Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jagjeet Samra a prisoner at HMP Parc on 26 May 2016

A report by the Prisons and Probation Ombudsman
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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*

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 Jagjeet Samra was found hanged in his cell at HMP Parc on 26 May 2016. Mr Samra was 36 years old. I offer my condolences to Mr Samra's family and friends.

Mr Samra had a history of drug misuse and had suffered from mental health problems which culminated in a serious incident of self-harm in September 2015. In early 2016, his mental health began to deteriorate. He was placed under Prison Service measures intended to monitor those at risk of harming themselves, and was moved to Parc's safer custody unit. In the early hours of 26 May, after staff were unable to satisfy themselves of Mr Samra's welfare they went into his cell. They found him hanging, and medical staff were unable to resuscitate him.

There was no indication that Mr Samra was likely to take his own life when he did, although I note that he had a history of abuse of New Psychoactive Substances (NPS) which had led to self harm in the past and I also note continuing problems with NPS at Parc. I am concerned that ACCT observations were made using CCTV cameras and not in person, despite Mr Samra not being clearly visible on screen. I am also concerned at the length of time it took for staff to react when they were unable to verify Mr Samra's welfare and the apparent lack of urgency in the response. I am pleased to see that Parc have already amended their policies to address these concerns.

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 **February 2017**

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Summary

Events

1. Mr Samra had a history of drug misuse and had been in prison before.

2. In September 2015, Mr Samra showed signs of paranoia, which culminated in an incident of serious self-harm when he cut his throat. He was assessed by mental health services, but they were unable to detect an enduring mental illness. Staff managed him under Prison Service measures designed to protect prisoners at risk of harming themselves (known as ACCT) until late December.

3. Mr Samra stated in early 2016 that, while he had taken New Psychoactive Substances (NPS) in the past, he had not done so for some time. Although it may be that he did take NPS while at Parc, there is no intelligence or other evidence, including the toxicology report, that he had done so.

4. In early 2016, Mr Samra began to display behaviour similar to that which he had displayed before harming himself in September. In early February, staff again began to monitor him under ACCT measures. They moved him to the prison's safer custody unit, where cells have cameras and staff are better able to monitor prisoners.

5. At a review of Mr Samra's ACCT status in May, it was agreed that his condition was improving. Staff reduced the level of observations required to two conversations per day and two observations per hour.

6. On 25 May Mr Samra seemed to be in good spirits. The duty director noticed him laughing and joking with another prisoner during the association period, and in a telephone call to his sister, Mr Samra showed no signs of distress.

7. At 9.28pm, after prisoners had been locked in their cells for the night, a prison officer checked on Mr Samra using the in-cell camera and although footage did not show Mr Samra clearly, the officer was content that he could see movement in the cell. Just before midnight the officer heard a noise and found he was able to view all prisoners in their cells on screen except Mr Samra. He went to his cell but the observation panel was obscured. The officer then asked for assistance, and, after several minutes, another officer joined him. After checking the camera images again, they were still unable to see Mr Samra so went to his cell and opened the door. They found Mr Samra hanging. They called an emergency and medical staff arrived and attempted to resuscitate him, however when the ambulance arrived, paramedics confirmed that he was dead.

Findings

8. Mr Samra could be a difficult patient for the healthcare team in Parc to manage. His early behaviour may have been exacerbated by his use of NPS, although there is nothing to suggest he used NPS after he moved to the safer custody unit. The post-mortem toxicology report could find no trace of any illicit drugs in Mr Samra's system, including NPS. Nonetheless, the clinical review showed that he received a good level of care for both his physical and his mental health.

9. Mr Samra was managed under ACCT procedures in Parc. The quality of the ACCT management was broadly good, with multidisciplinary reviews, caremaps updated, and due consideration given to the level of observation required.

10. On the night Mr Samra died, the prison officer undertaking ACCT checks did so using the in-cell cameras on the safer custody unit. Although Mr Samra should have been observed at least twice per hour, the officer did not actually see Mr Samra in person for two hours. We would usually make a recommendation, but as Parc have already amended their policy we do not do so.

