Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jared Perry, a prisoner at HMP Parc, on 3 November 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

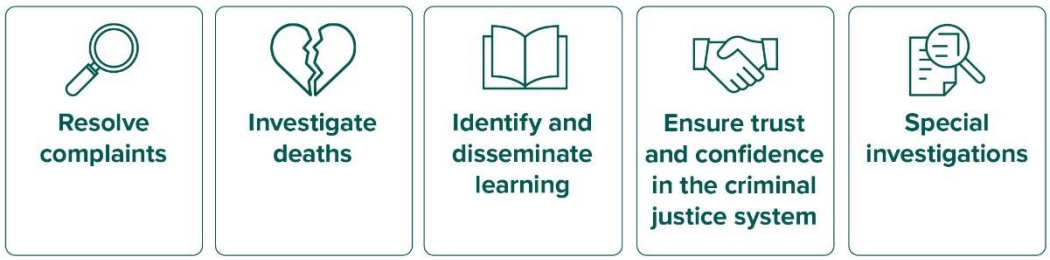
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Jared Perry died in hospital on 3 November 2019 after being found hanging in his cell at HMP Parc four days earlier. He was 32 years old. I offer my condolences to Mr Perry's family and friends.

Mr Perry had significant mental health problems. Staff managed him under suicide and self harm prevention procedures (known as ACCT) from January 2019 onwards. He often behaved bizarrely and was aggressive to staff. He was due to transfer to a secure psychiatric hospital the day after he died.

Staff recognised that he was mentally ill, and I am satisfied that they treated him with care and compassion. However, while there was much good practice, we have also identified some areas of concern.

Mr Perry's mental health needs were generally responded to in a timely and appropriate way. However, our investigation found that he should have been referred to the prison's mental health team when he first arrived at Parc, and that it took some time before the community mental health inreach team accepted him onto their caseload (possibly because of resource issues). These may have been missed opportunities to identify and meet his mental health needs sooner.

I am also concerned about the length of time it took to transfer Mr Perry to hospital once it had been identified that he had serious mental health needs that could not be met in prison. I recognise that this was not the fault of prison or healthcare staff and was probably due to a lack of available hospital beds. We cannot know whether an earlier transfer to hospital might have prevented Mr Perry's death.

I am concerned that just hours before Mr Perry was found hanging, an officer failed to remove a piece of material from his cell. Although we cannot be certain that this was the piece of material Mr Perry used as a ligature, we consider it highly likely.

I am also concerned that the officer who completed Mr Perry's ACCT observations by CCTV in the 30 minutes before he was found hanging, recorded that Mr Perry was standing by the door, even though he was not in fact visible on the camera. We cannot know if Mr Perry's death could have been prevented if the officer had acted more quickly, but Mr Perry would at least have been discovered earlier.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2021**

Contents

Summary

Events

1. On 6 August 2018, Mr Jared Perry was remanded to HMP Parc, charged with sexual offences.

2. At an initial reception screen, Mr Perry told a healthcare assistant that he had a history of drug-induced psychosis. She obtained his consent to request his community GP records but did not refer him to the mental health team. The prison received Mr Perry's GP summary on 8 August but did not prescribe his antipsychotic medication until 11 August. There is also no record that Mr Perry had a secondary health screen.

3. On 18 January 2019, Mr Perry was sentenced to 17 years in prison and returned to Parc. At his reception screen, a mental health nurse recorded that Mr Perry was tearful and had thought about taking his life. Prison staff started suicide and self-harm prevention procedures (known as ACCT). He continued to be managed under ACCT procedures for the remainder of his time at Parc.

4. Over the next seven months, Mr Perry's mental health deteriorated. He refused to take his medication and displayed strange behaviour and aggression towards staff. He was moved to the Safer Custody Unit (SCU) for additional support on several occasions. Primary care mental health staff reviewed Mr Perry regularly and twice referred him to the community mental health inreach team. However, the inreach team concluded that the prison's primary healthcare services could manage him.

5. On 16 August, a nurse referred Mr Perry to the mental health inreach team for the third time after his mental health deteriorated further. On 29 August, a consultant psychiatrist from the inreach team reviewed Mr Perry and referred him for assessment for a transfer to a secure psychiatric hospital.

6. On 10 September, a consultant forensic psychiatrist assessed Mr Perry and concluded he was psychotic and required a transfer to hospital. On 22 October, the psychiatrists completed the required medical recommendations to enable a transfer to take place. On 24 October, the Ministry of Justice issued a transfer warrant, and it was agreed that Mr Perry would transfer to hospital on 4 November.

7. At 10.17am on 30 October, three officers unlocked Mr Perry for a shower and some time out of his cell. In the meantime, an operational manager asked an officer to clear the rubbish from Mr Perry's cell. The officer picked up a piece of material but did not remove it from the cell.

8. At 11.28am and 11.41am, an officer used the in-cell CCTV to conduct an ACCT observation. He recorded that Mr Perry was standing by the door, but CCTV shows that Mr Perry was out of the camera's view from 11.26am onwards.

9. At around 11.50am, the officer noticed that he could not see Mr Perry. He went to his cell and looked through the cell door observation panel but could not see him. He asked another officer for assistance, who saw Mr Perry's feet by the door. At 11.52am, they opened the door and found Mr Perry hanging from the back of the door. An officer cut the ligature from Mr Perry's neck and started cardiopulmonary

resuscitation (CPR). At 11.53am, the other officer radioed a medical emergency code blue.

1. Shortly afterwards, members of healthcare staff arrived. Ambulance paramedics arrived at the cell at 12.09pm. At 12.17pm, they detected a pulse and at 12.27pm, they took Mr Perry to hospital, unrestrained, where he remained in a critical condition on life support.

2. On 3 November, Mr Perry died in hospital, with his family present.

Findings

Risk management

3. Mr Perry had a history of mental health problems and this made him challenging to manage. We are satisfied that prison and healthcare staff showed concern and compassion and tried to support his best interests.

4. His mental health deteriorated after he received a long prison sentence in January 2019. Staff recognised that he posed a risk to himself as a result and appropriately managed him under ACCT procedures for the remainder of his time at Parc.

5. While staff managed much of Mr Perry's ACCT well, we are concerned that they did not always set clear and meaningful caremap actions or record whether they were complete. There was also no co-ordinated plan for monitoring the progress of Mr Perry's transfer to a secure psychiatric hospital.

