

**The Death in Custody of  
a man at  
HMP Altcourse in July 2005**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2006**

This is the report of an investigation into the circumstances of the death of a man at HMP Altcourse. The man was received into Altcourse on 27 June 2005 and he hanged himself in his cell a fortnight later on 11 July. He was 32 years old.

I extend my sincere condolences to the man's friends and family for their loss.

The investigation was carried out by one of my colleagues. The clinical review into the man's care and treatment was carried out by North Liverpool Primary Care Trust (PCT). I would also like to thank the Director of Altcourse, and his staff for their help.

The man had some history of mental health problems. His sister said that he took medication intermittently. He would be well when taking medication, but when he ceased he would become unwell.

The man had a number of consultations with prison clinicians during the 14 days that he was in Altcourse. But on no occasion did a clinician consider the man to be showing signs of distress, and he was prescribed no anti-psychotic or anti-depressant medicines. In contrast, the man told non-clinical staff that if he did not receive medication he would kill himself.

The clinical review appended to this report reaches no clear view on whether the man should have been prescribed the drug olanzapine. I offer my layman's view that to have prescribed this drug would have been a low risk option, although I acknowledge that the arguments are not clear cut – even with the benefit of hindsight.

I have made five recommendations. One of these concerns drug prescribing protocols, one concerns the obtaining of community medical records, and three relate to emergency response procedures.

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**Prisons and Probation Ombudsman**

**July 2006**

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## SUMMARY

In June 2005, police were called to the home of the man's ex-wife following a disturbance. After spending that night in police custody, the man was taken to hospital and admitted there under Section 2 of the Mental Health Act. (Section 2 of the Act provides the authority for a person to be detained in hospital for the purpose of a mental health assessment.) Due to his behaviour, the man was excluded from the hospital the following day and he returned to his ex-wife's home. The police were called once more and, after again spending a night in police custody, the man was remanded into HMP Altcourse on 27 June.

Upon being received into Altcourse, the man was taken through a first reception health screening assessment conducted by a registered mental nurse (RMN). During this assessment, the man reported that he had suffered mental health problems in the past for which he had been prescribed olanzapine, an anti-psychotic drug. He said that he had been treated for depression in 1995 and at that time had taken an overdose of penicillin. The man was asked by both the RMN and, separately, by one of the prison doctors, whether he had any thoughts of self-harm that day. He denied each time having any such thoughts.

Nothing of significance appears to have occurred in his first few days in Altcourse, but from 30 June the man began reporting hearing voices inside his head. At the same time, he began to ask for medication.

The man reported his symptoms and his desire for medication at a consultation with the doctor on 2 July and at a consultation with an RMN on 4 July. On neither occasion was the clinician involved persuaded that medication should be prescribed.

On Thursday 7 July, the man told a resettlement officer that if he did not receive any medication he would kill himself. An F2052SH (self-harm at risk form) was opened for him to be subject to close monitoring. Healthcare was informed about his threat of self-harm and an appointment was made for him to see a doctor the following Monday, 11 July.

On 9 July, the man told the first Prison Custody Officer (PCO) that he would kill himself, or would kill someone else. This information was again passed to healthcare. The first PCO also told his unit manager, who went to speak to the man. The unit manager thought that the man seemed happy to learn that an appointment had been booked for him to see a doctor on the Monday.

As a result of the information passed to healthcare by the first PCO on 9 July, an RMN went to see the man on 10 July. The RMN's notes of the consultation included that he had displayed no symptoms of psychosis or depressive illness. The consultation ended when the man walked away.

On the morning of 11 July, the man had a further consultation with the doctor. He again reported hearing voices, which the doctor noted. The doctor also noted he was showing no signs of distress. The doctor did not prescribe medication, but his plan was for the man to be assessed by a psychiatrist.

The first PCO made a point of speaking to the man following his consultation with the doctor. The man was calm and it seemed to the first PCO that he was accepting of the doctor's decision, albeit that it might have been grudging acceptance. When the second PCO came on duty that afternoon, he also made a point of talking to the man about his consultation with the doctor. Again, he seemed resigned to the situation.

