

**Investigation into the circumstances surrounding the  
death of a man at HMP Altcourse  
in March 2009**

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

**March 2010**

This is the report of an investigation into the death of a man who died at HMP Altcourse on 25 March 2009. The man was found hanging in his cell at 9.30am that morning; he had used a belt attached to his cupboard.

He was discovered by a member of staff who had gone to see why he had not attended an education class. The officers on the landing responded quickly to the emergency and were soon supported by their healthcare colleagues and paramedics. Sadly, none of them could do anything to save his life. My colleagues and I would like to extend our condolences to the man's family and all those affected by his death.

The investigation was carried out on my behalf by two of my colleagues. I thank the Director of HMP Altcourse, for the co-operation offered by his staff, in particular by the prison liaison officer. As part of the investigation, a review of the man's clinical care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust (PCT), and I am also grateful to the clinical reviewer for his assistance. Although the man's clinical needs were few, the clinical review has found that he appeared to become lost in the healthcare system.

I make ten recommendations, the majority of which focus on healthcare and the need for wider information sharing. There are five recommendations to the Head of Healthcare at Altcourse which should be addressed in consultation with the Director. Another recommendation to the Director concerns attendance at suicide monitoring case reviews. There are two recommendations to the healthcare provider regarding external agency contracts and the electronic record system. Again, the Director should be involved in relation to the agency contracts. I also make one recommendation to the National Offender Management Service asking them to raise a matter with the Law Society regarding solicitors correspondence.

As with all deaths in custody, the local police carried out an investigation of their own. There were some delays in the police being able to finish their interviews and there has been a consequent delay in my issuing this report for which I must apologise.

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

**Stephen Shaw**  
**Prisons and Probation Ombudsman**

**March 2010**

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## SUMMARY

Prior to his arrest, the man who died is known to have harmed himself on at least two occasions. When he arrived in prison the escort services had already raised concerns about his self-harming behaviour which were passed on to prison staff. Suicide and self harm monitoring procedures were put in place from the moment he arrived at HMP Altcourse. He continued to be monitored under Assessment, Care in Custody and Teamwork (ACCT)<sup>1</sup> procedures for nearly three weeks. During this time he had the support of wing staff, the chaplain, a counsellor, carers<sup>2</sup>, and is said to have been able to speak to his cellmate about any concerns.

The man's ACCT was closed on 23 March, two days before his death. Whilst being monitored on the ACCT, he did not harm himself and outwardly appeared to settle well into the prison system – this was the first time he had been in prison custody. To ensure that he settled and would be able to cope, staff carried out a number of actions including allowing him a telephone call to his employers, locating him on a stable and more mature wing, and arranging counselling. Regular ACCT reviews were held. I make some observations about the cross-section of staff attendance at the reviews and the necessity to include a member of healthcare. I also found some issues with information sharing, particularly by the counselling service. I do not attribute this as a cause of the man's death but it did demonstrate some gaps in the care and treatment of prisoners.

In the week prior to this death, the man asked for paracetamol from officers on several occasions and, on the day he died, from the nurse on the unit. Individually, the dispensing seemed appropriate, however nobody was aware of the overall picture. There is a gap here, in that there is no formal monitoring by healthcare of who is getting paracetamol from uniformed staff. Although this should apply to all prisoners it is especially important for those on ACCT or at risk. This raises another issue because the nurses on the units do not appear to have any formal way of knowing who is on ACCT or at potential risk by having medication in their own possession. The toxicology tests carried out following his death revealed an amount of paracetamol in excess of the expected therapeutic dose. It was however below the amount expected to be detected after a fatal overdose. The post mortem concluded that hanging was the cause of the man's death.

The evidence would suggest that the man took his life after he received a solicitor's letter initiating divorce proceedings. However, there are questions about whether he had been storing medication with any immediate or longer

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<sup>1</sup> Assessment, Care in Custody and Teamwork (ACCT). The Prison Service's monitoring form and process for supporting prisoners at risk of harming themselves.

<sup>2</sup> A Carer is a prisoner, much like 'Listeners' in public prisons, who is trained by Samaritans and who offers support to other prisoners who are feeling vulnerable or at risk. However, unlike Listeners, Carers are not bound by the Samaritan confidentiality rules. On the First Night Centre all new prisoners are seen by a Carer. Following this they can ask to speak to one whenever they feel the need.

term intention or whether they could genuinely have been for pain relief. It is therefore difficult to know the exact trigger which led to him taking his life.

All those the investigators spoke to appeared to have formed the same opinion of the man who died: that he was a polite, mature, easy to manage prisoner. The general belief was that he had problems outside of prison but was coping well within it. Even his cellmate thought that he had 'perked up' during the few days he knew him.

## INVESTIGATION PROCESS

1. The principal investigator requested all the relevant records including the man's medical and core prison records. With her colleague the principal investigator visited Altcourse to interview staff on several occasions. One of the investigators also visited the prison to interview healthcare staff alongside the clinical reviewer. Notices to staff and prisoners were also sent to the prison to be displayed. In this instance, no-one other than those identified by the investigation team raised any concerns.
2. In all deaths in custody the police carry out an investigation of their own. In line with a Memorandum of Understanding between the Association of Chief Police Officers and my office, PPO investigations can be progressed on an individual basis in consultation with the police. A Detective Sergeant (DS) carried out the investigation on behalf of the local Police. The DS met with the investigators on 16 June 2009 to discuss both investigations. In this instance, the agreement was that the Ombudsman's investigators could interview staff after the police. This has inevitably caused some delay in the completion and issuing of this report, particularly as no notification was received from the police when they completed their investigation.
3. A clinical review into the man's clinical care in prison was commissioned and carried out by a clinical reviewer on behalf of the local PCT. This was received on 20 November 2009. The clinical reviewer was also delayed by the police enquiries.
4. HM Coroner for the local area was informed of my investigation and will receive a copy of this report.
5. Two members of staff at Altcourse visited the man's wife and son to tell them of his death. Although the man had given his son's details as next of kin, it was agreed at the time that his wife would be contact person. One of my Family Liaison Officers has been in contact with his wife to offer her and her son the opportunity to be involved in this investigation. They have not raised any questions for the investigation but have asked to receive a copy of this report.
6. In September 2009, the man's sister contacted the Ombudsman's office, having only recently found out about her brother's death. She explained that she and her parents had not been in contact with him for several years but they wanted to be involved in the investigation and for the following questions to be answered:
  - Why was he in prison custody?
  - How was he able to take his own life if he was being monitored?

- Where was his cellmate at the time of his death?
- Did he leave a note?
- Why was he allowed to have a belt in his possession?

I have endeavoured to answer these questions within this report.

## HMP ALT COURSE

7. HMP Altcourse is a category B contracted out (privately run) prison for remanded and sentenced adult males and young offenders. It is managed by Group 4 Securicor (G4S) under contract to the National Offender Management Service (NOMS). The prison opened in 1997 and currently holds up to 1,324 prisoners.
8. 'Admissions'<sup>3</sup> is the first area a prisoner arrives into whether he is straight from court or transferring from another prison. At Altcourse the number of prisoners passing through admissions ranges between 10 – 40 per day. Prisoners are initially seen by the admissions manager who checks the warrant and personal details. They are then seen by other admission officers who conduct a more in depth interview. Questions asked include previous self harm history, suitability for cell sharing, drugs problems and medical issues. Once the officers have completed their reception process, all prisoners are seen by a nurse. If an ACCT has been opened at any stage, this will be placed inside the file which will accompany the prisoner wherever they go until the ACCT is closed.
9. At the time the man who died was in custody, prisoners were moved to the First Night Centre (FNC) at the end of the admissions procedure to ease the transition into prison and to provide extra monitoring overnight. The next day they would move to the induction unit. This has recently changed and now all first night prisoners go straight to Furlong Green, which is the induction unit.
10. Melling unit is one of several residential units in the prison. Melling is split into two wings, Melling Brown (1) and Melling Blue (2). The unit is joined by a central office. Melling Blue is where the man moved to after his time on Furlong Green. It holds between 85 – 94 prisoners and is the 'drug free' and education unit. Prisoners on this unit are expected to undertake voluntary drug tests and attend education. Although drug abuse was not an issue for him, the unit is generally more stable and quiet than other units and has a more mature population. With the exception of prisoners who do not attend activity for any reason, prisoners are unlocked for the majority of the day.
11. Healthcare services at the time of the man's death, were provided by Medacs Healthcare Group. Medacs describe themselves as a healthcare staffing company providing recruitment expertise and managed healthcare solutions to both the public and private sectors. They were contracted to provide the healthcare services at Altcourse and operated with one manager, two doctors and 32 nurses – including registered and mental health nurses and healthcare assistants. Healthcare is now provided in-house by G4S.

