Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vasile Nastase, a prisoner at HMP Forest Bank, on 1 September 2019

A report by the Prisons and Probation Ombudsman

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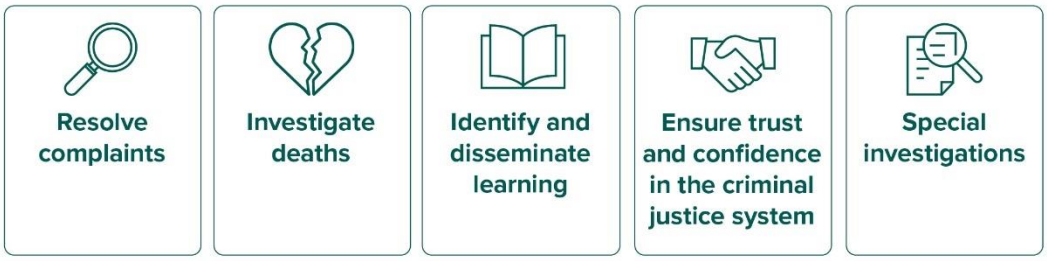
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Vasile Nastase died on 1 September 2019 at HMP Forest Bank, after making a cut to his throat. He was 49 years old. I offer my condolences to Mr Nastase's family and friends.

I am concerned that no one assessed Mr Nastase's risk of suicide and self-harm after he received a life sentence by video link on 27 August. Mr Nastase, a Romanian national, had a limited understanding of English and interpretation services were not used after he was sentenced. It was clear in the days afterwards he did not fully understand what had happened. This may have contributed to the dramatic deterioration in Mr Nastase's mental health.

Although suicide and self-harm prevention measures (known as ACCT) were started the day after Mr Nastase was sentenced, there was an emphasis on his physical health symptoms and the impact of his sentence was not explored. Staff also failed to review the measures in place to support him when his mental health deteriorated further.

The investigation found that the mental health care Mr Nastase received in prison was of a poor standard. I am concerned that despite prison staff and a nurse asking for an urgent mental health assessment the day before he died, this did not happen.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **September 2022**

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Summary

Events

1. On 11 February 2019, Mr Vasile Nastase, a Romanian national, was remanded in prison custody, charged with rape. He was sent to HMP Forest Bank. This was his first time in a UK prison, although he had previously served prison sentences in Romania.

2. Mr Nastase spoke little English. However, throughout his time on remand, Mr Nastase engaged well with the prison regime and was polite and friendly with staff and well-liked by other prisoners. He received treatment for several minor physical health issues and there were no concerns about his mental health.

3. On 27 August, Mr Nastase appeared in court by video link and was sentenced to life imprisonment with a minimum tariff of four years and 244 days. He returned to his wing and, according to other prisoners, was confused and did not understand his sentence. Mr Nastase's mental health deteriorated rapidly and the next day, staff started suicide and self-harm prevention measures (known as ACCT).

4. On the morning of 31 August, Mr Nastase was found in a trance-like state, screaming about demons in Romanian. An officer and a nurse asked a mental health nurse to assess him urgently, but this did not happen. Mr Nastase spent the afternoon watching television and sleeping.

5. Shortly after 4.00am on 1 September, during a routine ACCT check, an officer discovered Mr Nastase on the floor of his cell covered in blood, but conscious. The officer radioed a code red medical emergency and staff entered the cell. Mr Nastase was agitated and aggressive and staff had difficulty trying to establish where he was injured. Due to Mr Nastase's aggression, the nurse was not able to assess him. Staff moved Mr Nastase to the healthcare centre but around 4.40am, he suddenly became unresponsive. Prison and healthcare staff tried to resuscitate Mr Nastase. Paramedics arrived and continued resuscitation attempts but at 5.25am, declared he had died.

Findings

6. Staff failed to assess Mr Nastase's risk of suicide and self-harm after he was sentenced to life imprisonment. Mr Nastase had limited English, but there is no evidence staff used interpretation services to ensure that he understood what his sentence meant, and to help them understand the impact on his risk.

7. Mr Nastase was not offered a health assessment following his change of status from convicted to sentenced prisoner, as he should have been.

8. A mental health nurse completed an assessment as part of the ACCT review, but this was inadequate.

9. The ACCT review did not identify that Mr Nastase's mental health had deteriorated after he received a life sentence and relied on Mr Nastase's presentation and assurances that he did not intend to harm himself. The caremap was inadequate.

10. Prison staff and a primary care nurse were concerned there had been a further decline in Mr Nastase's mental health the day before he died, but the mental health nurse failed to assess him and prioritised other less urgent tasks. We consider that the decision not to assess Mr Nastase, despite requests from wing staff and a nurse colleague, was a significant error of judgement.

11. Staff should have considered reviewing Mr Nastase's ACCT or increasing the level of observations when his behaviour became increasingly bizarre on 31 August.

12. On the day before he died, Mr Nastase was in a distressed state and staff could not understand what he was saying. They could not use a telephone interpretation service because Mr Nastase would not leave his cell and the portable telephone was not compatible with Big Word the translation service. A Romanian prisoner had to be asked to act as interpreter.

13. The officer who initially found Mr Nastase in his cell correctly radioed an emergency code, but the control room failed to call an ambulance immediately, contrary to national guidance.

14. Not all the staff involved in the emergency response attended the debrief.

15. The prison's care team representative at the debrief was also the operational manager when Mr Nastase was found, and it was not appropriate to expect him to have to undertake this supportive role given his involvement.

16. Some prison and healthcare staff reported that they did not feel sufficiently supported in the days after Mr Nastase died. The prison cancelled two subsequent debriefs scheduled in September and October. When one was held on 24 November, only three people attended.

Recommendations

- The Director General of HMPPS should review PSO 3050 and PSI 07/2015 to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person.

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:

    - assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors, and not only on a prisoner's presentation or what he says;

    - set caremap actions that are specific, meaningful and time bound, aimed at reducing the prisoner's risk to themselves, and update the caremap actions if additional needs are identified;

    - consider if an additional case review is required, or the level of observations needs to be revised, if there is a change in behaviour or additional concerns; and

- be reminded to record factual information on the ongoing record, which is free from judgement or speculation.