The second PCO saw the man at 2.45pm in accordance with the requirements of the F2052SH process. He was sitting in his cell looking out of the window.

At about 3pm, officers heard a prisoner shouting for assistance. The second PCO ran to the man's cell and saw him hanging from a ligature. The PCO entered the man's cell, supported his bodyweight and with his hand was able to snap the ligature, which was made of shoelaces. Another PCO arrived at that point and, after removing the remnants of the ligature, the PCOs commenced attempts at resuscitation. Nursing staff and the doctor arrived and took over the resuscitation effort. After ambulance paramedics had arrived, the man was taken to outside hospital where he was pronounced dead at 3.25pm.

The issue of concern to all of the man's family was the decision not to prescribe him medication. On 27 June, the day of his admission to Altcourse, he was seen by two clinicians – an RMN and the doctor – for standard preliminary health care screening. After this, the man had four clinical consultations between 30 June and 11 July, all specifically relating to his reports that he was hearing voices inside his head and that he wanted medication. The doctor saw the man on two of these four occasions, at neither of which did he consider that medication should be prescribed. The doctor's view was shared by an RMN who had seen the man on 4 July and, it seems, by another RMN who saw the man on 10 July. Additionally, the notes made by the clinicians following their contact with the man indicate clearly that they did not consider him to be showing signs of distress.

In contrast to the assessment made by the clinicians involved were the comments made by the man to wing staff that, if he did not receive medication, he would kill himself.

My report makes five recommendations. I have recommended that Altcourse consider its drug prescribing protocols, and review its procedures for obtaining community based medical records. The other three recommendations all relate to processes and procedures when a possible death in custody is discovered.

## **INVESTIGATION PROCESS**

The investigation was opened on 15 July 2005 when my investigator met the Director of HMP Altcourse, the prison's Head of Resettlement, and a representative from the staff trade union. My investigator informed them of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation.

An independent clinical review of the management of the man's care and treatment was carried out by North Liverpool Primary Care Trust (PCT).

My investigator also spoke, separately, with the man's ex-wife, his father and with one of his sisters.

The man's family all raised very similar concerns that centred primarily on his clinical care and treatment. They asked why the clinicians at Altcourse did not contact the hospital for information about his diagnosis and medication. They wondered why he was not given any medication, especially given that he began making threats on the Friday before he died that he would kill himself or someone else if he did not get medication. They questioned why, after making those threats on the Friday, he then had to wait until Sunday before being seen by a nurse and had to wait until Monday to see a doctor. They also wondered whether he should have been found a place in Altcourse's healthcare unit.

In addition, the man's father questioned why the magistrate sent his son to prison rather than sending him to hospital; his sister raised a similar point. The man's ex-wife thought that his cell-mate should also have had his laces confiscated, although she realised that it was from a third prisoner that he obtained the laces.

## **HMP ALTCOURSE**

HMP Altcourse is a privately run local prison on the outskirts of Liverpool. It was opened in December 1997 and was designed and is managed by GSL UK Limited, formally part of Group 4.

The prison's residential units consist of six main house blocks, each divided into two units holding up to 83 prisoners in each unit. Separate buildings contain the healthcare unit, rehabilitation unit, college, sports centre and segregation unit. Altcourse has an operational capacity (maximum crowded capacity) of 903.

An announced inspection in February 2005 by Her Majesty's Chief Inspector of Prisons found Altcourse to be a very good local prison. It was found to have a good suicide and self-harm (SASH) prevention policy, with prisoners subject to SASH procedures reporting regular contact with staff and saying that they generally felt supported.

There have been a total of four self-inflicted deaths at Altcourse since I was given responsibility for the investigation of all deaths in custody on 1 April 2004. All four deaths occurred in 2005, and the man's death was the second of these.