11. When the officer was unable to see Mr Samra, he did not treat this as urgent but only asked for assistance. When another officer arrived, they did not immediately go into Mr Samra's cell, despite him being under ACCT management procedures. Again, Parc have issued an instruction to staff to stress the urgency of such situations so we do not make a recommendation.

12. When the prison officers went into Mr Samra's cell they found him hanging. They cut and removed the ligature and checked for signs of life, but nobody attempted to resuscitate him until a nurse arrived.

13. Once the nurse arrived at Mr Samra's cell, the emergency response was appropriate.

Recommendation

- The Director should ensure that all prison staff are briefed about the importance of beginning cardiopulmonary resuscitation as quickly as possible when a prisoner is unresponsive and not breathing normally.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

15. The investigator visited Parc on 8 June. He obtained copies of relevant extracts from Mr Samra's prison and medical records. He also obtained copies of police interviews with staff, and the report of Parc's internal investigation into Mr Samra's death which included interviews with staff. He interviewed one member of staff and one prisoner at Parc.

16. Healthcare Inspectorate Wales reviewed Mr Samra's clinical care at the prison.

17. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation and he sent the results of the post-mortem examination. We have given the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Samra's brother, to explain the investigation and to ask if he had any matters the family wanted the investigation to consider. Mr Samra's brother asked about the frequency and quality of checks made on the night Mr Samra died. Mr Samra's brother received a copy of our initial report. He did not have any comments.

Background Information

HMP Parc

19. HMP Parc is a local prison operated by G4S on behalf of the National Offender Management Service (NOMS). It holds approximately 1,300 prisoners including convicted adults and young adults, as well as young people convicted or on remand. There is 24-hour general healthcare and a local GP practice provides GP services, including out of hours cover.

HM Inspectorate of Prisons

20. The most recent report on HMP Parc was published in March 2016. Inspectors reported that while there were a high number of incidents of self-harm, ACCT documents were completed to a good standard. However, inspectors found that mental health provision was inadequate. Prisoners with mental health problems received limited support from the primary mental health team and referrals to the secondary mental health in-reach team were subject to restrictive acceptance criteria. In their survey of prisoners, more prisoners than those in comparator prisons said it was easy or very easy to acquire illicit drugs in the prison. Inspectors noted that Parc was working with the local police to disrupt the supply of drugs to the prison but their efforts to tackle availability were not sufficiently effective. The report criticised the use of CCTV to monitor some vulnerable prisoners.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2016, the IMB expressed concern about the increasing numbers of prisoners with mental health problems placing a growing demand on the prison's limited resources. The Board was concerned about the level of illicit drug use at Parc.

Previous deaths at HMP Parc

22. Mr Samra's was the fourth self-inflicted death at Parc since the beginning of 2014. There has since been another but there are no similarities between that death and the death of Mr Samra. We have previously raised concerns about the management of the ACCT process at Parc.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 *Management of prisoners at risk of harm to self, to others, and from others.*

Safer Custody Unit (SCU)

26. The Safer Custody Unit (SCU) is for prisoners in crisis or who are judged to be at increased risk of harming themselves. It has 10 single cells and five double cells, making a maximum capacity of 20 prisoners. Each cell contains a CCTV camera, monitored on a screen in the unit office

New Psychoactive Substances (NPS)

27. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

29. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

30. In August 2013, Mr Jagjeet Samra was released from prison on licence. On 16 April 2014, he was remanded to prison on further charges. Mr Samra had a history of problems with drugs and alcohol, and his records showed that he had been involved in trading drugs while in prison, incurring debts for New Psychoactive Substances (NPS). He was managed under ACCT procedures more than once: when he threatened to harm himself and when he told a nurse he was hallucinating and felt like taking his own life.

31. On 6 August 2015, Mr Samra was transferred to HMP Parc. He was given a reception health screening, and his history of drug use, mental health problems and mild depression were noted. He said he had not used drugs for some months. While he had no history of harming himself and had no such current thoughts, he disclosed that he did sometimes feel like doing so. The nurse referred him for a mental health assessment. He told the doctor that he thought that he had a curse on him but the doctor could not find any evidence of formal thought disorder, so Mr Samra was not given a mental health diagnosis.

