

**Investigation into the death of a man whilst in the custody
of HMP & YOI Altcourse in 4 April 2011**

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

March 2012

This is the report of an investigation into the death of a man who was a prisoner at HMP Altcourse. In April 2011, he was found hanging in his cell. He was taken to hospital but died. I offer my condolences to his family and friends for their loss.

One of my investigators was appointed to carry out the investigation. A review of the man's healthcare was commissioned by Liverpool Primary Care Trust (PCT). I am grateful to the clinical reviewer for carrying out the review, which is annexed to this investigation report. I am also grateful to the Director of HMP Altcourse and his staff for their co-operation and assistance during this investigation. I apologise that this report has been delayed.

The man arrived at Altcourse in March 2011. He said he felt under threat due to his size (he was five foot tall and weighed six stones) and was moved to the vulnerable prisoner unit. Although he appeared to settle in well and get on with his peers, he began to think that other prisoners were shouting at him. This culminated in him threatening to jump from the wing landing if he was not segregated. Suicide prevention measures were begun and, on the same day, he was moved to the segregation unit (known as the care and separation unit or CSU), where he took his life two days later.

While the man received adequate care in the CSU, these are inherently restricted environments which house some of a prison's most challenging prisoners. They are not appropriate places in which to best manage vulnerable prisoners at risk of self-harm, which is why Prison Service policy states that this should only occur in exceptional circumstances. It is troubling, not only that he was segregated, but that this appears to have become an increasingly common practice with prisoners at risk of self-harm at HMP Altcourse. I strongly recommend that the director addresses this issue and ensures that more appropriate settings are found for such prisoners.

The investigation also suggests a number of other lessons that can be learned, including a need to improve the use of radio codes when responding to emergencies – a point raised previously after a death in custody at Altcourse. It is to be hoped that, together, the recommendations help the prison to avoid tragic deaths such as that of the man occurring in future.

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.

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Prisons and Probation Ombudsman

March 2012

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SUMMARY

1. The man was remanded in to the custody of HMP Altcourse in March. Despite a history of harming himself and substance misuse, he was assessed as presenting no risk to himself at the point of reception. He was prescribed medication to help with his substance withdrawal and was taken to a wing used to manage prisoners going through detoxification. On 11 March, he requested to be moved to the vulnerable prisoner unit as he felt threatened by other prisoners. As there was no room in the unit at that time, he was relocated to the care and separation unit (CSU, also called the segregation unit by staff).
2. Suicide prevention measures were begun on 16 March when a chaplain reported that the man told him he was thinking about harming himself. However, he was primarily concerned about the type of sentence he might receive and, when these fears were allayed, the measures were stopped. He stayed in the CSU until 18 March when he was located in the vulnerable prisoner unit (VPU).
3. Staff and prisoners recalled that the man settled into the VPU quite well and associated with the other prisoners. Although he sometimes claimed that people were shouting at him, none of the staff or prisoner representatives thought he was at risk of harming himself. He did not isolate himself and was said to have got on well with his cellmates.
4. However, in the morning of 2 April, the man climbed over the landing bars on the first floor of the wing and threatened to jump. He said that other prisoners were taunting him and he needed to get off the wing. He was seen by a mental health nurse and suicide prevention measures were begun before he was taken to the CSU.
5. Staff recalled that the man seemed to cope adequately in the CSU, although he again told staff that he was being shouted at by other prisoners. Despite this, he was unable to indicate who had been shouting at him and he admitted that he might have been suffering from paranoia. On the day the man died he was found in his cell hanging, having tied a ligature from his neck to the sink. Prison officers and healthcare staff attempted to resuscitate him and he was taken to hospital. Unfortunately he died shortly after.
6. The investigation examined the suicide prevention measures put in place to protect the man and the decisions to locate him in the vulnerable prisoner unit and CSU. The report makes a number of consequential recommendations.