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<sup>3</sup> Also known as Reception

12. Canteen services at Altcourse are provided by Aramark. There is a National Product List (NPL) which contains approximately 800 items. Individual prisons then choose from this list to create a Local Product List (LPL) which contains approximately 350 items. Paracetamol and Lemsip have been available on the NPL, but Lemsip is now being removed. The Department of Health's Offender Health team are in favour of paracetamol remaining available on the canteen list with the following safeguards:

- Local discussion should occur between the prison and the healthcare provider as well as any other relevant parties.
- This should include a local risk assessment.
- Agreement should be reached at the Partnership board
- Audit, including clinical audit, should form part of continued monitoring.

The maximum amount of paracetamol that prisoners can buy in one week is one pack of 16 tablets. However, most prisons choose not to allow paracetamol on their local list. Altcourse is one of those that does not.

13. The last full inspection by Her Majesty's Chief Inspector of Prisons was in 2005. A short follow-up inspection was conducted in September 2007. The Chief Inspector found that Altcourse "... remained an impressively respectful prison, with well maintained and clean accommodation and very good staff-prisoner relations". In her summary, the Chief Inspector added that:

"... we have previously applauded 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. We were pleased to find that levels of purposeful activity remained exceptionally good."

14. In the 2007 inspection the Chief Inspector also noted that "mental health provision was very good, with evidence of joint working between primary and in-reach providers. All new prisoners underwent a mental health assessment on admission..." Two years have passed since the last inspection report so I do not go into more detail here. The full report, and previous reports, can be found at [www.justice.gov.uk/inspection/hmi-prisons](http://www.justice.gov.uk/inspection/hmi-prisons).

15. Every prison has an Independent Monitoring Board (IMB)<sup>4</sup>. The investigators spoke with the Chairman of Altcourse IMB, when they

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<sup>4</sup> Each prison in England and Wales is monitored by an Independent Monitoring Board (IMB), formed of volunteers from the local community. IMB members have access to every prisoner and each part of the prison. The Board produces an annual report.

visited the prison. They asked about the operation of the ACCT process and Melling Blue. The IMB chairman said that, in his view, the ACCT process worked well at Altcourse. He noted that there had been concerns about attendance at case reviews and the management of the personal officer scheme – which is also relevant to reviews. The investigators were told that the prison was currently running a refresher programme for staff and case managers to ensure the good quality of ACCTs. He said Melling Blue was a good stable unit, which was run well by professional unit managers. He confirmed that the man who died had not made any contact with the IMB either verbal or written. The IMB annual report can be found at [www.imb.gov.uk](http://www.imb.gov.uk).

16. The Ombudsman's office has been involved in the investigation of 16 deaths in custody at Altcourse since April 2004 when I took over the responsibility for all such investigations from the Prison Service. In the year preceding the man's death there were two deaths from natural causes and three that were self inflicted. The only significant similarity in my reports into those deaths and this one was the degree of understanding of some healthcare staff about ACCT procedures. I make a recommendation on this issue in this report.

## KEY FINDINGS

17. The man who died was remanded into custody from court to HMP Altcourse on 6 March 2009. The escort services had identified that he was at risk of self harm/suicide and opened the appropriate form. This was handed over with the Prisoner Escort Record (PER) by the escort staff to the prison admissions staff. The Admissions Manager noted the warning when he received the paperwork and highlighted it on the PER form. In interview, he said that he spoke to the man who had told him that, "if the chance arises he would attempt suicide". The Admissions Manager then opened an ACCT book, setting the monitoring at five observations an hour. (Observations are set depending on individual need and are regularly reviewed.) The ACCT book would have followed the man to the next stages of his induction and then onto the residential units for as long as it was open.
18. Officer W was one of the admissions officers on duty. He completed a Cell Sharing Risk Assessment (CSRA) with the man. (All prisoners are subject to a CSRA on admission to a closed prison. The CSRA process is designed to assess the risks posed by an individual to other prisoners.) He was deemed fit to share a cell but Officer W noted that an ACCT book had been opened. In interview, Officer W said he would have been with the man for 10 – 15 minutes. He could not remember him specifically, because he sees a lot of prisoners every day, but he did remember his name as he thought it was unusual. He also remembered that it was the first time he had been in prison. Officer W referred to the ACCT document in which he wrote: "low in mood, poor eye contact, first time in prison". After speaking with the admissions officers, the man, as with all prisoners, was seen by a member of healthcare.
19. During the admissions process, the man was interviewed by a member of healthcare, Registered Mental Health (RMN) Nurse K. Nurse K was responsible for the initial physical, mental and social screening assessment. He noted that the man had previously received medication for mental health problems and was receiving prescribed medication: LOSEC Fluoxetine, an anti-depressant. As a result of his medication, Nurse K referred him to the doctor and, because he was on an ACCT, for an appointment with one of his mental health nurse colleagues.
20. Nurse K completed his entries into the man's medical record during their consultation. The prison healthcare team use an electronic recordkeeping system, System One. Many of the questions in the initial screening are recorded by means of a drop down choice list. The medical record notes that the man said "no" to the question of previous self harm outside of prison. This was incorrect, but Nurse K said at interview that they relied on the information given by the prisoner. Also in the healthcare section of the CSRA, Nurse K ticked the "no" box for the question "following the self harm assessment have any concerns

been raised?" The investigator queried why this was, given that Officer W had noted in the section that an ACCT was already open. Nurse K replied that he would not make any notes on the CSRA but would put it in the ACCT book. There is no entry by any healthcare staff during the admissions process on 6 March. The only mention is a record made by operational staff that the man saw healthcare between 6.05 and 6.10pm. He also made an entry regarding the referral to another RMN for "follow-up on ACCT" in the medical record.

21. After completing the admissions process, the man was moved to the First Night Centre. Unit Manager M took the role of case manager for the man's ACCT document. Officer P completed the ACCT 'immediate action plan', and then wrote that the man told her he did "... want to kill himself but was not actively seeking methods and denied that he would do it at present". Officer P noted that he was in a shared cell and did not appear to have any issues with his cellmate. He was made aware of the telephone system (an agreed list of numbers that a prisoner applies for in advance of being able to make phone calls), Samaritans and Carers. She recommended five observations per hour.
22. The following day (7 March 2009), he was seen by a Carer. In the interview he told the Carer he was unsure how he would cope in prison as this was his first time. He was asked if he would like a follow up interview with the Carers but answered "not now". The interviewer noted that he believed the man to have 'first time nerves', a history of self harm and felt depressed.
23. Also on 7 March, Officer H completed the ACCT assessment interview. The man told Officer H that he had been experiencing relationship problems with his wife over the preceding few months. He said he had been taking anti-depressants since November (I assume this means 2008). He told the officer he had taken an overdose and cut his arm a couple of weeks previously hoping to "bleed to death". He added that he was upset that it had not been successful. He had been going to hang himself the day he got arrested but was disturbed by the police. He also said he had previously stabbed himself in the stomach and groin, but it is not noted when this was.
24. Officer H described him as "very tearful" during the assessment and "very low in mood". He told her that he was comfortable with his current cellmate and would like to remain with him. He added that he was feeling '50/50' and would not harm himself in custody, but would when he was released. When asked about coping strategies and reasons for living, he said that he did not know if his wife and son were talking to him and "the only thing that would make him better was if the problems with his wife disappeared". He also expressed concern about his dog, his job and getting someone to bring some belongings to him. Officer H and the man agreed that he would see a counsellor. Officer H explained about the Carers and Samaritans, which he again declined.

