Investigation into the circumstances surrounding the death of a man at HMP Altcourse in April 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the death of a man who was found hanging in his cell by a prison custody officer at 11.15 am on 29 April 2008. He was 35 years old. I offer my sincere sympathy and condolences to his family and friends for their loss.

During a medical assessment soon after he entered prison, the man told staff that he had been prescribed medication for depression for 13 years and had attempted suicide seven years previously. However, he also said that he was feeling better. After slowly adapting to life in prison, he said that he did not want to have contact with the mental health in-reach team. In March 2008, he told staff that he felt low and that his mood had been spiralling downwards for weeks. Staff opened a suicide and self-harm plan to provide him with additional support and he agreed to re-start an antidepressant medication. After the man appeared to recover, he and staff agreed to close the plan. However, only ten days later, another member of staff opened a second plan after noticing cuts on the man's wrists. The second plan was closed on 13 April as he appeared to have recovered.

On the morning of the man's death, two nurses from the mental health in-reach team assessed him. The man asked them if he could be transferred to hospital and they explained to him the stages involved in such a move. They agreed to arrange a doctor's appointment for later that day. Shortly afterwards, a prison custody officer discovered him hanging in his cell.

Deaths in prisons raise questions about the standards of care provided to those in custody and the Ombudsman's terms of reference rely on Primary Care Trusts to consider the care received by the person who has died. The care afforded to prisoners should reflect the standards set by the National Service Frameworks and a major objective in our investigations is to identify any failure in this provision. The local Primary Care Trust commissioned carried out a clinical review of the healthcare provided to the man. The clinical reviewer concluded that "Procedural failures contributed to delay in timely and effective care" for the man who died. I am grateful to the reviewer for his clinical review.

The investigation was undertaken by two investigators from the Ombudsman's office. I would like to express my thanks to the Director of HMP Altcourse and his staff for their co-operation, in particular the then Head of Safer Custody, whose assistance was invaluable to the investigators.

I make two recommendations relating to ACCT case reviews and emergency response procedures. The clinical reviewer has identified a further six regarding record-keeping and procedures for caring for prisoners with mental health problems which I endorse.

Jane Webb
Deputy Prison and Probation Ombudsman **July 2009**

CONTENTS

Summary

The investigation process

HMP Altcourse

Key findings

Issues

Recommendations

SUMMARY

The man was 35 years old when he died. He was treated for depression in his early twenties and subsequently had two admissions to a psychiatric hospital. He later stopped taking his prescribed medication as he found the side effects too unpleasant.

On 1 June 2007, the man was remanded into custody at HMP Altcourse. In Admissions, on his return from a court appearance later in the month, he told the assessing nurse that he had a 13 year history of depression which had been treated with medication. However, he had stopped taking it six months previously. At this assessment it was noted that the man had attempted suicide seven years before.

Whilst at Altcourse, he was placed on Melling Blue which is the voluntary drug testing unit. He established a good friendship with his cellmate and became an education mentor.

As the man had been treated in the community for mental health problems, he therefore came under the supervision of the prison's mental health in-reach team. He refused initially to engage with them but this changed in March 2008 when his mood had plummeted. Both the man and prison custody officers requested help from the mental health in-reach team.

Staff opened an Assessment Care in Custody and Treatment (ACCT) plan on 18 March 2008, which was in place for ten days. (The ACCT document describes the problems facing a prisoner at risk of harming himself and implements a plan to give him the support he needs to help him through a period of crisis.) Another ACCT plan was opened on 8 April and closed five days later. Both ACCT plans were closed without any contributions from medical staff.

Two mental health nurses interviewed the man on the morning of his death. As a result of this meeting, they arranged a doctor's appointment for him at 2.00pm that day to review his medication. At 11.10am, a prison officer went to inform the man of this appointment time and found him hanging in his cell. Attempts were made to resuscitate the man but, sadly, these proved unsuccessful. His death was certified by a locum doctor on 29 April 2008. Staff and prisoners were offered support after the man's death.

The clinical reviewer identified a number of procedural failures that he considered contributed to delay in timely and effective care for the man. In addition, the investigators found failings in the implementation of the ACCT procedures and the emergency response procedures. The prison has since addressed some of these issues and I have made a total of eight recommendations.

THE INVESTIGATION PROCESS

1. The man died on 29 April 2008. One of the investigators opened the investigation when she visited the prison on 1 May. She met the Director, the Controller, the Chairman of the Independent Monitoring Board (IMB), a trade union representative, and the prison's family liaison officer. She saw the man's cell and was given copies of his prison records. Both investigators returned to Altcourse three more times to conduct interviews with wing and healthcare staff.

2. A clinical review of the healthcare provided to the man was commissioned by the local Primary Care Trust. I am grateful to the doctor who completed the clinical review.

3. The objectives of the investigation were to:

    - Establish the circumstances and events surrounding the man's death, including the care provided by the prison and relevant outside factors.
    - Examine any relevant health care issues and assess clinical care, together with the National Health Service.
    - Examine whether any change in operational methods, policy, practice or management arrangements would help prevent a similar death in the future.
    - Ensure that the man's family had the opportunity to raise any concerns and that these were taken into account in the investigation and the report.
    - Assist the Coroner's inquest.

4. One of the Ombudsman's family liaison officers spoke to the man's family to ask if they had any concerns that they wanted to be included in the investigation. She and an investigator subsequently visited the family, who raised a number of issues during the meeting, primarily relating to Altcourse staff's knowledge and treatment of the man's emotional and mental health. I hope that this report goes some way to answering their questions.

HMP ALTCOURSE

5. HMP Altcourse is located on the outskirts of Liverpool. It opened in December 1997 and is managed by Global Solutions Limited UK (GSL). Healthcare is provided by a multi-disciplinary team. Primary Care is provided by Medacs and, at the time of the clinical review, consisted of two part time doctors, five Registered Mental Health Nurses (RMNs), five healthcare assistants and 16 Registered General Nurses. The psychiatric In-reach team, that is RMN led, is provided by Primecare. This team comprises a manager, two RMNs and a care programme approach (CPA) administrator. Four counsellors are provided by GSL and psychiatric cover is provided by an external Doctor.