6. We are concerned that an officer failed to consider the risk posed by the piece of material he found in Mr Perry's cell on the day he hanged himself. While removing the material may not have prevented Mr Perry's death, it would have stopped him accessing it. If the officer had reported it, it is also likely that there would have been an ACCT case review and additional support measures put in place.

7. We are concerned that the officer who completed Mr Perry's ACCT observations that day recorded that he was standing by the door, even though he was not visible on CCTV. While we cannot know whether Mr Perry's death would have been prevented if the officer had checked him sooner, he would have discovered him earlier. The officer has since resigned from his job at Parc.

Clinical care

8. The clinical reviewer concluded that, overall, the clinical care that Mr Perry received at Parc was equivalent to that which he could have expected in the community, and that his mental health needs were general met in a timely and appropriate way.

9. However, there were some failings: healthcare staff failed to refer him to the mental health team at his initial reception screen, to prescribe medication promptly or to conduct a secondary health screen. Although he was first referred to the community mental health inreach team in February 2019, and again in July, they did not accept him onto their caseload until August (possibly because of inadequate resources). These were missed opportunities to identify his mental health needs earlier.

10. We are also concerned about the length of time it took to transfer Mr Perry to a secure psychiatric hospital once it had been identified in August that his severe

mental health needs could not be met in prison. This was not the fault of prison healthcare staff. Communication between healthcare and prison staff about Mr Perry's hospital transfer could have also been more effective.

Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
  - set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; and
  - accurately record details of ACCT observations in the ongoing record and physically review prisoners who are not visible on in-cell CCTV.
- The Director should ensure that staff are extra vigilant about the care of prisoners who are being considered for or are awaiting transfer to a secure hospital.
- The Director should ensure that prison staff remove items which potentially pose a risk from a prisoner's cell and escalate their concerns.
- The Director should commission an investigation into PCO A's failure to remove an item of risk from Mr Perry's cell, with a view to considering whether disciplinary action is appropriate.
- The Head of Healthcare should ensure, in line with PSO 3050, that healthcare staff:
  - refer prisoners who report mental health problems to the mental health team;
  - prescribe medication promptly once a GP has confirmed a prisoner's existing prescription;
  - rearrange outstanding hospital appointments if necessary; and
  - offer all prisoners a full general health assessment within a week of their arrival.
- The HMPPS Executive Director for Wales should:
  - satisfy himself that the mental health needs of the prisoner population at Parc have been established;
  - satisfy himself that there is prompt assessment and timely access to integrated support and a full range of interventions for prisoners with complex mental health needs; and
  - write to the Ombudsman to confirm that he is so satisfied.
- The Head of Healthcare should ensure that:
  - local guidance is developed setting out the process for transferring prisoners to a secure hospital under Section 47 of the Mental Health Act 1983; and
  - prisoners with complex needs are reviewed weekly as part of a multidisciplinary team and decisions set out in an agreed written plan.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator visited Parc on 15 November 2019 and obtained copies of relevant extracts from Mr Perry's prison and medical records. He interviewed six members of staff at Parc on 18 December.

13. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Perry's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 12 members of staff at Parc between 20 January and 4 February 2020.

14. We informed HM Coroner for Cardiff, Bridgend and Glamorgan Valleys of the investigation and have sent him a copy of this report. No post-mortem examination was conducted.

15. One of the Ombudsman's family liaison officers contacted Mr Perry's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Perry's mother wanted to know:

    - why Mr Perry had to wait for months to see two psychiatrists; and
    - what support he was offered after his father died.

    We have addressed these concerns in this report and in separate correspondence.

16. Mr Perry's mother received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Parc

18. HMP Parc is a medium security prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under the age of 18.

19. G4S Medical Services provide primary physical and mental health care services. There are 24-hour general healthcare and palliative care facilities. A local GP practice provides GP services, including a daily clinic and out-of-hours cover.

20. The mental health inreach team (MHIT) and secondary mental health services are provided by Swansea Bay University Health Board (SBUHB).

HM Inspectorate of Prisons

21. The most recent inspection of HMP Parc was in November 2019. Inspectors found that the level of self-harm remained high despite some improvement over the previous 12 months and, combined with the relatively large number of self-inflicted deaths, continued to cause serious concern. Recommendations made by the Prisons and Probation Ombudsman were taken seriously and regularly reviewed by safer custody staff, as well as being monitored at the monthly safer custody strategy meeting. Although quality assurance measures were in place for prisoners assessed at risk of suicide or self-harm, weaknesses in the quality of recording, observational checks and caremaps were identified.

22. Inspectors found that the demand for mental health services was high and service provision did not meet demand. Although the support available for mild to moderate problems had improved, the range of specialist interventions and support for prisoners with more complex needs was inadequate and too many patients waited too long to access existing services. Secondary mental health services for those with complex mental health issues were provided by the Swansea Bay University Health Board. Inspectors found that the team was under-resourced, and also covered another prison (HMP Swansea).

23. Inspectors found that in the previous six months, three out of four transfers under the Mental Health Act had taken place promptly, with one slightly delayed and another - Mr Perry's transfer - cancelled as he had died on the day before transfer.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 28 February 2019, the IMB reported that although incidents of violence and self-harm remained high, the safer custody team had expanded, with several caseworkers developing and delivering a range of interventions to prisoners at risk.

25. The mental health pathway for access to primary care services was working well, but the lack of secondary psychiatric care, particularly for elderly prisoners, continued to be a major concern.

Previous deaths at HMP Parc

26. Mr Perry's death was the seventeenth at Parc since November 2017, two of which were self-inflicted. There has been one death since. We have previously made a recommendation about the use of medical emergency codes, and about the need to ensure adequate mental health service provision for prisoners with dementia.

Assessment, Care in Custody and Teamwork

27. 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.

28. 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 (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.

29. 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.

Transfer of prisoners to hospital under the Mental Health Act

30. When a prisoner has a mental illness that requires detention in a hospital for medical treatment, and the prisoner urgently needs that treatment, the prison can arrange for them to transfer to a secure hospital under section 47, 48 or 49 of the Mental Health Act 1983. PSI 50/2007, *Transfer of Prisoners to and From Hospital Under Sections 47 and 48 of the Mental Health Act 1983*, and the *Mental Health Act 1983 Code of Practice for Wales* (updated in 2016), set out the process.