## THE EVENTS LEADING UP TO THE MAN'S DEATH

The man's ex-wife said that she and her ex-husband had not been living together for a while when he came to her house on Friday 24 June 2005. He was clearly unwell and he threatened to kill her. She telephoned the police who came to the house and arrested him. In June, the man was taken into hospital under Section 2 of the Mental Health Act. The following morning, the man was excluded from the hospital for disruptive behaviour – he reported that it was because he had kicked a door. After his exclusion from hospital, the man stole a car and returned to his ex-wife's house. The police were called again and he was re-arrested. After spending the night in police custody, the man was remanded into Altcourse the following day.

On admission to Altcourse on 27 June, the man underwent a first reception health screen interview with a registered mental health nurse (RMN). The man reported having been treated for depression in a psychiatric hospital in 1995 and also said he had harmed himself that year as a result of his depression. In answer to a question about whether he had ever received medication for mental health problems, he said he had received olanzapine (an anti-psychotic medicine) which he had last taken five months before. The man reported that he had been taken by the police to hospital the day before coming in to Altcourse because he had been hearing voices. The man was asked whether he had any thoughts of self-harm and he said that he had no such thoughts. Following this assessment he was then seen by one of Altcourse's GPs. Again, the man denied any thoughts of self-harm. He was located into Bechers Blue wing, which holds remand prisoners.

On 30 June, an entry was made in the man's medical records that he had asked to see a psychiatrist as he was hearing voices and felt he needed medication. The entry went on to say that, during that consultation, he had maintained good eye contact, had spoken coherently and his body language was appropriate. Nevertheless, a referral was made for the man to be seen by an RMN.

On 2 July, the man attended a consultation with a doctor. This was unconnected to the RMN referral made two days earlier. The man again reported to the doctor that he was hearing voices, and said that he had had similar problems in the past for which he was successfully treated with olanzapine at hospital. At interview with my investigator, the doctor said that there had been nothing about the man's presentation to indicate that medication should be prescribed that day. Although the doctor noted the man's records that the hospital should be contacted for more clinical details, it would not seem that this contact was made until after the man's death.

A second RMN saw the man on 4 July. The second RMN said that during this consultation the man reported that he was becoming unwell. He gave details of his chaotic lifestyle, talked about his one day stay in hospital, and about the nature of the voices he was hearing in his head. The second RMN said at interview that, when assessing a person with a psychiatric problem, it is important for there to be consistency in their reporting of symptoms. With the man, there was an inconsistency in the information he gave. He reported one day being well and

another day not being well. He said that he had received psychiatric treatment in the past, but he was not able to explain what treatment he had received and the reasons underpinning the treatment. Nothing emerged during the consultation to indicate to the second RMN that the man should be prescribed any medication – and the second RMN’s note of the consultation referred to the man making good eye contact and appearing positive in his manner. The second RMN explained to my investigator that it is poor practice to prescribe medication solely based on demand. Instead, the practice at Altcourse is to concentrate more on ‘talk therapy’ (having the patient talk through their issues). The plan was for the man to be re-evaluated in a fortnight. No psychiatric referral was made at that stage as there were no indications for such a referral.

On 7 July the man was seen by a resettlement officer whose role is to help prisoners with accommodation problems. At interview, the resettlement officer said that the man asked her to find out what was happening with his medication – he said that he had seen a doctor two days earlier and had been told that he would be given medication. The resettlement officer spoke with the wing staff and they told her that they would contact healthcare. When the resettlement officer informed the man about what would be happening, he replied that if he did not get medication he would kill himself. In response to him making that comment, the resettlement officer opened an F2052SH form indicating that the man should be observed four times each hour (an F2052SH is a form used when monitoring prisoners who are judged to be at risk of self-harm). When the F2052SH form was opened, the man’s shoelaces were confiscated.

Following on from the call from wing staff to healthcare on 7 July, a nurse made an entry in the man’s medical record that he had said that he had received anti-psychotic medication in the past and would take his life if medication was not re-prescribed. An appointment was made for the man to be seen by a doctor on Monday 11 July.

