Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Pugh, a prisoner at HMP Swaleside, on 29 June 2024

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.

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 Michael Pugh was found hanged in his cell on 29 June 2024 at HMP Swaleside. He was 29 years old. I offer my condolences to Mr Pugh's family and friends.

Mr Pugh had been at Swaleside since 27 December 2023. He had previously been at HMP Woodhill and before that, spent nine years in a secure mental health hospital. Mr Pugh struggled to adjust to prison life and his complex mental health history meant he was supported by the mental health in-reach team at Swaleside. However, he did not take his prescribed medications as he should have. Mr Pugh was subject to suicide and self-harm monitoring (known as ACCT) for extended periods at Swaleside, however he was not considered to be at serious risk of suicide at the time of his death.

The investigation found that staff on C wing had not carried out ACCT checks on Mr Pugh as they should have and falsified records to indicate that observations had been completed. While I am satisfied that the issue of falsifying documents is not systemic across the prison, the evidence suggests that on C wing, this was not an isolated case.

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

Adrian Usher
Prisons and Probation Ombudsman **March 2025**

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....6

Findings 13

Summary

Events

1. Mr Michael Pugh was first detained in custody in January 2009, at the age of 14. Mr Pugh's behaviour in custody was very poor and he was often violent towards other detained children and staff. In October 2010, Mr Pugh was given an indefinite sentence for public protection following an assault on a female member of staff at HMYOI Feltham. His continued violent behaviour resulted in a psychiatric assessment, and in March 2013, aged 19, he was moved from the prison estate to Broadmoor High Security Hospital under section 47/49 of the Mental Health Act 1983. Mr Pugh spent the next nine years in either a high or medium secure hospital. While in hospital Mr Pugh was diagnosed as having mixed and other personality disorders. He was remitted back to prison on 14 September 2022.

2. Mr Pugh spent a short period at HMP Exeter before transferring to HMP Woodhill, where he remained until 27 December 2023. While at Woodhill, Mr Pugh engaged with mental health services and drug and alcohol recovery services. Mr Pugh struggled to readjust to the prison environment and at times he was violent towards staff and others. He also began to refuse to take medication for his mental health. Mr Pugh was subject to suicide and self-harm monitoring (ACCT) once at Woodhill between 15 January and 7 February 2023 after saying that he planned to harm himself and did not want to live.

3. On 27 December 2023, Mr Pugh transferred to HMP Swaleside. He continued to struggle to adjust to prison life and the mental health team continued to support him. Mr Pugh asked to be re-prescribed antipsychotic medication that he had stopped taking while at Woodhill, but changed his mind and was recorded as refusing medication despite encouragement from the mental health team.

4. Between 3 March and his death on 29 June, Mr Pugh was subject to ACCT monitoring three times due to intrusive thoughts and statements about his mental health. Mr Pugh was moved to the in-patient's department (IPD) between 23 March and 22 May, during which time the mental health team tried to address issues with his medication. He was located in the IPD again from 8 to 11 June under constant supervision after he expressed thoughts of suicide and cut his arm.

5. At 10.00am on 29 June, Mr Pugh was found in his cell with a ligature around his neck. Staff radioed a medical emergency code, and staff and nurses attempted to resuscitate Mr Pugh. At 10.25am, paramedics arrived. Efforts to resuscitate Mr Pugh continued but at 10.57am, paramedics pronounced his life extinct.

Findings

6. Mr Pugh had a number of risk factors for suicide and self-harm including his history of mental health issues, long-term hospitalisation under the Mental Health Act, previous violence, previous self-harm and suicidal thoughts and drug use. These were all appropriately identified when he arrived at Swaleside, and he was referred for additional support.

7. Staff began ACCT procedures appropriately and overall, Mr Pugh received consistent and personalised support from staff. ACCT reviews were responsive to his needs and his risk. There is no evidence that Mr Pugh's risk of suicide had substantially risen in the days before his death.

8. On 29 June, Mr Pugh was subject to hourly ACCT observations, these were recorded as taking place at 8.30am and 9.30am. The investigation found that the officer responsible did not conduct the checks and falsified the entries in the ACCT document. CCTV footage of 28 and 29 June identified six further observations that were recorded in the ACCT document but had not taken place.