31. Before the prisoner can be transferred to hospital, two doctors (one of whom must be a mental health specialist) must provide reports stating that the prisoner meets the criteria for transfer. The reports must not be more than two months old. The mental health inreach team then sends the reports to the Ministry of Justice's Mental Health Casework Section, who review the request and issue a transfer warrant. The transfer warrant, which is valid for 14 days, allows the prisoner to be transferred to hospital under the direction of the Secretary of State.

32. When a prisoner is identified as suitable for transfer to hospital, the local health board within which the prisoner is registered with a community GP is responsible for arranging a secure mental health bed.

33. The Department of Health for Wales's guidance, published in 2011, recommends that all prisoners who need to be transferred are moved within 14 days.

Key Events

August to December 2018

34. On 6 August 2018, Mr Jared Perry was remanded to HMP Parc for sexual offences.

35. At an initial reception screen, Mr Perry told a healthcare assistant that he had a history of drug-induced psychosis and had recently seen a GP for a medication review. He also said he had an appointment with a psychologist booked for that day. She obtained Mr Perry's consent to request his community medical records but did not refer him to the mental health team.

36. The prison received Mr Perry's GP summary on 8 August and a prison GP reviewed it on 11 August. The community summary confirmed that Mr Perry was prescribed olanzapine (an antipsychotic) and diazepam (to treat anxiety), and had received intermittent input from a private psychiatrist in the community for the past three years, with a current referral to an NHS psychiatrist. The GP re-prescribed olanzapine and diazepam.

37. There is no record that Mr Perry had a secondary health screen.

38. On 20 August, a prison pharmacist reviewed Mr Perry's medication and recorded that he said that he had stopped taking olanzapine due to timing issues. She noted that Mr Perry was tearful, and she referred him to the primary care mental health team for an assessment.

39. Over the next four months, prison and healthcare staff monitored and reviewed Mr Perry frequently. Mental health staff conducted an initial assessment, issued him with self-help guidance and arranged for him to attend depression-focussed group sessions.

January to March 2019

40. On 10 January 2019, a nurse conducted a follow-up mental health assessment and Mr Perry reported hearing voices. He said that his medication helped manage the voices but that he continued to struggle. She recorded that Mr Perry did not report any thoughts of suicide or self-harm and suggested that he should receive one-to-one support.

41. On 18 January, Mr Perry was sentenced to 17 years in prison and returned to Parc. At a reception screen, a mental health nurse noted that Mr Perry was tearful and had thought about taking his life. She told prison staff who started ACCT procedures.

42. On 19 January, a Prison Custody Officer (PCO) carried out an ACCT assessment and noted that Mr Perry appeared upset about his sentence. Shortly afterwards, an Operational Manager (OM) chaired an ACCT review in which a mental health nurse attended. Mr Perry told attendees that he had been expecting "10 years" and that his "head was all over the place". They assessed his risk as raised and recorded on his caremap that he should remain active and have access to a music class.

43. Staff continued to monitor Mr Perry under ACCT procedures until his death. Healthcare staff attended 56 out of 58 ACCT case reviews.

44. On 8 February, a nurse attended a multidisciplinary case conference and recorded that Mr Perry's mental state had deteriorated over the weekend. Staff conducted a Threshold Assessment Grid assessment (TAG - a brief assessment of the severity of an individual's mental health problems) and agreed to check if Mr Perry had been referred to the mental health inreach team.

45. On 14 February, Mr Perry cut his thumb with a razor and was noted to be very agitated and restless.

46. On 18 February, a nurse attended a case conference and recorded that staff had decided to move Mr Perry to the Safer Custody Unit (SCU – for prisoners who require additional monitoring and support) for an assessment. On 19 February, an OM chaired an ACCT case review and noted that Mr Perry was acting in a 'bizarre and unusual fashion'. There is no record that staff reviewed or updated his caremap.

First referral to MHIT

47. On 20 February, a pharmacist reviewed Mr Perry's medication and he agreed to take olanzapine again. The next day, a nurse referred Mr Perry to the mental health inreach team.

48. On 22 February, an OM chaired an ACCT case review, which several prison managers and a nurse attended. Mr Perry reported feeling guilty for his crimes and said that he had spoken to a chaplain about his standing with God. Attendees questioned whether Mr Perry's state of mind was due to substance misuse, but he denied taking anything illicit.

49. On 14 March, a mental health Inreach nurse visited Mr Perry to conduct an initial assessment. However, he refused to engage or to consent to the nurse requesting his community mental health records. The nurse noted that Mr Perry appeared emotional and concluded that his presentation could have been due to substance misuse or the reaction to a long sentence. He tried again to complete the initial assessment on 3 April, but Mr Perry again refused to engage.

18 April to 7 June 2019

50. On 18 April, the nurse tried to see Mr Perry for a third time. He still refused to engage in the assessment, citing his religious beliefs as a Jehovah's Witness, but agreed to an informal discussion. He told the nurse that his thoughts had spiralled out of control recently and that he may have been 'spiked' as he had not willingly taken illicit drugs for two years. He also said that he had reduced olanzapine and was not having any auditory or visual hallucinations. The nurse felt Mr Perry's mental health could be managed under primary care but said he would discuss him at a single point of access meeting (SPAM) before discharging him. (The SPAM meeting considers referrals to the mental health inreach team and decides whether to accept them.)

51. On 4 May, a prison chaplain noted that Mr Perry had spoken to his mother the previous night and she had told him that his father had died. The same day, an OM chaired an ACCT case review and recorded that although Mr Perry was upset, he did not report thoughts of suicide or self-harm.

52. On 8 May, a nurse reviewed Mr Perry following his father's death. He said that he had spoken to officers and Listeners (prisoners trained by the Samaritans to support other prisoners) and did not feel like talking anymore. She recorded that he remained subject to ACCT monitoring and did not report any thoughts of suicide or self-harm.

53. On 10 May**,** an OM chaired an ACCT case review. Mr Perry told attendees that he had mixed feelings and the OM encouraged him to take his medication. Mr Perry did not report any thoughts of suicide or self-harm and said that he was hoping to go to his father's funeral. On 15 May, a probation officer recorded that Mr Perry's application to attend his father's funeral was not supported, as the victims of his offences were family members.

