A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man at HMP Preston in May 2014. He died of asphyxia after tying a plastic bag over his head. He was 54 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Preston was undertaken. The prison cooperated fully with the investigation.

On 2 May 2014, the man was charged with serious sexual offences against a family member some years previously. He was taken to a police station, where he spent the weekend before appearing at Magistrates' Court on Monday 5 May. The court remanded him to HMP Preston. While in police custody, he had spoken of suicide and was subject to close observation. A mental health nurse had noted that he would be at high risk of suicide if he was remanded to prison and that prison staff should be alerted by highlighting this risk on his escort record. This was not done.

When the man arrived at HMP Preston, reception staff did not identify him as at risk of suicide or self-harm and, in the absence of a warning on his escort record, did not read the information from his police medical record as they should have done. An offender supervisor saw the information in his records the next day, but assumed that reception staff had already taken it into account. There is no evidence that the police medical record was ever passed to prison healthcare staff. The staff who assessed his risk of suicide and self-harm relied too much on what he told them rather than his evident risk factors, even without the information from the police. At lunchtime, he was found in his cell in bed with a plastic bag over his head. The emergency response was quick, if somewhat disorganised, but it was evident that he had been dead for some time.

Although the police should have flagged up the man's risk on his escort record, I am concerned that staff at the prison still had clear information about his risk of suicide when he arrived, which they should have taken into account. Had this been done, it is highly likely that staff would have monitored and supported him under Prison Service procedures for managing people identified as at risk of suicide and self-harm. We cannot know whether this would have prevented his death, but HMP Preston clearly needs to improve its reception procedures and processes for assessing risk. The prison also needs to review its emergency procedures.

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 **February 2015**

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SUMMARY

1. On Saturday 3 May 2014, the man was charged with serious sexual offences against a family member. The alleged offences took place between 1989 and1996 in Lancashire and the police took him from Suffolk, where he lived at the time of his arrest, to a police station to appear in court on Monday 5 May. He suffered from a number of chronic physical illnesses and depression. While he was in police custody, he initially refused to take his prescribed medication, or eat and drink, and said he wanted to die.

2. On Sunday 4 May, the man told a mental health nurse at the police station that he did not feel like going on and his main fear was going to prison. He was also concerned about being so far from home. The nurse noted in his custody record that custody staff needed to flag on his escort record that he would be at significant risk of suicide and self-harm if he was remanded to prison. This was not done. However, his risk of suicide was noted on a medical form which recorded his contact with healthcare professionals while in police custody. This was part of the documentation which went with him to court.

3. On Monday 5 May, the man appeared at magistrates' court and was remanded to prison. His risk of suicide or self-harm was not endorsed on his Personal Escort Record (PER). Court staff said that they had not seen the police medical information.

4. The man was sent to HMP Preston. The reception supervising officer did not read the whole of the police medical information, which she thought was a matter for the reception nurse. She therefore did not see that he had been identified as at risk of suicide. She understood that his alleged offence might make him more at risk, but was satisfied by his answers to her questions that he did not intend to harm himself. The PER did not indicate that there was any suicide and self-harm risk, although it noted he received medication for depression. The nurse who assessed him in reception did not see the medical information which referred to his risk of suicide in prison. He then went to the prison's first night centre. As in reception, no one considered that he was a risk of suicide and self harm.

5. The next day, 6 May, an offender supervisor looked at the man's records to complete a public protection assessment. She saw the police medical information and noted that he had said he was suicidal. She assumed that someone on the first night centre had seen the information, but could not recall whether she had told them. There is no record that she did. That day, a mental health practitioner saw him who said that he was feeling low but said he had never had any thoughts of suicide as it was against his Christian beliefs. The mental health practitioner did not see the police medical form and accepted what he had told him. A nurse assessed him as suitable to have his medication in possession.

6. The man moved to B Wing on 9 May and on 10 May, he put his name on the list to attend a church service the next morning. Later that day, he telephoned his wife and told her he intended to take his life as he could not live without her. No one at the prison was aware of the call. He received his medication to self-administer that day.

7. Officers unlocked prisoners' cells at around 9.00am, but just checked the prisoners were present, rather than getting a response from them. No one checked when the man did not turn up to the church service at 10.00am. Prisoners' cells were locked again at about 11.30am. At about midday, when unlocking prisoners for lunch, an officer found him unresponsive on his bed with a plastic bag over his head. Officers made an emergency alarm call, but locked his cell as they believed he was dead. Healthcare staff arrived and attempted to resuscitate him with chest compressions, although they considered he had died. They did not remove the bag from his head. Paramedics attended shortly afterwards. The paramedics found no signs of life and noted that rigor mortis was present. They pronounced his death.

