cause of death was given as hanging.

ISSUES

ACCT procedures

Initial opening of the ACCT

54. The man arrived at Preston with a suicide and self-harm warning form stating that he was at high risk of suicide, that he had been on constant watch in police custody and that he had recently attempted to hang himself at the police station.

55. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures, lists risk factors and potential triggers for suicide and self-harm. The man had a number of these risks, including being charged with a serious violent offence against a family member, relationship problems, further violent offences and early days in custody.

56. The reception SO was satisfied from the man's body language and from what he said that he did not need to open an ACCT. He said the reception nurse would make her own separate decision about opening an ACCT. The reception SO's failure to identify the man as at risk of suicide and self-harm when faced with such strong evidence of risk is concerning, but we recognise that this did not affect the man as both the reception nurse and the duty governor separately identified that he needed to be managed under ACCT procedures.

57. We were critical in the investigation report into another recent death at Preston, when reception staff relied too much on the prisoner's presentation rather than on his range of risk factors. We made a detailed recommendation about reception procedures and risk assessment, but accept that the prison did not receive this until after the man's death. Nevertheless, this investigation reinforces the need for the prison to improve its risk assessment procedures for new arrivals.

First ACCT case review

58. The man's first ACCT case review was on 26 September, chaired by the first SO. Due to a very high number of ACCT case reviews held that day, the review went ahead without a healthcare representative or representative of any other discipline working in the prison. However, a multidisciplinary follow-up review was set for the next day to compensate. PSI 64/2011 states that a healthcare representative should attend the first case review, or exceptionally make a written contribution if they cannot attend in person. We would normally expect a healthcare representative to attend a first case review and are surprised that the prison apparently prioritised ongoing cases over new arrivals. Nevertheless, we recognise that the prison arranged for a multidisciplinary review as soon as possible, the next day.

Assessment of risk and frequency of observations

59. Each of his ACCT reviews, on 26 and 27 September, assessed the man as low risk of suicide and self-harm. The investigator spoke to all three staff who attended the first review and to two out of the three staff who attended the second review. (The mental health nurse was unavailable.) All of the staff considered that the man engaged well and accepted his assurances that he would not harm himself again, after he had done so less than two weeks previously, while in police custody. Although this was not recorded in the record of the ACCT review of 27 September, the chaplain said that they had been concerned that the man appeared too controlled for someone in his situation. We consider that this should have alerted the staff at the review to place more weight on his evident risk factors and the circumstances of his alleged offences, rather than what he was telling them at the time; prisoners intent on suicide rarely say that this is their plan.

60. Staff judgement is fundamental in the operation of ACCT. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. It is not an exact science, but we are concerned that the staff relied so heavily on the man's positive presentation, rather than his known risk factors, not least because they did not know him. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered only as a single piece of evidence when making a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

61. In a Learning Lessons Bulletin published in April 2014, about risk factors in self-inflicted deaths, we said:

> "… Prisons must use all relevant information in order to assess the prisoner's current risk. Prisons should not solely rely on the prisoner's word or how they present at a particular moment – it is a truism that a smile does not indicate that a prisoner is not at high risk of harming themselves or taking their own life."

62. An important piece of information that was not considered at the second ACCT review was the mental health nurse's assessment that the man was at high risk of suicide. The second SO said that the mental health nurse did not tell the panel about this assessment, which would have affected her thoughts about the man's risk. We do not know whether the mental health nurse had the opportunity to review the man's medical records before he attended the review but we consider that it is important that all such information about a prisoner' risk is shared with all staff who need to know. In this case, the mental health nurse should have noted this in the ACCT document as well as his medical record, which is only available to clinicians.

63. Based on the assessments that the man was low risk, the frequency of observations was set at a corresponding level: from 27 September onwards he

was being observed three times during the day and hourly overnight. We noted that most of the hourly observations at night were usually at almost exactly hourly intervals and would therefore have been at predictable times. Setting the appropriate level of observations is again a matter of staff judgement. The man's sister asked why her brother was not placed on constant supervision, especially as he might have been facing a potential murder charge. Many prisoners are in custody charged with or convicted of serious offences. This is a risk factor but is not in itself a reason for constant supervision. While we do not think that the man warranted constant supervision, we consider that staff underestimated his level of risk and therefore set a level of observations, which were too infrequent.