9. The investigator viewed a wider sample of CCTV from across the prison. We did not find evidence of systemic falsification of records but found that other records on C wing, where Mr Pugh was located, also contained falsified checks. We raised this issue with the Governor.

10. The clinical reviewer concluded that the care Mr Pugh received at Swaleside was not of a reasonable standard and therefore not equivalent to what he could have expected to receive in the community.

11. She found that Mr Pugh had a complex mental health presentation and history prior to arriving at Swaleside and it was not clear from his clinical records whether the discharge summary from secure mental health hospitals had been shared with the healthcare team or Mr Pugh's psychiatrist. There was no evidence of an up-to-date mental health diagnosis or any professional curiosity around this, which led to gaps in Mr Pugh's treatment. Although Mr Pugh presented with symptoms of psychosis, there was no clinical record that psychosis had been explored, healthcare staff did not complete a mental health capacity assessment, and record keeping was not in line with guidelines.

Recommendations

- The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure herself that there is not a systemic issue with false entries.

- The Director General of HMPPS should communicate to Governors and Directors his expectation that in all but the most exceptional of circumstances, when there is evidence of making deliberate false entries, a formal investigation is instigated and, in appropriate circumstances disciplinary action follows.

The Investigation Process

12. HMPPS notified us of Mr Pugh's death on 29 June 2024.

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

14. The investigator visited Swaleside on 16 July 2024. He obtained copies of relevant extracts from Mr Pugh's prison and medical records and obtained body worn video camera (BWVC) footage and viewed relevant CCTV recordings.

15. The investigator interviewed seven members of staff at Swaleside on 3 and 4 September. He returned to Swaleside on 2 October to view further CCTV.

16. NHS England commissioned a clinical reviewer to review Mr Pugh's clinical care at the prison. She and the investigator jointly interviewed four members of medical staff on 27 August 2024.

17. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem and toxicology examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Pugh's father to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Pugh's father said that he was extremely concerned about the lack of care that his son received while in prison and said that he had contacted the prison on a number of occasions to highlight that, in his opinion, his son was at extreme risk of suicide.

19. Mr Pugh's father received a copy of our initial report but provided no response to our findings.

Background Information

HMP Swaleside

20. HMP Swaleside, on the Isle of Sheppey, is part of the long-term high security estate, predominantly holding prisoners judged to be high risk and those serving long sentences. Oxleas NHS Foundation Trust provides physical and mental healthcare services, including 24-hour nursing cover. Change, Grow, Live (CGL) provides substance misuse services.

HM Inspectorate of Prisons

21. The most recent inspection of Swaleside was in September 2023. Inspectors reported that safety remained a concern. They noted that Swaleside had made real efforts to improve despite the challenges faced by the restricted regime caused by the difficulties recruiting staff.

22. An independent review of progress was carried out in August 2024. In the subsequent report inspectors noted that the recorded rate of self-harm and the number of individuals involved had increased over the last 11 months and one very recent death in June 2024, was suspected to have been self-inflicted. There was compelling evidence that staff did not always complete the required checks on prisoners at risk of suicide and self-harm and inspectors were not confident that records they had examined were accurate. Some of the care plans in the ACCT documentation were months out of date and did not reflect the prisoners' current needs. None of the plans focused on getting prisoners into activity and sometimes the support was repeatedly stopped and restarted without addressing the underlying issues.

23. Illicit drugs were now even more readily available than they had been during the previous full inspection. This was demonstrated by the higher positive drug testing rate. The average rate was around 32% over the last year, but in June 2024 it had peaked at over 56%. Inspectors also noted that there had been a substantial change in the way drugs and other illicit items were being supplied and sophisticated drones were now used to deliver packages. This was undermining safety and stability in the prison and the use of drugs underpinned the lack of progress in many of the concerns set out in their report.

24. Inspectors reported that they were impressed that the acute shortage of officers which they noted in their last report, had now been addressed through proactive recruitment. However, at the time of the follow up inspection, just over half the officer group had less than a year in service and this would increase over the next two months as newly trained officers were due to take up post. This level of inexperience inevitably led to a continuing lack of confidence and assertiveness in the management of prisoners.