25. Dr A saw the man the same day. The doctor noted that he was on an ACCT and he had previously tried to stab himself. The doctor prescribed him anti-depressants (Fluoxetine). He was then seen by a nurse who cleaned and dressed his left arm. He told the nurse he had cut his arm approximately two weeks previously. Neither contact was recorded in the ACCT document other than to say he was “speaking with doctor”.
26. The man was also assessed by Registered Mental Health Nurse (RMN) D on 7 March. At interview, RMN D explained that the man had been placed onto their list following the opening of his ACCT during admissions. RMN D wrote in the medical notes that the man presented as “... tearful and low in mood, he did maintain eye contact throughout...” She added that he had told her his low mood was due to being in prison and having problems with his wife, whom he had hurt. He reiterated to RMN D that he would not harm himself in prison, but would do so on release if he had not reconciled the issues with his wife. RMN D offered the services of a counsellor, which he told her prison staff had already done. She also told him he could see an RMN again which he agreed to, and RMN D said she would see him again in a week. (The follow up appointment did not happen. RMN D told the investigation team that this was because she had been on sick absence and when she returned it was on a shift pattern which led her to work in Admissions. RMN D was of the view that her manager, RMN N saw the man instead, but this was in fact over two weeks later.)
27. Later that day, the first ACCT case review was held. The man and Unit Manager M were there and had the notes of a verbal handover from Officer H. No member of healthcare attended. When the investigator queried this, she was told that this was because the man’s needs at that time were not clinical. The man repeated much of what he had said to other members of staff. The ACCT remained open with the observations reduced to three per hour with one meaningful conversation with a member of staff in the morning and afternoon. A Caremap (part of the ACCT process detailing action to be taken to reduce the risk of self harm) was drawn up to try to help him. The plans included counselling for his relationship problems, to see a carer, clothes for his court appearance, and help to settle into prison. A further review was scheduled for 9 March.
28. The observation log in the ACCT shows that he asked for his name to go down for attendance at the chapel the following morning (8 March). He told the officer he was feeling ‘fine’ and was happy to remain on the first night centre for the weekend. (There was less need for spaces in the FNC over the weekend. Prisoners were sometimes able to stay for a bit longer than one night if the space was available.) He went to the chapel at 8.55am the following morning. The observation log shows that he was there for just over one hour. For the first 50 minutes it notes that he “appears ok”. There is then an entry showing that he

talked to Ms C, chaplain and ACCT assessor, for approximately five minutes. After this he was taken back to the FNC and was described as being subdued and tearful.

29. Officer P spoke to him shortly afterwards at 10.25am. He told her he had been tearful in church and that it all “came to a head”. The officer felt that his mood seemed to have deteriorated which was due to not having spoken to his family yet. He was going to try to telephone later. He had arranged to go back to the chapel to have some time alone. He also told the officer that he could speak to his cellmate with whom he had developed a good rapport. He returned to the chapel in the afternoon. Ms C told the investigator that she had a pastoral conversation with him. She added that pastoral discussions are not recorded, but she had made a brief note in his ACCT document. Ms C said in interview that they had a lengthy and emotional conversation and he had discussed feeling suicidal at times, mostly in the morning, because he had “lost so much”. However, Ms C (who, as noted above, is an ACCT assessor) did not have any concerns that there was an increase in his risk of self harm or suicide. She told the investigator that he seemed to be coping with prison and came across as a capable, intelligent man. He had told her he was upset that he had hurt his wife, but did not say he felt suicidal at the time and she had no concerns that this was the case. Ms C noted the conversation in the ACCT document and decided that she would check on him after a few days to see how he was feeling.
30. During the following morning (9 March) Officer P spoke to him again. She noted that he said he was feeling better than he had the previous day but was still unable to contact his family as he had put the wrong number down for the pin phones. He denied any current suicidal thoughts. For the rest of the morning the observation log shows that he generally spent it talking to his cellmate in their cell, until 1.50pm when he transferred to Furlong Green (2) which is the Induction unit. Mr S is one of the unit managers for Furlong and he took over as Case Manager for the man’s ACCT book. A case review is documented at 2.25pm, although it is not clear if this was the start or finish time. The review was a handover case review with Mr S, Unit Manager M and Officer L. (Officer L no longer works for the prison, and therefore was not interviewed.) The group discussed the man’s problems and checked that the Caremap actions had taken place. The Caremap was updated with actions about pin phone numbers, location and regime. The man said he felt like “ending it all” so the ACCT remained open with the current observations continuing. At interview, Mr S said that the man had told him other prisoners thought he had been in prison before because he was coping well for a “first timer”. This was a comment echoed by other staff interviewed by the investigator. Mr S explained that the man associated well and was a good prisoner on the unit. It is his view that he was struggling to cope with issues outside of prison, rather than within prison.

31. As recommended in his Caremap, he had an appointment with the counsellor, Ms F. Their first session took place in the afternoon of 9 March. There is very little information in the counsellor's notes, and during interview Ms F felt bound by her professional ethics and did not want to say too much about the detail he shared with her.
32. Although the Ombudsman's investigators have unfettered access to information held in the prison, the investigator decided to continue interviewing Ms F. They agreed that if there were questions which remained unanswered, she would terminate the interview to speak with Ms F's community manager. In the event, Ms F answered the investigator's questions and the information she appeared to omit related more to his offence and feelings about his relationship rather than any suicidal ideation. Ms F had written in the observation log, and discussed with the investigator, that he engaged well, that he said he did not want to live if his relationship with his wife was over, but then said he might want to live if he could keep his job. Ms F said that he told her he would not take his life in prison as there were "too many people around". This contact was noted in the ACCT document but the 'triggers' section was not updated with information about his relationship. Ms F and the man agreed to meet weekly for a six week period. Later that evening he spoke with a Carer.
33. On 10 March, Officer L wrote in the ACCT observations that he had spoken to the man who had told him he was feeling very low because he had not had his medication yet that day. I have been unable to find out why there was a delay. He also asked if he could try to contact his solicitor again as he had not been able to get through the day before (there is no log of any call made to his solicitor on the pin phone record). He told Officer L that he had seen a Carer and found it helpful.
34. Later that day, the chaplain, Ms C, went to see him following their conversation a few days earlier. He said that he did not feel suicidal or have thoughts of self harm at the time. At interview, Ms C reiterated that she had no more concerns about his safety. At 4.40pm, he went to the officer's console to ask about his evening medication – although it is not clear what his concern was. An hour and a half later he told one of the officers that he felt low because he still had not had his medication. As before, I have not been able to find out what the delay was. The following day the entries are more positive with the man talking to staff about football and exercise. No issues or concerns were raised.
35. When he was seen on the morning of 12 March, he told staff that he had not slept well but was feeling better. He had an appointment with his solicitor in the morning. He spent the rest of the morning watching television, and associating on the landing until he went to education in the afternoon. The ACCT case review set for 12 March took place in the evening in advance of his court appearance on 13 March. Ms F was unable to attend but Mr S, the man and an officer attended.

Because Ms F was not available, the group only conducted a mini review before his court appearance. There is no evidence that a written handover was given by Ms F or any of her colleagues, although Ms F had written a note of her meeting with him in the ACCT book on 9 March.

36. The summary of the review shows that the man who died was more relaxed than at the previous one: he was open in discussion and made good eye contact. He was, however, apprehensive about his court appearance and what would happen, saying that his solicitor had told him he would return to prison. He told the meeting that he had “got his head around that” and had no current thoughts of self harm because his family were too important to him. He added that his apprehension of prison had subsided and that he was settling and coping better. He had been in contact with the Carers and was taking medication for depression. The group discussed his progression from the induction unit onto a main residential unit. Melling Blue (2) was the suggested unit as it was a quieter, more stable wing with generally more mature prisoners. He was able to stay on Furlong until a place became available on his new unit. The observation levels on the ACCT remained at three per hour with a conversation every morning, afternoon and evening. The next review was scheduled for 16 March and it was noted that Ms F should be invited.
37. The man attended Crown Court for a preliminary hearing on 13 March and was remanded into custody to return to court on 1 May. He spoke to prison staff about his court appearance. They recorded that he said he felt “no better or worse” after court and that he had no issues being back on Furlong Unit as he was settled there. He said he had no thoughts of self harm at the time and the officer he was speaking to thought that he seemed “happy”.
38. He received a letter from his son (although another document says it was from his solicitor) on 15 March, with his son’s correct contact details because the telephone number he had was incorrect. He submitted an application for the number to be registered onto his account so that he could make contact. He told an officer that it had improved his day, and later that he was looking forward to being able to talk to his son the following day (allowing time for the number to be registered). He added that he had no thoughts of self harm at the time.
39. Ms F saw the man again on 16 March. In her notes, she wrote that his problems concerned his relationship and he was fearful about losing everything. In the ACCT document, Ms F wrote that he had engaged well but talked about feeling depressed in the morning and if he woke in the night. He told Ms F that he had “fleeting” thoughts of suicide which depended on whether his marriage was over or not. He spoke to Ms F about his plans to contact his son that day. Ms F said at interview that he also joked with her about playing football and how he

was “getting too old for it”. She added that he seemed to be in high spirits.