- The Head of Healthcare should:
  - carry out an in-depth analysis of how workloads are prioritised to ensure that staff can attend immediately when prisoners are deemed to be in a mental health crisis; that;
  - review the Mental Health Care pathway and consider if any revisions are necessary to enable staff to respond to a mental health crisis; and
  - review the use of risk assessments during ACCT reviews to act as aide memoirs so that more thorough risk assessments are completed ensuring key risk indicators are not missed.
- The Head of Healthcare should:
  - commission an investigation into the decision by Nurse A not to complete an emergency mental health assessment on 31 August;
  - implement any actions or learning deriving from this investigation as a matter of urgency; and
  - provide a report to the Ombudsman.
- The Head of Healthcare should ensure that healthcare staff are transferred from Sodexo to GMMH as a matter of urgency to enable the Mental Health Manager to manage the mental health team in a seamless manner, developing staff where required.
- The Director should ensure that:
  - formal translation guidance is produced for communicating with prisoners who do not speak or understand English well;
  - accredited interpretation services are used by all members of staff, including healthcare staff, when interviewing or assessing such prisoners;
  - staff should explain sentencing decisions to such prisoners using interpretation services; and
  - staff are able to use interpretation services in cells and other non-office situations when required (for example, by means of a handheld portable telephone).
- The Director and the Head of Healthcare should review the protocol with the local ambulance service to ensure they understand the prison context and that staff who request ambulances might not be able to provide detailed information about the patient immediately.

- The Director and Head of Healthcare should ensure that communications room staff call an ambulance immediately and are provided with sufficient training.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

18. The investigator visited Forest Bank on 4 September and obtained copies of relevant extracts from Mr Nastase's prison and medical records and visited D Wing. She interviewed four prisoners.

19. NHS England commissioned a clinical reviewer to review Mr Nastase's clinical care at the prison.

20. The investigator, accompanied by the clinical reviewer, interviewed ten members of staff at Forest Bank on 2 and 3 October. The investigator also interviewed three members of staff by telephone in November.

21. We informed HM Coroner for Greater Manchester West District of the investigation. We have sent the coroner a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr Nastase's next of kin, his daughter, to explain the investigation. Mr Nastase's daughter did not have any specific questions for the investigation to consider.

23. We shared aspects of this report with the prison, in line with our advanced disclosure process.

24. Mr Nastase's family received a copy of the initial report. They did not identify any factual inaccuracies.

25. HMPPS also received a copy of the initial report on 30 March 2020. However, we did not receive a response until 12 September 2022. In response to the feedback, we have made some changes to our report. The changes do not impact on our findings and our key messages on learning. We note that four recommendations, directed to the healthcare provider at Forest Bank, have not been accepted.

Background Information

HMP Forest Bank

26. HMP Forest Bank is a local prison in Salford, serving courts in north-west England. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services, who also provide primary health care services.

27. Up to 2016, Greater Manchester Mental Health (GMMH - formerly Greater Manchester West) provided secondary mental health care and Sodexo provided primary mental health services. However, after a joint prison and healthcare inspection in 2016, it was identified that there were difficulties with primary mental health services and a regulation notice was issued. A subsequent focused inspection identified there had been no improvement and primary mental health services were subcontracted to GMMH. Three mental health nurses are still employed directly by Sodexo. However, they are line managed by the GMMH manager.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Forest Bank was in May 2019. Inspectors found that foreign national prisoners who spoke little English were disadvantaged by the absence of translated material and limited use of telephone interpreting services, although these had improved since the equality team started to monitor use in January 2019. Prisoners valued the wing kiosks which gave access to information in multiple languages.

29. Health services had improved since the last inspection. Primary mental health support for prisoners with mild to moderate needs had improved significantly since the last inspection, and secondary mental health care remained good. There was evidence of learning from deaths in custody, and from serious and untoward incidents which had resulted in some changes to health services. The integrated mental health team of staff from Sodexo and GMMH was well staffed and provided daily support to prisoners, including attendance at ACCT reviews. However, three registered mental health nurses employed by Sodexo regularly covered general primary care duties, which affected their capacity to deliver mental health care. Appointments were prioritised according to need and prisoners who required an emergency response or had urgent needs were seen immediately.

30. Inspectors noted that self-harm had increased significantly and was exceptionally high. While data collated were useful and pertinent, there was no evidence of the information being used to inform a strategy aimed at reducing self-harm figures. Some improvements had been made to the management of ACCT documentation. Caremaps were more tailored to the prisoners' needs and progress against set objectives was recorded. Attendance at case reviews had improved since the previous inspection, but not enough to ensure that a multidisciplinary approach was taken to decision-making. There was still little done to keep prisoners at risk of self-harm occupied to reduce their risk. Records of contacts were mainly observational, and few meaningful interactions were recorded. Inspectors identified that managers claimed to operate a three-tier quality assurance process to ensure that ACCT

processes were properly managed but there was minimal evidence of the process being followed.

Independent Monitoring Board

31. 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 the last published annual report for the year to 31 October 2017, the Board found those prisoners with mental health issues were well cared for. There was, however, a proposed contract to link primary and secondary mental health services to improve access to psychological services and the opportunity for prisoners to see a psychiatrist.

32. The Board reported that equality and inclusion had a high profile within the prison. Provisions for foreign national prisoners were in place, translation services were available and there was a list of staff who spoke other languages.

Previous deaths at HMP Forest Bank

33. Mr Nastase was the eighth prisoner to die at Forest Bank since September 2017. Of the previous deaths, one was self-inflicted, one was drug-related and five were from natural causes.

34. In a previous investigation we identified delays in calling an ambulance in response to a medical emergency code but did not make a recommendation as the prison told us it had taken steps to address the issue. However, we have identified a similar issue in this investigation and have made a recommendation which the Director needs to address.

Assessment, Care in Custody and Teamwork

35. 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.

36. 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.

37. 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, Managing prisoners at risk to self, to others and from others (Safer Custody).

Key Events

38. On 11 February 2019, Mr Vasile Nastase, a Romanian national, was remanded in prison custody, charged with rape, and sent to HMP Forest Bank. He had been to prison before in Romania on a number of occasions (for robbery, rapes, sexual assault and false imprisonment). On 27 August, he was sentenced to life imprisonment with a minimum tariff of four years and 244 days (meaning the earliest he could be considered for release was 26 April 2024).

39. On 11 February, Mr Nastase arrived at Forest Bank around 2.35pm. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose), court staff had recorded that Mr Nastase had a number of risk factors associated with his offending and had several physical health conditions.

40. An officer completed Mr Nastase's reception screening at 4.48pm. Another officer recorded on the cell sharing risk assessment (CSRA) that Mr Nastase was high risk as he had a previous conviction for false imprisonment. There is no evidence that Big Word, the telephone interpretation service, was used.