6. Altcourse was restructured from a category A to a category B core local prison in June 2003. (Prisoners whose escape would be highly dangerous to the public are held in category A conditions. Those who do not require the highest security conditions but for whom escape must be made very difficult are held in category B prisons.) It receives both sentenced and remand prisoners from the courts in Merseyside, Cheshire, and North Wales. It also takes young offenders on remand. Young offenders reside alongside adults on all units other than the Vulnerable Prisoners Unit.

7. There is an operational capacity of 1,228 prisoners, including 90 spaces on the Vulnerable Prisoners Unit. The house blocks are colour coded and each is named after one of the fences in the Grand National steeplechase course.

8. There is a first night unit located under the healthcare centre and next to a Chapel. Whilst conducting their interviews, the investigators were informed that all prisoners are seen by the chaplaincy service within twenty fours of their arrival. Altcourse has volunteer prisoner carers who are at liberty to visit prisoners on other units to provide additional support where needed.

9. Vulnerable and remand prisoners are housed on the opposite side to the sentenced prisoners. All prisoners spend their first night on the First Night centre before moving to the Induction Unit or the Vulnerable Prisoners Unit. Induction for vulnerable prisoners takes place on the Vulnerable Prisoners unit.

10. An unannounced inspection by HM Chief Inspector of Prisons, Ms Anne Owers, was carried out from 17 to 19 September 2007. Ms Owers commended the prison for “the quantity and quality of time out of cell for prisoners at Altcourse, which placed its regime among the best of any local prison in England and Wales”. She also noted, “Altcourse remained an impressively respectful prison, with well maintained and clean accommodation, and very good staff-prisoner relations”. The investigators shared these views. The unit manager for Melling Blue, described to the investigators the unit routine which allowed the men to

be out of their cells for up to 13 hours a day. The cells are opened at 7.15am for breakfast. The cells are cleaned then education starts at 9.00am. The prisoners are locked in their cells for 20-30 minutes for a security roll check. This is repeated at 5.00pm for 30 minutes before they are unlocked again for the evening meal, games of pool, snooker or television. The prisoners are locked up again at 9.00pm for the night.

11. The Independent Monitoring Board report for the year 2007/8 has a section on healthcare provision in the prison. It highlight the constraints under which healthcare staff worked during the period:

> "The Healthcare Department is desperately short of office, storage and treatment space. … Waiting times for all outpatient clinics (always a source of pride to Healthcare at Altcourse) have inevitably been extended by an increasing population and staff shortages."

The report describes the provision of mental health care:

> "The in-reach team, comprising a Clinical Manager, two clinical practitioners (all RMNs) and a Practice Co-ordinator accept referrals from the doctors, the Primary Care Mental Health team and Probation Services. A typical caseload would be 95 prisoners at any one time. Transfers under the Mental Health Act during this period number twenty-eight. It is proposed to expand the service by employing the services of a sessional Cognitive Behavioural Therapist and a Psychiatrist."

12. There have been a number of deaths at HMP Altcourse since it opened, which sadly is very often the case for local prisons. There were two deaths in 2006 and another in April 2008. The Ombudsman's investigation into the earlier death in April revealed no similarities with the man's death. Of the two deaths in 2006, one was due to natural causes and, again, had no similarities. For the other, a self-inflicted death, the Ombudsman's report made recommendations about quicker access for ambulances and the need to hold a hot debrief. I am pleased to note that on this occasion, the ambulance moved quickly to the unit and a hot debrief took place.

KEY FINDINGS

13. After the man was arrested, he became agitated and said that he might as well hang himself. His care was later taken over by a doctor at a local hospital and a social worker. During this time, the man was prescribed an antidepressant but felt he no longer needed it. Against medical advice, he abruptly stopped taking his medication due to unpleasant side effects. These included loss of libido, feeling dehydrated, "killing his emotions" and feeling isolated.

14. The man was remanded into custody at Altcourse on 1 June 2007. The prison custody officer (PCO) who received him into the prison noted in his record "No problems being here. No history or thoughts of self-harm". A registered mental nurse (RMN), then assessed the man in order to complete the First Reception Health Screen form. The man told her that he drank socially and used both cocaine and cannabis.

15. When asked about his mental health, the man said that he had been treated by a psychiatrist for "depression in the past". He had been admitted to psychiatric hospital in 2000 and had a social worker. He also said that he was no longer receiving any medication, although he had been in the past. When asked whether he had ever self-harmed, he said that he had cut his wrists but could not remember when. He said that this was alcohol related. The RMN referred the man for a mental health review required and also to the doctor.

16. The following day, the same RMN reviewed the man and noted no cause for concern. The man also had an appointment with the doctor, as do all new prisoners at Altcourse. The doctor identified no additional issues. However, later that day, two PCOs gave the man formal warnings for his attitude towards staff. These were noted in his record. On 4 June, he received a third PCO's warning, again for his attitude to staff.

17. On 7 June, the man returned to court. However, after the hearing he was unable to return to Altcourse due to a "lock out" and was sent to HMP Holme House instead. (Lock outs happen when a prison is completely full and cannot accept any further prisoners. The escort company then takes the prisoners to the nearest prison that can accommodate them. This, as in the man's case, is sometimes many miles away. Lock outs are a national problem caused by very high prison numbers.)

18. The man was assaulted at Holme House by a group of prisoners who threw a television at him. He received cuts to his face and staff escorted him to the local hospital. The injuries required ten sutures on his nose and eight sutures to his right ear. He was prescribed a three day anti-biotic treatment and given an intra muscular tetanus injection. He asked to transfer to the Vulnerable Prisoners Unit for his safety and staff transferred him later that day. (His sutures were removed on 27 June.)

19. On the same day, an RMN interviewed the man to complete a mental health review. This was in response to information from the man's home Community Mental Health Team that he had written "bizarre letters". Staff in the team were concerned that, if released from custody at his next court appearance, he would pose a danger to the public. The RMN did not find any sign of mental illness during the interview and the man said that he was well. The RMN referred him back to the community team.

20. Later that month, he was convicted of two charges. He was remanded to Altcourse to await sentencing at in August 2007. When the man returned to Altcourse, a male RMN, assessed him. He noted that the man did not appear to be in any pain and described him as "fit and well". The man informed the RMN that he had previously suffered from depression and had been prescribed medication for 13 years. He had not taken medication for the past six months. The man documented that the man had attempted suicide seven years ago but that "he feels fine now".