At 1pm on Saturday 9 July, the first Prison Custody Officer (PCO) made an entry in the man’s F2052SH form:

*‘[the man] has been very aggressive all morning. Made threats to kill himself or some one else and I have concerns about this inmate’s mental health ... healthcare informed and unit manager updated requires watching closely.’*

The first PCO said that prisoners often make the sort of threats that the man was making. But because of the way that the man said it, and the way he looked, the first PCO was genuinely concerned and so spoke to his unit manager. The first PCO also spoke to a doctor in healthcare, after which he made a note that the doctor was not convinced that the man was mentally ill. .

After the first PCO had spoken to the man, the unit manager also went to speak to him. It seemed to the unit manager that the man’s main concern was to see a doctor to discuss his concerns about medication. When the man was told that an appointment had been booked for him to see the doctor on Monday, he seemed quite happy to hear this.

The RMN who had seen the man on the day of his reception on 27 June, was in the healthcare unit on 9 July. She made a note that wing staff had telephoned to say that the man had reported 'hearing voices' and was demanding to see a doctor. The reception RMN informed the doctor and she also advised the wing staff to make a referral for an RMN review. When the reception RMN's shift ended that afternoon, she had a hand-over with the third RMN, who was doing the late shift that day. The reception RMN informed her colleague about the man's referral to the RMN team.

The third RMN saw the man on Sunday 10 July following on from the handover from the previous day. The third RMN made a note of this consultation:

*'... inmate discontinued interview after [approximately] 20 minutes. Did not appear to appreciate close questioning regarding his symptoms and mental health history ...'*

In a separate section of the man's medical records, the third RMN made the following note of the same consultation:

*'... [seen in] dining room [in Bechers]. Presented as initially calm and asymptomatic – stated had been sectioned for one night (section 2) and had been given olanzapine which he had complied with for four weeks before recovering and discontinuing use. When attempting to explain current symptomology became unsettled and walked off. [Plan]: No symptoms of psychosis or depressive illness noted. No indication for follow up.'*

The same doctor who had seen the man on 2 July saw him again at around 10am on 11 July and wrote the following notes of the consultation:

*'Voices – for 3 to 4 weeks. One, the devil, telling him to kill himself. The other his wife telling him to kill himself ... Sometimes he hears the voice of his wife's son ... Worried about what will happen ... Previously heard voices six to seven months ago ... Good eye contact. No signs of distress. Not distracted. Is due for a psychiatric report for court, if not refer to visiting consultant psychiatrist.'*

At interview, the doctor said that compared to the previous consultation on 2 July, the man was now able to give a clearer account of the voices he was hearing. Other than his report of hearing voices, he was displaying no other outward signs of distress. He was calm and he made no comment about having any thoughts of self-harm. As far as the doctor was concerned, there was no indication on 11 July that the man should be prescribed medication. The doctor did plan, however, for the man to have a psychiatric assessment. The doctor said that the visiting psychiatrist generally attends Altcourse one day per week. In the case of a routine psychiatric referral, a patient would usually need to wait several weeks for an appointment. However, in the case of a person apparently in need of a more urgent review, the doctor is frequently able to arrange for them to see the psychiatrist on his next visit to Altcourse. The doctor added that the psychiatrist's preference is for patients to be free of medication when he assesses them, as he is then seeing them in their true state.

The second PCO, an officer in Bechers Blue wing, said that the man was a rather unusual prisoner in that he neither isolated himself from other prisoners but nor did he mix much with other people. Nor did the man use the gym or go to education – most prisoners make use of one or other of these facilities. The man had told the second PCO about his lack of success in obtaining medication, but he was always calm when he spoke about this. The only occasion when the man had not been calm had been following his consultation with the third RMN on 10 July. The second PCO was not on duty that morning and so he had not witnessed anything, but he recorded that the man had had ‘a little outburst’. The third PCO and another PCO had spoken to the man that afternoon when he had apologised for his earlier behaviour.