41. At 6.05pm, a nurse recorded in Mr Nastase's medical record that she had completed his initial health screen with the help of Big Word. She noted Mr Nastase had no thoughts of suicide or self-harm and had no physical health issues. Mr Nastase said that the information on the PER was not accurate. Another nurse recorded on the CSRA that there were no health issues that increased Mr Nastase's risk.

42. Mr Nastase requested vulnerable prisoner status because of his offence and was moved to D Wing, the vulnerable prisoner unit, for his own protection. Mr Nastase signed the custody and communications compacts, both written in English. The first night check list, which included a question about suicide and self-harm, which should have been completed when he arrived on the wing, was not completed. There is no evidence that a basic custody screening was completed.

43. Over the next few months, little information was recorded on Mr Nastase's prison record. On 2 May, an officer made an entry to reflect how hard Mr Nastase worked, that he was respectful and got on well with staff and other prisoners. She noted that Mr Nastase's English was improving.

44. On 19 June, an officer introduced himself as Mr Nastase's keyworker (a prison officer responsible for five or six prisoners who should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in prisoners' records about their progress). Mr Nastase told his keyworker that he struggled with the language difficulties but had settled well and enjoyed playing cards with his friends on the wing. Mr Nastase said he had no thoughts of suicide or self-harm.

45. The keyworker met with Mr Nastase each week for his key worker session. When the keyworker was on leave, another officer covered the keyworker role. On each occasion Mr Nastase said that he had good support on the wing from both staff and

prisoners who helped him improve his English. Mr Nastase never raised any issues or concerns.

46. On 27 August, Mr Nastase appeared in court, by video link, and was sentenced to life imprisonment. An officer made an entry in Mr Nastase's prison record that he had been sentenced, and another officer made a fuller entry, which noted that Mr Nastase had been given a tariff of four years and 244 days. The officer noted that Mr Nastase did not speak very good English and when he was asked if he understood everything, he just said 'solicitor speak to me'. An officer on D Wing was informed of the sentence and asked to complete a routine welfare check when Mr Nastase was locked in his cell. Another officer recorded, 'VCC welfare checks completed'. However, no evidence has been provided to show welfare checks were completed and there is nothing recorded in Mr Nastase's prison record.

47. On 28 August, an Operational Support Officer (OSO) was the night patrol officer on D Wing. During the night Mr Nastase could be heard shouting and crying and the OSG contacted the duty healthcare nurse for advice. A nurse made an entry in Mr Nastase's medical record at 6.04am: 'Called to wing after officer reported strange behaviour from resident. On arrival Mr Nastase crying loudly in bed, refused to get up and talk at cell door. He did however sit up and rocked, crying again extremely loudly. Spoke to padmate. States he's been sentenced and has been upset since then.' She added Mr Nastase to the list for an emergency mental health assessment.

48. The OSG started suicide and self-harm prevention measures (known as ACCT) at 6.15am and noted, 'Unusual behaviour wailing crying advised by Hotel 2 [duty nurse] to be placed on a book [ACCT] due to distress. Hotel 2 will arrange for mental health to see him.' A Senior Officer (SO) completed the immediate action plan. He arranged for the ACCT assessment and noted that Mr Nastase had been informed about the support available to him. Observations were set at twice an hour until the assessment and first case review had been completed.

49. At 10.30am, a SO completed Mr Nastase's ACCT assessment. Big Word was used, and Mr Nastase said that he 'didn't feel down or like he was going to hurt himself, he just felt like he had a build-up of pressure and it was making him very dizzy and emotional'. Mr Nastase said 'it had only crossed his mind once' to harm himself, but that he would not do it. He reiterated that he just felt emotional and did not want anyone to worry about him. He told the SO that he was happy with his cellmate and reassured her that he had no intention of suicide or self-harm. The SO explained what would happen about the ACCT review and noted no other problems. There is no record in the assessment that Mr Nastase's recent life sentence was discussed.

50. At 11.00am, a SO chaired the first ACCT review using Big Word, attended by another SO, a mental health nurse, a prison chaplain and Mr Nastase. The review noted that Mr Nastase said he had no thoughts of suicide or self-harm and that 'staff need not worry about him'. The review considered Mr Nastase was low risk. The SO was tasked to contact healthcare to examine Mr Nastase because he reported pressure in his stomach and feeling dizzy. This was the only action entered on the caremap. There is no evidence Mr Nastase was examined by healthcare.

51. The mental health nurse completed Mr Nastase's mental health assessment during the ACCT review and noted in the medical record that Mr Nastase had no thoughts of suicide or self-harm but was highly distressed and there was evidence of lowered mood and hopelessness. The nurse recorded, 'Whilst Big Word telephone services were being dialled, he [Mr Nastase] became hysterical and screaming. Initially no tears observed but later was tearful… No overt symptoms of psychosis observed. Tearful in mood due to offence and sentence… Reported to have had thoughts [of suicide or self-harm] but has not acted on them. No friends due to language barrier…Plan: Remains on ACCT book.' Staff reduced observations to hourly and scheduled a review for 4 September.

52. Staff on D Wing observed Mr Nastase every hour and made an entry on the ongoing record in the ACCT each time. At 1.10pm, Mr Nastase was taken to his place of work (workshop 5) but was returned to D Wing ten minutes later as he said he felt unwell. For the rest of the day, Mr Nastase was observed in his cell and he raised no further issues.

53. The next day, Mr Nastase attended work and was noted to be working well throughout the day and there were no concerns. He did not collect medication for a skin condition. At 2.23pm, an officer made an entry in Mr Nastase's prison record that she told him his key worker was on leave, but to raise any issues or concerns with wing staff. When he was unlocked for association at 5.30pm, Mr Nastase played cards with other prisoners. At 7.12pm, staff recorded that Mr Nastase was lying on his bed and at 7.45pm, that he had no issues when his cell was locked for the night.

54. The OSG was the night patrol officer. He observed Mr Nastase between 8.10pm and 4.45am on 30 August, noting that Mr Nastase raised no concerns and was either watching television or asleep. At 5.12am, he noted in the ACCT book, 'On bed appears to be awake, making the wailing noises again. I don't believe these are genuine as he appears to know exactly what he is doing. This wailing noises occur at exactly the same time in the morning, starts always around roll count, he does not make these noises at any other time.'

55. There are no entries on Mr Nastase's prison record on 30 August, but in the ACCT ongoing record wing staff noted that he spent much of the day sitting on his bed and indicated to wing staff that he was okay by a 'thumbs up' sign. He did not collect medication for his skin condition and a nurse made an appointment with him to discuss why he was not collecting his medication.

56. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The prison provided a summary in English of the calls Mr Nastase made between 9 June and 30 August, when he made his last call. In total he made 15 calls, totalling around 16 minutes, to his daughter and a friend. During these calls they spoke about family matters, he asked them to pray for him and spoke about not knowing when he was likely to be sentenced. There was nothing during these calls that indicated Mr Nastase was in crisis and he spoke about the future.

57. During his final telephone call to his daughter at 11.01am on 30 August, Mr Nastase told her that he 'hardly understood anything' that had been said in court when he was sentenced and that he had not received any papers about it. Mr Nastase

ended the call saying he had no money. The interpreter noted that Mr Nastase sounded low, subdued and tired.

58. At 4.10pm, an officer recorded in the ACCT, 'Whaling (sic) excessively, but says that he is alright' and at 5.20pm, 'Complained of stomach-ache, other than that ok.' At 6.18pm, another officer noted that she had given Mr Nastase some hot water, and at 6.45pm, had a longer conversation with him. Mr Nastase said he had been upset as 'he had problems' and that he had spoken to his family and they 'were fine'. She locked Mr Nastase's cell at 7.30pm and noted that he was lying on his bed. She checked him again 15 minutes later and recorded that he was still lying on his bed with 'no concerns'.

59. At 10.45pm, the OSG recorded in Mr Nastase's prison record that he had completed a routine check of Mr Nastase's IEP status, but this did not involve a conversation with Mr Nastase and was just an administrative task to ensure his status was correctly recorded. He checked Mr Nastase every hour during the night and noted on the ongoing record that he was either watching television or lying on his bed.

Saturday 31 August

60. There are no entries in Mr Nastase's prison record on 31 August. The ACCT ongoing record shows that Mr Nastase was seen lying on his bed and no concerns were recorded. At 9.05am, an officer noted, 'Laid on back talking to himself, asked if he was okay, thumbs up.' When he was checked an hour later by another officer, Mr Nastase was still on his bed talking to himself.

61. Although it was not recorded on the ACCT, Officer A told the investigator that she went to speak to Mr Nastase, but he was just lying on his bed moving his hands in a robotic movement. He did not respond, even when she attempted to speak to him in Romanian using an English/Romanian dictionary. She said she had never seen this behaviour before and described Mr Nastase as being in a trance-like state.

62. Officer A contacted Nurse A, the duty mental health nurse, and asked her to come to the wing to assess Mr Nastase as staff were so concerned about him. The officer said that the nurse told her she was too busy. The nurse told the investigator that she was completing reception screenings, but placed Mr Nastase on the list to see the next day.

63. Officer A contacted Nurse B, the duty general nurse, at around 10.30am, and explained her concerns about Mr Nastase. The nurse responded within a few minutes. She recorded that she found Mr Nastase in a catatonic like state (appearing to be in a daze and unresponsive), with his eyes closed and screaming in Romanian. She asked wing staff to try and find someone to interpret as she could not understand what Mr Nastase was saying and said she would return to assess him. (Big Word could not be used as Mr Nastase was not able to leave his cell and the portable telephones are not compatible with Big Word.)

64. Another Romanian prisoner agreed to interpret. Nurse B returned to the wing around 11.10am and the prisoner told her that Mr Nastase was screaming for Jesus to help him remove the demons from his room, that he appeared paranoid and

thought staff were trying to hurt him. The prisoner was noted to be highly distressed by Mr Nastase's presentation.

65. At 11.32am, Nurse B recorded in Mr Nastase's medical record that she thought he was experiencing an acute psychotic episode, a reaction to his sentence, and that it was an emergency mental health crisis. She went to speak to Nurse A in person, as she was so concerned about him, explained Mr Nastase's symptoms and asked her to assess him. She told the investigator that Mr Nastase was 'extremely disturbed' and she assumed that Nurse A would see him the same day.

66. Mr Nastase's cellmate was relocated to another cell on the wing, as staff were concerned for his safety and welfare. He told the investigator that he thought Mr Nastase might hurt himself and said he should be checked every five minutes. He was aware there were two disposable razors in the cell and questioned if these should have been removed but said as the day went on Mr Nastase seemed more settled and he began to wonder whether his behaviour was in fact an act.

67. Over the next few hours, Mr Nastase left his cell, collected his lunch and a drink and spent the afternoon on his bed asleep or watching television and, although he did not speak, he nodded and gave staff the thumbs up sign to indicate he was okay. Officer A said that although Mr Nastase was still not himself, he seemed much improved as the day went on. Another officer completed a roll check and noted in Mr Nastase's ACCT at 5.48pm that he was on his bed, vaping, watching his television.

68. Nurse B told the investigator she spoke to Nurse A again before she finished her shift at 8.00pm but could not remember specifically what time and did not record this conversation. Mr Nastase did not have a mental health assessment before he died.

69. When the OSG started his night duty, he checked Mr Nastase every hour and noted that he was lying on his bed or watching television.

Sunday 1 September

70. At 3.07am on 1 September, Mr Nastase was awake when the OSG completed his check. The OSG noted in the ACCT, 'Awake complaining about bedding in native language, told him to get to sleep will see Mon[day]'. He told the investigator that Mr Nastase was shaking his bedding, which looked 'a bit wet', and he thought it was probably due to him sweating as Mr Nastase used to sleep in his clothes.

71. Closed circuit television (CCTV) shows the OSG completed his next ACCT check at around 4.00am (the timings on the CCTV are around 5 minutes slow and we have used real time in this report). He looked through the observation panel of Mr Nastase's cell, saw that there was a significant amount of blood around the cell and immediately radioed an emergency code red (used to indicate severe blood loss). An ambulance was not requested by the communications room.

72. Two Custodial Operations Managers (COM), together with other staff, responded to the code red. Prison staff entered the cell at 4.03am, but they could not communicate with Mr Nastase because of the language difficulties. Mr Nastase was described as conscious and breathing and, although he had blood on him,

there was no obvious sign of injury. Due to the extent of Mr Nastase's aggression, a nurse was unable to clinically assess him, but she asked staff to try and identify where the bleeding was coming from. She said that prison staff were physically holding her back for her own safety.

73. Prison staff used towels to clean some of the blood off Mr Nastase and found a blade in his cell, which was placed in the wing sharps bin. Mr Nastase had a small cut to the side of his neck, but it was no longer bleeding, and there were no other apparent injuries. Mr Nastase would still not cooperate. He kept removing the oxygen monitor and would not have his blood pressure taken, so the decision was made to use an evacuation chair to take Mr Nastase to the healthcare centre where he could be properly examined in a more appropriate environment.

