

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Gregory, formerly a prisoner at HMP Forest Bank, who died at hospital on 26 January 2017

**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.

On 13 January, Mr Steven Gregory was released from HMP Forest Bank after three months in custody. In the early hours of 14 January, emergency services were alerted to a person on fire in the Collyhurst area of Manchester. The person was identified as Mr Gregory and he was taken to hospital with extensive burns. He remained in intensive care until his death on 26 January.

Although Mr Gregory was no longer detained in custody, in the tragic circumstances I decided that it was appropriate to exercise my discretion to carry out an investigation into the circumstances of his death in order to identify any learning for the Prison and Probation Service.

Mr Gregory had complex mental health needs and received a good deal of attention from the mental health team at Forest Bank who managed him well. They attempted to secure his admission to hospital under the Mental Health Act following his release. However, at a formal assessment it was decided that he was not detainable.

While in custody there was no suggestion that Mr Gregory was at risk of suicide or self-harm, and no monitoring was deemed necessary. I am satisfied that staff at Forest Bank did all they could to manage his risk appropriately and that they made appropriate plans and preparation for his release.

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

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Summary

Events

1. Mr Steven Gregory was sentenced to six months in custody at HMP Forest Bank on 17 October 2016, after breaching an anti-social behaviour order. This was not his first time in custody at Forest Bank, where he had previously served relatively short sentences.
2. Mr Gregory had a long history of mental health issues and, in July 2016, had been detained under section 2 of the Mental Health Act 1983 (MHA). This followed an earlier short period of custody at Forest Bank. When he arrived at Forest Bank in October, staff referred him to the mental health team, who had worked with him previously. There were no concerns around Mr Gregory's risk of harm to himself and no additional monitoring in relation to suicide or self-harm was considered necessary. Mr Gregory was said by healthcare providers, both in the community and in custody, to be difficult to engage with, and in the past had refused treatment.
3. During this period of custody, various meetings took place, involving prison and community mental health staff and other service providers, to plan care for Mr Gregory when he was released from custody. Mr Gregory seldom engaged and, although invited to the meetings, he refused to attend. Instead, on most occasions, staff would see him in his cell.
4. A mental health nurse and a psychiatrist believed that Mr Gregory would benefit from a further hospital admission under the MHA following his release and arranged for Mr Gregory to be assessed on 12 January. This assessment, which Mr Gregory did attend, concluded that Mr Gregory did not meet the requirements for detention.
5. On 13 January, Mr Gregory was released from custody. Prior to his release, appointments had been made for him to see a housing charity and community mental health services. He was also required to report to his supervising officer. Mr Gregory failed to attend any of the pre-arranged appointments.
6. In the early hours of Saturday 14 January, members of the public reported that a person was on fire in the Collyhurst area of Manchester. When emergency services attended, they discovered a man had set himself on fire after dousing himself in petrol. He was taken to the burns unit at hospital and later identified as Mr Gregory. Mr Gregory remained in intensive care until 26 January, when he died from severe burn injuries.

Findings

Prison care

7. Despite Mr Gregory's mental health issues, his general prison behaviour was reported as good, with no significant issues being raised. We are satisfied that Mr Gregory's treatment and care by staff at Forest Bank was appropriate and we make no recommendations in this regard.

Post release planning and intervention

8. Mr Gregory had had a supervising officer since 2015. The supervising officer said that Mr Gregory's compliance with supervision had been extremely poor and Mr Gregory had continued to exhibit signs of mental illness when he had contact with him.
9. The supervising officer said that as part of Oldham Community Rehabilitation Company's (CRC) Through The Gate (TTG) strategy, staff from Shelter had tried to interview Mr Gregory while he was in custody. He said that in normal circumstances the TTG strategy would involve efforts to find Mr Gregory accommodation prior to his release, to ensure a smooth transition from custody to the community. Failing this, Shelter would arrange for a homelessness interview to take place with a local housing provider. Unfortunately, Mr Gregory refused any contact with Shelter while in custody and he said that it was therefore not possible to refer him for a homelessness interview. He said that this would have been his responsibility following Mr Gregory's release.
10. The supervising officer met both the prison mental health in-reach team and Oldham community mental health team, to ensure a smooth transition of care.
11. Historically, Mr Gregory had not engaged with services, other than initial appointments with probation, and would "go walk about", showing up in other areas of the country. On the day of his release, Mr Gregory failed to attend any of his pre-arranged appointments. The supervising officer said that this would not have immediately raised concerns but, after 48 hours, if he had not reported, then it is likely that licence recall procedures would have been started. We consider that the prison made appropriate plans and preparation for Mr Gregory's release and therefore make no recommendation.