THE INVESTIGATION PROCESS

7. The investigation was opened on 4 April 2011, when my investigator issued notices announcing the investigation to staff and prisoners. He visited Altcourse on 6 April where he met the Director of Altcourse and the prison family liaison officer. The investigator also met the prison controller (a Ministry of Justice appointee responsible for monitoring a private prison's contract), and discussed the investigation with her. My investigator also visited the wing where the man lived. Transcripts of these interviews are annexed to the report. The investigator was provided with all documentation relating to the man.
8. The investigator visited HMP Altcourse with a colleague again on 24 May and 12 July. During these visits, they conducted interviews with eight staff and three prisoners. The investigator wrote to the Director providing initial feedback on the progress of the interview.
9. Liverpool Primary Care Trust (PCT) asked the clinical reviewer to review the man's clinical care on their behalf and he was provided with all relevant documentation to assist this review. The Ombudsman thanks the clinical reviewer for the clinical review, which was received on 25 October 2011 and is the first annex to the investigation report. The delay in receiving the clinical review has caused the delay in the publication of this report, for which the Ombudsman apologises.
10. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. The investigator provided the coroner with a progress report during the investigation to keep him informed of relevant developments. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
11. One of the Ombudsman's family liaison officer contacted the man's family to inform them of the investigation and invite them to ask questions or raise concerns about the care of the man. The investigator and the Ombudsman's family liaison officer met with members of his family on 20 May to discuss the investigation. They wished to know more about what suicide prevention measures the man was subject to, why he wore certain clothes during a visit from his solicitor, and what medical care he received. They also asked whether he had a television in his cell, why he had his shoelaces in his possession and raised concerns about the behaviour of the bedwatch officers.
12. Following the publication of the draft report, responses were received from the National Offender Management Service (NOMS) and the man's family. NOMS accepted all of the recommendations and their response to each recommendation is included from page 35 onwards. The man's family explained that they found the investigation report informative and helpful and raised no further concerns for the investigation.

HMP ALTCOURSE

13. Altcourse is a private prison run by G4S. It was opened in 1997 and holds over 1,000 prisoners. It accepts adult men and young offenders from the Merseyside, Cheshire and North Wales' courts. There is a healthcare unit at Altcourse with space for 12 prisoners.
14. The prisoners live in seven houseblocks, all named after Grand National fences. There is also a care and separation unit with 22 cells.

Care and Separation Unit (CSU)

15. The Care and Separation Unit (CSU) is a small area of the prison used to hold prisoners who are segregated from the mainstream. This may be as a result of breaching prison discipline or to protect them from other prisoners. Due to this, the regime is restricted and prisoners may have less access to facilities and activities than they would in the main prison.
16. When a prisoner is brought into the CSU certain procedures must be carried out to ensure that the prisoner can cope with the restricted regime. These include the completion of an Initial Segregation Safety Screen (a process to check whether the prisoner can cope in the CSU) and the beginning of a segregation history sheet. The CSU has room for 22 prisoners. It has a permanent staff of eight officers with three on duty at any one time during the day.

Indeterminate Sentence

17. An indeterminate sentence is a life sentence, where a minimum tariff is given, but the prisoner must satisfy the Parole Board that he is fit for release and does not pose any threat to the community. A prisoner's risk factors are identified by psychological assessments and they are required to complete work to help reduce their risk and improve their chances of being considered for parole.

Reynoldstown Blue

18. Reynoldstown Blue is the vulnerable prisoner unit (VPU) where prisoners are accommodated who are too vulnerable to live with the main prison population. This may be due to the nature of their offence, or because they are in debt or have been bullied. (Prisoners accused of sexual crimes are often located in vulnerable prisoners unit for their own safety.) There are usually about 90 prisoners on the wing. There are five single cells, four three-man cells and the rest are double cells.

Assessment, Care in Custody and Teamwork (ACCT) process

19. When a prisoner is deemed to be suicidal or at risk of harming themselves staff can use the ACCT (Assessment, Care in Custody and Teamwork) framework to monitor and protect the prisoner concerned. Once placed on an

ACCT, the prisoner is observed at predetermined intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. Only in “exceptional” circumstances should a prisoner have an open ACCT document and be located on the CSU.