74. At 4.09am, the communications record was noted to show that a COM stood the code red down. The nurse did not recall who made this decision, but said she was not consulted.

75. The COM told the investigator that he asked the nurse if she could glue the wound, but she said it needed a stitch. He said he knew the nurse was capable and he had seen her stitch wounds before, so he judged that an ambulance was not necessary and gave the instruction to the other COM to cancel the code red. (They both assumed an ambulance had been requested.)

76. CCTV shows Mr Nastase was taken out of his cell in the evacuation chair at around 4.27am. At 4.28am, he was taken along a corridor to the healthcare centre, which took nearly two minutes. Despite staff trying to keep Mr Nastase calm, CCTV shows him thrashing around and he continuously attempted to push staff away from him and remove the oxygen mask. All those interviewed said Mr Nastase continued to shout and speak in Romanian. There is no CCTV footage of when he arrived at the healthcare centre.

77. On arrival at the treatment room, the nurse attempted to take Mr Nastase's observations, but he remained agitated, and she was unable to do so. She said that Mr Nastase showed no signs of cyanosis (bluish discoloration due to poor circulation or inadequate oxygenation of the blood), his airway was clear and the wound on his neck was not actively bleeding. However, at 4.40am, Mr Nastase suddenly became unresponsive. He was moved to the floor. Staff started cardiopulmonary resuscitation (CPR) and the nurse attached an automatic defibrillator, which indicated that Mr Nastase had no shockable heart rhythm. An ambulance was requested, and staff continued CPR until paramedics arrived.

78. North West Ambulance Service records show they received a request for an ambulance at 4.41am, and an ambulance and rapid response vehicle were sent. According to the communications log at Forest Bank, the ambulance arrived at 4.53am, and the rapid response vehicle at 5.01am. Ambulance service records note that the ambulance arrived at 4.53am and paramedics reached Mr Nastase at 5.00am; the rapid response vehicle arrived at 5.00am and reached Mr Nastase at 5.15am. On the ambulance record notes, paramedics from the rapid response vehicle recorded that they were delayed by approximately 10 minutes at the gate when they arrived at Forest Bank.

79. Paramedics assessed Mr Nastase and moved him to the ambulance to carry out a further assessment while CPR continued. They noted he had no shockable rhythm, his pupils were fixed and dilated, and that continuing resuscitation was futile. At 5.25am, paramedics declared that Mr Nastase had died.

80. When Officer A arrived for her morning shift, the duty manager asked her to identify Mr Nastase's body, as the police were insisting this was done by someone who knew Mr Nastase personally.

81. The cellmate told the investigator that he and other prisoners on the wing felt annoyed that the mental health team had not listened to them and wing staff when they raised concerns about Mr Nastase. The investigator spoke to many prisoners, and received letters from other prisoners on the wing, who said wing staff, particularly Officer A, did everything they could to support Mr Nastase and get him help.

Contact with Mr Nastase's family

82. The prison appointed a family liaison officer (FLO). Mr Nastase had said he did not have a next of kin when he arrived at Forest Bank, so no information was available. The FLO tried to establish contact details from Mr Nastase's telephone records, and then visited his last known address to try and obtain any further information, but nobody could assist.

83. With assistance from Interpol, the Home Office and the Romanian Consulate, Mr Nastase's daughter was eventually located in Romania. The news of her father's death was broken to her on 3 September, and interpretation services were used to facilitate further contact between her and the prison. In line with national policy, the prison contributed towards the costs of Mr Nastase's funeral, which was held on 9 October.

Support for prisoners and staff

84. A senior manager debriefed most staff involved in the emergency response and offered support. Those staff who attended the debrief said they felt well supported immediately after Mr Nastase's death and they were offered support from a particular COM, who is a member of the Post-Incident Care Team (PICT).

85. A further debrief was scheduled for 26 September but did not happen because staff were not available. This debrief was rescheduled to 11 October, but that also had to be cancelled. A cold debrief was facilitated on 24 November, by a COM, but only another COM, the OSG and the response nurse attended.

86. Some staff told the investigator that they did not feel well supported. Staff felt that a more proactive response from the prison would have been beneficial.

87. The prison posted notices informing other prisoners of Mr Nastase's death and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm in case they had been adversely affected by Mr Nastase's death. Prisoners on the wing told the investigator that staff on D Wing were very supportive and Listeners provided additional support.

Post-mortem report

88. The pathologist concluded that Mr Nastase died from incised wounds to his neck (one of which had cut, but not severed, the jugular vein), with ischaemic heart disease as a significant contributory factor. (Ischaemic heart disease is a build-up of fat in the arteries which reduces blood flow to and from the heart, meaning that Mr Nastase had less cardiac reserve with which to respond to severe blood loss when compared to a healthy person.) Toxicology results show that Mr Nastase had not used any illicit substances.

Findings

Assessment of Mr Nastase's risk of suicide and self-harm

89. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the factors that might increase a prisoner's risk of suicide and self-harm. Several factors applied to Mr Nastase: he was a foreign national with a limited understanding of English, he was charged with a violent sexual offence and facing a lengthy sentence. In addition, because he was a Romanian national, there was limited information about his medical and social history, and the prison did not know if he had a history of self-harm or mental health issues.

90. However, during the six months that Mr Nastase was on remand, staff and prisoners all described Mr Nastase as someone who was always happy and smiling, who was very settled in prison and who engaged well with the regime, despite his limited English. He had a job, which he worked well at, and socialised with other prisoners, playing cards with prisoners and staff most evenings. Staff had no reason to consider that he posed a risk to himself during this period.

91. Prison Service Order (PSO) 3050, Continuity of healthcare for prisoners, says that events such as attending court or sentencing at court, are factors that might have a significant impact on the health of a prisoner. When prisoners pass through reception on their return from court, prisons are required to have protocols in place for screening them to identify any potential suicide and self-harm issues. When Mr Nastase appeared in court and received a life sentence on 27 August, he did so by video link. As Mr Nastase did not leave the prison, he did not pass through reception.

92. Nevertheless, PSI 07/2015, Early days in custody, states that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link. Forest Bank have a welfare policy for those prisoners using video conference call facilities which states: 'If a change in status occurs due to either guilty pleas being entered or sentencing, then a nurse must be offered to them [the prisoner], if acceptance of a nurse is requested the resident is to be taken to reception and a health screening will take place. Nurses are only offered for mental/emotional well-being, they are not to be offered for aches/pains. IT MUST BE DOCUMENTED ON THE WELFARE CHECK SHEET IF A NURSE HAS BEEN ACCEPTED OR DECLINED OR NOT APPLICABLE. If a change in status occurs due to either guilty pleas being entered or sentencing, then careful consideration must be given on whether to open an ACCT document. ACCT Documents can be opened anytime and not just for a change in status. THIS ALSO NEEDS DOCUMENTING ON THE WELFARE CHECK SHEET.