8. The investigation found that, although the police had not highlighted the man's risk of suicide on his PER, reception staff at the prison should have read the police medical information which would have identified his risk. Reception procedures were poor and it does not appear that the reception nurse was passed the information she needed to make an informed assessment. Staff did not fully consider his other risk factors. The police information was never transferred to his medical record which led to an inaccurate assessment for in–possession medication. It was apparent that he was dead when officers found him and resuscitation would not be possible but we are concerned that the emergency response was disorganised and that officer did not check his welfare when they unlocked his cell in the morning. Healthcare staff were not invited to a debrief after his death as they should have been. We make six recommendations.

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 her. No one responded.

10. On 19 May 2014, the investigator visited Preston and obtained copies of the man's prison and healthcare records. She later interviewed 20 current or former members of staff and one prisoner at Preston. She also interviewed a police sergeant and a senior custody officer.

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

12. NHS England appointed a clinical reviewer to review the man's clinical care at Preston.

13. One of the Ombudsman's family liaison officers contacted the man's wife to inform her of the investigation and to ask if she had any issues she wanted the investigation to consider. His wife had no specific additional issues for the investigator to take into account. She received a copy of the draft report. She pointed out one factual inaccuracy. This report has been amended accordingly.

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 first night and induction procedures were good. Assessment, care in custody and teamwork (ACCT) documents for supporting prisoners at risk of suicide and self-harm were generally of reasonable quality with thorough assessments. Inspectors noted that a recent inquest into a death at the prison in August 2011, had commented on the prison's failure (identified in our investigation report at the time) to deal appropriately with a fax which contained a warning about the prisoner's risk of suicide. They noted that action had been taken to address this.

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 commented that the reception area was cramped and inadequate. The Board noted that Listeners (prisoners trained by Samaritans to help other prisoners in distress) gave effective support. Prison chaplains also gave impressive help to prisoners and their families at times of bereavement or distress. The Board said that the prison was working hard to make a Preston a safe place to live and work.

Previous deaths at Preston

17. We have investigated two previous self-inflicted deaths at Preston where we have been concerned about issues similar to some of those identified during this investigation. In both the other cases, the men had been in the prison for only a short period and significant suicide and self-harm risks had not been recognised. We have also recently concluded the investigation into the death of a man who died at a different prison but who had previously been at Preston and information about his risk had not been identified when he arrived at Preston.

Assessment, care in custody and teamwork procedures

18. Assessment, care in custody and teamwork (ACCT) procedures is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the process 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. Part of the ACCT process involves assessing immediate needs and drawing up a caremap about how they will be met. Regular multi-disciplinary reviews should be held.

Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

Police custody

19. On Friday 2 May 2014, Suffolk police charged the man with seven sexual offences against a family member. The alleged offences were between 1989 and 1996, when he was living in Lancashire. He was due to appear at magistrates' court. He was taken to a police station for the weekend, to appear in court on Monday 5 May.

20. A police sergeant interviewed the man when he arrived at the police station. He reported that he suffered from asthma, coronary obstructive pulmonary disorder (COPD, the name for a collection of lung diseases including chronic bronchitis and emphysema), diabetes, angina, headaches, epilepsy, vitamin B deficiency and depression. He had had surgery for a hernia two years previously.

21. The man told the police sergeant that he did not intend to take his medication (which he had brought with him) or to eat and drink. The police sergeant told the investigator that the man had implied that he had nothing to live for and seemed to be in a 'dark place'. He was concerned about him and placed him in a cell with CCTV so he could be constantly observed. He also asked custody officers to check him every 30 minutes.

22. A police forensic medical examiner examined the man at 1.25pm and recorded that his physical observations were within the normal range. He was aware that if he did not take his medication, his life could be in danger, but he had the capacity to make decisions about his care. Mental health services had no information about him. The medical examiner recommended that he should stay in the cell with CCTV coverage.

23. At 7.45pm, the man told a nurse at the police station that he had suicidal thoughts and was refusing to take his medication as he wanted to die. The nurse advised that he should continue to be monitored in the CCTV cell at half hourly intervals and should be taken to hospital if he complained of chest pains. In the early hours of the morning, he complained he had back pain and took some of his pain-relief medication.