32. On 25 August, Mr Samra reported being in a low mood and staff were concerned. They began to monitor him under ACCT procedures. On 1 September, he told a member of the healthcare team that he was upset that his medication (prescribed for epilepsy and back pain) had been reduced. He was erratic, paranoid, and said he was not frightened to kill himself. Over the next few days, he told a nurse that he had a microchip in his arm and the government was controlling him, he attended an ACCT review where he appeared to be under the influence of drugs, and reported paranoid delusional beliefs. He was referred to the psychiatric service. He did not, however, disclose any thoughts of harming himself and on 17 September he was taken off ACCT management.

33. On 24 September, Mr Samra told a nurse that he was possessed, constantly heard voices and felt that he was going mad. A nurse from the mental health team assessed him again, and allocated a named nurse to assess and treat his depression and anxiety. That night, Mr Samra cut his neck with a razor in what appeared to be a serious attempt to take his own life. Nurses provided medical treatment to Mr Samra until the ambulance arrived and took him to hospital.

34. Mr Samra returned to Parc on 26 September, and was again managed under ACCT procedures. On 28 September, Mr Samra put a plastic bag over his head in an act of self-harm. A member of the mental health team assessed him, and Mr Samra said that he wanted to end his life. He showed signs of paranoia and believed that he was possessed. He told a prison doctor that he was concerned about changes to his medication, saying he would harm himself and/or go on hunger strike.

35. Through September and October Mr Samra's mental health appeared to deteriorate. He thought that he had had a microchip hidden in his arm, and he thought that prison staff had contaminated his tobacco. He telephoned his offender manager and threatened to kill him. He was assessed several times by mental health nurses and psychiatrists, but, while his behaviour was bizarre, they found no signs of psychosis or formal thought disorder, and one doctor thought

that he was trying to obtain medication. When he saw a doctor from the mental health team on 3 November, Mr Samra said that his hallucinations had gone, and that when he had harmed himself in the past it was when he had moved prisons or changed medication. The doctor noted that he behaved normally, and decided that he did not need medication or further input from the mental health services unless symptoms began again.

36. On 3 December, Mr Samra was diagnosed with tuberculosis. He was prescribed medication, a care plan set in place, and he was moved to the safer custody unit so he could be kept under better observation. Records showed that, despite his diagnosis, Mr Samra remained quite positive. At an ACCT review on 21 December, he asked if he could move from the safer custody unit back to an ordinary prison wing. The review noted that he had no thoughts of self-harm, and agreed that ACCT procedures could be closed.

37. On 4 January 2016, Mr Samra moved to A4 unit. His mental health, however, once more began to deteriorate and by early February staff were concerned that he was displaying behaviour similar to his behaviour before he harmed himself in September. At a case conference on 3 February, staff noted that Mr Samra was acting in a bizarre manner, was paranoid and delusional, and while not appearing to be psychotic, they felt it appropriate to open ACCT procedures. Mr Samra said that he was not happy at being on ACCT and did not care if he lived or died. He said he had been implanted with a microchip and was being monitored by the government. The only thing he wanted to live for was to meditate but he said the microchip was blocking his ability to do so. He admitted that he had taken NPS in prison but said that he had not done so recently.

38. The following day, 4 February, staff held another case conference. Mr Samra was refusing to engage in the wing regime, refused to attend a hospital appointment for his treatment for tuberculosis, and refused to attend a doctor's appointment in the prison. When talking to staff that morning, he said that if he was not taken off ACCT management procedures he would cut his own throat. He maintained that staff had told all prisoners that he had a microchip. He also said he had been unable to meditate so had taken NPS to allow him to do so. He refused to engage with his ACCT assessment, and had refused his medication. He had previously tried to take his own life after taking NPS, so on the doctor's advice staff moved him to the safer custody unit where he could be more closely observed.

39. On arrival in the unit, a mental health nurse assessed Mr Samra. He still had some auditory and visual hallucinations but fewer than previously. He denied using any illicit drugs, and said he had no thoughts of harming himself. Later that day, he told a prison officer that he was going to prove he had a chip in his wrist, and began to cut himself with a razor. The officer engaged him in conversation to stop him from going further, and eventually he handed over his razor blade. A nurse checked his wrist but it did not need treatment.