93. An officer recorded in Mr Nastase's prison record that he spoke to him after his court appearance, but also noted that Mr Nastase did not speak very good English and when asked about his sentence, 'just said solicitor speak to me'. There is no evidence that Big Word interpretation services were used to ensure that Mr Nastase properly understood his sentence or to assess if his risk of suicide and self-harm had increased. The investigator was not provided with a copy of the welfare check sheet. There is no evidence that Mr Nastase was advised he could see a nurse

following his change in status from convicted to sentenced prisoner. (During the consultation period, Forest Bank provided a copy of the welfare check sheet which notes Mr Nastase was asked if he would like to see a nurse, which he declined.)

94. Prison and healthcare staff said there was no routine assessment of prisoners following an appearance by video link, unless they were alerted to any concerns by staff facilitating the video conference. There seemed to be a reliance on observing physical distress, rather than considering the actual risk factors, and neither the requirements in the PSI or Forest Bank's own protocol were followed. We do not consider that it is sufficient simply to offer prisoners the opportunity to see a nurse. We consider that they should be screened automatically as they would be if they had attended court in person. We therefore make the following recommendation.

The Director General of HMPPS should review PSO 3050 and PSI 07/2015 to ensure that prisoners who attend court by video link are assessed for their risk of suicide and self-harm and seen by healthcare staff in the same way as prisoners attending court in person.

Management of the ACCT process

95. Staff started ACCT procedures at 6.15am on 28 August, the day after Mr Nastase was sentenced, when he began crying loudly in his cell.

96. PSI 64/2011 states that completion of a caremap is an integral part of the ACCT process and that it 'must reflect the prisoner's needs, level of risk and the triggers of their distress. Each action on the caremap must be tailored to meet the individual needs of the prisoner, be aimed at reducing the risk to themselves and must be time bound. At each case review, the case review team should consider whether the prisoner displays any additional needs that may require the caremap to be updated'.

97. A SO completed the ACCT assessment at 10.30am but made no comment about Mr Nastase's sentence. At the only ACCT case review half an hour later, the case manager added one issue to Mr Nastase's caremap: complaint of dizziness and stomach pain. He noted that Mr Nastase assured staff that he did not intend to harm himself and that they need not to worry about him. A mental health nurse told the investigator that he completed his mental health assessment during the case review and did not assess that Mr Nastase needed any further support from the mental health team. There is no evidence the physical symptoms identified on the caremap were assessed.

98. Although Mr Nastase had just received a life sentence and appeared to be very distressed, there was nothing specifically recorded at the ACCT review to show that these issues were discussed or properly considered. Staff appear to have relied on Mr Nastase's assurances that he would not harm himself.

99. The OSG, who has not completed any mental health training, made comments on the ACCT ongoing record to say that he did not think Mr Nastase's distress (wailing during the night) was genuine. These comments were speculative and judgmental.

100. Mr Nastase became increasingly distressed over the next few days and his behaviour was often bizarre. On the morning of 31 August, the day before he died,

he was described as screaming about demons in Romanian in a trance-like state and Nurse B thought he was having an acute psychotic episode. We are concerned that staff did not consider holding an ACCT review or increasing his level of observations in these circumstances.

101. Officer A said that she did not perceive there to be an increase in his risk of self-harm or suicide. She said she had discussed the concerns with her colleagues, including the wing manager, and that although Mr Nastase was not his usual self, he did engage and collect his food as the day progressed.

102. Officer A correctly informed both the duty mental health nurse and the emergency response nurse of her concerns. And said that having informed Nurse A of Mr Nastase's deteriorating mental health, she expected her to have assessed him as a priority. Officer A did not record this information in Mr Nastase's prison record but did make an entry in the wing observation book.

103. Mr Nastase's medical records show that he did not collect his medication for physical health ailments on several occasions during the period between the opening of the ACCT and his death. This indicates that he may have been disengaging and is a well-known risk factor preceding a suicide.

104. We consider that staff placed too much emphasis on Mr Nastase's assertions that he had no intention of suicide or self-harm and did not give sufficient attention to his risk factors, especially the lengthy sentence he had received, and the apparent dramatic deterioration in his mental health. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:

- **assess the level of a prisoner's risk of suicide and self-harm based on all available information and known risk factors and not only on a prisoner's presentation or what he says;**
- **set caremap actions that are specific, meaningful and time-bound, aimed at reducing the prisoner's risk to themselves, and update the caremap actions if additional needs are identified;**
- **consider if an additional case review is required, or the level of observations needs to be revised, if there is a change in behaviour or additional concerns; and**
- **be reminded to record factual information on the ongoing record, which is free from judgement or speculation.**

Clinical care

Mental health

105. The clinical reviewer concluded that the mental health care Mr Nastase received was of a poor standard and not equivalent to that which he could have expected to receive in the community.

106. When Mr Nastase arrived at Forest Bank, there was nothing to show if he had any significant mental health history. On 28 August, shortly after ACCT procedures had been started, a nurse appropriately made an emergency mental health referral because of his bizarre behaviour, which was a significant departure from how Mr Nastase had presented before he was sentenced.

107. A mental health nurse assessed Mr Nastase during the ACCT review later that day. He told the investigator that Mr Nastase engaged appropriately, and he did not consider he was particularly agitated or that he required any further mental health intervention. However, this contradicts the entry the nurse made in Mr Nastase's medical record at the time where he described him as "hysterical", and we note that the SO who chaired the ACCT review described Mr Nastase as "highly agitated".

108. The clinical reviewer found that the quality and depth of the mental health assessment by the mental health nurse was limited. This was in part due to the language barriers (despite interpretation via Big Word), but the assessment also lacked exploration and consideration of all risk factors, including Mr Nastase's recent sentence (which was not referred to at all). The nurse said because Mr Nastase complained of stomach pains and dizziness, he wanted to rule out any physical illness, which may have been an acute stress reaction to his sentencing. However, there is no evidence that the nurse considered this as a reason for Mr Nastase's presentation.

109. We consider that the assessment carried out during the ACCT review was inadequate and that the mental health nurse should have identified that a separate full mental health assessment was required. There was too much emphasis on Mr Nastase's physical health, and no consideration given to this being a manifestation of his mental distress.