24. At 1.30pm on Sunday 4 May, a mental health nurse from the Criminal Justice Liaison Team based at the police station saw the man. He told her that he did not feel like going on. He said that his main fears were going to prison and being remanded in custody so far away from his home. He decided to start eating and drinking again. The nurse wrote in his custody record medical advice and care plan that she had made custody staff aware that they would need to record on his personal escort record (PER) that there would be significant risks if he was remanded in custody on 5 May. She noted that she would ask her colleagues from the Criminal Justice Liaison Team to follow his progress and liaise with relevant services. There is no record that this was done.

25. A G4S custody officer who worked in custody suite at the police station prepared a risk indicator form as part of the man's PER. She circled that he was charged with sexual offences, listed his physical illnesses and wrote that he suffered from depression. She left blank the suicide/self harm category as a possible risk. The front page of the PER has a box for police use, which should be ticked if a care plan is enclosed with the PER. The box was left blank. She was unavailable for interview and is no longer employed by G4S.

26. A police sergeant said that custody officers normally complete PERs a few hours before the detained person goes to court. The custody officer has access to the person's custody record. The man's medical record was included with his PER, but the police sergeant could not tell from the form whether his medical record had been printed out and put in the PER at that stage, as court escort staff sometimes ask for a copy of the medical record after they review the PER. The man left the police station at 7.30am on 5 May, and arrived at magistrates' court at 8.08am.

27. On the man's PER, under the section called 'escort handover details' for the journey from the police station to court, 'property card' and 'medical assessment/care plan' are circled. 'Confidential medical documents' has also been partially circled. A senior custody officer at magistrates' court told the investigator that sometimes forms would be circled on the PER, but the actual document would not be present. However, as these records arrived at the prison with him they must have been with his documentation at court. Had the police indicated that he was at risk of suicide or self-harm, the senior custody officer was certain that one of the court staff would have acted on it by highlighting his risk of suicide or self-harm on the PER.

HMP Preston

28. Magistrates remanded the man to prison and he arrived at HMP Preston at 2.25pm. A Supervising Officer (SO) received him. She told the investigator that she did not usually work in reception. It was a Bank Holiday and only seven prisoners arrived from court that day. She noted that there was nothing on the front of the man's PER to indicate any concerns about his risk of suicide or self-harm and there was no suicide and self-harm warning form. She said that she was aware that his alleged offence made him a higher risk of suicide but she was satisfied from his answers to her questions and his general presentation that he was not at risk. She therefore did not open an ACCT.

29. The SO said she had looked at the accompanying police medical record, which was several pages long. She noted that it referred mainly to the man's physical health conditions and did not read the whole document as she considered these were a matter for the reception nurse. She could not say for certain that anyone had passed his police medical record to the nurse, but believed this would have been done.

30. A nurse carried out an initial reception health screen. The man told the nurse that he had had a triple heart bypass, suffered from angina, diabetes and

asthma and had fallen three weeks before, after an epileptic episode. He took 18 types of prescribed medication for his conditions.

31. The man said that he was feeling quite low and how he would react would depend on the outcome of his court cases. He said he had not harmed himself before and that he had no thoughts of suicide or self-harm. He told the nurse that he had not been in prison before. (In fact he had, but 30 years previously.) The nurse told the investigator that he had been very convincing and, although she had initial worries that he might be vulnerable, she had believed him when he said that he would not harm himself as he had strong Christian beliefs. She said his body language had been positive and he said that he loved his wife too much to take his life. Because of the extent of his physical ailments, the consultation had lasted about 20 minutes, which was longer than average. She said she had not received any other information about his health and made a note of this in his clinical record. She did not see the police custody health record.

32. The nurse said that, after she had finished her assessment, she had remarked to one of the reception officers that she had had some initial concerns about the man, but he had convinced her that he was okay. She completed the healthcare part of a cell sharing risk assessment (CSRA – to determine the risk of violence towards another prisoner in a shared cell) and noted that he did not have any immediate healthcare risks, other than he should be given the bottom bunk in a shared cell as he was epileptic. She also said that he should be given a ground floor cell, because of his poor health.

33. An officer completed the assessment. The man told him that he would refuse to eat or drink if he had to share a cell. When the duty governor spoke to him about this, he said that he was prepared to share a cell. His file of documents was placed in a box to go to the prison's offender management unit along with the files of other prisoners who had appeared in court that day.

34. The man went to the prison's first night centre, where an officer spoke to him in more depth about his immediate needs. He said that he had never been in prison before and that he wanted to make a telephone call. (It is not clear whether he was allowed a call.) He said he was very concerned about being in prison, but had not harmed himself before and did not feel at risk of doing so.