21. The following day, the man requested an appointment with the doctor as he had concerns about his physical health. It is not known what his concerns were because a code is given by way of explanation in his clinical notes (YX009). One of the prison doctors examined him and documented "No signs of mental illness".

22. On 27 June, the man made an application to the unit manager asking about various items of property and his canteen orders. The manager replied on the same day. The man said that his clothes were at one police station and a coat at another. His glasses, which were smashed when he was assaulted at Holme House were still there, he thought. Finally, he asked what had happened to his canteen order that he had not received because he went to Holme House and about his phone credit. The manager advised him to ask his family to collect his clothes from the police stations and to write to Holme House about his glasses. He also explained that the uncollected canteen order had been returned to the supplier.

23. The man moved to Beechers Unit on 28 June after completing his induction. On 10 July, an entry in his wing history sheet records the result of an apparent adjudication. There is no other information about this in his records. When prison staff think a prisoner has broken a prison rule, they put him "on report". The officer tells him within 48 hours what offence they think he has committed. A hearing (also called an adjudication) is then held, during which the prisoner and staff talk about the offence. The punishment was loss of 80 per cent of his earnings for seven days and loss of canteen for the same period.

24. The man's social worker from the Community Mental Health Team visited him on 25 July. This meeting was also attended by an RMN from the prison healthcare staff. The man informed them that his mental

health was very good. He was not experiencing any problems and did not want any medication or any appointments from professionals. The following day, the social worker sent her care plan to the prison doctor. However, rather than staff inputting the information in the plan onto the medical computerised system, they filed it. This meant that it was not readily available to medical staff.

25. On 2 August, another female RMN received a telephone call from the social worker after the man's father had passed her two letters. The first was a copy of a letter the man had sent to his sister and the second was a reply from his sister, which the man had received the previous day. The social worker was concerned that the man would become upset by the reply, so faxed copies over to the prison. The RMN informed the man's unit of this identified risk. On the same day, he was given notice that he would face disciplinary action for using abusive words and behaviour towards the educational tutor.

26. The man appeared in court again the following day. The social worker was at the court and learned that, whilst leaving court, the man had gestured to his father that he intended to hang himself. She telephoned the head of the mental health in-reach team at Altcourse. He passed the information to the nurse in Admissions with the request to assess the man's current state of mind and if appropriate to place him on an ACCT plan.

27. On 5 August, staff put the man and another prisoner on report for fighting. The duty manager went to the unit and spoke to him. The manager is one of the managers of Melling Blue, the drugs-free unit. He suggested that the man move there as it is generally a quieter and more stable unit. The man agreed and moved later that day.

28. An RMN assessed the man on 17 August because of his past contact with services. As most of the entry was written in codes, this entry is not very clear but does conclude that the man appeared "settled and well". He also noted that the man "declined any further input from ourselves or outside services but informed that we will contact his community mental health team when he is released as a matter of courtesy." The man received another PCO warning the same day after he made aggressive comments to education staff.

29. Three days later, a PCO noted in the wing history sheet that the man "has recently been displaying bizarre behaviour which includes talking to himself and laughing like he is conversing with another person when he is not. He is drawing attention to himself as other prisoners are beginning to question him regarding his behaviour and offence." Two days later, a prison social worker passed this information to the community social worker via a message on her telephone. However, the community social worker visited the man again on the same day and noted that he was very well, with no evidence of mental health problems.

30. On 8 September, the man swamped his cell in soapy water and sat on his bed talking to himself, laughing and joking as if talking to another person. The same PCO as before wrote in the wing history sheet that "this prisoner is regularly displaying unusual behaviour to say the least." On 11 September, the man was warned not to bang on the pipes.

31. Five days later, the man was given a supply of paracetomal for pain and high temperature, although there is no note of where the pain was. One of the unit managers, interviewed him about his intimidating behaviour towards education staff and issued a manager's warning. He also referred the man to an RMN.

32. The RMN who had interviewed the man in Admissions assessed him a week later, on 20 September. He documented that the man was:

> "Presenting with a variety of signs and symptoms any or all of which may be indications of mental illness. He displays pressure of speech, grandiosity, paranoid persecutory and grandiose delusions and complains of constant headaches and stomach aches. He does have a history of previous admissions to mental health units and it is possible that he is psychotic at the moment."

The RMN then discussed the man with the manager of the Mental Health In-reach Team (MHIT) and informed Melling wing so that the officers could monitor the man's behaviour and report any problems.

33. The MHIT manager saw the man two hours later for a follow up appointment. He noted that the man:

> "Spoke in grandiose terms of his own abilities and his family's wealth. He does not accept that his behaviour has deteriorated recently despite concerns raised by unit staff. He dismisses the remarks made by education staff as jealousy. He denies any current psychiatric concerns, does not require any mediation and feels he is coping well considering his placement and stresses inherent with detention in prison."

34. In October, the man became a mentor in the education department on the unit. He had spent some time as the education orderly on Melling Blue. The deputy education manager, recommended him for this role as he had a good rapport with the other prisoners. She told the investigators that he had a lot of patience and never lost his temper. He also marked some of the assignments completed by the other men.

35. A Consultant Forensic Psychiatrist interviewed the man on 23 October in order to prepare a report for the court. He said in his report that the man was very settled without any medication and there was no evidence to suggest he had suffered with manic depression. He agreed with the previous psychiatric assessment that the man's use of illicit drugs and alcohol was likely to have had a significant effect on his ability to

function. During this psychiatric assessment, the man reported that he could feel emotions again, enabling him to mourn the loss of his mother. He described no longer experiencing hallucinations or problems with his sleep and appetite.

36. The man appeared in court in November and was sentenced to 15 months imprisonment. He then appeared to settle into life on the unit and, by the end of the month, his personal officer wrote that the man "said he was happy" on the unit. The community social worker again visited the man on 27 November and wrote in her notes that "he looked physically well and has put on some weight. There were no signs of mental illness". The following month, he was promoted to the highest level on the Incentive and Earned Privileges scheme (IEP), which meant he had additional privileges. (The IEP scheme rewards good behaviour in prisons. There are three levels - basic, standard and enhanced. Incentives include access to in-cell television, a higher allowance of private cash to spend, wearing own clothes, more time out of cell and community visits.)