54. On 22 May, a pharmacist reviewed Mr Perry's medication. He told her that he had had a breakdown after his father's death. He said that he did not feel that he was being punished enough for what he had done, that his thoughts were disordered and that he had not been taking his medication. She encouraged Mr Perry to do so and recorded that he should remain on olanzapine.

55. On 23 May, a nurse told Mr Perry that his case had been discussed at a SPAM and that it had been decided that primary care could manage his symptoms. Mr Perry said that he had deep-rooted issues to work through and blamed himself, others and drugs for how he presented. The nurse recorded that Mr Perry did not show signs of psychosis and referred him to primary care with recommendations for counselling or psychological therapies.

56. On 28 May and 30 May, a mental health nurse tried to conduct a primary care mental health assessment. However, Mr Perry refused to engage on both occasions.

57. On 31 May, an OM chaired an ACCT enhanced case management review which several members of staff, including a nurse, attended. The OM recorded that Mr Perry had not been taking his medication and was displaying bizarre behaviour. As Mr Perry's mental health appeared to have deteriorated, attendees decided that he should move to the SCU for observation. Later that day, the probation officer contacted a substance misuse manager to enquire about a counselling referral for Mr Perry.

58. On 3 June, a prison chaplain saw Mr Perry who reported struggling with lots of different thoughts. Later that day, the substance misuse manager advised the probation officer that it would not be appropriate to start counselling as Mr Perry was subject to ACCT monitoring and needed a period of stability.

59. On 7 June, an OM chaired an ACCT case review and a nurse attended. Mr Perry did not report thoughts of suicide or self-harm but said that he was concerned about the noise on the wing. The OM added a caremap action to look at the possibility of moving Mr Perry.

1 July to 29 August

60. On 1 July, a locum GP saw Mr Perry for a medication review. He told her that he had a lot of issues to work through. She recorded that Mr Perry did not display any psychotic symptoms and had agreed to continue taking olanzapine.

61. On 9 July, an OM chaired an ACCT case review and recorded that Mr Perry came across as very bizarre. Mr Perry did not report any thoughts of suicide or self-harm but said he felt like he was "going backwards", despite taking his medication. The OM noted that he did not update Mr Perry's caremap, as the case manager was not available to chair the review.

Second referral to the MHIRT

62. On 15 July, a mental health nurse reviewed Mr Perry and recorded that he was pacing up and down his cell and was unable to sit still. She noted that he appeared to be responding to unseen stimuli and that it was difficult to assess his mental state as he refused to engage. Two days later, she re-referred Mr Perry to the mental health inreach team.

63. On 18 July, an OM chaired an enhanced ACCT case management review and case conference. Mr Perry told attendees that he did not have any thoughts of suicide or self-harm but wanted to return to the SCU as he felt the house block was too busy. Staff discussed the possibility of Mr Perry moving to another part of the house block to ensure he complied with his medication first. At that point, Mr Perry stopped engaging with the review and tried to assault the OM.

64. On 24 July, a mental health nurse recorded that following a discussion at a SPAM the previous day, it was felt Mr Perry's needs could be managed under primary care and the referral to the inreach team was not therefore accepted.

65. On 30 July, Mr Perry was moved to the segregation unit for trying to assault a member of staff during a disciplinary hearing. Later that day, an OM chaired an ACCT case review, in which a nurse attended. The OM recorded that although Mr Perry seemed more relaxed than earlier, attendees had decided to increase his level of ACCT monitoring to five observations an hour, with four conversations during the day and one at night.

66. On 1 August, a prison manager chaired an ACCT case review and Mr Perry told the attendees that he was okay and had no thoughts of suicide or self-harm. The prison manager noted that Mr Perry's behaviour had been very strange since he had arrived in the segregation unit. He did not expand on this.

67. On 2 August, a prison manager tried to chair an ACCT case review, but Mr Perry refused to engage. He added to the caremap an action for Mr Perry to engage in case reviews. Later that day, staff moved Mr Perry to the SCU and assigned him a safer cell (a cell specifically designed to minimise ligature points) with 24 hour in-cell CCTV surveillance.

68. On 5 August, an OM chaired an ACCT case review, in which a nurse attended. Mr Perry refused to engage and lunged at the OM. Staff used force to restrain him so they could exit the cell. A prison paramedic reviewed Mr Perry and recorded that he did not have any injuries.

69. On 7 August, staff discussed Mr Perry's recent presentation at the weekly multidisciplinary meeting for prisoners with complex needs and noted that a nurse would refer him to the inreach team. However, there is no record that she did so. That day, another nurse visited Mr Perry for a review, but there were not enough staff available to meet the requirement to have two officers present to unlock him.

70. On 13 August, a nurse recorded that Mr Perry had been allocated to her caseload for mental health support. She visited Mr Perry, but he refused to engage. The next day, staff discussed Mr Perry at the weekly healthcare meeting to discuss prisoners with complex needs and recorded that his unlock requirement had been increased to three officers due to his challenging behaviour.

Third referral to the MHIT

71. On 16 August, an OM chaired an ACCT case review, in which a Senior Operational Manager (SOM) and a nurse attended. He recorded that Mr Perry seemed pre-occupied and tried to push his way out of his cell door when staff tried to facilitate a phone call to his mother. The attendees agreed that as Mr Perry's mental health appeared to have deteriorated, he should be referred to the inreach team again. They assessed Mr Perry's risk as raised but reduced his ACCT monitoring to two observations an hour, with two conversations daily and one at night, as they felt he presented more of a risk to staff than to himself. That day, a nurse referred Mr Perry to the mental health inreach team again.

72. On 19 August, the mental health Inreach team manager and a mental health inreach nurse assessed Mr Perry. They spoke to staff in the SCU, who said that they had observed a deterioration in Mr Perry's behaviour and that they were now managing his unlock requirements to include three officers and a shield. The Inreach team manager questioned whether Mr Perry had psychotic depression following his father's death and tasked a GP to prescribe a short course of diazepam, which a GP did on 21 August.

73. On 22 August, an OM chaired an ACCT case review, in which a complex case manager, a nurse and two officers attended. The OM talked to Mr Perry through the door and asked him to move to the back of the cell. Once the door was open, My Perry kept edging towards the door and staff left the cell. After the review, attendees decided that although Mr Perry's behaviour was concerning, he did not present a significant risk to himself and could continue to be managed under two observations an hour.