35. The next day, 6 May, as part of his prison induction, an officer explained some prison procedures and ensured that the man understood that he could talk to Samaritans or Listeners (prisoners trained by the Samaritans to provide confidential support to prisoners in distress). The officer wrote in his prison custody record that he was very upset but said he was not thinking of harming himself.

36. Later that day, a prison chaplain spoke to the man. He told the investigator that the man stood out, because he lived a long distance from Preston. The man asked him for a Bible, some Christian reading material and asked him to

let his home pastor know where he was. (The chaplain did this and had a brief chat with him a couple of days later. He said that the man had been talking with other prisoners and seemed settled.)

37. An approved social worker and mental health practitioner from the prison's Well Man Clinic saw the man that day and discussed his history of depression. He said that his mood was low mood, but said that he had never had thoughts about suicide, as it was against his Christian beliefs. He said he had been in prison a number of years previously. He did not mention that he was far from his home. The social worker did not see his medical record from his time in police custody. He made a routine mental health referral as the man had mentioned suffering from post-traumatic stress disorder after a traffic accident. (This would have taken about four weeks.)

38. A nurse assessed the man and agreed that he was suitable to have his medication in possession. (Because of pharmacy arrangements, he did not receive his stock of medication until Saturday 10 May. Until then he collected his medication from the medicines hatch.)

39. On 6 May, an offender supervisor examined the files of the prisoners who had arrived from court the day before, to prepare public protection risk assessments. She saw the man's police medical form and wrote on her risk assessment "Expressed suicidal thoughts according to the medical form". She did not record the information anywhere else. She told the investigator that she had assumed that the first night centre would have seen it. She said that her usual practice would be to telephone a prisoner's residential wing when she saw such information, but she could not be sure whether she had let first night centre staff know. There is no evidence that any of the first night staff knew about this information.

40. On 9 May, the man moved to a cell on the ground floor of B Wing, which he shared with another newly arrived prisoner. The next day, Saturday 10 May, an officer introduced herself as his personal officer. (This meant she would be the first officer for him to speak to if he had any queries or issues he wanted to discuss.) He asked her to check that his medication would be brought to the wing and told her that he had had a triple heart bypass. He received his medication to self-administer later that day. She checked that he knew to press his cell bell if he felt unwell. She told the investigator that he seemed quite jolly. His cellmate was moving to share a cell with a friend, and she agreed that she would try to arrange a cellmate nearer to his age. In the meantime, he was content to be in a cell by himself.

41. The man put his name on the list to attend the Church of England service in the chapel the next day, Sunday. He was one of two B Wing prisoners on the list. On Saturday, he telephoned his wife and told her that he was going to 'end it all' as he did not want to go on living without her. The prison was not aware of this call.

42. The man's personal officer last recalled seeing him at about 4.15pm when she unlocked his cell so that he could collect his medication from the nurse. The

evening meal was served at about 5pm and prisoners were then locked in their cells until the next day.

43. The night officer on B Wing took over duty at about 8.00pm. He said that the night passed without incident. He normally worked on A Wing and did not know the prisoners on B Wing. He did not recall seeing the man.

Day of the incident

44. Between 5.10am and 6.00am, an officer carried out a roll check. (This was a visual security check to make sure that all the prisoners were present in their cells. He did not try to get a response from the prisoners.) He noted nothing untoward about the man or his cell. At about 6.45am, the officer handed over to Officer A. We did not interview this officer as the investigator was told he was working temporarily at another prison. In his written statement at the time, Officer A said that, after taking over from the first officer, he visually checked all prisoners by looking through the observation panels of their doors and checked and wrote in the ACCT documents of two prisoners on the same landing as the man. He noted no concerns.

45. Officers unlocked the cells on B Wing at about 9.00am. The five officers on duty on B Wing were unable to recall which of them had unlocked the man's cell. According to the staff detail, a particular officer was responsible for the ground floor landing, but he told the investigator that he thought he was working on the third floor landing that day. He said that, as 11 May was a Sunday, officers unlocked cells as usual, but unlike weekdays, prisoners were free to stay in bed and sleep if they wanted, so the officers did not attempt to get a response from them. He did not see the man that morning and no one else remembers seeing him. From 9.00am to 9.30am, prisoners collected their medication, exchanged their clothing and bedding for clean items. Prisoners were allowed out of their cells from 9.30am to 11.30am and any who were on the list to go to the chapel were expected to go to the third landing to be collected at about 10.00am. Staff did not try to find them if they did not appear.