Command suite

20. The command suite is a room used by staff when managing a serious incident. The commander of the incident will be based in the command suite to coordinate the prison’s response.

Carer

21. A carer is a prisoner used by Altcourse to provide emotional support to other prisoners. They are trained, selected and supported to offer emotional support, 24 hours a day, to fellow prisoners in distress. They do not offer a confidential or counselling service.

Independent Monitoring Board (IMB)

22. Each prison has an Independent Monitoring Board (IMB) made up of members of the local community. The IMB’s role is to ensure that the prison is properly run and that prisoners are treated decently. Each IMB produces an annual report for the Secretary of State. The most recent report from the Altcourse IMB covers the period of July 2009 to June 2010. The Board’s report notes that safer custody is given the highest priority at Altcourse. At the time of the report there were 12 full-time and 5 part-time carers.
23. The Board was complimentary of the staff in the CSU but expressed some concerns regarding the quality of the educational materials available to prisoners there. The report also included an explanation of changes in the CSU that now allowed risk-assessed prisoners to exercise together, and collect their meals from the servery.

Her Majesty’s Chief Inspector of Prisons

24. Altcourse was most recently inspected by Her Majesty’s Chief Inspector of Prisons from 15 to 22 January 2010. The report described Altcourse as a safe prison, where there was good support for prisoners at risk of harming themselves. Overall, ACCT processes were described as good, although it was noted that not all reviews involved staff from a number of departments.
25. The segregation unit staff were described as “professional but a limited regime restricted interactions with prisoners and segregation reviews lacked depth.” With regard to education, the report noted: “Teaching and coaching in the education centre were good, but on the wings there was too much reliance on individual resource-based learning.”

Previous deaths at Altcourse

26. The man's death was the ninth self-inflicted death at Altcourse since the Ombudsman began investigating deaths in custody in 2004, although there had not been one since March 2009 until the man died. There were no overt similarities with the most recent death.

KEY EVENTS

Reception to Altcourse

27. The man was arrested and charged in March 2011.
28. In the morning of 9 March, the man passed from the custody of the police to the escort services who took him to court. The police gave the escort services his person escort record (PER). The PER is a document, individual to each prisoner, agreed by all the agencies involved in the management of the transfer of prisoners between the police, courts and prisons. The man's PER included the following reference in the risk section: "Cut wrists about 1 year ago. Tried to end it all tonight on risk assessment." The person in the police station who completed the PER noted that the man suffered from non-diagnosed depression.
29. At 7.58am, Prisoner Custody Officer (PCO) A (a member of the escort staff taking the man to court) opened a suicide/self-harm warning form due to information on the PER. She wrote on the form: "DP [detained prisoner] interviewed. States he has no thoughts [of suicide or self-harm] at the moment. Also stated 'that does not mean I won't try anything.'" She deemed it necessary for the man to be checked irregularly.
30. The man appeared in court and was remanded into custody. His case was scheduled to be heard in court on 15 April 2011. The reasons given for the refusal of bail were:
 - “1 you are unlikely to attend if you are given bail.
 2. you are likely to offend if you are given bail.
 3. you need to be kept in custody for your own protection.

This is because:

 1. you have tried to commit suicide.
 2. you have made threats.”
31. According to the PER, the man arrived at Altcourse at approximately 3.00pm. It was not his first time in custody, but he had not been in Altcourse before.
32. All prisoners entering a prison must undergo the reception process in the prison, including a number of assessments and interviews. A cell sharing risk assessment (CSRA) was undertaken to assess the man's risk of assaulting a cellmate. The assessment acknowledged his charge of arson and noted that he said he had no problems with sharing a cell. It was also noted that he needed the Integrated Drug Treatment Service (IDTS) due to his history of alcohol and drug misuse. PCO B judged the man to be at low risk of assaulting a cellmate. Section 3 of the CSRA is completed by a member of the healthcare staff. The member of healthcare (signature illegible) agreed that the man was at low risk of assaulting a cellmate. The nurse noted the

self-harm concerns that had been raised. The man underwent a voluntary drug test which was positive for opiates and cannabis.