37. On 9 January 2008, a female RMN from the in-reach team, assessed the man as part of his care programme approach. This was the first time she had met him. She said during an interview with the investigator and clinical reviewer that she had not seen the man's notes or care plan before going to see him "as it was a bit of a last minute visit." She described her duties as supporting prisoners who have contact with outside services while they are in prison and liaising with those services.

38. The RMN noted that the man presented as "somewhat grandiose in manner regarding his achievements and other people's lack of abilities". He described how medication had "ruined his life" and declined any further input from the in-reach team. She concluded the entry with "no further action unless requested by the man". She telephoned the community social worker to let her know she would not be attending an forthcoming professionals' meeting as the man had "refused to engage" with them.

39. The man was interviewed by a unit manager for assessment for the Parole Board on 22 February. The manager noted that he was aware that the likelihood of being released on licence was very limited. A probation officer also interviewed him on 28 February to discuss the process.

40. On 9 March, a PCO submitted an RMN referral form as the man had requested to see a psychiatrist. On 13 March, a different PCO requested a mental health assessment as the man was "extremely low in mood, feels depressed and has been on a downward spiral for approximately three weeks".

41. The next day, a staff nurse from healthcare carried out a mental health assessment in relation to the referral five days earlier. She noted:

> "Presented as low in mood, little or no eye contact throughout interview but did engage freely in conversation. States that he was on medication for depression but since coming into prison has not taken any. When first in prison states he was going to the gym, doing association and interacting well on the unit. Over the last two weeks, feels his mood has deteriorated and has stopped doing his normal activities due to feeling low in mood and now feels he should be taking medication."

A doctor's appointment was arranged for four days later.

42. The man approached an officer on the unit on the morning of 18 March and told him he was feeling low. The PCO noticed that he was "as white as a ghost". He spoke to him and was so concerned that he asked a more experienced colleague, a female PCO, to speak to the man. The man then went upstairs into his cell where the female PCO spoke to him a few minutes later. His cellmate was also in the cell.

43. The female PCO told the investigators that the man agreed to talk to her when she first introduced herself. She asked if he would prefer to speak in his cell or the dining area and they met in the dining area about five minutes later. She said that he presented as someone who had a lot on his mind. His speech was slow and he appeared unkempt. "His body language was poor, he was all turned in on himself." She asked the man if he was suicidal to which he replied "yes". The man said the only obstacle in his way to hanging himself was his consideration for his cellmate. He said he "could not see an end to it" and that he could not cope. The female PCO asked him what "it" was and he told her that he meant his feelings. He said he had no issues with Altcourse, the prisoners or his cellmate. However, his time at Holme House had caused him stress. The man said he currently had the same sick feeling as he had experienced after the loss of a close relative.

44. The man finished the conversation after 30 minutes and the female PCO opened an ACCT plan for him. She made it clear that she was just next door and would not hesitate to come and see him if he needed her. She remembers that the man was always polite and courteous to staff. She wrote on the ACCT that the man:

    > "… appears very low in mood. He has poor eye contact when speaking to myself. The man stated that he wants to kill himself, he can't think straight anymore. He stated he was on medication but stopped taking it on the outside and now he wants to die. He said that he has overdosed in the past with pain killers but at this time he has no medication but his way would be to hang himself."

45. The female PCO then took the man to one of her colleagues who completed the ACCT assessment at 9.40am. The man came out of the meeting at 10.05am and returned to his cell to watch television. At

10.40am, the female RMN visited him to carry out the mental health assessment triggered by the PCO's referral five days earlier. She felt that the man engaged quite well with her and she made a doctor's appointment for medication as she "felt he could do with something to lift his mood". The ACCT first case review meeting took place at 11.00am. This means that the opening of the ACCT, the assessment and case review took place in under two hours which is commendably prompt.

46. That afternoon, a prison doctor examined the man during the appointment arranged four days earlier. The doctor diagnosed depression and prescribed the anti depressant medication mirtazapine, in 15mg doses.

47. A week later, on 25 March, the unit manager decided to reduce the level of interactions required under the man's ACCT monitoring to three per day and three observations an hour at night. The female RMN saw the man during the day and he told her that he felt "slightly better today" and "had no thoughts of harming himself at this time". She wrote in his record, "to see again in two weeks time".

48. Around this time, the man stopped mentoring because he wanted to go to art classes. He said his medication had been changed and he felt he needed to study art. The deputy education manager told him that this was fine and she would not advertise his place for the time being in case he wanted to come back.

49. The next day, the man told a PCO that he felt deeply depressed. The PCO wrote that the man looked terrible and he referred him immediately to the triage nurse who interviewed him and referred him to healthcare. Staff transferred him to healthcare at 8.00am. The man had an appointment arranged to see a prison doctor just after 9.00am the same morning as he was complaining of having "hit rock bottom". The doctor noted "no active thoughts of self-harm but passive wish to die". He changed the medication to fluoxetine. The man was asking to return to his unit and the doctor had no objection to this but wanted him reviewed by an RMN first.

50. The female RMN saw him later that morning for this review and wrote:

> "Seen in healthcare at request of the doctor. The man presented much the same as when I saw him yesterday and told me he had no thoughts of self-harming at this time. He states he doesn't know how he feels about returning to his unit. I advised that trying to keep busy on the wing could benefit him. However, he appeared keen to stay on healthcare at this time and so was advised to stay overnight and maybe go back tomorrow, to see again as planned in two weeks."

51. The female RMN said in interview that she had not seen the doctor's entry made earlier in the day and that she only went to assess the man as he was asking to return to his unit. When asked whether any formal

tool of measurement had been used to assess the level of depression at any stage, she said that there was none available at the time but they have since implemented one. The man transferred back to his unit the following day at approximately 7.00pm. The discharge from healthcare summary said, “The man has improved since admission and feels he would further improve by returning to normal location.”

52. An ACCT review took place two days later, attended by the man, the case manager and a PCO. They decided to close the ACCT and the manager noted in the summary that:

> “The man is very much better since coming back from healthcare. He stated that the doctor has changed his medication and this has helped a great deal. He is taking full part in purposeful activity and has taken on extra art work for the weekend. All in attendance agreed ACCT should be closed.”