The events of 31 August

110. We are very concerned that Nurse A, the duty mental health nurse, did not see Mr Nastase to assess him when Mr Nastase's mental health deteriorated further on the morning of 31 August, despite being asked to do so twice, first by Officer A, and then by Nurse B, who told her he was in a catatonic-like state, screaming about demons in Romanian and that she thought he was having an acute psychotic episode.

111. Nurse A told us that she could not assess Mr Nastase immediately as she had to complete reception screening assessments. She said she planned to see Mr Nastase when she had completed this duty, although it was likely she would not have time during her shift, so she placed Mr Nastase on a list to be seen the next day. She said she reviewed Mr Nastase's medical record when she was first

contacted by Officer A, but before she spoke to Nurse B, so was aware ACCT measures were in place.

112. Nurse A said she is expected to complete reception screenings and did not feel she could prioritise a mental health assessment over this task. When she was asked if she could have swapped duties with Nurse B so that she could have assessed Mr Nastase, she said that she did not feel there was any urgency to see him.

113. The clinical reviewer was extremely concerned about Nurse A's decision, which she considered showed poor risk assessment and a lack of structured professional judgement. She considered that, in the light of what Nurse B had told her, Nurse A should have seen Mr Nastase as a priority.

114. The Primary Healthcare Manager said it would have been acceptable to swap duties to enable the mental health assessment to be completed. However, Nurse A said that she did not feel that she could do this. The clinical reviewer found there was an organisational culture of task orientation over prioritising of workload, against a background of nursing staff not feeling empowered to use structured professional judgement over work order.

115. The Primary Healthcare Manager said that she and her healthcare manager colleague had not had a collective discussion or review about the circumstances of Mr Nastase's death. She said that she had completed the 72-hour review but had not identified any issues for discussion. Given the circumstances surrounding Mr Nastase's death, we consider the lack of a collaborative review was unacceptable.

116. We found there was too much focus on tasks rather than clinical decision-making where patients may be in crisis. This prevented Mr Nastase from being assessed in a prompt fashion on 31 August. If a psychiatrist was not available to see him quickly, we note that there was a GP working in reception that day, who may have been able to assess him in the interim or Mr Nastase could have been taken by ambulance to Accident & Emergency. The clinical reviewer concluded that a full mental health assessment may have triggered further intervention which may have in turn facilitated a Mental Health Act assessment if needed.

117. We consider that the management of Mr Nastase's mental health crisis on 31 August was very poor. We make the following recommendations:

The Head of Healthcare should:

- **carry out an in-depth analysis of how workloads are prioritised to ensure that staff can attend immediately when prisoners are deemed to be in a mental health crisis; that;**
- **review the Mental Health Care pathway and consider if any revisions are necessary to enable staff to respond to a mental health crisis; and**
- **review the use of risk assessments during ACCT reviews to act as aide memoirs so that more thorough risk assessments are completed ensuring key risk indicators are not missed.**

The Head of Healthcare should:

- **commission an investigation into the decision by Nurse A not to complete an emergency mental health assessment on 31 August;**
- **implement any actions or learning deriving from this investigation as a matter of urgency; and**
- **provide a report to the Ombudsman.**

118. Immediately after the PPO interviews were conducted in October 2019, the clinical reviewer escalated her concerns about mental health provision to the Mental Health Manager and the Clinical Head of Healthcare, as well as the healthcare commissioners. The clinical reviewer identified that the complicated system of having two service providers (Sodexo and GMMH) was a significant risk to the smooth running of services and a contributory factor in the behaviour of clinical staff. She was told that, despite the efforts of the Mental Health Manager to facilitate staff transfers from Sodexo to GMMH, this had not happened. We therefore make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are transferred from Sodexo to GMMH as a matter of urgency to enable the Mental Health Manager to manage the mental health team in a seamless manner, developing staff where required.

Physical health

119. The clinical reviewer found the clinical care Mr Nastase received for his physical health was equivalent to that he could have expected to receive in the community. During his time at Forest Bank, Mr Nastase was treated for a severe sore throat and experienced a number of skin infections which were appropriately managed with antibiotics, steroids and antifungal creams, which were regularly reviewed by nursing staff.

Interpretation services

120. PSI 64/2011 states: 'All members of staff must consider the use of translation services when dealing with prisoners whose first language is not English and, in particular, when conducting assessments of risk and/or during the risk management process.'

121. The Prison Service's policy on foreign national prisoners states: 'Language barriers obviously make all other problems worse. Staff should not assume that prisoners with some comprehension of English have completely understood what is being said to them. Poor communication between staff and prisoners may have implications for things like risk of self-harm and good order and discipline.'

122. Forest Bank has a contract with a professional telephone interpreting service: Big Word. When Mr Nastase first arrived at Forest Bank, he was asked to sign prison compacts that were written in English and there is no evidence that two officers used Big Word to facilitate the reception assessment.

123. Forest Bank has an electronic kiosk system which prisoners must use to contact various departments and make requests (such as booking medical appointments).

This has numerous languages available, including Romanian. However, once past the initial screens there is a limited amount of information which has been translated from English. During their inspection in May 2019, HMIP identified the need to improve translation services and information, as this disadvantaged foreign national prisoners.

124. Mr Nastase was confused about his sentence, and despite other prisoners trying to explain it to him, he told his daughter he did not understand his sentence. It would have been difficult for him to have used the kiosk system to contact either the custody or offender manager teams, because of its limitations.

125. We are concerned that no one used Big Word to explain to Mr Nastase what his life sentence and the tariff meant, and that this may well have contributed to the distress he experienced after he was sentenced. After the initial report was issued, Forest Bank told the investigator that there was an interpreter present at the sentencing hearing via videolink. While what was said at the sentencing hearing may have been interpreted into Romanian, this is not the same as someone communicating with Mr Nastase in his own language to assess whether he understood his sentence and to check his welfare.