Clinical care

12. The clinical reviewer completed the review into the clinical care provided to Mr Gregory. He concluded that, overall, the care that Mr Gregory received from healthcare staff at HMP Forest Bank was at least equivalent to the standard of care he would have received in the community. He said that Mr Gregory's mental health care was well managed by the mental health in reach team; in particular a nurse who, in his opinion, provided a high standard of care. The mental health team recognised that Mr Gregory's schizophrenia required assertive management due to his lack of insight, the negative symptoms of his psychotic illness and the likelihood that he would disengage from services. No recommendations are made for the healthcare team at Forest Bank as a result of our investigation or the clinical reviewer's review.

The Investigation Process

13. 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 responses were received.
14. HMP Forest Bank provided copies of relevant extracts from Mr Gregory's prison and medical records.
15. NHS England commissioned Spectrum Community Health to review Mr Gregory's clinical care at the prison. A clinical reviewer was appointed to complete this review.
16. The investigator and clinical reviewer interviewed three members of medical staff at Forest Bank.
17. We informed HM Coroner for Bolton of our investigation and requested a copy of the post mortem report, which was duly provided. A copy of this report will be made available to the Coroner to assist with the inquest process.
18. One of our family liaison officers contacted Mr Gregory's mother and brother to explain the investigation process on 23 February.
19. Mr Gregory's family received a copy of the initial report. They raised a number of questions regards the source of information that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Forest Bank

20. 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 managed by Sodexo Justice Services. Sodexo provides primary health care (including primary care mental health), with secondary care mental health provided by Greater Manchester West Mental Health NHS Foundation Trust (GMWMHT).

HM Inspectorate of Prisons

21. The most recent inspection of HMP Forest Bank was conducted in February 2016. Inspectors reported that most areas of health provision were reasonable, but the provision of primary mental health services was poor and the inpatient unit, again used principally for those with mental health issues, was very poor. The report states that one of Forest Bank's strengths was its function as a resettlement prison. Despite a backlog of offender assessments (OASys), the quality of offender supervision was effective and home detention curfew and public protection arrangements were sound. More needed to be done to strengthen links with the new community rehabilitation company (CRC) and demand for services was high, often following a comparatively short sentence. The resettlement strategy was, however, predicated on a proper assessment of need and provision was good across the range of resettlement pathways.

Independent Monitoring Board

22. 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 October 2016, the IMB reported that the provision of mental health services was an area that it considered a priority for monitoring. The Board said that if Forest Bank is typical, then it was concerned at the number of prisoners with apparently serious mental health issues for whom a prison is unlikely ever to provide a satisfactory place of treatment. In its most recent report, the Board at Forest Bank states that, historically, it had not given resettlement preparation the same priority as other areas of its responsibility. Other than dealing with prisoner applications in this area, routine monitoring of matters such as sentence planning, transfers, IPP and lifers and support for destination after release had not been undertaken during the year.