The first PCO said that he had seen the man a number of times through the morning of 11 July. The first time was at around 7.45am when prisoners were unlocked from their cells for medication and breakfast. The first PCO made a point of speaking to the man to see if he was okay. The man was calm and they laughed and joked because his training shoes had fallen out of his cell window. The man was given lace-less plimsolls in place of his own footwear. The first PCO spoke to him again when he came back from his consultation with the doctor. The first PCO asked the man how things had gone and he replied with a shake of the head. His demeanour seemed to indicate acceptance. The first PCO spoke with the man several more times before going off duty at midday.

The second PCO worked an afternoon shift on 11 July. He spoke to the man at some time after 1pm and asked him how he had got on with the doctor. The man said that the doctor had told him he was fine, but he told the second PCO that he was still hearing voices in his head. The second PCO told the man not to give up, that there were other avenues and that the doctor would look into things further if he felt that he still had a problem. At the end of their discussion, the man thanked the second PCO and said ‘tomorrow’s another day’. The second PCO checked on the man at 2.45pm, at which stage he was sitting on his bed looking out of the window. Although the man was in a shared cell, his cell-mate was at court.

## **THE DISCOVERY OF THE MAN'S DEATH**

At 2.50pm, the second PCO was on the ground floor landing supervising prisoners queuing for the gym. The PCO heard a prisoner shouting for assistance on the first floor landing. He ran up the stairs and went to the man's cell where the other prisoner had been standing. While this was happening, another PCO contacted the control room for a Code One alarm to be activated. (A Code One alarm alerts staff that a prisoner has extreme breathing difficulties requiring immediate attention.)

When the second PCO reached the man's cell, he looked through the observation hatch and saw him hanging from a ligature tied to the bunk-bed ladder. The second PCO entered the cell, supported the man's body and snapped the ligature (which had been made from shoelaces). At about this point, another PCO came into the cell and the two officers first loosened and then pulled away the half of the ligature still around the man's neck. This PCO said that the ligature had been very tight and he had to slip his fingers between the ligature and the man's neck in order to loosen the ligature. He said that officers do not carry anti-ligature knives as standard equipment. Instead, an anti-ligature knife is kept in a locked cabinet in the wing office. The second PCO said that, if he had been carrying an anti-ligature knife, it would have saved time in removing the ligature.

Once the ligature was removed from the man's neck, the officers checked his vital signs (airway, breathing and circulation) and then commenced attempts at resuscitation, which they continued until relieved by healthcare staff.

An RGN was the first of the healthcare staff to attend. He checked the man's vital signs and noted that he had no pulse and was cyanosed (cyanosis is a bluish discolouration of the skin caused by lack of oxygen in the blood). The RGN instructed the officers to continue attempts at resuscitation while awaiting the arrival of other healthcare staff.

The staff nurse was one of several other nurses who next attended. She thought that it had taken them around one minute to reach the man's cell after hearing the alarm. Upon her arrival, the staff nurse took over giving the man chest compressions. The RGN was giving oxygen and another nurse set up the defibrillator (a defibrillator measures the heart for electrical activity and administers electrical shocks to restart the heart). The staff nurse said that the doctor arrived within a minute or two of her arrival.

The doctor carried out further checks on the man and noted that the defibrillator was showing that he had no cardiac output. At interview, the doctor said that he had three years experience of working in anaesthetics, from which he learned that it takes just three minutes of oxygen starvation to the brain for death to occur.

The man was taken to hospital by ambulance where he was pronounced dead at 3.25pm.

## **AFTER THE MAN'S DEATH**

On the evening of 11 July, two staff from Altcourse – the family liaison officer and one of the chaplains – visited the man's next-of-kin, his ex-wife, to break the news of his death.

While with his ex-wife, the prison staff took a contact telephone number for his sister. Arrangements were also made for contacting the man's father and it was left to him to contact other family members.

The man's ex-wife was offered the opportunity to visit Altcourse if she so wished. She was also offered help with funeral arrangements and expenses.