However, no member of healthcare or the mental health in-reach team was at the review. Senior managers have since instituted the practice of multi-disciplinary case reviews.

53. At the post-closure ACCT review on 3 April, the man said that his medication was working well, he was taking extra art classes and he was in contact with his family. However, in spite of these positive signs, he made three requests to see an RMN and a doctor between 1 and 7 April.

54. On 8 April, a PCO opened a new ACCT plan due to his concern about how low the man was. He told the investigators that he watched the man at breakfast time and then followed him up to his cell. He spoke to him and he stated that he “just didn’t feel right”. The PCO saw scratches on his arms and asked if he had made them himself. The man nodded faintly in reply. The scratches were not very severe and were healing but the evidence of self-harm combined with the man’s blank facial expression concerned the PCO. He noted in the ACCT that the man “feels physically drained, is passing urine throughout the night and is complaining of severe depression”. The unit manager set the level of observations at five per hour at irregular intervals.

55. One of the prison chaplains carried out the ACCT assessment later that day. He said at interview that the man was very depressed and wanted to go to the healthcare centre but also wanted to stay with his cellmate. The man had informed him that he was extremely low and depressed. He was not sleeping and had very low energy. He was very worried about his depression and struggled to cope. He said that the medication he had been receiving for the past three weeks was not helping and he would like to see an RMN. The man kept telling him that he did not want to die. The chaplain told the investigators that he had no doubt that the man was very “depressed and desperate”.

56. The unit manager held the case review the next day but the chaplain was not present which should have been normal practice. The manager noted “advice from the female RMN, In-reach team.” He spoke with the man at the review and wrote:

> “The man presented himself as a person with little hope of helping himself through this relapse. He says he is lacking motivation and energy to do anything and that he is lying awake at night because he can’t sleep so when he is unlocked he is tired and unfit for participation in the regimes.”

The manager told the man that staff would be encouraging him to do “all the normal things” and that he should make an effort to attend the gym and participate in other activities. He stipulated that staff should have at least one detailed conversation with the man during each shift and make three observations per hour at night.

57. On 11 April, the female RMN assessed the man on the unit. She noted that he “presented as flat in affect with poor eye contact” and that he was “finding it difficult to go on”. Afterwards, she asked the doctor to consider increasing his medication, which he did.

58. Two days later, the second case review was held. The manager, a PCO and the man attended. The summary of this review was that:

> “The man has had a good few days in which his whole demeanour has lifted. He presented in a cheerful manner at this meeting and did not give any negative indications about how low he is feeling. In fact, he is now going to the gym, has started back on education and has had his medication changed. Altogether a more positive outlook. Happy to converse with staff if it returns.”

The ACCT was closed, again without input from healthcare or in-reach team staff. The unit manager told my investigator that the man had positive improvements in his outlook and all present, including the man, agreed to close the ACCT plan. A post closure interview was completed on 16 April by the unit manager.

59. Later that day, the man was assessed again by the female RMN and the unit manager, following an incident of deliberate self-harm. The female RMN wrote:

> “Seen in treatment room on Melling Unit in the company of Unit Manager for ACCT review. The man presented as slightly low in affect. However, his medication has been increased and he is attending gym and education regularly. He states he feels tired most of the time as he finds it difficult to sleep at night. He has no thoughts of suicide or self-harm at this time. Seen following concerns raised re deliberate self-harm. To see again in two weeks time.”

Following this entry, there is a confusing note by the female RMN that reads:

> "ACCT review in respect of the man attended by the unit manager and myself. The man states he has no thoughts of suicide or self-harm at this time and has today been removed from ACCT Booklet". According to the documentation, the ACCT was indeed closed on 13 April. A post closure interview held on 16 April was signed by the unit manager.

60. On 23 April, a PCO submitted another mental health referral form expressing concerns about the man not sleeping and being low in mood. He asked for someone to see him that day. A staff nurse from the primary care team assessed the man and noted, "No thoughts of suicide or self-harm but feels low in mood, poor sleep and lethargy. The man sees the in-reach team for ongoing support".

61. The following day, the same PCO asked for another mental health assessment. He said that the man was very low in mood and was constantly informing unit staff that he was mentally unwell. He alerted the unit manager to his concerns and they spoke to the man privately in an office upstairs. They told him that they were concerned about his demeanour and he replied that he needed help and he was not sleeping. The unit manager asked if he felt like self-harming or was suicidal and the man said that he did not but he needed help. The unit manager contacted healthcare staff, who said that the man was number 18 on the waiting list to see the doctor. When this information was relayed to the man he replied "Thank you for that I know now that I am going to see the doctor".

62. On 25 April, staff on Melling Unit telephoned the female RMN to see if she had an appointment with the man as they had sent a referral over that day. She explained that an RMN had assessed the man two days earlier and she would be seeing him again the following week.

63. The following day, a female PCO put in another referral for the man, as he had asked to see an RMN. The female PCO also rang the healthcare centre to see if the female RMN was in at the weekend but she was not. The same day, the man telephoned his sister. During this call he said how low, depressed and desperate he felt and that he was not getting any help. He asked his sister to get in touch with his father to tell him how he felt. The man's records contain an entry noting that "this phone call was monitored by a member of staff on 29 April 2008 at 11.30". A PCO made a further referral on 26 April for an RMN assessment as the man had asked for his medication to be increased.

64. The female RMN and a male colleague assessed the man on 29 April. The time is documented in the notes as 10.54am. The entry reads:

> "Seen in treatment room on Melling Unit, the man presented as low in mood and states he feels very depressed. No biological symptoms

evident at this time and he was able to express his feelings with clarity. The man was requesting he be taken to hospital as he feels so unwell. It was explained to him that transfer to hospital was a formal process and that they would need to liaise with services in Warrington. They would discuss his past contact with Warrington Services with a member of the services on Thursday. An appointment will be made for the man to see the GP to review his medication. The man kept repeating to them that he wanted medication, he wanted his medication changed today and I want to go to hospital today."