74. On 27 August, an OM chaired a case conference attended by Mr Perry's mother, a nurse from the Inreach team, a SOM, the complex case manager, a nurse and a prison chaplain. Mr Perry's mother told the attendees that he had a history of mental health and substance misuse problems and did not take his medication consistently in the community. She also gave staff a psychiatric report from 2018, which indicated that Mr Perry had schizophrenia and would need intense antipsychotic treatment.

75. Later that day, the OM chaired an ACCT case review and recorded that Mr Perry was distressed and tearful. He told Mr Perry that he had spoken to his mother and offered to facilitate a phone call. However, shortly after agreeing to speak to his mother, Mr Perry assaulted the OM by punching him in the head. Staff stopped the review and used force to secure Mr Perry. An action was added to the caremap for staff to encourage Mr Perry to have regular contact with his family.

76. On 29 August, a consultant psychiatrist from the mental health Inreach team and a nurse reviewed Mr Perry in the presence of three officers with a shield. The psychiatrist recorded that Mr Perry's bizarre behaviour, poor engagement, non-compliance with medication and possible diagnosis of psychotic illness meant that

he could not assess him in a prison environment. He noted that he would refer Mr Perry to Hywel Dda Health Board's forensic psychiatry team to be assessed for a secure hospital transfer.

2 September to 29 October

77. On 2 September, an OM chaired an ACCT case review which prison staff and a mental health nurse attended. The OM recorded that Mr Perry refused to engage and 'approached staff in an aggressive manner' when he tried to explain the reason for the review. He noted that a shield was used to push Mr Perry away and added a caremap action which was to speak to the use of force co-ordinator for suggestions on how to manage Mr Perry's behaviour.

78. On 6 September, an OM chaired an ACCT case review and recorded that Mr Perry agreed to phone his mother, before changing his mind. A nurse asked the OM to ask Mr Perry if he was hearing voices and he replied, "Yes and no." He then proceeded to move towards staff, and they left the cell. The attendees decided to continue with two ACCT observations an hour and noted that Mr Perry's compliance and engagement was better than it had been for a considerable time.

79. On 8 September, a nurse reviewed Mr Perry and recorded that he presented as unkempt, appeared to be responding to unseen stimuli and lacked capacity to make rational decisions. He asked the inreach team to prioritise their assessment as he did not feel that staff could sufficiently meet Mr Perry's needs.

Assessment for a transfer to a secure hospital

80. On 10 September, a PCO recorded that Mr Perry refused to have his breakfast and became aggressive. She noted that he continuously banged on his cell door and told staff to go away when they spoke to him. That day, a consultant psychiatrist from Hywel Dda Health Board conducted an assessment. The ongoing ACCT record indicates that Mr Perry's observations continued to take place twice an hour.

81. On 11 September, an OM chaired an ACCT case review through Mr Perry's cell door as he was aggressive towards staff. He told her that he did not want to go to hospital but refused to say more. The attendees assessed Mr Perry's risk as raised and kept his ACCT observations at five an hour. There is no record to indicate when the observations were increased.

82. Later that day, a nurse made a retrospective entry in Mr Perry's medical record which noted that the consultant psychiatrist felt Mr Perry presented as psychotic and needed a hospital transfer under section 47 of Mental Health Act 1983. She noted that he would prepare a report and liaise with the inreach team.

83. On 26 September, a nurse contacted the consultant psychiatrist to ask for an update on his assessment. He informed her that he had completed a section 47 report and a nurse assessor from Hywel Dda Health Board added that they would start the process of identifying a bed in a mental health hospital. That day, the nurse spoke to Mr Perry through his cell door as officers could not meet his unlock requirement. He said he was not feeling too bad but did not want to speak to her.

84. On 30 September, an OM looked through Mr Perry's cell observation panel and saw him huddled up on his bed. He told him that he was going to conduct an ACCT case review and asked Mr Perry to stay on his bed. Staff entered the cell and Mr

Perry told them that he was “not good” and “needed to be punished for the things he has done”. Mr Perry then asked staff to beat him and began to get up. At this point, the OM instructed all staff to leave the cell.

85. On 2 October, a SOM emailed the mental health Inreach team manager to ask for an update about several prisoners, including Mr Perry. That day, the Operational Head of Safety also emailed the Inreach team manager for an update about Mr Perry’s hospital transfer as prison staff were becoming increasingly concerned about him. The Inreach team manager contacted the consultant psychiatrist, who informed him that Mr Perry was almost certainly schizophrenic and required admission to a Psychiatric Intensive Care Unit (PICU). He said that there were currently four people waiting for a bed and that a nurse manager would visit the prison to assess Mr Perry.

86. On 3 October, the mental health Inreach team manager informed the SOM that the hospital offering Mr Perry a bed had arranged a nursing assessment for the following week. Later that day, an OM met several staff before an ACCT enhanced case management review. They discussed the difficulty staff had minimising the amount of force used on Mr Perry and the SOM asked staff to contact the use force co-ordinator. This action was added to the caremap. The OM recorded that when staff entered Mr Perry’s cell to conduct the review, he approached them aggressively and they used a shield to enable them to leave the cell safely.

87. On 8 October, two members of hospital staff assessed Mr Perry’s suitability for a psychiatric hospital admission. The mental health Inreach team manager accompanied them and recorded that Mr Perry tried to attack an officer shortly after leaving his cell. He also noted that Mr Perry was pre-occupied and reported hearing voices and a radio playing in his head. Hospital staff assessed Mr Perry as suitable for a PICU and advised that a bed should be available within two weeks. The Inreach team manager recorded that he would liaise with the consultant psychiatrist and prepare the relevant paperwork.

88. On 11 October, a PCO recorded that Mr Perry’s behaviour had improved over the last few days. Later that day, an OM chaired an ACCT case review and recorded that Mr Perry repeatedly said, “I’m sick”. The OM noticed that Mr Perry was holding a letter from his mother and offered to help him read it but there is no record to say whether he accepted.

89. On 15 October, an OM chaired an ACCT case review and recorded that Mr Perry had attended to his personal hygiene. Later that day, a psychiatrist visited Mr Perry for a review, but he charged at him and an officer had to stop him. He noted that Mr Perry remained psychotic and that he was waiting for the consultant psychiatrist’s medical recommendation to complete the second recommendation.

