

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Glass, a prisoner at HMP Altcourse, on 20 February 2024

A report by the Prisons and Probation Ombudsman

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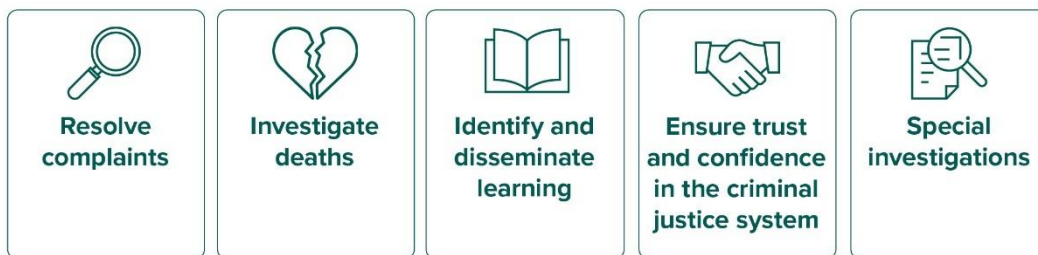
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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr David Glass was found hanging in his cell at HMP Altcourse on 20 February 2024. He was taken to hospital but was pronounced dead on arrival. He was 48 years old. I offer my condolences to Mr Glass' family and friends.

Mr Glass was the seventh prisoner to take his own life at Altcourse in three years. Up to the end of July 2024, there has been one further self-inflicted death at the prison.

Mr Glass was being held in the segregation unit when he was found hanging. He was refusing to move back to a standard wing because he said he was under threat from other prisoners. We are satisfied that Mr Glass gave no indication to staff that he was at imminent risk of suicide. However, we consider that staff could have done more to explore Mr Glass' concerns about being under threat. I have asked the Director to review Altcourse's violence strategy so that more guidance is available to staff on dealing with alleged threats of violence.

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

Adrian Usher
Prisons and Probation Ombudsman

November 2024

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Summary

Events

1. On 29 November 2023, Mr David Glass was sentenced to one year in prison for assault. He was sent to HMP Altcourse. It was not his first time in prison.
2. Mr Glass had a history of substance misuse and had anxiety and depression. When he arrived at Altcourse, Mr Glass told staff he had attempted suicide by taking an overdose in the past but had no current thoughts of suicide or self-harm.
3. Mr Glass was reviewed by a mental health nurse and a substance misuse worker. Neither had any concerns.
4. On 12 December, Mr Glass told a prison custody officer (PCO) that he was affiliated with a gang and had problems because of selling drugs and being in debt.
5. On 9 February 2024, prison staff found Mr Glass with an improvised weapon. Staff put Mr Glass on report (a disciplinary charge), and confined him to a cell on his own, while he waited for an adjudication (a prison's version of a court hearing.)
6. The next day, Mr Glass told the adjudicator that the weapon was for self-defence. He said someone had come to his cell and threatened him. The adjudicator found Mr Glass guilty of breaking prison rules and gave him seven days' cellular confinement as punishment. Staff moved Mr Glass to the segregation unit.
7. On 16 February, Mr Glass refused to go back to his previous unit and was placed on report again for refusing a lawful order. The next day, at his adjudication, Mr Glass told the adjudicator that other prisoners had accused him of being a sex offender and he was going to be assaulted. (Mr Glass did not have a conviction for a sexual offence.)
8. Mr Glass said he was willing to move to the vulnerable prisoners' unit (VPU) but would not move to any other unit. The adjudicator rejected Mr Glass' request to move to the VPU and found Mr Glass guilty. As punishment Mr Glass was given a further seven days' cellular confinement and remained in the segregation unit.
9. At 8.23am on 20 February, two PCOs, a nurse and a chaplain went to Mr Glass' cell to conduct a welfare check and deliver breakfast. Staff found Mr Glass with a ligature around his neck, which he had tied to the TV stand on his wall. Staff immediately entered the cell. The PCOs cut the ligature, radioed a medical emergency code and started CPR.
10. At 8.37am, paramedics arrived and continued CPR. They found faint signs of life and took Mr Glass to hospital. However, Mr Glass was pronounced dead on arrival at 9.38am.

Findings

11. We are satisfied that Mr Glass gave no indication to staff at Altcourse that he was at risk of suicide or self-harm and that they could not have foreseen his actions.
12. We consider that staff did not do enough to explore Mr Glass' concerns about being under threat. Although Altcourse has a Violence Strategy, it provides very little guidance to staff on how to support and manage victims of bullying, intimidation, or violence.
13. Mr Glass was held in segregation for 11 days but did not have an Initial Segregation Review Board throughout that time. The prison told us that as Mr Glass was held under cellular confinement, he did not require one. Segregation policy was updated two years ago to say that staff should hold an Initial Segregation Review Board for any prisoner held in segregation for more than 72 hours regardless of the Prison Rule under which they are held.