46. The Church of England service ended at about 11.00am and the prisoners who attended returned to their wings. At around 11.30am, staff locked prisoners in their cells in preparation for lunch. As with the morning unlock, none of the five officers on duty that morning could remember which one of them locked the cells on the ground floor before lunch.

47. At around 11.45am, officers began to unlock each landing in turn, starting with the fourth landing and ending with the ground floor. Officer A unlocked the ground floor cells for lunch. When he opened the man's cell at about 12.05pm, he noticed that he was still in bed. After unlocking two more cells, he saw that the man had still not left his cell. He went into the cell and put his hand on his shoulder to rouse him. He was lying on the bottom bunk with his head towards the cell door and his feet towards the window. A towel was draped over the back of the bed. The officer noticed that he felt cold and his arm dropped from the edge of the bed when he touched it. He then saw that

the man had a plastic bag over his head tied with several plastic bands around his neck. He looked grey and his eyes were open. The bag had condensation on the inside.

48. Officer A went to the wing office and asked Officer B to raise the alarm as there had been a death. He did not remove the bag from the man's head or attempt resuscitation as he was sure that he was dead. Officer B told the investigator that Officer A appeared shocked and said that a prisoner looked like he had suffocated himself with a plastic bag in cell B2-09 and appeared to be dead. He immediately telephoned the communications room. He did not recall whether he had a radio.

49. An operational support grade (OSG) in the communications room received a telephone call at about 12.06pm requesting medical assistance at cell B2-09 as there was a prisoner with a plastic bag over his head. He then immediately radioed a code blue (which indicates an emergency where a prisoner is unresponsive or might not be breathing.) He called an ambulance at 12.07pm. Officer B telephoned the communications room again and asked if an ambulance had been called. The OSG assured him he had called one.

50. Nurse A responded to the emergency call and ran to B Wing, closely followed by a colleague, who brought the emergency bag and a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). She told the investigator that as she got to B Wing, there were a lot of officers on the landing and an officer gestured to her that the man was already dead. She asked them if there was a code blue emergency as she thought it strange that there did not seem to be a sense of urgency. The officers pointed to the door of cell B2-09 which was locked. She unlocked it and saw him lying on the bed with a clear polythene bag on his head. She thought he appeared to have been dead for some time as he was rigid and cold. His face and hair were wet with condensation inside the bag.

51. Nurse B arrived a few seconds later. They said they were both shocked as none of the officers had given them any indication of what to expect. The second nurse then began chest compressions. A healthcare assistant and another nurse arrived to assist. Nurse A went to see if the prison's GP was in the prison's drug unit, but as she got there some officers told her there was no doctor in the prison and she went back to the cell.

52. Nurse B's recollection was slightly different. She told the investigator that, when she arrived on B Wing, Nurse A signalled to her to stop running and said that the man was already dead. She said she had asked one of the officers on the landing whether paramedics had been called but they said they had been waiting for the nurses. (In fact, the communications room had called an ambulance immediately when they called the code blue emergency.)

53. Nurse B said that she had checked for signs of life and found none. She had radioed for more healthcare staff and a doctor to attend. She attached the defibrillator, but there was no shockable rhythm. Although her assessment

was that he was clinically dead, she believed she was obliged to attempt resuscitation because she was not qualified to pronounce death. Nurse A left to get the doctor. Nurse A said she did not remove the bag from the man's head as she was in shock. Nurse B said she left it on as she thought it might contaminate the evidence. She told the investigator that, in retrospect, she could not understand why she had left the bag in place. Paramedics arrived at 12.14. They found no signs of life and that rigor mortis was established. At 12.17 they pronounced him dead.

54. The man left a note in his cell for his family which indicated that he had intended to take his life. A check of his medication indicated a significant amount of his painkilling and antidepressant medication was not accounted for.

55. The healthcare staff went back to the healthcare centre and discussed what had happened and supported each other. They were upset that when they had arrived on B Wing, none of the officers had made it clear that they thought the man was dead or told them the manner of his death. They were also concerned that there had been uncertainty about whether an ambulance had been called and could not understand why the officers had not attempted to resuscitate him.