90. On 22 October, the consultant psychiatrist visited Mr Perry again and completed the first medical recommendation for a transfer to a secure hospital. The prison psychiatrist completed the second medical recommendation shortly afterwards. The next day, healthcare staff submitted the section 47 application to the Ministry of Justice Mental Health Casework Section (MoJ MHCS). MoJ MHCS gave the prison a transfer warrant on 24 October, and staff scheduled the hospital transfer for 4 November.

91. The prison told us that between 8.15am and 8.46am on 26 October, in-cell CCTV footage shows that Mr Perry is out of view of the camera. The ACCT observation record indicates that Mr Perry was stood by his door, but CCTV footage covering the SCU does show an officer going to his cell during this time. At 3.28pm, in-cell CCTV shows Mr Perry ripping what appears to be bedding and placing it under his duvet.

92. At 10.30am on 28 October, an OM chaired an ACCT case review, in which a nurse and two officers attended. She asked Mr Perry how he felt, and he said, "This isn't me". She asked him if he understood that he would be going to hospital, but he did not respond. At 6.14pm, in-cell CCTV shows Mr Perry pick up a piece of material from his bedside table and appear to tear it several time before putting it back down.

93. On 29 October, the accommodation fabric check box (AFC, a visual inspection of the cell to ensure it is safe) in the SCU ledger was signed 'staff' instead of the name of the individual who conducted the AFC, as the document requires. However, the ongoing ACCT record states that Mr Perry refused to leave his cell throughout the day and told staff taking his food into his cell that he wanted to "punch someone".

Events from 30 October to 3 November

94. At 8.00am on 30 October, an OM chaired a morning meeting in the SCU and asked staff to encourage Mr Perry to leave his cell as he had not been out for a day. At 10.17am, three PCOs unlocked Mr Perry and took him to the shower. Shortly afterwards, CCTV footage shows that Mr Perry went to the unit's exercise yard for around 30 seconds before he returned inside. At this point, the OM arrived and asked PCO A, who was monitoring the cameras to clear the rubbish from Mr Perry's cell.

95. PCO A entered Mr Perry's cell and gathered rubbish and leftover food. While doing so, he picked up a piece of material next to some used polystyrene plates on Mr Perry's bedside table. He inspected the piece of material before putting it back where he found it.

96. In the meantime, Mr Perry spoke to the OM and asked him why he looked down or depressed. The OM told him that he been ill recently. Mr Perry stood up and walked towards him saying, "I'm going to punch him". The OM encouraged Mr Perry to stay out of his cell a while longer before leaving the unit to avoid antagonising him further.

97. At 10.47am, officers informed Mr Perry that he had to return to his cell. Mr Perry began to move towards a PCO, who used a shield to hold him against a wall. A PCO grabbed Mr Perry's left arm while another PCO dropped the shield and they guided him back to his cell. CCTV shows that Mr Perry did not resist staff. Both PCOs told the investigator that Mr Perry did not report thoughts of self-harm or display any behaviour that may have indicated an increased risk of suicide.

98. At 11.01am, a nurse reviewed Mr Perry through his cell observation panel and recorded that Mr Perry did not report sustaining any injuries in the earlier restraint. At 11.24am, a PCO conducted an ACCT check and recorded that Mr Perry was lying on his bed.

99. At 11.18am, Mr Perry pressed his emergency cell bell and spoke to a member of staff. Although it has not been possible to establish who answered the cell bell, a PCO told us that Mr Perry often used the intercom to ask staff to let him out of his cell shortly after he had spent time in the unit.

100. At 11.26am, in-cell CCTV footage shows that Mr Perry walked into a blind spot behind the door, with a piece of material in hands. At 11.28am and 11.41am, a PCO said that he used the in-cell CCTV monitor in the staff office to conduct the ACCT observations. He recorded that Mr Perry was standing by the door on both occasions. However, CCTV footage shows that Mr Perry remained out of view of the camera.

101. At around 11.50am, a PCO conducted Mr Perry's ACCT check by looking at the CCTV monitor and noticed that he could not see him. He went to Mr Perry's cell and looked through the observation panel but still could not see him. He asked another PCO for assistance due to Mr Perry's unlock level and he too looked into the cell. The PCO told us that he could not see Mr Perry initially, but then saw his feet by the door.

102. A PCO suggested that they unlock the cell to check Mr Perry as this was not his usual behaviour. At 11.52am, they opened the door and found Mr Perry hanging by a piece of bed linen attached to an exposed rivet holding the inundation point to the door. The PCO cut the ligature from Mr Perry's neck, placed him on the floor and started cardiopulmonary resuscitation (CPR). At 11.53am, another PCO pressed his personal alarm and radioed a medical emergency code blue (indicating that a prisoner is unconscious or has breathing difficulties).

103. At 11.54am, a nurse arrived and saw that officers were performing CPR. He radioed for all nurses to attend and obtained an emergency medical bag from the medication hatch in the SCU. In the meantime, several members of healthcare staff arrived while a PCO collected a defibrillator. A prison paramedic inserted an airway and asked nurses to use the defibrillator, which analysed Mr Perry's heart rhythm but advised not to issue a shock. Prison and healthcare staff continued CPR.

104. An ambulance arrived at the prison at 12.03pm and the first paramedic reached Mr Perry's cell at 12.09pm. At 12.17pm, paramedics detected a pulse and at 12.27pm they took Mr Perry, unrestrained and escorted by two officers, to the Princess of Wales Hospital, Bridgend.

105. At 1.10pm, a hospital consultant told prison staff that Mr Perry was on life support and in a critical condition. Healthcare staff remained in daily contact with the hospital for updates on Mr Perry.

106. On 3 November, after consulting with Mr Perry's family, hospital staff decided to turn off his life support. Mr Perry died at 3.50pm, with his family present.

Contact with Mr Perry's family

107. At 1.30pm on 30 October, Parc appointed the complex case manager as the family liaison officer. She phoned Mr Perry's mother and told her that he had been taken to hospital. At 4.25pm, complex case manager and a prison manager met Mr Perry's mother and sister at the hospital. They offered their support and remained in daily contact with Mr Perry's mother.

108. At 8.30am on 3 November, the complex case manager met Mr Perry's mother at the hospital and offered support. She stayed at the hospital until 12.30pm. At 5.30pm, Mr Perry's mother phoned the complex case manager and told her that Mr Perry had died.