Independent Monitoring Board

25. 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 30 April 2024, the IMB reported that they remained concerned about the mental health of prisoners who had suffered long-term lockdown. This was evidenced by the number of opened ACCT documents, self-harm cases and violent incidents. The IMB said that the first indications from the recent improvement in regime were positive. However, the need for increased psychology and psychiatric services still needed to be assessed.

Previous deaths at HMP Swaleside

26. Mr Pugh was the twentieth prisoner to die at Swaleside since December 2021. Of the previous deaths, seven were self-inflicted, 10 were natural causes and two were drug related. Up to the end of December 2024, there had been one further self-inflicted death and one natural causes death since Mr Pugh's death.

Assessment, Care in Custody and Teamwork (ACCT)

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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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 multidisciplinary review meetings involving the prisoner.

28. 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. 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.

Key Events

29. In January 2009, Mr Pugh was remanded to a secure children's home charged with grievous bodily harm (GBH). He was 14 years old. While at the children's home he assaulted other young people and caused extensive damage to property. In June 2009, Mr Pugh received a three-year detention and training order (DTO, where the young person is subject to a period of detention and training followed by a period of supervision in the community).

30. Between June 2009 and 19 March 2013, Mr Pugh spent time at three young offender institutions (YOIs) where his behaviour was problematic. His record shows serious assaults on both staff and other young people with improvised weapons. In October 2010, Mr Pugh was given an indefinite sentence for public protection for an earlier assault on a female member of staff at HMYOI Feltham, with two further assaults being taken into consideration.

31. On 19 March 2013, following assessments by psychiatrists, Mr Pugh was moved to Broadmoor High Security Hospital under section 47/49 of the Mental Health Act 1983. He was 19 years old. Mr Pugh was an inpatient of either high or medium secure hospital for nine years. Mr Pugh's diagnosis was mixed or other personality disorder.

32. On 14 September 2022, hospital staff considered that he no longer needed to be detained in hospital and he was transferred to HMP Exeter.

33. In October, staff at Exeter referred Mr Pugh to the Psychologically Informed Planned Environment (PIPE) unit at Swaleside. (PIPE units are specifically designed to support the progression of prisoners with identified complex needs or personality related difficulties.) Mr Pugh was assessed by video link on 16 November. Staff noted that as he was in his parole window (a period during which the Parole Board consider whether the prisoner is suitable for release) the referral would be reviewed again after his parole hearing, which was scheduled for July 2023. Mr Pugh's referral was closed in October 2023, after he declined to engage.

34. On 14 December 2022, Mr Pugh was transferred to HMP Woodhill. On his arrival, a nurse completed a transfer health screen. The nurse recorded that Mr Pugh denied any thoughts of suicide and self-harm, and that he was in receipt of sertraline (antidepressant), clozapine (antipsychotic), and lithium carbonate (for mania and depression). The nurse referred Mr Pugh to the GP for a medication review and referred him to the mental health team. Mr Pugh raised no concerns about his physical health.

35. On 16 December, a nurse from the primary mental health team saw Mr Pugh. The nurse recorded that there was no evidence of delusional ideations or perceptual disorders during their conversation. The nurse noted that Mr Pugh had a history of support under prison suicide and self-harm monitoring procedures (known as ACCT). Mr Pugh had never physically harmed himself and his ACCT history related to comments made about his mental well-being and thoughts of self-harm. Mr Pugh denied current thoughts of suicide or self-harm. Mr Pugh said that his protective factor was his father and that he maintained regular contact with him but had no contact with other family members. Mr Pugh was also managed under the

challenge, support and intervention plan (CSIP), to support him through this transition back to prison.

36. On 15 January 2023, a Supervising Officer (SO) opened an ACCT after Mr Pugh handed her a letter saying, "I don't want to be here anymore" and "I don't see it getting any better". Mr Pugh told her that he was writing down his thoughts and he had felt unwell for some time, although he did not actually want to die.

37. The next day, the SO chaired a multidisciplinary ACCT review. Mr Pugh spoke about how the prison environment, particularly the noise, made him anxious, and that he wanted to withdraw and stay in his cell. He said that he did not want to die, and he did not want to kill himself. Mr Pugh said that his father was his main support, but he did not want to tell him how he was feeling as he would worry. Staff agreed that they would arrange for his mental health keyworker to speak with him about ongoing mental health support and about maintaining contact with his father. Staff ended ACCT procedures on 7 February.