65. At interview, the male RMN told the investigators that he went with the female RMN as she thought the man might want to increase his fluoxetine and as he was a more experienced RMN. In fact the man requested a return to venlafaxine despite having had side effects previously with this medication. The male RMN felt that this was an odd thing to ask so he queried why he wanted to return to a medication that gave him side effects. He said that the man ignored this question and said he wanted to go to hospital, which he had not asked for before. He said that the man was very focused and insistent on going "there and then". He could not remember if the man said he "wanted" or "needed" to go to an outside hospital. The nurses told the man that they would have to find a place to take him and the Ministry of Justice would have to do a risk assessment before a transfer took place.

66. The male RMN also told the investigators that he did not ask the man if he was suicidal as it is his practice not to ask directly but to look for signs of hopelessness. Only then would he raise suicide and self-harm issues. He felt that the man had a plan for the future in that he wanted to get out of prison and into hospital. He said that he discussed admitting the man to healthcare but the man did not want this. He explained that he would refer him to the doctor to review his medication that afternoon. The interview took approximately 15 minutes and, when they had finished talking, the man was reluctant to leave. He continued to demand to go to hospital at once, due to his depression. The male RMN said that when the man left to return to his cell, he looked fine.

67. The man's cellmate was in the cell when the man returned. He told police later that he had asked the man how he had got on, to which he replied "not too well". He said that the man seemed a little miserable and a little bit down but this was not unusual. The cellmate left to attend an education class but the man had not been going to his classes for the last few days as he had been feeling down.

68. At approximately 11.10am, a female PCO received a message that an appointment had been made for the man to see a doctor at 2.00pm that day. A male PCO said he would take the message up to the man. Before going into the cell, he opened the viewing flap to check if the man was awake. He knew that the man had problems sleeping and if he had been asleep he would have passed the message on later.

69. When the PCO looked through the viewing flap, he saw the man hanging from a steel wall cabinet on the right hand wall, suspended by a blue prison-issue sweat shirt. The cupboard was about six and a half feet in height and his feet were not touching the ground. The top of the sweat shirt was jammed in the top hinge. The PCO immediately ran to the top of the stairs (a distance of approximately four metres) and shouted to his colleagues at the staff console for assistance. He then ran back into the cell and lifted the man by the top of his legs to take the pressure off his neck. The female PCO alerted another PCO who was in a nearby cell and then called "Code 1" on her radio to alert staff that there was a serious medical emergency on the unit. The other ran ahead, entered the cell within seconds and used his anti-ligature knife to cut through the sweat shirt.

70. The staff lowered the man to the floor and the second PCO checked there was nothing in his mouth. He felt for a pulse but could not find one. He briefly went onto the landing to check that help was on the way and informed the control room by radio that they needed an ambulance. He returned to the cell, took out his resuscitation mask and began mouth-to-mouth resuscitation until the healthcare staff took over. The first PCO performed chest compressions at a ratio of 30 to two breaths and continued until he was relieved by the medical staff.

71. The duty staff nurse was in the healthcare centre when she heard the Code 1 call. She and the other healthcare staff took the emergency equipment bags, including a defibrillator and ran to Melling Blue. She was the first nurse to enter the cell. She immediately felt for a pulse on the man's neck but could not find one. She put an oxygen mask on the man another staff nurse to take over the chest compressions from the PCO. Several other healthcare staff arrived and took turns in administering the breaths and chest compressions. The nurses did not get any response from the cardio pulmonary resuscitation (CPR), so they put the defibrillator pads on the man's chest. (A defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart.) They continued with manual CPR and shocks with the defibrillator until the ambulance crew arrived. The first staff nurse briefed the paramedic and he then took over treatment. The paramedics' records show that they received the call at 11.10am. They arrived at the prison two minutes later and drove round the inner perimeter road to the rear of Melling Blue. They reached the cell at 11.15am.

72. A large number of both uniformed and healthcare staff responded to the emergency call. The CCTV footage shoes that approximately 16-18 people went into or stood outside man's cell. A prison doctor was one of the healthcare staff to go to the cell. When he arrived, the man showed no sign of life, no pulse or spontaneous breathing, in spite of the paramedics giving injections of adrenaline and atropine to stimulate the heart. The doctor therefore pronounced death at 11.27am.

73. At the time of the man's death, Altcourse had only one family liaison officer. He was not in the prison that day and so was not available to break the news to man's family. However, the Controller knew the family and volunteered to go and tell them, which they said later that they appreciated.

74. The Care Team and counsellors went to Melling Unit to support the prisoners and also the staff involved in finding and attempting to resuscitate the man. The Head of Residence held a hot debrief in his office later in the day. The man's cellmate transferred to the healthcare centre for closer monitoring and support and an ACCT document was opened as a precautionary measure. Later that afternoon, senior managers went to each cell and informed the prisoners of the man's death. I commend the sensitive and individual way in which this was done. The prisoners held a collection for a wreath.

ISSUES

Health

75. The clinical reviewer, identified seven procedural failures that he feels contributed to the delay of timely and effective care for a "vulnerable man with a history of depressive illness".

> "1) Despite previous recommendations it was still not routine to request the medical notes of patients with identified mental health problems on admission. The argument that these are likely to unforthcoming from Primary care no longer applies now that computerisation allows a summary record to be produced with consummate ease in primary care. These should be, and are now, requested routinely.
>
> 2) For effective care co-ordination to benefit the patient, there needs to be continuity of care, and lines of responsibility and accountability need to be clear. The referral process needs to be straightforward and action taken on referral needs to be clearly documented. Action has already been taken by Medacs to ensure proper documentation of referrals.
>
> 3) Proper use should be made of nurse triage allowing the doctors and RMNs more time to assess patients properly. It requires courage and leadership to dispense with archaic practices that duplicate work and militate against detailed and skilled assessment - especially as it requires a change of contractual arrangements.
>
> 4) Part of this assessment should include the use of a depression screening tool and risk assessment tool in appropriate patients to provide objective evidence on which to base treatment.
>
> 5) Clear criteria for onward referral to a psychiatrist and clear lines of responsibility would avoid confusion over who should refer to the prison psychiatrist and when it is appropriate to involve the CMHT. A referrals meeting is now being held on Monday mornings between Primary care and in-reach RMNs to discuss what further action should be taken. This should go a long way towards ensuring that nobody is overlooked.
>
> 6) There are indicators that there may be a shortage of clerical support, particularly at weekends and a heavier than average workload on the in-reach team. An assessment of the level of staffing and correction of any shortfall may prevent some of the documented problems.
>
> 7) Highlighted deficiencies in the operation of System One should be taken up with the supplier as a matter of urgency. It is clearly unacceptable that an entire list of patients can be deleted accidentally and equally unacceptable that the task system has no audit trail or failsafe mechanism."