Previous deaths at HMP Forest Bank

23. There have been no similar deaths investigated at Forest Bank.

Key Events

Background

24. Mr Steven Gregory was 32 years old, and had been diagnosed with paranoid schizophrenia in 2005. Schizophrenia is defined as a major psychotic illness, characterised by hallucinations - often auditory, (hearing voices), tactile (feeling that you are being touched), olfactory (smell or taste) or visual, with delusory thoughts and beliefs, often of a persecutory nature. People can also experience feelings of withdrawal, lack of motivation and generalised apathy. Mr Gregory had eight previous admissions into psychiatric inpatient care, often detained under the MHA. He was well known to prison mental health services.
25. Mr Gregory's psychotic symptoms manifested themselves in delusory ideas that he was being persecuted by the devil, that staff in prison were practising witchcraft on him and that he was under threat. He also complained of tactile and olfactory hallucinations.
26. This was not Mr Gregory's first period in custody; he had served a series of short sentences previously. These often followed breaches of community orders. During 2016, he had five brief periods of imprisonment.
27. During earlier sentences in March and July 2016, prison mental health teams made various attempts to secure Mr Gregory's compulsory admission to hospital under Section 2 of the MHA 1983. In March, a review panel decided that Mr Gregory was not detainable. However, in July, he was admitted to hospital in Oldham, initially for assessment under Section 2, subsequently for treatment under Section 3 which allowed him to be detained as an inpatient for up to six months. Mr Gregory appealed against this decision and was released from Section 3 following a mental health review tribunal (MHRT) in October 2016. The following day, 6 October 2016, he discharged himself from hospital.
28. In the community, Mr Gregory had a chaotic lifestyle. He was homeless and despite efforts of mental health professionals and probation, he would not engage with services offered. He had limited involvement with his family, and a restraining order was in place preventing him from contacting certain members of his family. A review of Mr Gregory's medical history indicates that he was not receiving medication for his psychosis. Previously, he had been treated with a variety of anti-psychotic medication, including olanzapine, quetiapine and aripiprazole. Mr Gregory had refused to take medication and, as a result, had not received any regular treatment since February 2015.
29. Mr Gregory had often attempted to self-harm, the first time when eight years old. In 2010, he doused himself and his flat with petrol and emergency services were called. However, there was no ignition and no further action was taken.

17 October 2016 onwards

30. On 17 October 2016, Mr Gregory was sentenced to six months in custody after breaching an anti-social behaviour order, and sent to HMP Forest Bank. He was to serve three months, with a release date of 13 January 2017.

31. On arrival at Forest Bank, a mental health nurse assessed Mr Gregory and completed the first reception screen to ascertain any physical, mental health or substance misuse issues that Mr Gregory might have and make any onward referrals for treatment. Mr Gregory's mental health diagnosis of paranoid schizophrenia and the fact that he had recently discharged himself from hospital were recorded. It was also recorded that Mr Gregory had been drinking heavily and would require alcohol detoxification.
32. Due to his previous periods of custody, Mr Gregory was known to the prison's primary and mental healthcare services and was referred to the mental health team at Forest Bank. During previous periods of custody, Mr Gregory had been subject to ACCT (Assessment, Care in Custody and Teamwork) monitoring, used to support those deemed to be at risk of self-harm or suicide. However, no evidence that Mr Gregory was suicidal or threatening self-harm was recorded during his reception. Throughout this period of custody, Mr Gregory never spoke of feeling suicidal, threatened self-harm or presented to staff as being at risk of either.
33. A prison GP saw Mr Gregory during his reception. He recorded that there were no acute concerns, no evidence of suicidal thoughts, his mood was good, and he did not appear overtly psychotic. He recorded that Mr Gregory had been drinking heavily and prescribed a standard reducing alcohol detoxification regime. This included: chlordiazepoxide 10mg, 24 tablets over 5 days, chlordiazepoxide 5mg, 16 tablets over 6 days, thiamine 100mg, 2 tablets twice daily for 28 days, and vitamin B compound tablets, 1 tablet twice daily for 28 days. Nursing staff monitored Mr Gregory's alcohol withdrawal daily and no concerns were raised during his detoxification.
34. A mental health nurse was appointed as Mr Gregory's key worker. They were well acquainted from previous spells Mr Gregory had spent at the prison. As she was on annual leave when Mr Gregory arrived back into custody, another nurse made initial contact and referred Mr Gregory to a consultant forensic psychiatrist. She also attempted to book Mr Gregory a physical examination, as he had not had one since 2014 due to his failure to attend appointments.
35. On 25 October, the nurse contacted Mr Gregory's care coordinator at East Oldham Community Mental Health Team (CMHT). She invited a representative from the prison in-reach team to a Multi-Disciplinary Meeting (MDT) on the 11 November to discuss Mr Gregory's care and release plans.
36. Mr Gregory was due to attend an appointment with the prison's visiting consultant forensic psychiatrist on 3 November. He provides two sessions a week at Forest Bank. When not providing clinics at the prison, he works as a consultant at the Edenfield Centre, a medium secure psychiatric unit in Manchester. Mr Gregory failed to attend.
37. Because of his failure to attend, the clinical team manager and a mental health nurse visited Mr Gregory in cell. The manager told the investigator that Mr Gregory was adamant that he did not need to be seen by anyone. She said that Mr Gregory did not have any idea why he had been sectioned in July 2016 but said that after his release from hospital he had been homeless. She told the investigator that Mr Gregory did not present as overtly psychotic and she had no