## FINDINGS AND CONCLUSIONS

When the man arrived in Altcourse on 27 June, he was seen by an RMN who carried out a first reception health screening assessment. The RMN recorded that the man had been taken to hospital the previous day as he was hearing voices. The man reported that five months before he had received medication – olanzapine – for mental health problems. He also reported that he had been treated for depression in 1995, at which time he had tried to harm himself by taking an overdose of penicillin. Another of the questions in the first reception health screening assessment was about present thoughts of self-harm. The man said that he had no such thoughts that day. When seen by the doctor following his assessment with the reception RMN, the man again said that he had no thoughts of self-harm.

On 30 June, an entry was made in the man's medical records reporting that he was asking to see a psychiatrist. He said that he was hearing voices in his head and felt that he needed medication. An appointment was made for him to see an RMN.

While still awaiting a consultation with an RMN, the man attended a GP surgery on 2 July. The man reported to the doctor that he was hearing voices in his head. He said that in the past he had been successfully treated with olanzapine for the same symptom. Despite what he said, the doctor was not persuaded that he should prescribe medication.

At that consultation, the doctor noted that the hospital should be contacted for further information. This seems not to have happened. However, as the man only remained in hospital for one day, it is questionable whether any information gathered from that source would have been of assistance to the clinicians at Altcourse.

Following the arrangements made on 30 June, the man was seen by the second RMN on 4 July. At interview for this investigation, the second RMN said that there was inconsistency in the information given by the man and nothing emerged to indicate that he should be prescribed medication. The second RMN said that it is poor practice to prescribe medication solely based on patient demand.

In contrast to the assessment of the clinicians, Altcourse's wing staff had somewhat different views about the man. On 7 July, a resettlement officer went to see the man to find out if he had any accommodation problems. However, the man could not focus on accommodation issues. Instead, he asked the resettlement officer to help him with medication and said that if he did not receive medication he would kill himself. The resettlement officer opened an F2052SH form for him to be subject to special monitoring. In addition, the resettlement officer told the wing staff what the man had said and that information was then passed on to healthcare. This resulted in an appointment for the man to see a doctor on 11 July.

The man made further threats of self-harm on the morning of 9 July. The first PCO noted those remarks in the man's records. At interview, the first PCO said

that it was not uncommon for prisoners to make such remarks, but it was the way the man looked and the way in which he made the remarks that caused the first PCO particular concern. The first PCO contacted healthcare, informed the unit manager and made a note of the action he had taken. When the unit manager spoke to the man after the first PCO reported his concerns, the man seemed content as he had been told that an appointment had been made for him to see the doctor on 11 July.

The first PCO's telephone call to healthcare on 9 July resulted in the third RMN visiting the man on Sunday 10 July. The consultation lasted around 20 minutes. The notes made of this consultation included the third RMN's opinion that the man was displaying no signs of psychosis or depressive illness, and that he had not seemed to appreciate close questioning of his symptoms and mental health. The consultation ended when the man walked away. The third RMN noted that there was no indication of the need for follow-up.

As a result of the appointment made on 7 July, the doctor saw the man once more at 10am on 11 July. The doctor said that, compared to the consultation on 2 July, the man had this time given a clearer account of the voices he was hearing. Nevertheless, the man was showing no signs of distress in the doctor's view and he was not persuaded that the man should be prescribed any medication. The doctor did note, however, that the man should be seen by a psychiatrist.

Two PCOs spoke to the man following his consultation with the doctor. It seemed to both officers that the man was accepting or resigned to the doctor's decision not to prescribe medication.

The last time that the man was seen alive by an officer was at 2.45pm when he was checked by the second PCO. At that point, the man was sitting on his bed looking out of the window. Within around five minutes of that check, the second PCO was alerted by a prisoner that something was wrong. The second PCO ran to the man's cell and saw the man hanging. The second PCO was able to snap the ligature by which he was suspended, and with another PCO was able to prise away the half of the ligature still around the man's neck. The officers had used their hands to remove the ligature as anti-ligature knives are not carried by staff as standard equipment – instead, the anti-ligature knife is locked in the wing office. Once the ligature had been removed, the officers began attempts to resuscitate the man. The PCOs continued with their efforts until relieved by healthcare staff. The man was then taken by ambulance to outside hospital where he was pronounced dead at 3.25pm.