38. Between April and May, a psychologist saw Mr Pugh five times to complete a psychology report for his forthcoming parole hearing. She recorded that Mr Pugh did not fully engage with the process and during a discussion on 15 May, Mr Pugh said that he had now stopped taking all of his prescribed antipsychotic and mood stabilising medication as he felt his dosage was wrong. Mr Pugh said that he felt stable, happy and safe, had no intrusive thoughts or urges and felt that he had never really needed medication.

39. Between June and November, Mr Pugh was twice downgraded to the basic level of the incentives scheme (meaning certain privileges, including in-cell television were removed). He was placed on report twice after staff found a makeshift weapon in his cell, he entered another prisoner's cell with a weapon, was found in possession of two litres of fermenting liquid (home brewed alcohol, also known as hooch) and assaulted staff with weapons. On 27 November, Mr Pugh was moved to the segregation unit.

40. On 21 December, Mr Pugh's father contacted the prison and raised concerns about his son's well-being. Staff spoke with Mr Pugh and Mr Pugh told them that he just wanted help with his mental health. Mr Pugh also told staff that it was his choice to come off his medication and a return to prison might have been a mistake.

41. Mental health staff saw Mr Pugh on several occasions in the segregation unit and reported no psychotic symptoms. Mr Pugh continued to decline medication when offered.

HMP Swaleside

42. On 27 December, Mr Pugh was transferred to Swaleside.

43. A nurse completed Mr Pugh's transfer health screen and recorded his past ACCT history, previous mental health history and referred him to the mental health team and Change, Grow, Live (CGL), drug and alcohol support services (Mr Pugh had used psychoactive substances in the community). The nurse also recorded his risk behaviours including previous violence toward staff and prisoners. Mr Pugh denied thoughts of suicide and self-harm.

44. On 28 December, a mental health nurse recorded information provided by Mr Pugh's mental health keyworker at Woodhill. The nurse referred Mr Pugh for the enhanced care programme approach (CPA) assessment (a package of care for prisoners with significant mental health problems).

45. That day, a worker from CGL completed a substance misuse induction with Mr Pugh. Mr Pugh declined to engage with the service. An officer from the safety team also spoke to Mr Pugh that day as part of a welfare check. Mr Pugh said that he did not currently need any support.

46. Mr Pugh initially lived on D wing but, on 3 January 2024, he was moved to C wing, as part of a routine move.

47. On 14 January, staff completed a routine search of Mr Pugh's cell and found a small quantity of paper which later tested positive for a psychoactive substance. No further action was taken against Mr Pugh, but a negative comment was placed on his prison record.

48. On 18 January, an officer completed a keywork session with Mr Pugh. The officer recorded that he asked Mr Pugh about the recent negative comment about illicit drugs, and Mr Pugh just laughed and did not seem to care. Mr Pugh said that he had lost nine stone in weight since coming back into prison due to his use of psychoactive substances and his mental health. Other than the item found on 14 January and his own admission, there was no other recorded evidence that Mr Pugh was using illicit substances. Mr Pugh said that he was struggling due to his mental health but had good family ties. The officer spoke to Mr Pugh again on 9 February, and Mr Pugh said that he was feeling better as he had spoken with the mental health team, and they had agreed to see him at least fortnightly. Mr Pugh also engaged with CGL.

49. On 3 March, a SO opened an ACCT for Mr Pugh after he appeared distressed and said he was hearing voices. Staff concluded that the ACCT could be closed the following day.

50. During the afternoon on 23 March, Mr Pugh approached a SO and appeared upset. He said that he had spoken with his father and told him that he was going to end his life. Mr Pugh said that the voices in his head were so bad it was the only way to make them stop. The SO asked whether he felt that this was imminent, and Mr Pugh said that he would do anything to make it stop. The SO opened an ACCT and set observations at twice hourly initially, however, following further discussion, Mr Pugh was placed on 15-minute observations in the in-patient department (IPD).