Caremap

64. Completion of a caremap is an integral part of the ACCT process. The caremap gives detailed and time-bound actions aimed at reducing the risk posed by the prisoner. The first SO did not complete a caremap on 26 September and said he understood this would be done the next day. The second CM did not agree that he had said this.

65. The second SO chaired the follow-up ACCT review on 27 September and again did not complete a caremap. She said this was not an oversight, but the man had no issues to go on a caremap.

66. It is a mandatory action of PSI 64/2011 that at the first ACCT review the panel should:

> "Complete the caremap giving detailed and time-bound actions aimed at reducing the risk posed by the prisoner."

At further reviews, panels should:

> "Consider and record progress against the initial caremap, and the prisoner's general well-being … Consider whether the prisoner exhibits any additional needs which may require the caremap to be updated."

67. The man spoke at his assessment interview about wanting to keep in contact with his family, including his two sons one of whom was only ten. Assisting the man with making that contact should have been included on his caremap. Other caremap areas could have included a mental health assessment and support for his forthcoming court appearances.

Reviewing risk

68. On 27 September, a pedestrian who had been injured by the car that the man had been driving on the day he was arrested, died in hospital. The man had already been charged with his attempted murder so it was possible that this would lead to a murder charge. The death was reported in the local news but there is no reference to this in the man's records. The man learnt about this in a telephone call to his brother on 29 September. If staff at Preston had known

of this development, we consider it should have led to a further review of his risk. PSI 64/2011 says that an additional ACCT review should always be held when there is a change of circumstances that could affect the prisoner's risk.

69. The investigation has identified a number of areas for improvement in the management of ACCT procedures and the assessment of the risk of suicide and self-harm. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **Staff open an ACCT whenever a prisoner has recently self-harmed or has other significant risk factors;**
- **Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;**
- **Staff take full account of all known risk factors when determining a prisoner's risk of suicide or self-harm;**
- **The level of observations properly reflects prisoners' level of risk and that checks are at unpredictable intervals;**
- **Effective caremaps are completed;**
- **Additional ACCT reviews are held whenever an event occurs that could mean the prisoner is at increased risk.**

Emergency procedures

70. When the night officer checked the man at 3.10am, he was no longer in bed and she could not see him properly as he had placed a towel across the end of the bunk bed. She kicked the door but the man did not respond. She tried to radio the NOO but could not get a radio signal so telephoned him from the landing office a few metres away. The NOO responded quickly and went into the cell with the OSG. They quickly established that the man was hanging and little time was lost before nurses and an ambulance were summoned.

71. As the night officer could not properly see the man, she decided she should not go into the cell alone and should call the NOO first. Preston's policy in situations such as this states that staff must ensure their own safety before entering a cell. We are satisfied that the night officer's decision was reasonable and was ready to open the cell when the NOO arrived within seconds. Although it was not possible to resuscitate the man, the emergency response was quick and professional.

Clinical care

72. The clinical reviewer also identified concerns about ACCT procedures as outlined in our section above. In addition, she made a recommendation about the record keeping which the Head of Healthcare will need to address.

73. The man's sister asked why her brother was not moved to Preston's healthcare unit. We are satisfied that there were no clinical reasons to indicate that he needed inpatient treatment.

RECOMMENDATION

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- Staff open an ACCT whenever a prisoner has recently self-harmed or has other significant risk factors;
- Multidisciplinary case reviews are held with all relevant people involved in a prisoner's care;
- Staff take full account of all known risk factors when determining a prisoner's risk of suicide or self-harm;
- The level of observations properly reflects prisoners' level of risk and that checks are at unpredictable intervals;
- Effective caremaps are completed;
- Additional ACCT reviews are held whenever an event occurs that could mean the prisoner is at increased risk.