40. However, Ms F said she then spoke to Mr S and told him that, although he was upbeat, he was still saying that he could not go on if he lost everything. A clerk who overheard their conversation mentioned a letter that the man had received. Ms F thought from memory (the investigator has not had access to the letter) that it said “you have made a right mess of it this time, you better pray for forgiveness”. The writer added that praying had helped them during a difficult period. Ms F believed that the letter was written to be supportive but was worried he might not understand it properly. Mr S reassured her that the ACCT would remain open. Again, the ‘triggers’ section of the ACCT document was not updated.
41. Ms F was due to go on leave for a week. She told the man and arranged to see him again on 26 March.
42. Later that day, he attended his ACCT case review with Mr S and an officer. He told the group that he had not harmed himself since arriving at Altcourse and had no current thoughts of self harm or suicide. He said he needed to get more information from his son about what was happening outside regarding his wife and their relationship. He believed that his wife would ask for a divorce. He also said that he might lose his job if he stayed in prison.
43. Arrangements were being made to move the man to Melling Blue. In interview, Mr S said that this took some time because he could only move once a space was available and Mr S had a few days off pending. He wanted to arrange the move when he would be present for the handover review. The man said he was coping with prison and had played a football match that morning. He was trying to keep as busy as possible to help him stop thinking about his problems outside. In interview, Mr S said he believed the man’s problems were external to the prison. In his view, the man did not give the impression that he was struggling to cope with prison. His observation levels remained unchanged and the next review was scheduled for 20 March.
44. The man who died made a telephone call<sup>5</sup> to his son that afternoon (16 March). He asked his son to visit him and said that he was in “a mess”. He wanted information about his wife and told his son that the marriage was probably over. The next day the ACCT document shows two entries by an officer who felt that he was “down”. He told one of the officers that he felt most vulnerable to thinking of harming himself at night time, but seemed to be controlling it and had no current thoughts.

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<sup>5</sup> Telephone calls are recorded for random or specific monitoring. Not all telephone calls would be routinely monitored by prison staff and there would have been no reason to specifically monitor the man’s conversations. The recordings used by the investigator were produced on request following his death and had not been listened to previously.

(This differs to what he told Ms C about feeling most vulnerable in the morning.) Later that day he telephoned his son. Again, he was mostly concerned with what was happening outside and what his wife's plans were. He asked his son to arrange to visit him. He made a second telephone call to his son that night. The conversation was similar to the previous one and he asked for information about his wife, but his son, who seemed to be in a difficult position, kept the information quite general.

45. On 18 March, the man moved to Melling Blue (2). Because of the move, Mr S and Mr D, Unit Manager on Melling Blue and new Case Manager, brought forward the ACCT case review scheduled for 20 March. The two unit/case managers and the man who died attended and discussed his move. There were no current issues outstanding in his Caremap and arrangements were being made for his medication to be transferred to the medical hatch on Melling Blue. He said he was waiting for a visit from his son which he thought would be soon. The group agreed that the counselling he was receiving would continue and it was noted that Ms F should be invited to the next review, which was set for 23 March. The investigator asked Mr S why no healthcare staff were present at the case reviews. He said:

“I’ve made a conscious decision, right from the start, to involve counsellors and not feel there was any overriding physical need and he never mentioned any physical needs to have anybody from healthcare there. Obviously he was on anti-depressants and he was getting medicated for that. But looking at it, that was a symptom to his problems and his problems were being treated, they were being dealt with by a counsellor, you understand what I’m sort of pointing at? ... It wasn’t the fact that he had a mental health problem where you needed excessive involvement with RMNs, he’d been to the counsellor to get at the root problems of his depression. So if he’d been medicated to deal with the actual symptom of his depression and the counsellors were dealing with the root problems of it, so I didn’t feel as though there was any overriding need to involve the RMNs at that point.”

46. Mr S added that healthcare do attend many case reviews but it is based on individual need. He confirmed:

“We have an excellent relationship with healthcare and the RMN team here and it is co-joined, it’s really good. And what they do is if there are any specifics relating to SASH [suicide and self harm] they do advise us of that. And obviously with him being on an ACCT book, if they did have any concerns it would be raised through the ACCT book when they’ve seen him.”

47. Later that morning (18 March) at 11.50am, the unit officer's paracetamol log shows that he was given two paracetamol. There is no record of this in his ACCT document. Later that day, he had his hair cut. When staff spoke to him, he was cleaning his cell and appeared in good spirits. He told Officer C that he was settled and had no issues or concerns. He made no telephone calls that day.
48. The man's new cellmate on Melling Blue was Mr A. At interview, Mr A said that he was aware the man was being monitored on ACCT procedures. He spoke to the man about prison and his court case and Mr A told him that there were ways to start his life over again. Mr A said he was a bit down, but seemed to perk up over the following days.
49. In the morning of 19 March at 7.50am, he approached the officers console. He told staff that he needed to go to healthcare at 10.00am to pick up some medication. He reiterated that he was settling onto the unit but had a headache and was issued with two paracetamol by an officer. The officer recorded this in the ACCT, adding that he made good eye contact and there were no other issues raised.
50. Just over an hour later, Officer T spoke to him on the landing. He complained of a headache but Officer T noted that he had taken paracetamol less than four hours previously. The ACCT record shows that at 10.45am he went to the healthcare centre but this is not entered in his medical record. His medical record only makes an entry at 8.18am showing 'surgery', but gives no explanation and it is possible it was to collect his anti-depressant medication.
51. At 1.55pm another officer spoke to him. The man who died said he was getting on with his cellmate and had no thoughts of self harm. He added that he had a migraine but had seen the nurse earlier and was waiting to get some medication. (Again it is not clear in the evidence available to the investigator whether he received this or not.) Later that evening Officer C spoke to the man. He talked to her about telephoning his son and was looking forward to a visit from him. He had tried telephoning his son on seven occasions that evening but there was no answer. He asked Officer C what courses were available for him in prison, saying that it was his first time in prison and it was "a lot different than he imagined".
52. In the morning of 20 March, he told officers on the unit that he was due to have a case review soon – but did not say when. He said again that he was settled on Melling Blue and was getting on with his cellmate. He added that he had no thoughts or feelings of self harm and would like to come off the ACCT monitoring. The officer noted this, but he continued to stay on ACCT until his case review. He telephoned his son twice that day; both were short conversations. They centred much around the previous calls and what was happening concerning his wife. He said that he was "going to be stuck in here a long time" and had lost his job. (It is not known how he knew he had lost his job or if he indeed

had.) He wanted his son to tell his wife that he just wanted to be out of prison and would leave her alone if that was what she wanted. He would not, as he phrased it, “come after her” because of his imprisonment.

53. The man again asked his son to arrange a visit. Over the next few days he carried on his routine and no concerns were raised. He went to healthcare in the afternoon of 21 March to get medication. There is no explanation but it is again possible that he was still waiting for his anti-depressants to be transferred over to Melling Blue. He also saw the nurse on the unit on the morning of 22 March but there is no further information relating to the contact. Later that day, during one of the observation conversations, he spoke about his forthcoming review and that he hoped to come off the ACCT monitoring. Again he said that he had no issues and maintained good eye contact and body language. He made a telephone call to his son; this was much the same as before but there was also mention of a friend visiting him the following Tuesday (24 March). The next day he rang his son again. The conversation revolved around his wife and her plans. He told his son that some other prisoners had said he would get two years imprisonment. He felt that it was wrong that he was in prison. His son said that he could not get through on the visits booking line but would try again.
54. At 11.45am on 23 March the paracetamol log shows that the man was issued with two paracetamol by Officer C. This action was not logged in the ACCT. At 2.30pm, he had another ACCT case review. Mr D, Officer K, and RMN N were in attendance. Mr D wrote in the log that the man was positive in the review, and that he said he had settled on to Melling Blue, was doing full time education (numeracy and art) and that the bulk of his day was spent purposefully. The group discussed the impending court case. He said he would not be contacting his wife but expected to see his son. RMN N explained to the meeting details of his medication. In interview, he said that this referred to his explanation to the man about the effects of stopping the medication and the need to take it consistently. Mr D wrote that the man gave no negative indicators and that his body language and eye contact was good. Everyone was in agreement that the ACCT book should be closed and this was done.
55. In interview, Mr A said that the man enjoyed a laugh and joke with him and other prisoners, so much so on one occasion that one officer had gone into the cell and said (good humouredly), “have you three forgotten you are in jail”. Mr A thinks this was on the Sunday – the day before the ACCT was closed.
56. A post closure ACCT review date was not entered into the record of the review. (They are usually held within seven days of the ACCT closing.) Although it is unlikely a review would have taken place prior to his death, the investigators questioned why it had not been set. Mr D

explained that it was an oversight. He said he would have checked his diary first and would probably have written it there, but had not got round to writing it into the ACCT document.