The man's shoelaces had been confiscated when the F2052SH form was opened on 7 July. The second PCO understood that the man had obtained a pair of shoelaces from one of the young offenders in Altcourse and used those laces to make the ligature. That he was able to obtain shoe laces in this way is not something that Altcourse could have reasonably been expected to prevent.

All of the man's family – his ex-wife, his father, and his sister – were of the view that the man should have been prescribed medication. They thought this should have happened especially once he had threatened or warned staff that he would

take his life if medication was not prescribed. His ex-wife also said that her husband was a person who did not cope well with stress.

The second RMN explained in his interview that it is poor practice to prescribe medication on demand. He said that at Altcourse prisoners are encouraged to talk through their problems. In the man's case, nothing had emerged to indicate that he should have been prescribed medication. The doctor saw the man on three separate occasions – 27 June, 2 July and finally the morning of 11 July, the day on which he died. Like the second RMN, the doctor had also thought it inappropriate to prescribe medication for the man.

The clinical review undertaken by North Liverpool NHS Trust discusses the man's psychiatric care and treatment and also discusses the decision not to prescribe medication. The review is somewhat inconclusive in dealing with this question. On the one hand, the reviewers state that prescribing medication in response to threats or warnings could be viewed as giving in to manipulative behaviour. However, the reviewers also accept that it is possible that the man's mental health state might have improved had medication been prescribed.

I can understand the arguments made for not prescribing medication. The arguments include the preference on the part of the visiting psychiatrist to be able to assess prisoners in an unmedicated state. However, this can mean a fairly long and potentially difficult time for some prisoners. I am neither qualified nor empowered to make clinical judgements, but I offer my layman's opinion that to have prescribed olanzapine for the man would have been a low risk option pending a psychiatric review. It also seems from the man's medical history that he was content to discontinue taking olanzapine once he felt well again.

As with a previous investigation into a self-inflicted death at Altcourse in 2005, I remain unclear as to the identity of the person who requested that an ambulance be summoned. Altcourse's contingency plans state that it is for healthcare staff to decide whether an ambulance is needed, but interviews with staff showed that some were unsure about these arrangements. Despite the confusion over this, I acknowledge that an ambulance arrived promptly in this case so there was clearly no delay in the request being made.

## RECOMMENDATIONS

The following recommendations were made in the draft report. The Prison Service's responses are included in a table following each recommendation:

1. The Director should arrange a review of medication prescribing protocols and practices at Altcourse to take account of circumstances when it might be prudent to prescribe medication before a psychiatric review has been made.

Prison Service response		Target date for completion
Recommendation not accepted	All options for prescribing medication are available to the Senior Medical Officers within the prison. Medication is prescribed where clinically indicated. It will remain the decision of the medical officers to prescribe or not.	Not applicable.

2. The Director should review the arrangements for obtaining prisoners' community medical records to ensure that such records are obtained with an absolute minimum of delay.

Prison Service response		Target date for completion
Recommendation accepted	Since the death of the man, there has been a consequential review of procedures for the gathering of such information. An improved system is now in place both for requesting information from community healthcare providers and following up such requests if a response is not received within the required time frame. Supporting documentation can be provided to demonstrate that this new system is working effectively.	Completed.

3. The Director should consider introducing anti-ligature knives as a standard piece of equipment to be carried by all staff who might be first on scene when a hanging is discovered.

Prison Service response		Target date for completion
Recommendation accepted		Completed.

4. The Director should review the instructions to the first officer on scene of a possible death in custody to allow that officer to request that an ambulance be summoned.

<b>Prison Service response</b>		<b>Target date for completion</b>
Recommendation accepted	Officers have received new instructions and have the authority to call an ambulance.	Completed.

5. The Director should arrange for staff to receive training on the procedures contained in the contingency plans relating to deaths in custody.

<b>Prison Service response</b>		<b>Target date for completion</b>
Recommendation accepted	Awareness training has been arranged.	Completed.