51. Mr Pugh remained in the IPD, under ACCT monitoring until 22 May. There was a total of thirteen multidisciplinary ACCT reviews while Mr Pugh resided in the IPD, with his level of observations increasing and decreasing depending on his perceived risk to himself. During this period, Mr Pugh self-harmed by making scratches and cuts to his arms and face. Mr Pugh's main issues were with his medication and his belief that he was not being prescribed appropriate medication. These issues were followed up by the review team. Mr Pugh also received well-being visits from safer custody staff who discussed his issues and concerns and at times liaised with the mental health team on his behalf. Mr Pugh's father contacted

the safer custody team and raised concerns about his son, and the team conducted well-being visits.

52. A psychiatrist saw Mr Pugh weekly. Mr Pugh said he wanted to restart his antipsychotic medication, including clozapine. However, when the psychiatrist explained that he would have to undergo standard tests, including an electrocardiogram (ECG, which checks the heart is beating normally) before clozapine could be prescribed, Mr Pugh declined. Mr Pugh requested regular one to one support from the mental health team, but the psychiatrist explained that the team were not resourced to provide this level of care.

53. In May, the in-reach mental health team submitted an application for Mr Pugh to be assessed for a return to a secure hospital. The application was refused on the basis that Mr Pugh was already in a secure prison setting and a transfer to a secure hospital was not considered to be any benefit to him. Mr Pugh was informed of the decision on 20 May, and on 22 May he moved from the IPD to B wing.

54. During a multidisciplinary ACCT review on 27 May, Mr Pugh said that he was happy to have moved out of the IPD and onto B wing. Mr Pugh was encouraged to take his medication as prescribed, and staff reiterated the importance of this. (Mr Pugh sporadically took his prescribed medication but was frequently advised about the importance of taking it as prescribed.) Mr Pugh said that he was in regular contact with his father and hoped to arrange a video call. It was agreed that the ACCT would remain open, but observations were reduced to three during the day and four at night.

55. On 7 June, a SO chaired a multidisciplinary ACCT review. Mr Pugh was smiling and said that he was well. Mr Pugh said that he had not collected medication the previous day or that morning. Mr Pugh agreed to collect his afternoon medication. Mr Pugh said he had no thoughts of suicide or self-harm. When challenged about illicit drug use, staff recorded that Mr Pugh laughed. The review team encouraged him to engage with CGL. They agreed that Mr Pugh was no longer in crisis, had not self-harmed since he arrived onto B wing, and was fully engaging with the regime. The review team agreed to close the ACCT. A post-closure review was planned for 14 June.

56. On the morning of 8 June, staff unlocked Mr Pugh to collect his medication. He showed a SO a fresh cut that he said he had inflicted on himself in the early hours. The SO asked Mr Pugh why he had done this, particularly after the positive case review the previous day. Mr Pugh said that his head was “not in it”, and he wanted to “end it”.

57. Officers asked nursing staff to see Mr Pugh after he continued to state his intention to attempt suicide. The ACCT document was re-opened, and Mr Pugh was placed under constant supervision in the IPD.

58. On 9 June, a SO and an officer attended a constant supervision review in IPD. Mr Pugh said that he had been using psychoactive substances on B wing and would be willing to engage with CGL on E wing as he could see no way out on B wing. Further ACCT reviews took place on 10 and 11 June, and staff agreed that Mr Pugh was no longer in immediate crisis and reduced observations to hourly and moved him to C wing.

59. On 20 June, a SO held an ACCT review. Mr Pugh spoke openly about his use of illicit substances and said that he used them as a way of escaping. He was unsure whether this was a method of self-harm, but he wanted to be free of drugs. Mr Pugh said that he had not been compliant with his medication, but he intended to start taking it again, and healthcare staff said that they would support him with this. Mr Pugh said that he was happier on C wing and had support from peers and staff. The ACCT remained open, observations remained at hourly, and a review was scheduled for 26 June.

60. On 26 June, a SO chaired an ACCT review, but Mr Pugh refused to attend. The SO spoke with Mr Pugh in his cell and recorded that he told her he was all right. She also recorded that Mr Pugh had still not been taking his medication and adjustments had been made to ensure he received his evening medication. She also noted that the mental health in-reach team had seen Mr Pugh since the last review. She noted that a further case review would be scheduled for 28 June.