40. In April, Mr Samra said that he wanted to move off the safer custody unit as other prisoners had been trying to antagonise him. He told a member of the chaplaincy that he felt depressed and suicidal as he felt that no-one was taking any notice of him. He told a prison officer that he did not want to be unlocked

with other prisoners as he felt under threat, although he did not specify why. However, when he saw his mental health nurse on 19 May, Mr Samra said that he felt the best that he had for a long time, and had no issues or concerns. He said he had no thoughts of harming himself. The nurse discharged him from the mental health team caseload.

41. When staff reviewed Mr Samra's ACCT on 20 May he said he felt better, and appeared to be so. He said he still had some delusional beliefs, but tried not to think of them. He said he had no thoughts of harming himself. He was complying with his medication, and was sleeping better. The improvements had been since he had been spending more time during the day out of his cell, although he still struggled with crowds and often returned to his cell after short periods out. He said that using NPS had been the cause of him harming himself in the past. Those at the review agreed that he would remain on ACCT measures, with staff checking him twice per hour.

Events of 25-26 May

42. On the afternoon of Wednesday 25 May, Mr Samra came out of his cell during the association period. The duty director visited the unit and noted him laughing with another prisoner. Mr Samra told him that he was happy and felt well. Just before 5.30pm, he telephoned his sister and they spoke for just over a quarter of an hour. There was no indication in the call that Mr Samra was upset or in any kind of crisis.

43. After prisoners had been locked into their cells for the night, Officer A came on duty on the safer custody unit and took over responsibility for undertaking observations of prisoners under ACCT management. He went to Mr Samra's cell at 9.28pm for an ACCT check, noting that Mr Samra was sitting on his bed. Thereafter, he conducted the ACCT checks using the CCTV camera rather than going to the cell in person. He noted in the ongoing record that at 10.01pm Mr Samra was pacing in his cell, at 10.31pm he was doing a jigsaw, and was also doing this at 11.00pm and 11.30pm. However, CCTV footage does not show Mr Samra clearly on these last two occasions.

44. At some time between 11.45pm and midnight, Officer A heard a loud noise, which he likened to someone kicking a door. He checked all the cells by means of the monitor and could see all prisoners except Mr Samra. He therefore went to Mr Samra's door, arriving there at approximately 12.08am. He was unable to look into the cell as Mr Samra had covered the observation panel, so he knocked on the door, without response. He tried to contact the night orderly officer in charge of the prison overnight on his radio. He was unable to get a signal so went back to the office and, at 12.15pm, asked for the night orderly officer, but was told that he was unavailable. He went back to the cell and again tried to get a response from Mr Samra, without success.

45. The night orderly officer then telephoned the office and Officer A told him that he could not get a response from Mr Samra. He said he was busy and asked the officer to contact Officer B, which he did. Officer B arrived on the unit at approximately 12.29am and spoke to Officer A in the office. Officer A said that he could not see Mr Samra, had not done so for an hour and could not raise a response. They looked at the monitor but were unable to see Mr Samra, so went

to his cell. Officer B kicked the door and called Mr Samra's name but did not get a response. He therefore unlocked and opened the door and the officers went in. This was at 12.33am.

46. Mr Samra was hanging from a ligature made from bedding that he had threaded through the intercom plates in the cell wall. Officer B used his radio to call a code blue emergency (meaning a prisoner hanging or having difficulty breathing), while Officer A cut the ligature and lowered Mr Samra to the floor. The code blue call was made at 12.34am. Officer A went to the office to get a defibrillator (a machine that monitors the heartbeat and, in some circumstances, delivers an electric shock to restart the heart). The officers checked Mr Samra for signs of life and Officer B thought he detected a faint pulse, so they tapped his face and called his name.

47. The code blue call had alerted other staff to the emergency and prompted the control room to request an ambulance. A healthcare assistant, a nurse and the night orderly officer arrived on the unit at 12.37am, and while the healthcare assistant went to the medical room on the wing to collect oxygen, the nurse assessed Mr Samra. She could not detect any signs of life, and thought that Mr Samra was dead. Nevertheless, she began to perform cardiopulmonary resuscitation. Staff continued to try to revive Mr Samra, including using oxygen and a defibrillator until paramedics arrived and took over. At 1.01am, they pronounced Mr Samra had died.