57. That evening (23 March), the man called his son. Their conversation again lasted only for a few minutes. As before, he wanted to know what his wife was doing and told his son that it was up to her to get him out of prison. His son told him that one of his friends was due to visit the following day. He had not seen his name on the visits board so was not aware. He thought he might be able to give the friend's address as somewhere to live and could apply for bail. He said he would call his son the following evening. He tried on four occasions, but got no answer.
58. The man received a letter from his wife's solicitors on 24 March. (Although correspondence is not logged at Altcourse, the letter was written on 23 March and, as prisoners receive their post in the afternoon, it is safe to assume that he received the letter on 24 March.) It is likely that the letter would have arrived under Rule 39<sup>6</sup>. The letter notified him that his wife wanted to pursue divorce proceedings and enclosed a copy of the divorce petition that had been lodged with the court on 23 March.
59. That evening the man had a visit with a friend. Two people were due to visit, but only one attended. It appears that this was the person he had hoped would give him a bail address. The details of the visit are not known to staff, but when the investigators spoke to his cellmate, Mr A, he said that he thought the man had been expecting his son. Mr A thought the man was a bit down, and he went to sleep early saying that he had a headache. No concerns were raised to staff either by the visitor or the man.
60. Mr A said that, on the morning of 25 March, the man who died woke up and had a cup of tea. He then went to the officers console to get an application form because his friend had brought some property for him. None of the staff asked by the investigators could remember the request. He told Mr A that he had a migraine and would not be attending education. Mr A said he had complained of migraines before so it did not cause any alarms for him.
61. His medical record shows an entry at 9.25am by Nurse B. (This entry would have been made after the nurse had dispensed medication and returned to healthcare to complete the prisoner records and her contact with him is likely to have been nearer 8.00 – 8.30am.) Nurse B recorded that he was given medication for "cold symptoms/sore throat". She said in interview that he came up to the hatch and, when she asked how he was, he replied "I'm fine". Nurse B described him as

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<sup>6</sup> Rule 39 is used for post which is confidential because of legal privilege. Staff are not permitted to read the contents.

looking as if he had flu symptoms and that he appeared “flushed”. She added that he told her he wanted “something for my throat, my bones are aching”. As well as re-ordering his anti-depressant medication, he was given a 12 tablet pack of 200mg Ibuprofen “given for pain” and a two day supply of paracetamol “given for pain/high temp” (16 tablets).

62. Nurse B explained that she would put the person’s name and date on the box so that subsequent prescriptions could be monitored. The details would also be written in a book and then added to the medical record after dispensing was finished. She added that she would also let the officers know so that they would not issue any paracetamol. There is no evidence that this happened on 25 March in respect of the man. The investigators asked whether Nurse B would know if somebody was at risk, for example on an ACCT document. Nurse B said that she would not know unless she had been involved with them before. She added that information was sometimes shared between the nurses and officers, but there was no formal standardised system.
63. The officers on duty on Melling Blue that day were Officer T, Officer C, Officer R and Officer U. Officer U is usually assigned to Melling Brown (1), but his colleagues on Melling Blue that morning were all relatively new staff and he was asked to help out as he was more experienced.
64. Mr A was preparing to go to education between 9.10 and 9.15 am and, while he was waiting, spoke to Officer C. He said in interview that he asked the officer to keep an eye on the man who died as he had a migraine and did not want to go to education. Mr A then told Ms X, Education Instructor, that the man would not be attending that day. Ms X said that she told Mr A to inform the officers although this was not confirmed by Mr A. Officer C said Mr A had not raised it with her as specific concern over suicide, but had mentioned it as part of a conversation which she felt was just ‘chat’ before he went to education. She remembers, however, walking past the man’s cell shortly after she started her cell checks. She did not speak to him but remembers him sitting on his bed.
65. Education registration is between 9.00am and 9.15am. A list of those in attendance is passed to officers who then check to see why any prisoners have not attended. Shortly after registration, at approximately 9.20am, Mr A went into the classroom. He realised that there were no pens so went back to his cell to get some. He had to use his key to unlock the door. He assumed that the man who died had locked the door because of his migraine. The curtains were also closed. He told the investigators that the man was standing between the bed and the sink. They passed comment on the lack of pens in education and Mr A left the cell again. He then recalls all the prisoners being told to go into their cells approximately ten minutes later.

66. At approximately 9.30am, Officer T started to go round to check those who were not on the register. The man's cell is one of the first next to the officers console. In interview, Officer T described finding the man as follows:

"I went into the cell at first, I just like opened the door and just looked in and he wasn't there and I turned around and just checked that because sometimes the teachers miss, but the cell's right by the education block. So I just turned around and just double-checked that they hadn't missed him off because I knew it just wasn't like him at all. And then I shouted his name because that's what, if you can't find them you shout them, shouted his name and then, I don't know if something, I believe something told me to go back in the cell, but I'm not sure. And I just went back in and I lifted the bed covers up just to see in case I hadn't seen him and the toilet door was left slung back open. And I just stepped back and moved it and seen him hanging ..."

67. Officer T shouted for her colleague Officer R and called a 'Code 1'<sup>7</sup> over her radio. Officer R was on the landing above as was Officer C. He quickly responded to Officer T's call. When he arrived Officer T lifted the man to take the weight from the ligature, which was found to be a belt tied to his cupboard door. Officer R used his anti-ligature knife<sup>8</sup> to cut the belt and the officers lay him flat on the ground. Officer C, who had not initially realised the urgency of the call for assistance, was also in the cell by this point and tried unsuccessfully to find his pulse.

68. Officer O who works on Melling Brown, the unit next to Melling Blue with a shared office in the middle, was in the office when she heard the Code 1. She quickly went to the cell – approximately ten to twelve metres from the office – and saw the man on the floor. He was "blue in colour". At the same time, Officer U, who had been on the top landing in Melling Blue, arrived at the cell.

69. Officers U and O started cardio pulmonary resuscitation (CPR) until healthcare staff arrived to take over. In the meantime, all other prisoners on the unit were locked into their cells. The Unit Manager, Mr G, had also responded to the call for assistance. It was his role to direct and support staff and generally control the area.

70. CCTV shows some nurses entering the wing with what looks to be an emergency equipment bag at 9.32am. They checked his vital

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<sup>7</sup> Code 1 is an emergency code sent across the radio calling for staff and medical assistance. It is commonly used in the event of a prisoner being found hanging.

<sup>8</sup> A knife designed make the cutting of a ligature easier. It is shaped like a fish and is sometimes known as a fish knife.

observations (pulse, breathing, temperature) but got no response. One of the nurses called for paramedics and then attached the defibrillator<sup>9</sup>. There is some discrepancy in the documents about the arrival time of the paramedics. The communications room log records that an ambulance was called at 9.40am and that the ambulance arrived at the gate at 9.45am. According to the CCTV, a first response paramedic arrived outside Melling Blue at 9.40am. The paramedics took over the resuscitation attempts. The CCTV shows an ambulance crew arriving at 9.48am although the crew did not enter the unit for a couple of minutes. It may be that the communications officers have not entered the arrival of the first response paramedic and the correct time for the call, or it may be that the CCTV clock was wrong on the day.

71. The emergency services tried to resuscitate the man out on the landing for seven or eight minutes before he was put on a stretcher and taken to the ambulance. From the CCTV, it looks as if the paramedics continued to carry out chest compressions while he was being taken out on the stretcher. He was then taken to hospital in the ambulance. When he arrived at the hospital a doctor pronounced his death. This is recorded at 10.30am on 25 March 2009.