concerns regarding any risk of suicide or self-harm. She made a further appointment for Mr Gregory to see the psychiatrist at his next clinic. However, on 18 November, Mr Gregory again refused to see him or attend for a physical examination. Staff made another appointment.

38. The psychiatrist visited Mr Gregory in his cell on 29 November, accompanied by a mental health nurse. It was recorded that Mr Gregory was adamant he did not want any medication. He was guarded in his responses, telling the psychiatrist "you lot sent me to hospital last time". The psychiatrist recorded that Mr Gregory did not appear overtly psychotic, but his personal hygiene was poor, he had not showered and his clothing was dirty.
39. The psychiatrist documented his contact with Mr Gregory in a detailed letter, which set out Mr Gregory's past involvement with mental health services. When interviewed, he said that in his opinion Mr Gregory had a clear diagnosis of paranoid schizophrenia and he believed that a further period of treatment after release would be beneficial.
40. On 14 December, a Care Programme Approach (CPA) professionals meeting was held to discuss the options for Mr Gregory's future care. The CPA is the process of coordinating care for people with severe and enduring mental health problems. The meeting discussed Mr Gregory's homelessness and his supervising officer agreed to look for an Approved Premises place for him in Manchester. As Mr Gregory had refused to attend the meeting, his key worker, the care co-ordinator and his supervising officer visited him on the wing. However, he still refused to engage with them. The staff agreed that they would arrange a further meeting for the early part of January, prior to Mr Gregory's agreed release date.
41. It was apparent that Mr Gregory would not willingly engage with staff, and when interviewed, his key worker said that an assertive approach was needed to engage him. When asked by the clinical reviewer whether Mr Gregory had been referred to services in the community that could provide an Assertive Outreach service, she said that such services are no longer available in Manchester and would now form part of community mental health.
42. In her continued attempts to engage with Mr Gregory his key worker attempted a further assessment on 28 December, but again he refused to attend.
43. At the start of January, it was reported by another prisoner to officers that Mr Gregory had said that when he was released he intended to kill all children and their parents. Staff submitted a security report and the MH team were immediately informed.
44. On 6 January, Mr Gregory attended an assessment with the psychiatrist and his key worker. The psychiatrist said that he was aware of the alleged threats that Mr Gregory had made prior to the assessment. He said that when he asked Mr Gregory about these, Mr Gregory was adamant that it was not true. He and the key worker both said that Mr Gregory was visibly upset when questioned about the allegations further, and they were unable to gain any clarity from him about the threats to kill. It was recorded that, during the assessment, Mr Gregory appeared to have 'pressure of speech' (where rapid speech occurs as an

underlying symptom of a psychotic illness). He was unkempt and restless, and very guarded in his responses. His key worker said that she felt that this was because Mr Gregory was aware that prior to his last two releases from prison, staff had sought to have him admitted to hospital.