109. The complex case manager provided ongoing support to Mr Perry's mother until his funeral on 20 November. The prison contributed toward the cost in line with national policy.

Support for prisoners and staff

110. On 26 September, a prison manager debriefed staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. After Mr Perry died, a prison manager offered support to the staff present at the hospital.

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

Post-mortem report

112. No illicit substances were identified in routine post-mortem toxicology tests.

Findings

Management of Mr Perry's risk of suicide and self-harm

113. For the most part, Parc managed the ACCT process well. The case reviews indicate that staff made concerted efforts to work with Mr Perry to reduce his risk and that healthcare involvement in the process was frequent. Both prison and healthcare staff attempted to support Mr Perry by referring him to available support networks. They encouraged Mr Perry to participate in ACCT reviews and involved his mother in the process. Enhanced case reviews with senior managers took place as his condition deteriorated and staff asked the mental health inreach team for updates about his hospital transfer. Staff were aware that Mr Perry was mentally unwell and demonstrated compassion and managed his aggression appropriately.

114. Despite this positive work, we have identified some areas for improvement.

Caremaps

115. PSI 64/2011 states that completing 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. The caremap should set time-bound actions and be aimed at reducing the risk the prisoner presents to themselves. Caremap actions should be updated at future case reviews, with new actions added when appropriate.

116. Staff only updated Mr Perry's caremap once between the first case review on 20 January and the 10th case review on 13 March. A date for completing the actions was not set and staff did not sign them off as complete. The following two issues added to the caremap were marked as complete, but staff failed to record at which case reviews this took place.

117. At an ACCT case review on 2 August, staff recorded that Mr Perry's engagement in the process was an issue and set an action for him to engage in reviews. At an ACCT review on 22 August, an action was added for staff to encourage Mr Perry to contact his family and, on 6 September, an action was added for staff to encourage Mr Perry to have a regime. Although we recognise that staff tried many times to engage with Mr Perry, it would have been more meaningful to set out how staff planned to encourage him to participate in ACCT reviews, maintain family ties and have a regime.

118. Staff failed to update an action to seek advice from the use of force co-ordinator on 2 September. An OM told the investigator that he tried to chase it up, could not get a response and left the action blank. While we are satisfied the action was later re-visited, we are concerned that the original action was not updated and that a new one was not added sooner.

119. We are also concerned that there was no co-ordinated plan for arranging and monitoring the progress of Mr Perry's hospital transfer. Prison staff requested updates from the inreach team, but a more joined-up approach with a specific plan may have helped to improve communication.

ACCT checks

120. We also have concerns about the ACCT checks on 30 October.

121. PSI 64/2011 states that staff must follow the level of observations and conversations stated on the ACCT document and must record these immediately or as soon as reasonably practical. ACCT records indicate that staff conducted Mr Perry's observations but that the conversation aspect was not always fulfilled. However, the ongoing record shows that staff frequently encouraged Mr Perry to talk and participate in activities. Since Mr Perry had a psychotic illness and often displayed aggression towards staff, we are satisfied this action was appropriate.

122. A SOM told us that staff are expected to go to a cell to check in person if they cannot see a prisoner on an ACCT on CCTV. When a PCO conducted Mr Perry's ACCT observations at 11.28am and 11.41am on 30 October, he recorded that Mr Perry was standing by the door, even though Mr Perry was not visible on the camera. The PCO told the investigator that although he could not see Mr Perry, he heard a banging noise coming from his cell. He said this was not unusual for Mr Perry and he was not concerned. We are concerned that the PCO did not go to the cell when he could not see Mr Perry, and that he did not do so until 11.50am, 22 minutes after Mr Perry was not visible on the CCTV.

123. We note that the PCO first recorded an inaccurate ACCT observation at 11.28am, two minutes after Mr Perry had moved into the blind spot in the cell with a piece of material. While we cannot know whether Mr Perry's death could have been prevented if the PCO had checked on him instead of relying on what he heard, he would have discovered him earlier.

124. The PCO has subsequently resigned from his job at Parc.

Cell checks

125. PSI 64/2011 states that where there is information to suggest that prisoners have acquired an item which they could use to harm themselves, and which has not been agreed or its risk assessed, they must be searched and the item removed.

126. When PCO A went into Mr Perry's cell on 30 October, he picked up a piece of material but did not remove it or inform a member of staff. The PCO told us that he did not think the material presented a significant risk as it did not appear long enough to be used as a ligature. We disagree. Mr Perry was living in a cell with 24-hour CCTV surveillance, was assessed as at a raised risk of suicide and subject to a high level of monitoring. We therefore consider that regardless of the ligature's length, the item presented a significant risk and should have been removed and reported.

127. We cannot be certain that the piece of material that PCO A picked up was that which Mr Perry used as a ligature, but we consider it highly likely. While removing the material from the cell and informing another member of staff may not have prevented Mr Perry's death, Mr Perry would not have had access to the material. In addition, reporting the finding may have resulted in an ACCT case review and additional support could have been put in place for Mr Perry.

128. Previous PPO investigations have identified that prisoners who are being considered for or awaiting a transfer to a secure hospital are at particular risk of suicide. It is, therefore, a particular concern that two PCOs were not as vigilant as they should have been.

129. We make the following recommendations:

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

- **set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; and**
- **accurately record details of ACCT observations in the ongoing record and physically review prisoners who are not visible on in-cell CCTV.**

The Director should ensure that staff are extra vigilant about the care of prisoners who are being considered for or are awaiting transfer to a secure hospital.

The Director should ensure that prison staff remove items which potentially pose a risk from a prisoner's cell and escalate their concerns.

The Director should commission an investigation into PCO A's failure to remove an item of risk from Mr Perry's cell, with a view to considering whether disciplinary action is appropriate.

Clinical care

Mental health care

130. The clinical reviewer concluded that prison healthcare staff generally responded to Mr Perry's mental health needs in a timely and appropriate way.

131. They completed appropriate assessments, attended ACCT reviews and reviewed Mr Perry's medication frequently. The chaplaincy also offered Mr Perry support following his father's death and probation staff explored bereavement counselling. The clinical reviewer also considered that staff appropriately discussed his care at healthcare meetings to review prisoners with complex needs.