Contact with Mr Samra's family

48. Mr Samra's family lived in the Midlands. Because of both the distance from Parc, and the need to let the family know what had happened in person as soon as possible, a manager from a prison nearby went to the family home to break the news of Mr Samra's death. In line with Prison Service policy, Parc made a contribution to the cost of Mr Samra's funeral.

Support for prisoners and staff

49. After Mr Samra's death, the Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

50. The prison posted notices informing other prisoners of Mr Samra's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Samra's death.

Post-mortem report

51. The post-mortem examination confirmed that Mr Samra had died from hanging. There were no other significant injuries. The toxicology report could find no trace of any illicit drugs in Mr Samra's system, including NPS, although it stated that due to their chemical nature of these compounds it was impossible to exclude their use altogether.

Findings

ACCT

52. Mr Samra was managed under ACCT procedures three times while in Parc. The last time ACCT procedures were begun was in February 2016, and Mr Samra was still under ACCT management when he died. ACCT procedures were generally carried out well. Case reviews were multidisciplinary, with healthcare staff attending every ACCT review, which is good practice. The caremap was regularly considered and updated, and consideration was given to the frequency of observations. The ongoing record shows that staff made observations with the required frequency.

53. On the night of 25 May, staff were to check on Mr Samra twice per hour. Officer A went to Mr Samra's cell to check on him at 9.28pm, when he noted that Mr Samra was sitting on his bed. After this, he made the ACCT checks using the in-cell CCTV camera.

54. Guidance on managing prisoners at risk of self-harm is contained in Prison Service Instruction (PSI) 64/2011. The instruction specifies that staff must actively engage with the prisoner, encouraging him to talk. In Parc's safer custody policy, as it was when Mr Samra died, the section on ACCT procedures said they would "utilise its in-cell CCTV capabilities in circumstances where it is deemed appropriate to minimise a level of risk". While we accept that prisons may wish to use in-cell cameras to monitor some prisoners in certain circumstances (during the night for example) their availability should not automatically replace physical checks.

55. Since Mr Samra's death, Parc have amended their safer custody policy. It now stipulates that prison officers making ACCT checks on prisoners in the safer custody unit must now go to the cells at least once per hour. Consequently, we do not make a recommendation.

New Psychoactive Substances

56. Mr Samra had a history of drug use. This included involvement in the drug culture in prison. When he arrived in Parc he was not on a detoxification programme, and told healthcare staff that he had not used drugs in 18 months. He was not therefore referred for detoxification.

57. At an ACCT review on 3 September 2015, Mr Samra appeared to be under the influence of something. On 10 September he told a mental health nurse that, among other drugs, he had previously used NPS in prison. On 17 September, his medical records indicate that he was self-medicating, and displaying drug-seeking behaviour. It was shortly after this that Mr Samra made what appeared to be a serious attempt on his own life when he cut his throat on 24 September. Thereafter, there is no intelligence to suggest that Mr Samra took any illicit drugs. When his mental health began to deteriorate in early 2016 and he appeared to be displaying behaviour similar to that before he had harmed himself in September, he was moved to the safer custody unit, where staff could observe him better, and where he was less likely to be able to obtain illicit drugs. There

was no suggestion that he had done so, and the toxicology report after Mr Samra died did not show any indications of known NPS.

58. In June 2016, HMIP published a report on an inspection of Parc. Inspectors noted that there appeared to be a high availability of NPS in the prison. The prison had made efforts to address this, working more closely with local police, putting in place additional security measures, and improving education. These efforts, though, had only had limited effect. The report recommended that the prison should further develop substance misuse services.

59. As well as addressing it in their overall drug strategy, Parc have been developing a separate NPS strategy. There is no evidence to suggest that Mr Samra used NPS after he was transferred to the safer custody unit, or that it played a prominent part in his death. We do not, therefore, make a recommendation.

Night of 25 – 26 May

60. After Officer A went to Mr Samra's cell at 9.28pm for an ACCT check, he then noted in the ACCT document that he made camera checks at 10.01pm, 10.31pm, 11.00pm and 11.30pm. He noted that on the last three of these four checks Mr Samra was doing a jigsaw puzzle. CCTV footage, however, does not clearly show Mr Samra at these times. He seems to have assumed that Mr Samra was doing a jigsaw because he had been doing so earlier. In interview with one of the prison's managers, he said that while he did not see Mr Samra on the camera monitor after 10.06pm, he could see shadows and movement.