45. On 9 January, at a CPA meeting, the team agreed that an assessment to consider Mr Gregory's detention under the MHA should take place before his release. If detention was agreed then a bed at the Psychiatric Intensive Care Unit (PICU) at Stepping Hill Hospital in Stockport would be available and he would be transported there on release. His key worker arranged for the assessment to take place on 12 January.
46. The assessment and application for detention has to be carried out by an Approved Mental Health Practitioner (AMHP) who is in most cases a social worker. Two medical recommendations are also required, usually the patient's GP and another doctor approved under section 12 of the MHA.
47. An AMHP social worker was assigned to Mr Gregory. She would make any application, along with the psychiatrist and a consultant who had previous knowledge of Mr Gregory. For a person to be detained under section 2 of the MHA the following criteria must apply:
 - The person is suffering from a mental disorder of a nature or degree which warrants his/her detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period, and
 - The person ought to be so detained in the interests of his/her own health or safety or with a view to the protection of others.
48. The MHA assessment took place on 12 January, led by the social worker and attended by the forensic psychiatrist, a consultant psychiatrist and the key worker. Mr Gregory attended and is recorded as having participated in the assessment. Mr Gregory denied having any psychotic symptoms and denied that he had made threats to kill a child. When asked about his appearance, Mr Gregory said that he had not been showering in protest at being detained in prison again. He denied hearing voices and talking to Satan.
49. In view of his presentation, the social worker and consultant psychiatrist did not believe that Mr Gregory was detainable under the MHA. The forensic psychiatrist did not agree. He told the investigator that, although Mr Gregory was not admitting to any psychotic ideas and was very guarded in his responses, he felt that this was because Mr Gregory had been detained previously and knew that any admission of delusional ideas would have led to a further period of detention in hospital. He said that, given Mr Gregory's history and the alleged threats, he felt that his health would deteriorate if not detained. He said that as staff had secured a bed for him, in his opinion, a further period of assessment would have been prudent.
50. Neither the consultant psychiatrist nor the social worker was interviewed as part of the investigation as their actions fall outside the remit of this office and the clinical review. However, their written report indicated that they believed Mr Gregory's behaviour was a lifestyle choice, influenced by his alcohol dependence.

51. A plan for Mr Gregory's release into the community was put in place, in the event the assessment concluded that he was not detainable. Because of previous poor behaviour, he was not considered suitable for emergency housing, and his supervising officer arranged an appointment with homeless charity, Shelter, and an appointment with the CPA co-coordinator for 10.30am on the day of release.
52. On 13 January, Mr Gregory was released from Forest Bank at around 9.00am. As he had been sentenced to six months' imprisonment, he was automatically released at the halfway point. His sentence would end on 17 April and he would be subject to 12 months post-sentence supervision, in line with the Offender Rehabilitation Act 2014.
53. Mr Gregory had hoped to be collected by his brother but, as he was starting a new job, he was unable to do so. His key worker said that she spoke with Mr Gregory in reception just before his release and told him that his brother was unable to collect him. She said that Mr Gregory had enough money to get to his pre-arranged appointments. He was due to attend Oldham Community Rehabilitation Company (CRC) office at 11.30am, to meet his supervising officer. Mr Gregory failed to attend any of these appointments.
54. On Saturday 14 January, at 3.15am, three separate 999 calls were made from members of the public, reporting that a person was on fire in the Collyhurst area of Manchester. There was some confusion over the exact location, which caused a slight delay in the fire brigade attending. When emergency services arrived, they discovered a man had set himself on fire after dousing petrol over his head. The man was taken to the burns unit at hospital and later identified as Mr Gregory. The investigator has spoken with the police, who have confirmed that there was no third party involvement.
55. Mr Gregory remained in intensive care at the hospital until 26 January, when he died from extensive burns following an unsuccessful skin graft operation.

Contact with Mr Gregory's family

56. As with any incident in the community, the police notified Mr Gregory's family of his actions and of his being in hospital. The prison was made aware of his actions and eventual death, but has not had any contact with Mr Gregory's family.

Post-mortem report

57. The Coroner has indicated that the cause of death was severe burn injuries.

Findings

Prison care

58. Mr Gregory had been at Forest Bank for short periods on previous occasions. During earlier sentences he had been subject to suicide and self-harm monitoring because of historic warnings recorded on the PER. On arrival at Forest Bank in October, the same information was recorded. Reception staff and staff from the safer custody team spoke with Mr Gregory and asked whether he had any current thoughts or intentions of self-harm. Mr Gregory denied having such thoughts or feelings and staff were satisfied that there was no immediate need for additional monitoring.
59. Despite his mental health problems, on the most part, Mr Gregory's prison behaviour was considered appropriate. When, in January, another prisoner reported to staff that Mr Gregory had allegedly threatened to harm a child after he was released from custody, staff appropriately reported the information to the prison security department and the mental health team interviewed Mr Gregory. Mr Gregory denied making the comments and there was no other evidence to take any further action. However, the alleged comments were shared with the community mental health team.
60. There is little information recorded about Mr Gregory's behaviour during this period of custody. From what is available, we feel that the prison's treatment and care for Mr Gregory was appropriate, and there are no recommendations for the prison resulting from our investigation.