61. On the morning of 27 June, Mr Pugh telephoned his father. The call lasted 25 minutes. There was nothing significant in the conversation in relation to Mr Pugh's risk to himself. (Mr Pugh had sufficient money to make calls to his father throughout his time at Swaleside.)

62. On 28 June, staff recorded that Mr Pugh refused to attend his scheduled ACCT review. There is no evidence that staff spoke to him to understand why he had refused. There was no update on the ACCT document and an ACCT review did not take place.

63. At 4.00pm on 28 June, CCTV footage shows Mr Pugh on the landing, talking to other prisoners before returning to his cell. Staff locked his cell door for the night. Mr Pugh was still subject to hourly ACCT observations. Officer A and Officer B between them signed the ACCT document to record that they had checked Mr Pugh at 4.00pm, 5.30pm, 6.25pm, 7.20pm, 8.02pm and 9.00pm. CCTV footage shows that they did not complete these checks.

64. An Operational Support Grade (OSG) was on night duty on C wing on 28 June. She completed hourly checks on Mr Pugh between 10.00pm and 6.00am. She said that she had no reason to attend Mr Pugh's cell other than for the ACCT checks during the night and on each check, she had a good view into the cell, and had no concerns about Mr Pugh. Her checks were verified by CCTV footage.

Events of 29 June

65. The following account has been taken from documentary evidence provided by Swaleside, CCTV and Body Worn Video Camera (BWVC) footage, medical records and transcripts of interviews with staff.

66. At 7.22am on 29 June, Officer C completed an ACCT check on Mr Pugh as he was also performing the morning routine roll check. When he looked into Mr Pugh's cell the observation panel was blocked from inside. He said that morning, there were a couple of cells with blocked observation panels. He said that he tapped on Mr Pugh's door and heard moaning. He then continued with his roll check, signed for the roll and completed the ACCT documentation. He did not report or record that

observation panels were blocked, and he made no further attempt to confirm Mr Pugh's well-being.

67. At 8.30am and 9.30am, Officer D signed that he had conducted ACCT observations. According to CCTV footage, the 8.30am and 9.30am checks did not take place. At interview, Officer D said that he had not completed the checks that he had signed for.

68. At 9.57am, Officer D went to Mr Pugh's cell and the observation panel was blocked. CCTV shows him trying to get a verbal response from Mr Pugh. He then left the landing. He returned within a minute and entered Mr Pugh's cell on his own. He can be seen on CCTV crouching down and then stepping into the cell, before stepping back and walking away, leaving the cell door open.

69. In his written statement, Officer E said that at approximately 10.00am, Officer D ran into the wing office shouting 'code blue' (the emergency code used to indicate that someone is not breathing or having difficulty breathing, and which instructs the control room to call an ambulance). Officer E said that he immediately ran with Officer D to Mr Pugh's cell and, on the way, told him to call the code blue over his radio, which he did. Control room staff called an ambulance.

70. Officer E said that Mr Pugh was lying on his front, with the top half of his body under his bed. When the officers tried to pull Mr Pugh from under his bed, they noticed that there was a ligature around his neck, which was secured to the bed. He removed the ligature and with the assistance of other staff who had arrived, moved Mr Pugh onto the landing. Officers and nursing staff began cardiopulmonary resuscitation. At 10.25am, paramedics arrived and took over treatment. More critical care paramedics arrived at 10.55am. At 10.57am, a paramedic pronounced life extinct.

Contact with Mr Pugh's family

71. For undocumented reasons, immediately after Mr Pugh's death, the prison contacted Kent police to request assistance in informing Mr Pugh's father who was his nominated next of kin. Kent police in turn contacted Somerset police who visited Mr Pugh's father that day and informed him of his son's death.

72. Swaleside did not telephone Mr Pugh's father or appoint a prison family liaison officer (FLO) until 30 June, when one was appointed. However, contact with Mr Pugh's father was not made until 2 July. The FLO offered condolences and explained the process that would follow. The prison had not kept written records of the decisions around liaison with Mr Pugh's family, so the investigation was unable to ascertain their appropriateness.