Recommendations

- The Director should review the prison's Violence Strategy so that it provides clear guidance to staff on how to identify and support prisoners at risk of bullying, intimidation, or violence.
- The Director should ensure that:
 - staff hold an Initial Segregation Review Board within the first 72 hours of segregation irrespective of which Prison Rule a prisoner is segregated under; and
 - all relevant segregation paperwork is updated to reflect the changes outlined in the June 2022 Security Briefing Note on Segregation.

The Investigation Process

14. HMPPS notified us of Mr Glass' death on 20 February 2024.
15. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator visited Altcourse on 7 March. He obtained copies of relevant extracts from Mr Glass' prison and medical records. He also obtained CCTV and Ambulance Service records. He obtained further information from the Deputy Head of Safety and the Head of Reducing Reoffending.
17. The investigator interviewed four members of staff at Altcourse on 7 March and 23 May. In May, June and July, he interviewed a further two staff and one prisoner over telephone and video call.
18. NHS England commissioned an independent clinical reviewer to review Mr Glass' clinical care at the prison. The clinical reviewer and investigator conducted joint interviews with two members of healthcare staff in July by video call.
19. We informed HM Senior Coroner for Liverpool of the investigation. We have sent the Coroner a copy of this report.
20. The Ombudsman's office contacted Mr Glass' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Glass' mother raised no issues and asked for a copy of this report.
21. We shared our initial report with HMPPS. They pointed out factual inaccuracies, which has been amended in this report.
22. We sent a copy of our initial report to Mr Glass' family and their solicitor. The family's solicitor pointed out some factual inaccuracies, which have been amended in the report. The family's solicitor raised some other concerns, which have been addressed in a separate letter.

Background Information

HMP Altcourse

23. HMP Altcourse is a local prison in Liverpool, which receives sentenced and remanded adult male prisoners and young offenders from the Cheshire and Merseyside courts. About half the population are on remand or serving very short sentences. Sodexo took over management of the prison from G4S in June 2023.
24. Practice Plus Group provides primary healthcare services at Altcourse. Mersey Care provides mental health services. Phoenix Futures provides non-clinical substance misuse services.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Altcourse was in November 2021. At the time of inspection Altcourse was run by G4S.
26. Inspectors noted that prisoners' safety was not sufficiently good and had deteriorated since the last inspection in 2017. Eight prisoners had taken their own lives; four in the previous 12 months. Levels of self-harm remained high and Early Learning Reviews had not been transferred into longer term safety plans. Staffing numbers had a detrimental impact on the development of primary and mental health care.
27. Staff-prisoner relationships remained a real strength. Inspectors observed supportive and caring interactions between staff and prisoners across all units. Key work took place more frequently than in similar prisons and was of a better standard.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2023, the IMB reported that staff shortages had impacted on the prison. Incidents of self-harm had risen.

Previous deaths at HMP Altcourse

29. Mr Glass was the twentieth prisoner to die at Altcourse since February 2021. Of the previous deaths, six were self-inflicted, 11 were from natural causes and two were drug related. Up to the end of July 2024, there has been one further self-inflicted death and two from natural causes.
30. Following a self-inflicted death at Altcourse in April 2021 (under G4S management), we recommended that the Director should ensure that staff identified and managed prisoners at risk of bullying, intimidation, or violence in line with the prison's violence reduction policy.

31. We were told that the prison planned to deliver Challenge, Support, and Intervention Plan (CSIP) training and awareness sessions for all operational staff in April 2022. The training would address the key principles of CSIP, the referral process and the requirements of staff when managing at risk prisoners. It would also ensure staff were aware that the CSIP process must be considered as a tool to support all apparent victims of violence, bullying and intimidation.