126. We are also concerned that when Mr Nastase's mental health deteriorated on 31 August, staff were not able to use Big Word to speak to him because he could not be taken to an office to use the telephone and the portable phone was not compatible. We found that there is no formal guidance available to staff at Forest Bank on how to communicate with prisoners when English is not their first language. We note Officer A was proactive in working with the librarian to prepare a one-page document to help Mr Nastase communicate. The current kiosk system and information available to prisoners in other languages needs to improve, and compatible handheld portable telephones (like the phones used to contact the Samaritans) would help staff with prisoners who cannot leave their cells. We make the following recommendation:

The Director should ensure that:

- **formal translation guidance is produced for communicating with prisoners who do not speak or understand English well;**
- **accredited interpretation services are used by all members of staff, including healthcare staff, when interviewing or assessing such prisoners;**
- **staff should explain sentencing decisions to such prisoners using interpretation services; and**
- **staff are able to use interpretation services in cells and other non-office situations when required (for example, by means of a handheld portable telephone).**

Emergency response

127. The clinical reviewer concluded that the duty nurse's response to a very difficult and challenging situation was appropriate. She is an experienced accident and emergency nurse. Although Mr Nastase was covered in blood and it was difficult for her to identify the source of his injury due to his of agitation and aggressive

behaviour, she did not assess that his condition was a life-threatening one. She said she intended to stitch the wound on the side of Mr Nastase's neck and that obtaining his observations in a medical setting would have been easier. Mr Nastase showed no signs of cyanosis, was not having any difficulty breathing and the wound to the side of his neck had not been bleeding for over 30 minutes. We are satisfied that the decision to move him to the healthcare centre for further assessment was appropriate in the circumstances.

Requesting an ambulance

128. Forest Bank's local protocol is clear that an ambulance should be called immediately, when a medical emergency code is radioed, in line with PSI 3/2013 - Medical Emergency Response. The OSG correctly called a code red at 4.01am, but an ambulance was not requested.

129. The officer in the communication room said he was aware of the national guidance, but that more information was often requested about an incident before an ambulance was called. He said there was pressure from the ambulance service to provide details about an incident (which they would not always know in the communications room), so they usually attempted to contact an operational manager to confirm if an ambulance was required.

130. The officer said when he received the code red at 4.01am, he immediately attempted to contact the operational manager, but he did not get a response until 4.09am, as they were busy dealing with Mr Nastase. Both COMs said they assumed an ambulance had been requested before they cancelled the code red but were not certain. An ambulance was not called until 4.40am.

131. Following a death in February 2016, the Director of Forest Bank issued Director's Instruction (No 9) – Emergency Response Codes in April 2016, reiterating the need for control room staff to call an ambulance immediately when a medical emergency code is radioed. The prison provided us with training records to show that staff in the communications room had signed to say they understood the national guidance, and two members of staff were given formal warnings for not following this guidance.

132. We did not make a recommendation in that investigation as Forest Bank had already re-issued instructions. However, our investigation into Mr Nastase's death found that there continue to be significant misunderstandings about the need to call an ambulance immediately following a medical emergency code.

133. The investigator spoke to several staff, who all said that when an emergency medical code is radioed, more information is often obtained before an ambulance is called. We found that staff were worried that they would be disciplined if they made the wrong decision. The investigator was told that, since Mr Nastase's death, all communication room officers have had to sign to say they understand the national guidance, but that no additional training or explanation has been given.

134. Staff need to understand the national guidance and feel confident that they are making the right decisions. It is not sufficient to simply ask staff to sign a form to say they have read the guidance, without providing training to ensure this guidance is properly understood by everybody.

135. We are also concerned that a key reason why communications room staff do not call an ambulance immediately is that they are pressed by the ambulance service to provide details before they will dispatch an ambulance. PSI 3/2013 requires prisons to agree written emergency response protocols with the local ambulance trust so that they understand the prison context to help eliminate such delays.

136. We make the following recommendations:

The Director and the Head of Healthcare should review the protocol with the local ambulance service to ensure they understand the prison context and that staff who request ambulances might not be able to provide detailed information about the patient immediately.

The Director and Head of Healthcare should ensure that communications room staff call an ambulance immediately and are provided with sufficient training.

137. PSI 03/2013 also contains mandatory instructions that prison staff should prevent unnecessary delay in escorting ambulances and paramedics to the patient. The ambulance service recorded that they were delayed entering the prison and that it took approximately 10 minutes to reach Mr Nastase.

138. However, we found that the first ambulance, which arrived at 4.53am, was escorted immediately to Mr Nastase and arrived with him around six minutes later. The second response vehicle was delayed at the gate as the night staff were escorting the first ambulance and ensuring the paramedics reached Mr Nastase. Because the prison was in night state, there were not enough staff to escort the second response vehicle through immediately. Given the size and geography of the prison, and the number of gates the vehicles had to pass through, we are satisfied there was no unnecessary delay of either vehicle. This is, however, something that should be covered in the protocol agreed with the ambulance services.

Staff support

139. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed. It also provides those directly involved with an opportunity to process events.

140. Although a debrief was held after Mr Nastase's death, the OSG who discovered Mr Nastase and the officer who was in the communications room, were not present, as they had finished their shift. The OSG said that although he received a text message from his manager and was asked if he was fit to work the next night, he was not offered any formal support for several days after Mr Nastase's death. The officer said he received no contact from prison managers or the care team. The first discussion he had had about Mr Nastase's death was with the PPO investigator.

141. A COM, a member of the prison's Post-Incident Care Team (PICT), was the PICT representative at the debrief, even though he had been directly involved in the emergency response himself. Although he told the investigator that he wanted to support his colleagues, it is important that the prison recognise that there should be clear distinction between roles, particularly when someone has been involved in

such a distressing incident. He said he received good support from his colleagues and manager.

142. Officer A was asked to view Mr Nastase's body to identify him, when she arrived for her day shift. The duty director said that the police were insistent that Mr Nastase was formally identified by someone who knew him. The officer said she did not receive sufficient support afterwards and that it was difficult viewing Mr Nastase's body, particularly as she had done her best the previous day to get him assessed by the mental health nurse and felt frustrated that he had not been seen.

143. Healthcare staff were provided with support from the healthcare provider and their managers but said that there was no formal support from the prison immediately after Mr Nastase's death. The response nurse said that she was invited to a cold debrief on 26 September, but when she replied and said she could not make it as she was on a night shift, she received what she considered to be a curt email response asking when she was available. She recalled seeing a comment in the email chain that the prison would be fined for the debrief being late. She said she later received an email with the details for trauma support.

144. A cold debrief was eventually held on 24 November, but only five people attended. There should have been a debrief for all staff involved in the emergency response, as set out in PSI 09/2014, Incident Management Manual. Given the circumstances of Mr Nastase's death a critical debrief with all staff involved in the emergency response and the events the previous day would have been beneficial. We make the following recommendation:

The Director and Head of Healthcare should ensure that all relevant staff are able to attend a debrief following a death in custody.

Inquest

145. The inquest into Mr Nastase's death concluded in September 2023. The conclusion was that Mr Nastase's died as a consequence of self-inflicted wounds and the associated blood loss exacerbated by his underlying heart condition and at the time the wounds were inflicted his intentions were unclear or unknown.

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