76. Two of the issues have been improved since the man's death. RMNs from the primary care and in-reach teams have a referrals meeting every Monday morning. Medacs has also taken action to ensure proper documentation of referrals.

Healthcare and in-reach team managers should establish clear guidelines for referral for a psychiatric assessment to avoid confusion over who should refer a prisoner to a psychiatrist and ensure that the need for an assessment is identified and arranged in a timely manner.

77. The clinical reviewer raises the concern that despite previous recommendations, when prisoners arrived at Altcourse, healthcare staff still did not routinely request the medical notes of those with identified mental health problems. In addition to his medical notes, the man had a comprehensive care plan devised by his community social worker who knew him extremely well. She has confirmed that she sent a copy of the man's care plan and risk assessment to Altcourse staff. However, this was filed rather than being put onto the computer system so staff did not use this valuable information. The staff also did not draw up their own care plan.

When staff identify a prisoner with a mental health history, they should routinely request their medical records.

The in-reach team should liaise with relevant community services to ensure continuity of care.

78. An entry in the community social worker's care plan states that the doctor would not discharge the man from his services as he felt that he had not been medication free for long enough. He requested that the man stay in touch with the social worker to enable her to monitor his mental health. The risk assessment identified signs of deterioration and relapse indicators for the man:

- failure to engage with services
- financial difficulties
- excessive alcohol
- drug misuse
- non compliance with medication
- poor impulse control
- family conflict.

Mental health staff should ensure that they have all the relevant and up to date information before assessing a prisoner and making decisions about their care. This includes checking system one for the latest entries.

79. As part of the reception screening, the nurse should identify and note high risk dates such as anniversaries, birthdays, and/or death of a loved

one with the prisoner. This will enable staff entrusted to care for them to provide additional support to someone who might be struggling. This information might also help to explain why a prisoner is behaving in a manner that is not normal for them.

Reception screening should include identifying high risk dates and noting them in prison and medical records.

80. The clinical reviewer recommends changes to the nurse triage system (a process of prioritizing patients based on the severity of their condition) to provide both doctors and RMNs more time to assess patients properly. He also highlighted the lack of a depression screening tool to measure the severity of the man's symptoms. A tool such as the Beck's Inventory can be filled out by an RMN. (The Beck Depression Inventory is a series of questions developed to measure the intensity, severity, and depth of depression in patients with psychiatric diagnoses.) This assessment tool has now been added to the computer system.

81. The clinical review raises concerns over the level of staffing of the mental health in-reach team and the workload of the unit's RMNs. He recommends an assessment of the team's needs and correction of any shortfall.

82. The reviewer recommends that highlighted difficulties in the operation of the computer system should be taken up with the supplier as a matter of urgency. It is unacceptable that an entire list of patients can be deleted accidentally and that the task system has no audit trail or failsafe mechanism. The manager of the in-reach team, made recommendations to improve the communication and effectiveness of System One in the health care unit approximately 12 months ago but his recommendations were not implemented. The investigators interviewed him and feel he is well placed to advise on the area of improving nursing records and communication and share his frustration that his experience and knowledge have not been utilised.

83. The man's medical notes contain several codes that are not universally understood by prison healthcare and in-reach staff staff. Healthcare records are a tool of communication within the team. If medical staff cannot understand the codes, as was suggested at interviews, this problem needs to be addressed as a training issue or amended to ensure clarity. There are also several entries with names of nursing staff but with no comments. The designation of staff is not included on entries so it is not clear whether it is a doctor, nurse or administrative staff making an entry.

Healthcare managers should address, as a matter of urgency, deficiencies in the operation of system one to ensure accurate and complete record keeping and effective and up to date communication between disciplines.

84. It would not have been realistic to transfer the man into a community psychiatric secure hospital at such short notice on the 29 April. Such transfers usually take a considerable time to arrange and the prisoners are diagnosed as having severe and enduring mental health issues. He was not admitted to healthcare for closer monitoring and, in the female RMN's interview, she said that her male colleague had explained to the man that healthcare was full. The male RMN said that the man did not want to go to the healthcare centre. They did not open an ACCT as neither nurse asked the man pertinent open questions about whether he felt like harming himself when they saw him on the morning of the 29 April. The female PCO who spoke to the man on 18 March gives a model example of what they should have asked. By asking him if he was suicidal and if he had given any thought to how he would do this she gained the information needed for which led to the first ACCT being opened.

ACCT plans

85. The same PCO initiated both ACCT plans as soon as he realised that the man needed help. His sensitivity to the man's distress and promptness of action is commendable. There is evidence in the man's records that he found another PCO an approachable prison officer when he needed support. This PCO made relevant referrals to the nursing team following his concerns about the man's mental health.

86. The first ACCT plan was open for ten days and the second for five. The second was opened only ten days after the first one was closed and five days after the post-closure review. The unit managers who chaired the case reviews when the ACCT plans were closed were both clear about their reasons for doing so. In each case, they looked for signs that the man had improved and was coping with his problems. Each time they listed the positive changes in the man's behaviour.

87. In the case review held on 13 April, the man was advised to engage in all his normal activities. This is unrealistic advice for someone who has depression as it is very hard to concentrate on or enjoy the things you would normally enjoy doing. The man had also explained that he was not sleeping at night and was too tired to do anything in the morning when his cell was unlocked.

88. A major omission in the ACCT plans was the lack of multi-disciplinary case reviews. Prison Service Order 2700, Suicide Prevention and Self-Harm Management states:

> "…where a provider of any specialist service (e.g. healthcare, mental health services, substance misuse, probation, psychology, family advice, bereavement counselling) is referred to or otherwise involved in the care of a prisoner on an ACCT Plan, that specialist must be invited to contribute to the ACCT case reviews of that prisoner."