61. When Officer A heard a loud bang shortly before midnight, he checked all the cells by means of the camera monitors and could see all the prisoners onscreen except for Mr Samra. He went to check on Mr Samra but did not arrive at his cell for several minutes. Mr Samra had covered the observation panel in his door so he was not able see him. When interviewed, he said that Mr Samra had covered his observation panel and cameras in the past, so he was not immediately concerned. He also said, however, that Mr Samra would usually respond and on this occasion he did not do so.

62. Officer A was responsible for monitoring a prisoner under ACCT procedures, but did not actually see him for two hours. When he heard a noise and was able to confirm that he could see all prisoners except Mr Samra, he did not go to Mr Samra's door for several minutes. When he did so and found the observation panel covered it was another eight minutes before he contacted the night orderly officer. When Officer B arrived they tried to view Mr Samra on the monitor before going to the cell four minutes later. It was only then that they went into the cell and found Mr Samra hanging.

63. Mr Samra was not thought to be at high risk of harming himself, and had recently had the level of ACCT observations reduced to two per hour. Officer A had no reason to think that Mr Samra was in crisis or in imminent danger of taking his own life. Nevertheless, Mr Samra was under ACCT management and he did not actually see him for some two hours. When he did have reason to go to his cell, he did not respond with the degree of urgency we would hope to see when an officer is unable to see a prisoner under ACCT procedures.

64. We understand that following an internal investigation Parc has dismissed Officer A. Additionally, the Director has issued a written order reminding staff that when making ACCT checks by camera they must be able to see the prisoner. If they are unable to do so, they must make a physical check and if they still cannot see the prisoner, they should summon assistance and enter the cell. We do not therefore make a recommendation.

65. When both officers found Mr Samra hanging, they cut the ligature and checked him for signs of life. They thought that they detected a faint pulse, but nobody attempted to resuscitate Mr Samra until the nurse arrived and began cardiopulmonary resuscitation. We make the following recommendation

The Director should ensure that all prison staff are briefed about the importance of beginning cardiopulmonary resuscitation as quickly as possible when a prisoner is unresponsive and not breathing normally.

Mr Samra's healthcare

Mental health

66. Mr Samra did not have a mental health diagnosis, and was not on any psychiatric medication. The clinical review noted that his mental health was appropriately assessed on arrival at Parc, and he was referred to the mental health team. When he was under ACCT management procedures in August and September 2015, healthcare staff were involved in the process and concerns were properly addressed. After he seriously harmed himself on 24 September, healthcare staff assessed his mental health needs but he showed no evidence of psychosis or mental illness. When he began to show increasingly bizarre behaviour in October he was promptly reviewed.

67. When ACCT procedures were commenced on 3 February 2016, healthcare staff engaged fully, and reviewed Mr Samra's mental health again. Until May his mental health fluctuated, but then he began to feel better, with improved sleep and expressing positive views about the future. He was discharged from the mental health team's caseload on 19 May. The review notes that the mental health team was represented at the ACCT review on 20 May when Mr Samra's observations were reduced to two per hour, and that this seemed appropriate in light of his improved mental health.

Physical health

68. The clinical review noted that Mr Samra had a reception screening on arrival in Parc, and staff obtained and noted a detailed clinical history. He was offered rehabilitative treatment for back pain but he declined. When diagnosed with tuberculosis an appropriate care plan was put in place. Appropriate decisions were taken to ensure he was in a suitable location for his health needs.

69. When the emergency call was made on 26 May healthcare staff responded promptly, with the necessary equipment. Resuscitation was carried out appropriately until paramedics arrived and took over.

70. The clinical review noted that Mr Samra presented a range of challenges but the healthcare provided to Mr Samra was equivalent to that he could have expected

to receive in the community. His mental health appeared to have been improving and there is nothing to suggest that healthcare staff could have anticipated his death.

Prisons & Probation Ombudsman
Independent Investigations

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