Key worker scheme

32. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:
- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
 - Key workers must have completed the required training.
 - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
33. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.
34. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

35. On 29 November 2023, Mr David Glass was sentenced to one year in prison for assault. He was sent to HMP Altcourse. It was not his first time in prison.
36. When he arrived at Altcourse, Mr Glass told the reception nurse that he had anxiety and depression. He said that he had never self-harmed but had attempted suicide 18 months earlier by taking an overdose (five months earlier, according to his pre-sentence mental health assessment and years earlier according to medical records). Mr Glass told staff he had no current thoughts of suicide or self-harm. A GP continued his prescription for mirtazapine (an antidepressant).
37. Mr Glass told the reception nurse that he had a history of substance misuse and tested positive for several illicit substances including cocaine and methadone (a medicine used to treat heroin addiction). The nurse referred him to the prison's substance misuse service (SMS). A GP continued the methadone prescription.
38. Staff allocated Mr Glass to a cell on Furlong Red, an induction and detoxification unit. Healthcare staff monitored him for withdrawal symptoms and assessed that he was showing no significant symptoms.
39. On 1 December, a nurse carried out a mental health assessment with Mr Glass. He said he had no mental health concerns and no thoughts of suicide or self-harm. She noted his diagnoses of anxiety and depression and had no concerns. She told him how to contact the mental health team if he required support.
40. On 4 December, a member of the SMS team reviewed Mr Glass. He said that he had taken an overdose previously but had no current thoughts of suicide or self-harm. The SMS worker gave him harm minimisation advice and booked another review in 13 weeks.
41. On 10 December, a prison custody officer (PCO) saw Mr Glass for a key worker session. He noted that Mr Glass told him he was fine and had no problems. Mr Glass said he wanted to be drug free and move to Furlong Green, the substance misuse recovery unit.
42. On 12 December, the gang liaison officer visited Mr Glass. Mr Glass told her that he had issues due to dealing drugs and debts in the community. She told us that when she tried to explore further, Mr Glass was evasive and would not give her a straight answer. (Information suggested Mr Glass had issues with a local gang and there was a "remote chance" he was under threat.)
43. On 14 December, Mr Glass was moved to Reynoldstown Blue unit (a standard residential unit).

2024

44. On 8 February 2024, at 10.28am, Mr Glass phoned home and spoke to his brother. The investigator listened to the call. Mr Glass told his brother he had bought vapes for £10 from other prisoners. To pay for the vapes, Mr Glass asked his brother to transfer £10 into someone's bank account. Mr Glass' brother agreed to transfer the

money. (Mr Glass' family noted that the actual amount Mr Glass requested they send to a prisoner's partner's bank account was £10.01.)

45. At 6.26pm, Mr Glass phoned home and spoke to his mother. The investigator listened to the call. He asked her to transfer the money for the vapes he had bought. Mr Glass' mother said she was not able to transfer the money until the following morning. Mr Glass also spoke with his brother and told him he had received a court fine of £1200 and needed to pay a lump sum of £150 within 56 days of his release.
46. On 9 February, CCTV footage shows Mr Glass had his cell door closed throughout the morning. Prison staff then found Mr Glass with an improvised weapon. Staff put Mr Glass on report (issued him with a disciplinary charge for breaking prison rules) and moved him to a cell on Canal Green unit, while he waited for an adjudication (a prison's version of a court hearing).
47. The next morning, at his adjudication, Mr Glass told the adjudicator, an operational middle manager (OMM), that he had the weapon for self-defence. He said someone had come to his cell and threatened him. The OMM found Mr Glass guilty of breaking prison rules. As punishment, she gave Mr Glass seven days cellular confinement. Prison staff then moved Mr Glass to the Care and Separation Unit (CSU - the segregation unit) to serve his period of cellular confinement.
48. A nurse completed an initial segregation health screen (segregation algorithm) and assessed that there were no health reasons why Mr Glass could not be held in segregation. A nurse or GP saw him daily and had no concerns.
49. On the morning of 16 February, Mr Glass had completed his cellular confinement, but refused to go back to Canal Green. Prison staff put Mr Glass on report for refusing a lawful order. Later that morning, Mr Glass phoned home, but no one answered.
50. The next morning, at his adjudication, Mr Glass submitted a written statement, in which he said other prisoners had accused him of being a sex offender and prisoners would stab, slash, or throw hot water at him. (Mr Glass did not have a conviction for a sexual offence.) He said there was a price on his head and that he could not go to any of the units in the prison other than Melling, the vulnerable prisoners' unit (VPU), and even if he went to the VPU, he would have to make a 'shiv' (an improvised weapon) to protect himself.
51. The adjudicator, the Head of Residence, rejected Mr Glass' request to move to the VPU as he did not meet the vulnerable prisoner criteria. (Vulnerable prisoners are those who would be at risk due to their offence (sexual offences) or due to being a former police or prison officer.) He found Mr Glass guilty of refusing a lawful order to move back to a standard unit. As punishment he gave Mr Glass a further seven days in the CSU.
52. A nurse partially completed a segregation algorithm and indicated that there were no health reasons why Mr Glass could not continue to be held in segregation. A nurse or GP saw Mr Glass daily and had no concerns.