89. The case reviews for the man's ACCT monitoring did not include members of the mental health in-reach team. It is of particular concern that both ACCT plans were closed without such input. Coincidentally, the Head of Safer Custody wrote to all case managers on 16 April 2008 setting out procedures for ensuring that reviews are multi-disciplinary.

The Director must remind all case mangers of the requirement to hold multi-disciplinary reviews and management checks should ensure compliance.

The number of staff at the man's cell

90. When the female PCO pressed the emergency response button on the top of her radio and called "Code 1", a large number of staff responded. Each day, three officers are designated the first response team and their role is to get to the scene as quickly as possible. However, when the female PCO made the call officers who were not in the first response team also arrived as did a number of managers. Similarly, all available members of the healthcare staff went to the cell, including a student nurse and the Head of Medical Services of G4S who was visiting the prison at the time.

91. In their rush to try to resuscitate the man, a considerable number of staff entered the cell. Prison Service Order 2710, Follow up to Deaths in Custody, sets out procedures for staff to follow. Paragraphs 2.5 to 2.8 emphasise that staff must do everything to assist the prisoner while ensuring their actions preserve what might be a crime scene. The number of staff at or in the man's cell could have been detrimental to a possible investigation.

The Director should remind staff of the procedures for responding to an emergency call.

The provision of family liaison officers

92. At the time of the man's death, the prison had only one trained family liaison officer (FLO). His duties had taken him out of Altcourse on 29 April, so he was not available to go and break the news to the man's family. Fortunately, the Controller knew the family and she volunteered to inform them. However, one FLO for a prison as large as Altcourse is insufficient. I consider that a local prison of this size requires a team of FLOs to ensure sufficient cover. Having several trained staff allows for flexibility in assigning FLO duties and provides mutual support for the staff taking on such an important and demanding role. Senior managers have acknowledged this and have now recruited and trained additional FLOs.

Family concerns

93. The man told his family that, after his return to Altcourse, a manager from Holme House came to interview him and subsequently he was punished. The investigators made enquiries at both prisons but could find no record of such a meeting. A possible explanation is that the manager was one of the unit managers at Altcourse. He spoke to the man after his fight with another prisoner, for which he was placed on report. Alternatively, whilst he was still at Holme House, the man pressed an alarm bell and was put on report. He was then subject to an adjudication before a governor who punished him.

94. The family raised the question of why the man was accommodated in a cell with ligature points, given his mental health. Most of the accommodation in Altcourse was built in 1997, at a time when cells were not designed to exclude ligature points. Only prisons built after 2003 were constructed with a certain percentage of safer cells. The male RMN discussed with the man whether he wanted to be admitted to the healthcare centre. However, the man said he did not – he wanted to be transferred to an outside hospital.

95. The family also asked whether people in the man's position can be given 24 hour care. The in-patient unit in the healthcare centre offers a close level of observation. In extreme situations a prisoner can be put on constant supervision. Prison Service Order 2700 states:

> "Constant supervision can only be authorised by a doctor or nurse (in consultation with the Duty Governor) or the Duty Governor (in consultation with a doctor or nurse); must only be for the shortest time possible and how the prisoner will be returned to normal location and/or a lesser level of conversations and observations, must be reflected in the CAREMAP."

96. After the man's death, one of his elderly neighbours contacted his family to say that he had written to her saying that he was going to kill himself. The family asked if prisoners' letters are read by staff before being posted. My investigators asked a senior manager who said that not all letters are read. The policy is to read a random sample of outgoing mail, which is currently five per cent. Staff do not record which letters are read unless the prisoner's mail is being monitored for public protection reasons.

Conclusion

97. The man had mental health issues for a number of years before his imprisonment. He had also attempted to take his life several years before. When he first went into prison, he was considered to be fit and well, but a few months later he began to exhibit worrying behaviour and became low in mood. He was twice subject to monitoring under ACCT procedures, which was implemented promptly on both occasions.

However, deficiencies were found in the case reviews which were not multi-disciplinary, as required and had no input from mental health staff. The investigation has not established if there was a specific reason why the man took his life, but the clinical reviewer concluded that there were procedural shortcomings which led to a delay in providing “timely and effective” care for him given his vulnerability. I concur with the clinical reviewer’s recommendations and have added a further two.

RECOMMENDATIONS

1. Healthcare and in-reach team managers should establish clear guidelines for referral for a psychiatric assessment to avoid confusion over who should refer a prisoner to a psychiatrist and ensure that the need for an assessment is identified and arranged in a timely manner.

   This recommendation was accepted. The prison response was: "A weekly referral meeting between the In-Reach team and the primary care mental health staff now occurs. All referrals are prioritised and reviewed for appropriateness."

2. When staff identify a prisoner with a mental health history, they should routinely request their medical records.

   This recommendation was accepted. The prison response was: "Any prisoner identified as having previous involvement with mental health services are referred to healthcare administration who routinely request all available information."

3. The in-reach team should liaise with relevant community services to ensure continuity of care.

   This recommendation was accepted. The prison response was: "This is current practice however this will be reinforced with the in-reach team."

4. Mental health staff should ensure that they have all the relevant and up to date information before assessing a prisoner and making decisions about their care. This includes checking system one for the latest entries.

   This recommendation was accepted. The prison response was: "This is current practice, changes have been made to system one to ease access.

   Update to be reviewed in collaboration with Liverpool PCT IT"

5. Reception screening should include identifying high risk dates and noting them in prison and medical records.

   This recommendation was accepted. The prison response was: "Any specific high risk dates identified are documented as a trigger and recorded through the ACCT process."

6. Healthcare managers should address, as a matter of urgency, deficiencies in the operation of system one to ensure accurate and complete record keeping and effective and up to date communication between disciplines.

   This recommendation was accepted. The prison response was:

"A request has been forwarded to Liverpool PCT for a meeting with themselves and their IT provider to address this issue."

7. The Director must remind all case mangers of the requirement to hold multi-disciplinary reviews and management checks should ensure compliance.

   This recommendation was accepted. The prison response was:
   "All case managers have been advised of the procedures and all closed ACCT plans are now audited by the SPC to test compliance."

8. The Director should remind staff of the procedures for responding to an emergency call.

   This recommendation was accepted. The prison response was:
   "All staff have been reminded of the procedures in place when responding to incidents including the preservation of evidence."