56. A custodial manager was the orderly officer (responsible for day to day operation and for responding to incidents). He told the investigator that, when he heard the code blue he asked his assistant orderly officer to attend. He then looked onto B Wing, which he could see from his office and saw that the staff looked distressed. He went onto the wing and overheard a healthcare worker say that a prisoner had died. He did not go to the man's cell and did not know he had a bag on his head that had not been removed, or how the death had occurred. He asked an operational support grade to start a log of events and timings and noted that the duty governor had arrived on the wing. He did not write an incident report or attend the hot debrief.

57. The assistant orderly officer told the investigator that the two other assistant orderly officers went to B Wing first, but he did not go onto the wing until he saw the shocked faces of nurses when they came out of the man's cell. He said he had asked a member of staff to keep a log of who went into the cell and he took control of the area around it. He did not go into the cell until after paramedics had declared his death. It was only then that he saw the man still had a plastic bag on his head. The other assistant orderly officers helped to lock up prisoners.

58. The duty governor told the investigator that he had gone to B Wing as soon as he heard the code blue. The assistant orderly officer briefed him when he arrived about how the man had been found. The paramedics then arrived and, after being in the cell for a short period, one of them told him the man had been dead for several hours and that there was a note in the cell. He left the assistant orderly officer on B Wing in charge of the incident and went to the communications room to follow the contingency plans for a death. He said that he had not been aware that the plastic bag was still in place until he

went into the cell later with the police. He told the investigator that he had regarded this as the responsibility of healthcare staff, as they had led the resuscitation attempt.

Contact with the man's family

59. As the man's wife lived a long way from Preston, the prison arranged for a family liaison officer from HMP Warren Hill to go to his wife's home and break the news of her husband's death, that day. The Head of Safer Prisons and Equalities at Preston telephoned his wife the next day to give condolences and offer support. The prison contributed towards the cost of the funeral in line with national Prison Service guidelines.

Support for staff and prisoners

60. Later that day, the man held a debrief with some of the staff involved in the emergency response and informed them of the support available from the care team. None of the healthcare staff attended and some said that no one had informed them that it was taking place. He acknowledged that he thought the healthcare staff had gone home by the time he convened the meeting.

61. The prison issued notices to prisoners and staff to let them know of the man's death and sources of support for anyone affected. Staff put individual notices under each cell door on B wing that morning, explaining what had happened. Staff reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by his death.

ISSUES

The Person Escort Record

62. There was clear information on the health record from the man's time in police custody that police custody staff had identified him as at risk of suicide. A mental health nurse at the police station had instructed that his personal escort record (PER) should be clearly marked that he would be at risk of suicide if he was remanded to prison, yet this did not happen. It would undoubtedly have made his risks more obvious if staff at the police station or at the court had clearly marked the PER to flag up his risk, as they are required to do.

63. Good information sharing between criminal justice agencies about a detained person's risk of suicide and self-harm is crucial to safety and the PER is the principal mechanism used to convey this information. Unfortunately, too often vital information is missed. In 2011, HM Inspectorate of Constabulary and HM Inspectorate of Prisons analysed a sample of 181 PERs and found that 33 of them were not fully completed. They were also concerned that risk information in police custody records was often not reflected on the PER.

64. The police should have drawn attention to the man's risk which would have alerted prison reception staff and most likely have led to them monitoring him under ACCT procedures as a risk of suicide and self-harm. The actions of the police are outside the remit of this investigation, but we make the following recommendation to the prison:

    The Governor should draw this investigation report to the attention of Lancashire Constabulary to emphasise the need for effective sharing of information about prisoners' risk of suicide and self-harm, using Person Escort Records.

Assessment of the man's risk of suicide and self-harm

65. Although the police did not flag up the man's risk on the PER, they provided significant and comprehensive information about his risk of suicide in the form of his healthcare record from his time in police custody. This arrived with him with his documents from court. Staff in reception at Preston had access to the record, yet did not read it fully and take it into account when assessing his risk. The reception supervising officer said that, as it was medical information, she expected the reception nurse to consider it. Although the supervising officer believed that the nurse would have seen the information, the evidence suggests otherwise. It is concerning that there does not appear to be a clear system to ensure that all relevant reception staff see important information that might help effective assessment of risk of suicide and self-harm.

66. Prison Service Instruction (PSI) 74/2011, about early days in custody, sets out mandatory reception procedures and requires reception staff to examine the 'Person Escort Record (PER) form that must accompany each new prisoner,

and any other available documentation (our emphasis) ,…to identify any immediate needs and risks already recorded'. As no one read the information from the police we do not consider that the prison complied with this instruction.

67. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, both list a number of risk factors and potential triggers for suicide and self-harm. The man had a number of these at the time of his reception into Preston which we consider should have alerted staff to his risk. These included mental and physical health problems, a recent history of suicidal ideation, being charged with a serious offence against a family member, early days in custody and (so far as reception staff were aware) this was his first time in prison.

68. The reception supervising officer recognised that the charges he was facing increased his risk of suicide and self-harm, but was satisfied from his body language and what he said that she did not need to open an ACCT. Similarly, the reception nurse said she had concerns about the man, but was convinced by his assertion that he had no thoughts of suicide or self-harm. She did not have the medical information from the police at the time of her assessment so was unaware of his stated suicidal thoughts. The supervising officer had seen the information but had not read it. Nevertheless, he had a number of other risk factors which do not appear to have been considered in the round. Neither the supervising officer nor the nurse discussed their concerns with each other and it is not apparent that they considered his range of risk factors.

69. Staff judgement is fundamental to the ACCT system. 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. However, we are concerned that the staff relied so heavily on the man's presentation, rather than his known risk factors. 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 as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged.

70. On the day after the man arrived, the offender supervisor examined his records as part of her role. She saw the medical record from the police and was aware of his recent suicidal thoughts. She did not record this anywhere on his case notes which would have been accessible to other staff. She assumed that others would have been aware of the information (as they should have been) and would have taken it into account when assessing his risk. However, the information should at least have been passed on to the first night centre staff as a 'back-stop' and she should have considered whether to open an ACCT in the light of the information.

71. Robust recording and collation of information helps to build a better picture of issues that a prisoner is facing and his risks. In the man's case this did not happen. We have recently made a recommendation to Preston (in relation to

an investigation into a death of a man at another prison who had previously been at Preston) about the need for more effective assessment of risk for newly arrived prisoners. We make a similar recommendation, with the addition of the need for effective operating procedures in reception, so that all staff working there are clear about their responsibilities:

The Governor and Head of Healthcare should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk in an appropriate manner**
- **Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.**

Clinical care

72. The clinical reviewer was satisfied with the general standard of healthcare the man received at Preston, but was concerned about the poor transfer of information from the police to the prison, that nurses left the plastic bag on his head when they attempted resuscitation, and that he was allowed to keep his medication in his possession. The first two of these issues are covered elsewhere in this section.

73. Ideally prisoners should be responsible for managing their own medication and have the autonomy they would have in the community. There are a number of benefits to this approach, but prisons also have a duty of care to ensure security and the safety of prisoners. The risks and benefits therefore need to be carefully assessed. When the man first arrived at Preston, he had to collect his medication until a risk assessment was completed to allow him to hold his medication in possession.

74. The nurse who completed the risk assessment did not see the police medical records and without this information had no reason to conclude it was inappropriate to allow him to have all his medication. The nurse was aware that the man understood his conditions, how to take his medication and that he had been managing his own medication in the community. She asked him all the standard template questions for the risk assessment and he gave appropriate answers. He received his in-possession medication on Saturday 10 May. Some of his medication is unaccounted for and it is possible that he overdosed on this before attaching the bag to his head. (There were no toxicology reports from the post-mortem examination at the time of writing this report.)

75. We are satisfied that the nurse made a reasonable assessment that the man was suitable to have his medication in his possession, based on the information available to her. However, if the information from his time in police custody had been flagged up, or entered on his prison medical record, it is unlikely that he would have been allowed to keep his medication in his cell. As with the assessment of his risk of suicide and self-harm, the risk assessment for in-possession medication was severely hampered by the prison's failure to take proper account of the information from the police. We make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare staff receive and carefully scrutinise medical records from prisoners' time in police custody and summarise and highlight relevant information in the prison medical record to inform decisions about their care.

Emergency response

76. When Officer A found the man unresponsive in his cell at around 12.05pm on 11 May, he quickly sought assistance. The prison communication room received a call at 12.06pm and radioed a code blue emergency. At 12.07, they called an ambulance. This ensured that healthcare staff went quickly to the cell and paramedics also arrived quickly – reaching the cell by 12.14pm. This was a commendably rapid response.

77. When Officer A found the man, he was certain that he was dead so did not attempt resuscitation. When nurses arrived they were also certain that he was dead but felt obliged to attempt resuscitation. None of the staff removed the plastic bag from his head. Paramedics quickly recognised his death and found that rigor mortis was present. They estimated that he had been dead for at least several hours. We are therefore satisfied that, from the point that the officer found him, nothing could have been done to save him.