53. On 19 February, Mr Glass called home five times. There was no answer for four of the calls but, at 2.38pm, someone answered and spoke with Mr Glass for 15 seconds. (The investigator was unable to listen to this call due to the changing of the telephone system at Altcourse and the loss of the recording.) At 3.40pm, someone transferred £30 into Mr Glass' prison account.
54. CCTV footage shows that at around 6.50pm, staff unlocked Mr Glass and took him to collect his medication. Staff then returned Mr Glass to his cell.
55. CCTV footage shows that throughout the night and into the early morning of 20 February, prison staff checked Mr Glass hourly. There were no concerns.

Events of 20 February

56. At 6.58am on 20 February, a PCO carried out a routine check of all prisoners on the CSU. He told us in interview that he saw Mr Glass lying on his bed under his blanket, with his knees up.
57. Later that morning two PCOs, a prison chaplain and a nurse were doing welfare checks and handing out breakfast in the CSU. CCTV footage shows that they arrived at Mr Glass' cell at 8.23am.
58. A PCO looked through Mr Glass' observation panel and saw Mr Glass with a ligature around his neck. Mr Glass had made the ligature from a bed sheet and had attached it to a TV stand above the sink in his cell. The PCO said Mr Glass' feet were touching the floor.
59. The PCOs immediately entered the cell, followed by the nurse. Both PCOs cut the ligature. A PCO radioed a code blue medical emergency (used when a prisoner is unconscious which tells the control room to call an ambulance immediately).
60. The nurse told us she shook Mr Glass by the shoulder and called his name. She said Mr Glass did not respond and she could not find a pulse. She said she and the PCOs put Mr Glass on his back, and they started CPR.
61. At 8.24am, control room staff called an ambulance.
62. The nurse told us that after two rounds of CPR Mr Glass still had no pulse or signs of life. She then took over chest compressions. More prison and healthcare staff arrived, and CPR continued.
63. A PCO fetched the defibrillator, which healthcare staff attached to Mr Glass. Another nurse noted that the defibrillator advised no shock, so staff continued CPR.
64. At 8.37am, paramedics arrived at the cell and took over CPR. Shortly after, a second ambulance crew arrived. Paramedics detected faint signs of life and took Mr Glass to Aintree Hospital. However, a hospital doctor pronounced him dead on arrival at 9.38am.

Contact with Mr Glass' family

65. On 20 February, at 9.45am, the prison appointed a family liaison officer (FLO). At 10.50am, the FLO and the Prison Director attended Mr Glass' mother's address and informed her of Mr Glass' death.
66. The FLO maintained contact with Mr Glass' family over the following days, offering support and advice. On 28 March, the FLO, as a prison chaplain, led Mr Glass' funeral service.
67. The prison contributed to the costs of Mr Glass' funeral in line with national policy.

Support for prisoners and staff

68. After Mr Glass' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
69. The prison posted notices informing other prisoners of Mr Glass' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Glass' death, and prison carers were deployed in the CSU to support prisoners if needed.

Post-mortem report

70. We have not yet received the post-mortem report from the Coroner.

Findings

Assessment of Mr Glass' risk

71. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm. It sets out the risk factors and triggers that could indicate increased risk.
72. Mr Glass had previously attempted suicide by taking an overdose. However, we are satisfied that Mr Glass gave no indication that he was at risk of suicide or self-harm while he was at Altcourse. This included while he was in the CSU when he was seen daily by either a GP or nurse. No concerns were ever raised. We are satisfied that staff could not have foreseen Mr Glass' actions.

Violence reduction

73. Mr Glass told staff that he was under threat from other prisoners, and he refused to leave the CSU to go back to a standard residential unit because he was scared that he would be attacked. He asked to go to the Vulnerable Prisoners Unit, but staff refused this request.
74. We have previously noted the links between bullying and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013-2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated, and responded to robustly.
75. Altcourse's Vulnerable Prisoner (VP) Policy dated March 2023, says, "In the event that a prisoner claims to be under threat, he will be interviewed by the FLM and the details surrounding the threat / issue explored. Consideration will be given to a possible change of cell or unit location. The prisoner will not be offered VP status unless he fits the criteria for VP due to his offence."
76. Mr Glass' offence did not meet the criteria for VP status, so we consider it reasonable that his request was refused. However, staff did very little to explore the nature of the alleged threat against Mr Glass.
77. Altcourse has a Violence Strategy dated January 2024, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence, using the Challenge, Support, and Intervention Plan (CSIP) model. However, the focus of Altcourse's strategy is on the perpetrators of bullying, intimidation, or violence, with little to no guidance on how to support and manage victims. All it says is, "Particular attention will always be paid to the victims of violence or bullying. They will require support and may have concerns regarding their personal / mental wellbeing or the safety of their families and will require help to restore confidence and feel secure." We consider that this does not provide sufficient guidance to staff.