### **Events after the man's death**

72. The prison's Family Liaison Officer, Ms E, and the prison chaplain, Mr R, were the members of staff who went to tell the man's son, who was recorded as his next of kin, and his wife about his death. They had been in contact with the police local to the man's home address and went to meet the police officer who had arrested him. As the family were known to her, the police officer accompanied Ms E and Mr R to the man's home address. His wife was at home but his son was out. The staff asked her to contact her son at which point she asked if she was going to be told that the man was dead. Ms E confirmed this and gave some brief details. His wife then contacted her son and asked him to come home. When he arrived, the prison staff explained what had happened. They also discussed practical matters such as help towards the funeral costs and a visit to the prison if the family wished.

73. Staff involved in finding and attempting to save the man attended a 'hot debrief' in line with prison contingency plans. (This gives staff the opportunity to talk through what had happened as a means of support and to identify any issues or learning points.) The minutes of the debrief show that staff felt the incident had been managed as well as

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<sup>9</sup> A defibrillator can restart the heart in some cases by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the user.

was possible, and that good communication was evident. Staff to whom the investigators have spoken all felt they were given adequate support and knew where to ask if they needed any more.

74. In line with policy, the man's cell was secured following his death until the police arrived. The police found a note in the pocket of one of his items of clothing. It is not certain if this was intended as a suicide note and it is undated. It says "good buy [sic]" twice. It also says, "I wish I cuad [sic] go back in time so you cuad love me again. I love you so [wife's name] baby." It then adds, "she did this, I love her so much [wife's name]".
75. A post mortem was carried out. The toxicologist found high levels of paracetamol in the man's system. There was also Ibuprofen, which was found to be within a therapeutic dose. The following extract is from the toxicology report:

"The comments and interpretations that follow are based on the reading of scientific and medical literature, and should be viewed as general comments only. In addition, it is not possible to determine from measurements on a single blood sample precisely when a drug was consumed, nor the exact dose consumed.

"Paracetamol – ... in the case of the man, the concentration of paracetamol detected in the blood is high and significantly in excess of the concentration I would expect to detect after the normal therapeutic use of this drug. It is possible that the use of such a large amount of paracetamol could have produced observable damage to the liver. It should also be noted that if a significant number of hours had passed between the ingestion of paracetamol and his demise the paracetamol concentration may have been greater than that detected since paracetamol is relatively rapidly eliminated from the body."

The toxicologist explained changes in the body following death and commented that due to these changes:

"... it is not possible to estimate the actual drug concentration at the time of death. Therefore, it should be noted that I cannot exclude the possibility that the post-mortem paracetamol blood concentration found may not be representative of the circulating levels at the time of death due to the post-mortem redistribution of the drug ... In the case of the man it should therefore be noted that I am unable to rule out the possibility that the elevated paracetamol concentration detected above may be due to post-mortem redistribution."

In respect of Ibuprofen the toxicologist commented:

“... the concentration of ibuprofen in the blood sample is within the range of concentration detected after the therapeutic use of this drug. Therefore I would not expect this drug to have been capable of exerting any adverse effects on the man immediately prior to his death and hence shall not be considered further.”

In conclusion the toxicologist wrote:

“Paracetamol was detected in the blood sample at a high concentration, in excess of the concentration I would expect to detect after the normal therapeutic use of this drug, but below the concentration I would expect to detect after a fatal paracetamol overdose. This finding suggests the possibility of a relatively recent paracetamol overdose.

“The analyses were negative for alcohol, commonly encountered drugs of abuse, prescription and non-prescription drugs (other than paracetamol and ibuprofen), this rules out the possibility that he was affected by these substances at the time of his demise.”

76. Following the toxicology results, the police searched the man’s cell and removed the following:

- An empty box of Paracetamol (dated 23.03.09)
- An empty box of Ibuprofen – 12 pack (dated 23.03.09)
- A box of Omeprazole 20 mg – 10 pack, 3 remaining
- An empty box of Ibuprofen – 12 pack (dated 23.02.09 but prescribed to another prisoner)

(Regarding the first two findings, the investigator had asked the police and coroner’s officer for confirmation of the date dispensed as other evidence suggests it was issued on 25 March. No confirmation has been received and thus I make the assumption that it was a typing error in the police notes.)

77. When the investigators spoke to Mr A he said it was a shock as he had seen the man ten minutes earlier. He said, in his view, the man had perked up but that perhaps this was just a front he had put on. He reiterated that he might have had some bad news at his visit the night before. Mr A was not sure, but he had seemed fine the next morning. He said that even in hindsight he would not have expected him to take his life. For instance, he did not think that someone picking up an application to bring property in would be thinking about taking their life. Mr A said that the man was ‘getting on with it’ (meaning prison), playing pool, mixing with other prisoners and did not keep going to officers and asking for things. In Mr A’s view there was no indication that he was not coping.

78. Mr A also told the investigators that on one occasion when the man was on an open ACCT he asked a nurse for medication and they gave him a whole box. Mr A did not confirm what the medication was or when it happened, but it was likely to be Paracetamol or Ibuprofen. He said that he went to one of the officers and said, “you know he’s on watch and they’ve given him a whole box ...” and the officers went and removed it. (There is no recorded information to confirm this and I simply report what Mr A has told the investigators.)

## ISSUES CONSIDERED

### Clinical care

#### *Admissions*

79. Nurse K completed the man's cell sharing risk assessment after the admissions officers. He did not give further information regarding his risk of self harm on the CSRA. He qualified this in his interview by saying he would write it in the ACCT and in the medical record. There is no record of the man's contact with Nurse K in the ACCT document and non-healthcare staff would not have access to his medical record. Whilst I do not suggest that this omission contributed in any way to his death, it was not good practice.
80. If somebody is at risk of self harm and this is known at the time of completing the CSRA, it should be recorded. The ACCT document, once closed, would be filed away, and the medical record is not seen by officers. In contrast, the CSRA is kept in a prisoner's wing history sheet and is therefore more accessible to all staff. The CSRA is there for a reason and all relevant information should be logged within it.
81. Additionally, the doctor and nurse both saw him on 7 March but neither made any entry in the ACCT document.

**The Head of Healthcare should ensure that all healthcare professionals are aware of the ACCT process and recording systems. It might be necessary to have refresher training specifically targeted at healthcare professionals.**

#### *Communication*

82. Because he had been placed on an ACCT, the man was referred to and seen by a mental health nurse, RMN D, following his admission to prison. This was good practice. However, RMN D was then away from work with sick absence and, following her return, worked in a different area of the prison. In interview, RMN D was of the opinion that the man was seen by her colleague instead, but this was over two weeks later and only because he had been asked to attend an ACCT case review.
83. It was explained to the investigators during the interview with RMN N that the nurses are individual practitioners with their own caseloads. It became clear that if a particular RMN could not carry out their follow-up appointments their colleagues would be unaware, and it would fall to the prisoner to highlight any missed appointments. I believe that the duty of care should lie with medical staff. Prisoners accessing RMN support or who are on an ACCT might not be fit or well enough to pursue this service.

84. The clinical reviewer has found that the man was “lost” by healthcare following his initial assessments by the doctor and RMN. There appears to have been a lack of communication between the RMN team in this instance, and I agree with the clinical reviewer’s view that a system needs to be put in place to ensure that workload is handed over if one of the team is absent for any reason.

**The Head of Healthcare should implement an auditable system to ensure that caseloads from the mental health team are handed over when any staff are absent.**

85. Another area highlighted to the investigators concerns information sharing by the counsellors. In interview, Ms F was reluctant to talk about her contact with the man for fear of breaching confidentiality. It became apparent also in RMN N’s interview that counsellors do not log their contact in a prisoner’s medical record. This again leaves the potential for omissions in treatment and care if a counsellor is unavailable or absent from work. For example, when RMN N attended the man’s case review on 23 March he only had the history written by RMN D. He did not have access to contact records with Ms F. Given that Ms F was on leave, it would have been very useful to others to have had a note of her concerns. Ms F had not seen the man since her last verbal handover to operational staff prior to his ACCT review on 16 March. This was by chance rather than design. I do not believe the lack of written record contributed to his death, but it would have given RMN N more information to work with. It might also be important in situations for other prisoners in the future.