78. Usually when officers find a prisoner unresponsive, we would expect them to raise the alarm and begin basic life support until healthcare staff arrive. Officer A was certain that the man was dead so did not do so, although he did not first check for any signs of life as we would have expected. However, we do not criticise him for that decision, which appears to have been in line with the European Resuscitation Guidelines for Resuscitation 2010 which state, "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".

79. We are concerned that when the nurses arrived on the wing, no one appears to have briefed them about the circumstances in which the man was found and the initial decision not to try resuscitation. The nurses believed they were responding to an incident requiring emergency assistance. It is therefore not surprising that they were perturbed to find that no one was doing anything to assist him. When they asked where the emergency was they were directed to a locked cell. The nurses were unsure who was in charge of the incident and the officers gave them incorrect information about whether an ambulance was on its way.

80. It is inexplicable why the nurses considered that chest compressions could be effective while the man had the plastic bag on his head, but this seems to have been partly because of shock, partly because they were certain he was dead anyway and partly because there was a suggestion that someone had told them that they should not tamper with the evidence. (This would explain why officers had locked the cell door, which is a prison procedure after a death.) There is no clear evidence that anyone directed nurses not to remove the bag, but the clinical reviewer commented that the maintenance of life should take precedence and in any event, nurses should have disregarded such an instruction, if one was made.

81. Although nothing would have changed the outcome for the man, we are concerned that there was considerable confusion about communication and responsibilities in relation to managing the emergency incident and about resuscitation. We recognise that events were concentrated in a very short time frame of fifteen minutes or so. A number of the staff involved were understandably very shocked and inevitably some accounts of events differ. However, we consider that the orderly officer or one of the assistant orderly officers should have taken immediate charge of the scene. They should have gone into his cell before it was locked, established the nature of the incident, removed the plastic bag from his head and briefed healthcare staff when they arrived.

The Governor should ensure that the orderly officer or other designated person immediately takes charge of an incident where a prisoner has been discovered, apparently dead. Staff should check for signs of life and take any required urgent action without waiting for healthcare staff to arrive.

Unlock procedures

82. None of the five officers working on B Wing on the morning of the incident accepted that they were the officer who had unlocked the man's cell at around 9.00am or had locked it at around 11.30am. It is not clear what time he died but, at midday, the paramedics considered that he had been dead for several hours. It is therefore possible that, had the officer who unlocked the cell at 9.00am, and checked him, he might have been discovered before he died.

83. Staff told the investigator that prisoners were left to sleep on Sunday mornings and so they did not attempt to get a verbal response from them when they opened their cells in the morning. While we understand that officers will not necessarily want to wake prisoners, safety should take priority. We consider they should be satisfied that a prisoner is actually alive and take some action if there are any concerns. At unlock they should make take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response

you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

84. Prison Service Instruction 10/2011 states that:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

We make the following recommendation

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Staff support

85. PSI 64/2011 reminds governors that in line with instructions on post-incident care for staff involved in traumatic incidents, they should hold a 'hot debrief' immediately after a death in the prison. The instruction requires a senior member of staff to act as the debriefer and a member of the care team to attend. All staff directly involved in the incident, including healthcare staff, should be invited.

86. Officers and healthcare staff found the circumstances of the discovery of the man shocking and distressing. Some staff considered that there had been poor communication between managers, officers and nurses but did not have an opportunity to discuss this. The orderly officer held a debrief meeting later on the day of the man's death, but we are concerned that a number of the healthcare staff said that they had not been informed of the debrief and none were present. We make the following recommendation:

The Governor should ensure that all staff, including healthcare staff, are included in a hot debrief after a death at the prison.

RECOMMENDATIONS

1. The Governor should draw this investigation report to the attention of Lancashire Constabulary to emphasise the need for effective sharing of information about prisoners' risk of suicide and self-harm, using Person Escort Records.

2. The Governor and Head of Healthcare should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:

   - Have a clear understanding of their responsibilities and the need to record relevant information about risk in an appropriate manner
   - Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records
   - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.

3. The Governor and Head of Healthcare should ensure that healthcare staff receive and carefully scrutinise medical records from prisoners' time in police custody and summarise and highlight relevant information in the prison medical record to inform decisions about their care.

4. The Governor should ensure that the orderly officer or other designated person immediately takes charge of an incident where a prisoner has been discovered apparently dead. Staff should check for signs of life and take any required urgent action without waiting for healthcare staff to arrive.

5. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

6. The Governor should ensure that all staff, including healthcare staff, are included in a hot debrief after a death at the prison.