33. Nurse A, a Registered Mental Health Nurse (RMN), conducted a first reception health screen with the man at 4.45pm. The nurse referred the man to the doctor and the drugs treatment service regarding detoxification for his substance misuse. The man was assessed as fit for normal location, work and cell occupancy. He told staff he was concerned that he was at risk from other prisoners due to his small stature. He said that he had no mental health problems and had no thoughts of harming himself at that time. However, he said that he had harmed himself about a year previously and had been admitted to a psychiatric hospital. The nurse referred the man for a mental health assessment.
34. Prison doctor A carried out a further health assessment at 6.45pm to determine the man's level of withdrawal. He noted the positive tests for opiates and cannabis, and his denial that he had taken heroin. He said he was on codeine medication which could have caused the positive opiate test. The doctor prescribed Chlordiazepoxide (for anxiety issues regarding alcohol withdrawal) and Thiamine and vitamin B compound tablets (used to treat the symptoms of vitamin B deficiency associated with alcohol abuse). He was prescribed Naproxen to relieve symptoms of arthritis. He said that he used alcohol daily but had not injected drugs for over 15 years. He was located on the IDTS unit.
35. The man was provided with a tobacco pouch and offered a telephone call. PCO B wrote in his prison file:

“Not been here before, states no thoughts of SASH [suicide and self-harm] at this moment. Came with SASH marker from court but stipulates he feels fine. One remand for arson i.e. tried to burn his house down. Inmate is requesting detox due to alcohol and drug misuse.”
36. The first night officer noted in the 'urgent needs' section of the Prisoners' Initial Custody pack that the man had cut his wrist a year ago due to depression and a desire to "end it all". Next to that was written "states has no thoughts at present but that doesn't mean he won't try anything." The man received prison issue clothing, footwear and a belt as he did not have any other clothing with him.
37. In line with first night procedures at Altcourse, the man was observed twice an hour overnight. (All prisoners are placed on a first night watch when they first come into custody at Altcourse.) Carers see all new prisoners on their first night in custody and prisoners can request to see a carer at any time. The man met the carer who recorded that, although the man had harmed himself previously, he was not worried about bullying and was able to cope in prison. The carer wrote: "Currently feels fine but worried without medication he will not feel so good over next few days. Waiting to see psychiatrist." (However, there is no evidence in the medical file that the man was scheduled to meet a

psychiatrist. He was awaiting a mental health assessment which may have been what was meant.)

38. On 10 March, the man received his gym induction, was introduced to the chaplaincy and underwent an education assessment. He also saw another carer. The carer completed a form noting that he had concerns about the man as he had talked about harming himself. The carer wrote: "Prisoner talking about harming himself. Could officers keep eye on him will refer him to a councillor." The carer noted that he planned to see the man on 15 March.

The Care and Separation Unit

39. It was noted in the man's personal record that he requested vulnerable prisoner status on 11 March. He said he felt under threat from other offenders from the Widnes area who had knowledge of his background. He was moved into the care and separation unit (CSU) at 3.05pm. This removed him from the general population while he was assessed as to his suitability for vulnerable prisoner status. He had a television in his cell. An initial segregation health screen was undertaken by Nurse B. The man was judged able to cope in the CSU and no healthcare intervention was needed at that time.
40. The man was interviewed by a manager in the CSU to see if it was appropriate to locate him on the VPU. It was agreed to move him to Reynoldstown Blue (the vulnerable prisoner unit) when a space became available. It was noted that he was not a sex offender and would participate in the regime on the wing.
41. PCO C described the man when he first came to the CSU:

"When he first come down he was very strange, if you'd say strange. He was very 'I haven't done anything, you know, why am I in prison? why am I in jail?', but then he kind of come round and he got his head round and he was fine. He seemed to be happy that he was alright and said he was safe."
42. Nurse C who was a RMN conducted a mental health assessment in healthcare at 4.18pm following the referral made in reception due to the man's history of harming himself and current detoxification treatment. He presented well in mood and behaviour, and maintained appropriate eye contact. He said he had no thoughts of harming himself or intent or plan of suicide. The nurse provided information to the man on how to access the mental health team. She told the investigator that: "when I saw him he presented no obvious mental health issue."
43. The man said he had requested vulnerable prisoner status as he felt under threat from other prisoners from his local area, but did not mention any names. He also said that he felt vulnerable because of his size and urinary incontinence through the night. Nurse C said that she would speak to the unit manager regarding this request.