78. We recommend:

The Director should review the prison's Violence Strategy so that it provides clear guidance to staff on how to identify and support prisoners at risk of bullying, intimidation, or violence.

Segregation review board

79. Mr Glass was segregated for a total of 11 days between 9 and 20 February. Staff did not hold an Initial Segregation Review Board for Mr Glass throughout that time.
80. Prison Service Order (PSO) 1700 on segregation recognises that a prisoner's mental health is likely to decline when they are kept in segregation. One of the purposes of the Initial Segregation Review Board is to discuss any concerns about how the prisoner is coping with segregation and to consider whether segregation continues to be appropriate or whether additional steps are needed to safeguard the prisoner's mental health.
81. PSO 1700 used to say that only prisoners held under Rule 45 (a specific Prison Rule which does not cover prisoners segregated for cellular confinement after an adjudication) would receive an Initial Segregation Review Board after 72 hours. However, following a previous PPO investigation, we recommended that an Initial Segregation Review Board should be held for all prisoners held in segregation beyond 72 hours, irrespective of the Rule under which they were held. HMPPS accepted this and in June 2022, issued a Security Briefing Note to this effect to all prisons.
82. Mr Glass was not held under Rule 45 so prior to June 2022, would not have required an Initial Segregation Review Board. However, he did require one under the updated segregation policy. If an Initial Segregation Review Board had taken place in Mr Glass' case, it would have given an extra opportunity to identify any decline in his mental health and to offer additional planning and support. We recommend:

The Director should ensure that:

- **staff hold an Initial Segregation review within the first 72 hours of segregation irrespective of which Prison Rule a prisoner is segregated under; and**
- **all relevant segregation paperwork is updated to reflect the changes outlined in the June 2022 Security Briefing Note on Segregation.**

Clinical care

83. The clinical reviewer concluded that the care Mr Glass received at Altcourse was not of a satisfactory standard and was not equivalent to that which he could have expected to receive in the community. He identified that Mr Glass' secondary health screening was completed outside the seven-day timescale and the medicines reconciliation was completed outside the 72-hour timescale. Also, the second

segregation algorithm was not fully completed, and some of the reviews conducted by healthcare staff were not recorded in Mr Glass' medical records.

84. The Head of Healthcare said that staffing shortages had affected the timeliness of the secondary health screen and medicines reconciliation. She said that steps had been taken to address the issues with the segregation algorithm, including training for healthcare staff and liaison with the Head of Safety with a view to improving joint working between prison and healthcare staff for segregated prisoners.
85. The clinical reviewer made several recommendations not directly related to Mr Glass' death, which the Head of Healthcare will wish to address.

Key work

86. All prisoners in the male closed estate are supposed to receive weekly key worker sessions. However, since arriving at Altcourse, Mr Glass only received one key worker session in December 2023, while he was on Furlong Red, an induction and detoxification unit.
87. The Head of Reducing Reoffending accepted that it was not reasonable for Mr Glass to have received only one key worker session while at Altcourse.
88. The Head of Reducing Reoffending said Altcourse had faced post COVID-19 challenges, which included staffing issues. He said not all prisoners received key work. To address key work delivery at Altcourse, he said work was being done on staff recruitment and retention; assigning residential unit staff specifically for key work duties; monitoring delivery and improving the quality of sessions.
89. The Head of Reducing Reoffending said that currently they were targeting key work delivery towards more vulnerable prisoners, and the number of key work sessions delivered had improved.
90. It is difficult to say whether Mr Glass would have shared any risk related information with a key worker. Mr Glass gave no indication to staff that he was a risk of suicide. It is possible therefore that key worker sessions would have made no difference to the outcome for Mr Glass. Nevertheless, key worker sessions are important in establishing good relationships between prisoners and staff and should be fully resumed as soon as staffing levels allow.

Inquest

91. At the inquest, held from 14 to 23 September 2026, the jury reached a narrative conclusion:

David John Glass had experienced a history of mental health difficulties including anxiety and depression, suicide attempts and ideation and an increasing fear of perceived threats. These circumstances contributed to his decision in taking his own life. David subsequently died as a result of injuries sustained in his suicide attempt.



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