86. I appreciate that healthcare have a duty to maintain patient confidentiality, but the issue of ‘medical in confidence’ should not be used as justification for not sharing information or completing ACCT documents as required. As before, I do not suggest that this contributed to the man’s death because he was monitored closely and his contact with healthcare was minimal. However, on at least one occasion a member of operational staff did not invite healthcare to a case review because she did not consider his needs to be clinical.

87. There is guidance by both the Prison Service and the NHS on the sharing of medical information. Particularly relevant is Prison Service Order (PSO) 2700, the full version of which, including reference to other guidance, can be found on the Prison Service website. The PSO is quite clear about the responsibility of healthcare staff at paragraph 1.11:

“Prisoner safety and well-being means that managers need to be trained to ACCT Case Manager level (as they are likely to need to undertake these duties), and all staff in contact with prisoners need to be aware of and trained to ACCT foundation level. Therefore it is important that Healthcare Managers –

through their Partnership Board – make every effort to ensure the local training strategy reflects this in respect of all healthcare staff (agency wherever possible and permanent employees, whether existing or new) and mental health in-reach teams.

“Healthcare Managers must ensure all healthcare staff (as above) are aware of the importance of sharing risk and care information with staff from other disciplines, are informed that this does not contradict professional guidelines, and do share such information with those managing individual prisoners.”

**The Head of Healthcare and Safer Custody Co-ordinator should work together to ensure that healthcare professionals are fully aware of their duty and role in the ACCT process. This might be incorporated into the training recommended above.**

**Medacs should have in place a Service Level Agreement with all external agencies, including the counselling service, contracted to carry out services through them to ensure effective team work. The Director of Altcourse should be satisfied that all contracted agencies share information effectively.**

#### *Medication management*

88. The man who died was prescribed an anti-depressant whilst in custody. This was not to be held in his possession although there was no risk assessment in the documentation provided to the investigators. The clinical reviewer also found that there were discrepancies in the understanding of who should carry out a risk assessment and, indeed, if one was carried out at all. Although there was no other evidence to support it, his cellmate told the investigators that the man had been given medication in-possession whilst on the ACCT but that the officers removed it after he alerted them. All prisoners should have a risk assessment for in-possession medication and this should certainly be the case for prisoners on an open ACCT.

**The Head of Healthcare should ensure that the in-possession medication risk assessment procedures are clear to all staff and are carried out appropriately. The Director should ensure this also forms part of the cell searching procedures.**

89. There do not appear to have been any issues regarding collecting medication prior to the man’s move to Melling Blue. However, thereafter there are several entries in his ACCT document about ‘waiting for’ or going to healthcare for his medication. None of the staff interviewed could give an explanation, and I can only assume that it took longer than normal for the prescription to be transferred between the two units where he lived.

90. In the week prior to his death, the man requested paracetamol from the officers on the wing. Current practice at Altcourse allows officers to give a prisoner two paracetamol twice a day. This is logged in a book at the officers desk. The day that he died, he asked for and received paracetamol and ibuprofen from the nurse on duty, Nurse B which he was given in-possession.
91. This practice presents two issues. First, although Nurse B said that she would check the officer's log, this did not appear to happen and is not necessarily something all healthcare staff would do. There was also no transfer of the information from the officer's log into his medical record. This means that he, or any other prisoner in the same situation, could have had access to more than the allowed limit of paracetamol by asking both an officer and nurse separately. For prisoners on ACCT this is especially risky, particularly when there is no risk assessment for in-possession medication.
92. Secondly, Nurse B said in interview that she would not necessarily have been aware that he was on, or had been on, an open ACCT. The current system seems to rely on informal communication between officers and nurses on the wing. Again, this leaves a vulnerable gap in which prisoners can access medication inappropriately.
93. I have considered the fact that paracetamol is on the approved list for canteen shopping (even though this is not authorised at Altcourse), before being critical of the practices mentioned above. However, a maximum of 16 tablets a week is the authorised amount on the National Product List. The system at Altcourse allows for a nurse to issue 16 tablets as a two day course. If the prisoner is then allowed to get more paracetamol from officers without this being checked by healthcare professionals, he can end up with more than the recommended limit within a short space of time. The toxicologist found high levels of paracetamol in his system and, although not a lethal quantity, an amount possibly leading to an overdose. I strongly recommend that the practices surrounding the dispensing of medication are reviewed. It would be good practice to include the Safer Custody Co-ordinator in discussions around ACCT and over the counter pain relief.

**The Head of Healthcare and the Pharmacist should review the medicine management policy in relation to over the counter medication to ensure that potentially unsafe practices cease.**

**This should include:**

- **a system to ensure that healthcare professionals know which prisoners are on ACCT or at risk**
- **a system for ensuring nurses and officers do not give out more than safe amounts of over the counter medication.**

### *Record keeping*

94. In the nearly six years that the Ombudsman's office has been investigating deaths in custody, I have had frequent cause to criticise handwritten records. However, in this instance it is the electronic records which give rise to the clinical reviewer's recommendation, which I endorse.
95. The clinical reviewer has found that the electronic recording system used by Medacs at Altcourse (System One) was difficult to follow and had numerous meaningless entries for example 'surgery' but with no further explanation. There were also omissions in the records. On two occasions the man missed or was delayed in receiving medication but the reasons were not recorded and there are no follow-up prompts.
96. When the ACCT was closed on 23 March, there was no entry in the medical record. I have already mentioned that the counsellors do not record their contact in the medical record.

**Medacs should review System One to ensure that it is fit for purpose taking into account the comments above.**

**The Head of Healthcare should instruct all healthcare staff, including counsellors, to log all contact with prisoners to ensure continuity of care.**

### **Assessment, Care in Custody and Teamwork**

97. Some of the man's family have questioned why his ACCT monitoring came to an end. I hope that the key findings demonstrate the reasoning and the decision made by staff. PSO 2700 advises that:

"The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so, i.e. that the problems that caused the ACCT Plan to be opened have been resolved or reduced, the prisoner is able to cope with any remaining difficulties, they have access to and are making use of at least some positives, e.g. friends, family, counsellor, member of chaplaincy team, hobbies, education/employment, and they know who to contact (and how) should they need support in the future."
98. The actions in the man's Caremap were generally practical issues involving settling into prison. All the issues had been actioned. Some staff were aware that he was having problems outside prison, but he presented as someone who was coping with prison. He had access to and had been in contact with a counsellor, the chaplaincy team, and the Carers, and he was receiving anti-depressant medication. Support from officers was also available. He was engaged in full time

education and spent his time purposefully. He also had some contact with the mental health team, albeit that there was an oversight with the follow up appointment.

99. The clinical reviewer has made a recommendation that the National Offender Management Service (NOMS) consider having a named RMN for every prisoner on an open ACCT. I appreciate that this might not always be feasible. It is a concern, however, that a member of healthcare was not routinely invited to the case reviews, although I understand the logic that the man was under the supervision of a counsellor and did not present with any physical health problems. That said, I have already indicated the clinical reviewer's view was that he was 'lost' by healthcare.
100. Mr S said in interview that there was good joined up working between healthcare and the officers with regards to the ACCT process. I think that this good working relationship should be utilised more fully. Involving a member of healthcare at all case reviews means they can both contribute medical information unknown to operational staff and also take information away to better inform the rest of the healthcare team. For example, the use of paracetamol could be better monitored.
101. I believe that to ensure no information is missed a member of healthcare should always be invited to attend case reviews. That said, it will only work efficiently if information is shared within the healthcare agencies themselves. This re-enforces the need for the counselling service to be more formally involved with the healthcare department.

**The Director and Head of Healthcare should ensure that a member of healthcare is invited to attend all ACCT case reviews.**

102. One of the man's sister's questions was how he was able to have access to a belt given that he had been on an ACCT. The following is an extract from the guidance on the removal of personal items from prisoners. (Full details can be found in Chapter 8 of PSO 2700 on the Prison Service website.)

"... previous methods of self-harm can be a good indicator of likely risk. Cigarette lighters, matches and flammable materials should also be considered for removal where the individual has a history of self-burning, arson or self-harm by smoke inhalation, as should medication, both that belonging to the individual and to a cellmate, and (particularly for women) plastic bags.

"However, removing personal belongings from a person who is feeling hopeless and depressed (especially items of clothing, belts or shoelaces) can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Fear of losing their normal possessions can discourage prisoners from disclosing suicidal feelings. And

removal of some items in possession (such as pens) can deprive the individual of access to creative activities which might distract them from their painful feelings. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so.”