73. The prison contributed towards funeral costs in line with national policy.

Support for prisoners and staff

74. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-

inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

75. Immediately after Mr Pugh's death, a duty governor debriefed those staff immediately involved. The staff care team provided support and the prison followed the postvention toolkit. Follow ups with those staff involved were completed. Notices informing prisoners of Mr Pugh's death were published with signposting to chaplaincy support for those that required it. Those prisoners subject to ACCT monitoring were reviewed in case the events had a negative impact on them.

Post-mortem report

76. The post-mortem report gave Mr Pugh's cause of death as hanging. No illicit substances were found in his body.

Inquest

77. An inquest into Mr Pugh's death was concluded on 14 July 2025. The Coroner found the following to be failures in the process that are relevant to Mr Pugh's death, but states that whilst these points have been mentioned, it cannot be established that these failures caused or contributed to the death of Mr. Pugh:

- A failure to adequately follow up on non-compliance in taking prescribed medication. This would amount to a serious failure as the medication could have resulted in the desired stability required for further support.

78. The inquest also identified some less serious procedural failures:

- ACCT observations conducted on 28th June 2024 were concluded to be satisfactory although documentation was lacking.
- The lack of ACCT observations conducted on the morning of 29th June 2024 between 7.23am and 9.56am was unacceptable.
- The adequacy of the roll check/ACCT observation at 7.22am on 29th June 2024 fell below the acceptable standard.
- The failure to report the blocked observation panel in accordance with procedure on 29th June 2024 was unsatisfactory.

Findings

Assessment of risk

79. Prison Service Instruction (PSI) 64/2011 on safer custody, in place at the time of Mr Pugh's death, requires all staff who have contact with prisoners to be aware of the triggers and risk factors for suicide and self-harm, and take appropriate action. Mr Pugh's risk factors were appropriately identified when he first arrived at Swaleside, including his history of significant mental health issues, long-term hospitalisation under the Mental Health Act, previous violence, previous ACCT history and drug use. Referrals to relevant support were made including mental health, psychiatry, primary care and drug and alcohol support.

80. Mr Pugh had been subject to ACCT monitoring before arriving at Swaleside. Staff at Swaleside first began ACCT procedures on 3 March, when they appropriately recognised that Mr Pugh was struggling both mentally and emotionally. Mr Pugh was then managed under ACCT procedures for most of his time at Swaleside. When staff considered he was in crisis, he was moved to the IPD and placed under constant supervision. We consider that staff adjusted the frequency of checks appropriately according to his perceived level of risk.

81. Multidisciplinary reviews were responsive to Mr Pugh's identified risks and observations were set accordingly. However, while Mr Pugh's care plan identified his risks, triggers and protective factors, staff did not always set support actions that were reflective of these. The prison identified this issue after Mr Pugh's death and risks and triggers training is currently being delivered by the psychology team at Swaleside.

82. Case reviews were held regularly and chaired and attended by those that knew Mr Pugh and were involved in his care. However, Mr Pugh refused to attend the last two case reviews. The ACCT case reviews were not conducted in his absence which is not in line with policy. Following Mr Pugh's death, the Governor issued guidance to staff (in line with a safety briefing that is now on the front of all ACCT documents) on the correct process to be followed when a prisoner refuses to attend case reviews.

83. The ACCT documentation overall indicates that Mr Pugh received consistent and personalised support from staff. He was considered to require continued ACCT support at the time of his death. However, the investigation found no evidence to indicate that staff should have considered Mr Pugh to be in crisis, or imminent risk of suicide in the days before his death.

ACCT observations

84. On 29 June, Mr Pugh was subject to hourly ACCT observations. CCTV shows that staff last checked him at 7.22am (when his observation panel was covered). However, Officer D recorded that he completed an ACCT check at 8.30am and 9.30am and CCTV footage showed that these checks did not take place. At interview, Officer D said that he had not completed the checks due to pressure of work, and therefore falsified the ACCT record.

85. The investigator viewed CCTV footage from 4.00pm on 28 June. When viewed, six ACCT checks that staff said they had completed between 4.00pm and 9.00pm could not be verified by the footage. When interviewed, both officers involved in these checks stated that they had completed the checks as recorded.