132. He did, however, identify some areas for improvement.

Initial health screens

133. When Mr Perry arrived at Parc in August 2018, he reported a history of drug-induced psychosis at his initial health screen, and an outstanding appointment with a 'psychologist' (later confirmed by the community GP records to be an appointment with a psychiatrist).

134. The clinical reviewer considered that as Mr Perry reported a mental health issue, staff should have referred him for an assessment by the prison's mental health team and that the GP should have asked healthcare staff to re-arrange his outstanding psychiatric appointment, in line with National Institute of Clinical Excellence (NICE) guidance. He also considered that healthcare staff took too long to prescribe Mr Perry's medication following receipt of his community GP record.

135. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that newly arrived prisoners should be offered a general health assessment in their first week. This did not happen. Given Mr Perry's reported medical history, it was particularly important for healthcare staff to have conducted a secondary health screen to ensure he received prompt and appropriate support.

136. The clinical reviewer said that these were all missed opportunities to pick up on Mr Perry's mental health issues, and that taking these actions could have led to earlier assessment and support in managing his existing mental health needs.

137. We make the following recommendation:

The Head of Healthcare should ensure, in line with PSO 3050, that healthcare staff:

- **refer newly arrived prisoners who report mental health problems to the mental health team;**
- **prescribe medication promptly once a GP has confirmed a prisoner's existing prescription;**
- **rearrange outstanding hospital appointments if necessary; and**
- **offer all prisoners a full general health assessment within a week of their arrival.**

The involvement of the mental health inreach team

138. Healthcare staff first referred Mr Perry to the mental health inreach team in February 2019 (in response to his bizarre behaviour) and again in July (when they considered that his mental state and behaviour had deteriorated). On both occasions the inreach team concluded that Mr Perry could be managed by the prison's primary care mental health team. Their reasons are not clearly recorded. The inreach team finally agreed to accept Mr Perry onto their caseload in August after a third, urgent referral.

139. We note that when HMIP inspected Parc very shortly after Mr Perry's death, they found that mental health services for prisoners with complex needs were inadequate and that the mental health inreach team was under-resourced. We are concerned that this may have influenced the inreach team's decisions not to accept responsibility for Mr Perry until August 2019, and that this may have been another missed opportunity to support and manage his mental health needs.

140. We recommend:

The HMPPS Executive Director for Wales should:

- **satisfy himself that the mental health needs of the prisoner population at Parc have been established;**
- **satisfy himself that there is prompt assessment and timely access to integrated support and a full range of interventions for prisoners with complex mental health needs; and**

- **write to the Ombudsman to confirm that he is so satisfied.**

Transfer to a secure psychiatric hospital

141. The clinical reviewer is satisfied that both prison and healthcare staff appropriately escalated their concerns about the deterioration in Mr Perry's mental state and that these were in turn escalated to staff within Hywel Dda Health Board.

142. On 29 August, a consultant psychiatrist from the mental health inreach team referred Mr Perry to the Health Board's forensic psychiatry team to be assessed for a secure hospital transfer. As a result, a forensic consultant psychiatrist from Hywel Dda assessed Mr Perry on 10 September and concluded that Mr Perry was almost certainly psychotic and needed a hospital transfer under the Mental Health Act. He said that he would prepare a report and liaise with the inreach team to arrange the transfer.

143. However, despite repeated requests from prison and healthcare staff for urgent action, there was then a delay until 22 October when the consultant forensic psychiatrist completed the required recommendation for a transfer to a secure hospital.

144. Thereafter, things moved quickly. Healthcare staff submitted the application to the Ministry of Justice on 23 October, the Ministry of Justice issued a transfer warrant on 24 October and the transfer was scheduled for 4 November.

145. We agree with the clinical reviewer that healthcare staff at Parc appropriately emphasised the need to prioritise Mr Perry's hospital transfer because staff were becoming increasingly concerned about their ability to manage Mr Perry safely in prison. We recognise that the delay in transferring Mr Perry appears to have been caused by the difficulties in finding an available hospital bed for him. We are satisfied that there was nothing more prison and the primary healthcare team could have done to speed things up.

146. However, we have expressed concern over many years about the lengthy waiting times for hospital transfers in England and Wales. The Mental Health Act does not specify any waiting time limit for transfers from prison to secure hospital, and factors such as the lack of bed availability can lead to prisoners with severe and complex mental health needs having to spend significant amounts of time in prison, where they cannot receive the level of care they need.

147. This problem was recognised by Lord Bradley in his 2009 Review of people with mental health needs and learning disabilities in the criminal justice system. He recommended that the Department of Health should develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting49. The Department of Health accepted this recommendation, and in 2011 published a good practice guide about the transfer of prisoners under the Mental Health Act, which included a suggested timescale of 14 days. However, it is still not a legal requirement.

148. An additional problem is that delays are not always well recorded. The recording of the length of a waiting time does not generally begin until an assessment has taken

place. This opens up the possibility of assessments being pushed back, until there is the possibility of a bed becoming available. In this case, Mr Perry was initially referred by the inreach team on 29 August and was first assessed on 10 September, but the necessary report was not completed until 22 October.

149. We cannot know whether an earlier transfer would have prevented Mr Perry's death, but where a secure hospital has been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken to ensure this takes place within the 14-day target.

150. We also note that although the clinical reviewer considered that the inreach team did what they could to follow-up Mr Perry's hospital transfer, he found that they did not communicate this information effectively. This left prison and primary care staff without a clear indication of what was happening.

151. The mental health Inreach team manager told us that although Inreach staff do not have the resources to attend ACCT case reviews, prison healthcare staff could access their notes through the shared clinical records. We agree with the clinical reviewer that a more joined-up approach and guidance for staff on the transfer process would have led to greater clarity and enabled staff to develop a formal plan for managing Mr Perry while he waited for his transfer, accessible to all those involved.

152. We make the following recommendation:

The Head of Healthcare should ensure that:

- **local guidance is developed setting out the process for transferring prisoners to a secure hospital under section 47 of the Mental Health Act 1983; and**

- **prisoners with complex needs are reviewed weekly as part of a multidisciplinary team and decisions set out in an agreed plan.**

Inquest

153. At the inquest, which took place on 27 March 2024, the Coroner concluded that Mr Perry died of misadventure. To which a failure to undertake indicated observations; a delay in his transfer to a secure mental health unit; and failure to remove material as per procedure contributed.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100