Post release planning and intervention

61. Mr Gregory had had a supervising officer since 2015. The supervising officer said that Mr Gregory's compliance with supervision had been extremely poor and when he had had contact with him, Mr Gregory had continued to exhibit signs of mental illness.
62. The supervising officer said that on numerous occasions Mr Gregory had told him that he wished to live a vagrant lifestyle. In the past, had been found sleeping rough in locations across the North West, including the hard shoulder of the M62. He said that on each of these occasions, he had exhibited indications of mental illness, but had been assessed as capable of making his own decisions.
63. The supervising officer said that on 30 September he received information from Forest Bank that Mr Gregory had been received as a remand prisoner. He had been charged with a breach of an anti-social behaviour order and being drunk and disorderly, for which he was later sentenced to six months in custody. He said that, as on previous occasions, Mr Gregory refused any help with accommodation while in custody. However, he made enquiries about the availability of a place at St Joseph's approved premises for those with mental health problems in Manchester, but was informed that Mr Gregory was not eligible for such a place. Even if he were, no place would be available until a month after his release and he said that this was therefore not a realistic plan.

64. Through The Gate (TTG) is the term used to describe the supervision given to anyone who serves one day or more in custody, following release. The supervising officer said that as part of Oldham CRC's TTG strategy, staff from Shelter tried to interview Mr Gregory while he was in custody. He said that under normal circumstances, the TTG strategy would involve efforts to find Mr Gregory accommodation prior to his release, to ensure a smooth transition from custody to the community. Failing this, Shelter would arrange for a homelessness interview to take place with a local housing provider. Unfortunately, Mr Gregory refused any contact with Shelter while in custody and he said that it was therefore not possible to refer him for a homelessness interview. He said that this would have been his responsibility following Mr Gregory's release.
65. The supervising officer said that meetings would also be held with local mental health services to ensure a transition of treatment from custody to the community. This did happen with Mr Gregory, and the supervising officer met both the prison mental health in-reach team and Oldham community mental health team. However, on 12 January, Mr Gregory was found by an attending psychiatrist to have capacity and was released the following day.
66. The supervising officer told the investigator that Mr Gregory did not engage with services, other than initial appointments with probation, and would then "go walk about" and show up in other areas of the country. On the day of his release, Mr Gregory failed to attend any of his pre-arranged appointments. He said that this would not have immediately raised concerns, but if Mr Gregory had failed to report after 48 hours, then it would have been likely that licence recall procedures would have been started. We consider that the prison made appropriate plans and preparation for Mr Gregory's release and therefore make no recommendation.

Clinical care

67. The clinical reviewer completed the review into the clinical care provided to Mr Gregory. He concluded that, overall, the care that Mr Gregory received from healthcare staff at HMP Forest Bank was at least equivalent to the care he would have received in the community. He says that Mr Gregory's mental health care was well managed by the mental health in reach team, in particular by his key worker who, in his opinion, provided a high standard of care. The mental health team recognised that Mr Gregory's schizophrenia required assertive management due to his lack of insight, the negative symptoms of his psychotic illness and the likelihood that he would disengage from services.
68. The clinical reviewer comments that he had concerns regarding a missed opportunity to provide Mr Gregory with a further period of assessment and treatment in the PICU at Stepping Hill Hospital after his release. In his opinion, based on his review of Mr Gregory's healthcare records, there was adequate evidence that Mr Gregory had a past history of a treatable mental illness and that his health was at risk on release from prison without appropriate care and treatment. He indicates that the forensic psychiatrist and the key worker supported this view at interview, but the consultant psychiatrist and the social worker did not support the opinion.

69. The clinical reviewer says that the reception screening at Forest Bank was delivered effectively. It appropriately identified Mr Gregory's long term mental health and alcohol issues and appropriate referrals were made. The standard of record-keeping within SystemOne was of an acceptable standard.
70. No recommendations are made for the healthcare team at Forest Bank following this investigation.

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