103. Additionally, the PSO refers to prisoners who have items removed being ‘singled out’ or teased by other prisoners which is something that staff need to take into consideration.
104. Sadly, prisoners can find all manner of materials to use as ligatures or implements of self harm should they choose. For example, bedsheets or clothing are readily available. With regard to previous methods used, the man is recorded as stabbing himself on one occasion and tying a noose in another. In these circumstances, it would have been disproportionate for staff to have removed all items from his possession. Moreover, even if staff had deemed it necessary to remove his belt for all or part of the time he was on an ACCT, this would have been returned to him when the ACCT was closed.

### **Legal correspondence**

105. The day before he died, the man received notification that his wife was seeking a divorce. This was something that he had feared, but he was working with the counsellor on the subject. The letter arrived from his wife’s solicitors who were based out of the local area. Correspondence from legal services is not monitored by staff as it is confidential. Although the investigator did not have the envelope in which the letter arrived, it is reasonable to assume this correspondence was processed under Rule 39. This would mean that, unless he had told someone, no staff or prisoners would be aware that he had received the letter. There is no evidence to suggest that he did tell anybody.
106. The only other way that staff could be made aware of these situations is if the legal representative or a concerned family member or friend notifies them. In this instance the prison did not receive any such information. At Altcourse, a notice is displayed in the domestic and official visits areas for all visitors, including legal staff, asking them to make staff aware of any news or information which might cause a prisoner distress. In this instance, the letter arrived from out of area and therefore the firm sending it would not necessarily be familiar with Altcourse’s procedures or notices.
107. The clinical reviewer has recommended that the prison needs to further explore strategies by which it could be forewarned of any bad news letters arriving from solicitors. I feel that Altcourse already try to reduce the risk of this happening so do not make a recommendation to the prison directly. Unfortunately, the size of the prison population means

that many prisoners are out of their or their family's local area. This means that there is a gap where solicitors, friends or family are not familiar with the processes and procedures of the prison.

108. This is something I have reported on in other investigations. I am aware that the Safer Custody and Offender Policy group within NOMS have approached the Law Society to ask them to issue guidance to all their members. However my understanding is that the Law Society has not agreed to any formal action. I would urge NOMS to approach the Law Society again.

**NOMS should approach the Law Society seeking their agreement to issue guidance to all solicitors to notify prisons directly if they are delivering difficult or distressing information to a prisoner.**

### **Family comments following receipt of the draft report**

109. The man's wife said in her response to reading the draft report that although, divorce proceedings were underway she did not know, until reading the report, that any papers had actually been served on the man. She added that she had been told by her solicitors, following her husband's death, that the proceedings had been stopped and no papers served. She did not receive any paperwork relating to the divorce when his property was returned. This might be because the police had taken them from his cell. It was her understanding that her husband was aware she was filing for divorce and said that when their mutual friend had visited him the day before he died, he had spoken to him about it. She has also said that amongst the paperwork which was returned with his property was an instruction to his defence solicitor not to contest any of her evidence. She hopes that it will be acknowledged in the wider context of his death that the catalyst for the divorce was her husband's offence against her.
110. The man's sister did not find out about his death until September 2009, she contacted the prison but was unable to get a response from them. The investigator let the prison know about his sister's involvement in the investigation, however the prison dealt only with his registered next of kin - his son and also with his wife. Although the prison decided not to liaise with his sister at that time, it would have been courteous to return her initial call and explain their reasoning. The relevant PSO indicates that it is not uncommon for liaison to be necessary with more than one person in a family. The prison has since agreed that his sister can contact the Head of Safer Custody at the prison and his contacts details were forwarded to them in January 2010.
111. The man's sister still believes that his post should have been monitored more closely. I have explained the process for Rule 39 post

above. It would not be reasonable, or practical, to expect wing staff to be aware of all the Rule 39 mail being passed to prisoners. It may well be handed out by an officer who is not regular to the wing or another member of staff who is only delivering the mail and would not be familiar with the prisoners on the wing. His ACCT was closed, the reasons for which I have explored earlier in the report and remain satisfied with. By closing the ACCT staff believed he did not need any additional support. The only way staff could reasonably know that he had received a solicitor's letter and that he potentially found the contents distressing would be if he told them. He did not do this nor did he tell his cell mate.

## CONCLUSION

112. When the man who died arrived in prison, concerns had already been raised about his self-harming behaviour. He was monitored under ACCT procedures for nearly three weeks. During this time he had extensive support from wing staff, the chaplain, a counsellor, Carers, and is said to have felt able to speak to his cellmate about any concerns.
113. Whilst being monitored on the ACCT, the man did not harm himself. All those to whom the investigators spoke appeared to have the same opinion that he was a polite, mature, easy to manage prisoner. The general belief was that he had problems outside of prison but was coping well within it. Even his cellmate thought that he had 'perked up' during the few days he knew him. The man said on several occasions that he would not harm himself in prison.
114. Regular ACCT reviews were held and, although they could and should have involved a better cross-section of staff, the likelihood is that the ACCT would still have been closed on 23 March. In hindsight, it would be easy to argue that it should not have been closed. However I am satisfied that with the information and knowledge staff had at the time, and given his positive behaviour, the ACCT was closed appropriately.
115. He received a letter initiating divorce proceedings the day before he died. He also had a letter in his pocket that suggests he took his life because his marriage was over. Given they did not know about this, there was little more staff could have done for him as he was already receiving counselling for help with his marriage problems. I am satisfied that, had they known he had received distressing news, they would have dealt with it appropriately and may well have opened another ACCT. We cannot know exactly what triggered his decision to take his life at the time.

## RECOMMENDATIONS

### *HMP Altcourse*

- 1 The Director and Head of Healthcare should ensure that a member of healthcare is invited to attend all ACCT case reviews.

This recommendation has been partially accepted. The prison has responded as follows: "All staff will be reminded of the need to have appropriate personnel present at all case reviews."

- 2 The Head of Healthcare should ensure that all healthcare professionals are aware of the ACCT process and recording systems. It might be necessary to have refresher training specifically targeted at healthcare professionals.

This recommendation has been accepted.

- 3 The Head of Healthcare should implement an auditable system to ensure that caseloads from the mental health team are handed over when any staff are absent.

This recommendation has been accepted.

- 4 The Head of Healthcare and Safer Custody Co-ordinator should work together to ensure that healthcare professionals are fully aware of their duty and role in the ACCT process. This might be incorporated into the training recommended above.

This recommendation has been accepted.

- 5 The Head of Healthcare should ensure that the in-possession medication risk assessment procedures are clear to all staff and are carried out appropriately. The Director should ensure this also forms part of the cell searching procedures

The recommendation has been accepted.

- 6 The Head of Healthcare and the Pharmacist should review the medicine management policy in relation to over the counter medication to ensure that potentially unsafe practices cease. This should include:
  - a system to ensure that healthcare professionals know which prisoners are on ACCT or at risk.
  - a system for ensuring nurses and officers do not give out more than safe amounts of over the counter medication

The recommendation has been accepted.

- 7 The Head of Healthcare must instruct all healthcare staff, including counsellors, to log all contact with prisoners to ensure continuity of care.

This recommendation has been accepted.

- 8 G4S healthcare services should have in place a Service Level Agreement with all external agencies, including the counselling service, contracted to carry out services through them to ensure effective team work. The Director of Altcourse should be satisfied that all contracted agencies share information effectively.

This recommendation has been accepted.

- 9 G4S healthcare services should review System One to ensure that it is fit for purpose taking into account the comments above.

This recommendation has been accepted.

#### *National Offender Management Service*

- 10 NOMS should approach the Law Society seeking their agreement to issue guidance to all solicitors to notify prisons directly if they are delivering difficult or distressing information to a prisoner.

This recommendation has been partially accepted. NOMS has responded as follows:

“The Law Society have already been asked to agree to circulate a letter, drafted by Safer Custody and Offender Policy, to legal advisors with some information about what they should do if a prisoner they are interviewing presents a risk of self harm or suicide. They declined to do this although they did agree that they would draft their own practice note to explain to solicitors their duty of confidentiality if a client discloses that they may harm themselves. The Law Society feels that a pragmatic approach is already taken by solicitors and that they would alert staff if they thought an individual was at risk.”