86. The actions of staff and their apparent falsification of documentation was shared with the Governor. The findings were also shared with Kent police who confirmed to us shortly before we issued this report that they would not be pursuing criminal charges against Officer D. The Governor told us that she would decide what internal action to take once the police and CPS had concluded their considerations. The Governor said that investigations against the other officers who falsified the records were not commissioned due to the passage of time but told us that they had received formal advice and guidance.

87. The investigator viewed a wider sample of CCTV footage from across the prison and compared it with recorded ACCT checks. This exercise indicated that the falsification of ACCT checks was not a systemic issue across the prison. However, on C wing, the comparison of CCTV footage and recorded ACCT checks identified a number of occasions where checks that had been recorded by officers had not been carried out. This wider sample was taken from a date some ten weeks after the death of Mr Pugh so any mitigation the prison has put in place to end this practice has yet to be effective.

88. We view the falsification of any document by a public servant extremely seriously. There will be many factors that might prevent any routinely required check from taking place at the relevant time which can be excused by the exigency of other duties. However, the recording of a check that has not taken place is a deliberate, and considered, act with intent to deceive. This dishonesty is most grievous when the action lied about was monitoring the welfare of an individual known to be at heightened risk and who has subsequently taken their own life. Bereaved families can never be sure whether or not their loved ones might still be alive had the relevant checks been made. That we come across such practice within HMPPS on a number of occasions every year gives cause for some concern, and we will, as a matter of policy, refer all such instances to the police and respect the decision they take, as we have here. Notwithstanding police involvement we consider that when we present hard evidence to a prison governor of dishonest practice that this represents an opportunity for them to send a clear message to all staff that HMPPS views it as utterly unacceptable. The absence of such a robust stance makes it hard to see how it will be eradicated. We make the following recommendations:

The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure herself that there is not a systemic issue with false entries.

The Director General of HMPPS should communicate to Governors and Directors his expectation that in all but the most exceptional of circumstances, when there is evidence of making deliberate false entries, a formal investigation is instigated and, in appropriate circumstances disciplinary action follows.

Clinical care

89. The clinical reviewer noted that Mr Pugh had a complex mental health history and presentation prior to arriving at HMP Swaleside. His medical records show that the mental health in-reach team supported him and engaged with him on a regular basis. They ensured that he was involved in his care, and he was able to express his wishes. However, she found that Mr Pugh's mental health care plan put the responsibility on him to request ACCT monitoring if he felt he needed it, rather than staff considering ACCT monitoring based on his perceived risk. Mr Pugh's mental state fluctuated such that the clinical reviewer felt that Mr Pugh might have been, at times, unable to communicate the need for ACCT procedures to keep him safe.

90. The medical records show that clinicians explored various medications with Mr Pugh, however Mr Pugh's non-compliance and use of illicit substances meant that he was not regularly taking any medication.

91. The clinical reviewer concluded that the care extended to Mr Pugh at Swaleside was not of the required standard and therefore not equivalent to which he could have expected to receive in the community. She said that that it was not clear from the clinical records or interviews that the discharge summary from the mental health hospitals had been shared with healthcare staff and Mr Pugh's psychiatrist at Swaleside. There was no evidence of an up to date mental health diagnosis or any professional curiosity around this, which led to gaps in Mr Pugh's treatment. The clinical reviewer made three recommendations relating to care planning and record keeping which were not directly related to Mr Pugh's death but which the Head of Healthcare at Swaleside will wish to address.

Governor to note

92. Following Mr Pugh's death, the prison contacted the police to request that they informed the next of kin of the death. The prison did not record the reasons for requesting the police assistance or whether they had attempted to make contact with a prison closer to the next of kin. Once the police had made contact, Swaleside did not appoint a family liaison officer until the following day and did not contact the next of kin until 2 July, again for undocumented reasons.

93. The prison's approach to liaison with Mr Pugh's family was not in line with national guidance and fell short of the standards expected. It is unsatisfactory that we have not been able to establish how decisions around family liaison were made following Mr Pugh's death.

94. The Governor should satisfy herself that the prison has sufficient trained family liaison officers and that senior managers understand the national guidance on liaising with the next of kin following a death.

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