44. PCO D met the man during this time in the CSU. He said that the man told him that he was worried about being attacked on normal location, due to differences he had with some prisoners. The PCO recalled that the man was happy to go to Reynoldstown Blue as it would be safer and he would have access to greater facilities than in the CSU. He described the man to the investigators as:
- “He was sound. He was dead quirky, he had a good sense of humour, he was funny, that’s what I can remember from him, you know, never had any issues with him, he never caused any trouble whatsoever to staff.”
45. The man was assessed again on 13 March by Nurse D. The nurse noted that the man was low in mood and self esteem, and that he was possibly suffering from depression. The man said he was concerned about his brother and sister who had not been to see him. He also said that he had no money in his account to telephone them and had no cigarettes. The nurse recorded that he needed another mental health review. The man was also placed on the IDTS review list as he said he was withdrawing from opiates. He was prescribed medication to help relieve his bladder problems and it was decided that the man should remain in CSU at that time.
46. A mental health referral form was submitted by a member of staff on 13 March. It said “Low in mood and self-esteem presenting with depression, query needs coping mechanisms. No thoughts of SASH/self-harm.”
47. Another carer saw the man on 14 March and ticked the box indicating that he was concerned about him as the man talked of harming himself. The carer wrote on the form “Wants to go on the VP wing. Wants to stay off wings with Widnes lads on.”
48. Nurse D held an IDTS review with the man at 3.08pm. She noted that he was currently taking chlordiazepoxide (used for anxiety relief) and had been in prison for a week. The man said he felt like he was withdrawing from the codeine medication he was taking prior to coming into prison and said that his arthritis medication was not working. (Codeine is an opiate typically used to treat pain.) The nurse scored his opiate level as 6 (mild withdrawal) and referred him to the doctor for a medication review.
49. A segregation authority review was completed on 14 March by the Head of Safer Custody at the time of the man’s death), Nurse E (a Mental Health nurse), the suicide prevention co-ordinator and Head of the Altcourse IMB). The man was told that he was segregated for his own interests. It was noted that the man was fully compliant and raised no issues. He did not raise any mental health concerns. (The CSU records show that the man had not raised any issues in the previous days.) The man underwent another voluntary drug test on 14 March where he was found to test positive for benzodiazepines and cannabis. (Benzodiazepines are drugs used for a number of reasons such as to treat anxiety, insomnia and agitation.)

50. ACCT procedures were begun at 10.40am on 16 March by a member of the chaplaincy department. The man had returned from a visit with his solicitor and believed he was looking at an indeterminate sentence of at least 15 years. He said that his head was all over the place as he was confused at his potential prison sentence. He asked to see a doctor but did not want to see a nurse. He said he wanted something to calm his nerves as he was seriously thinking about harming himself. (PCO D told the investigators he believed the man's concern was connected to a lack of tobacco.) Although he did not state he would harm himself, the chaplain believed he may have harmed himself if things did not go as he wanted them to. The immediate action plan required the man to remain in the CSU, be observed five times each hour and for carers and telephone calls to be made available should he need them.
51. PCO E conducted the assessment interview at 2.00pm. He told the investigators that the man was concerned by the implications of an indeterminate sentence, but was confused rather than visibly upset. He told the officer of his history of alcohol and substance misuse. The PCO told the investigators he was adamant he would not harm himself.
52. A 'prisoners in CSU on ACCT' form was completed at 4.00pm. It appears to have been signed by Head of Safer Custody. On it was written:
- "Placed himself into CSU as he claims he is under threat at Altcourse from other prisoners. Not a sex offender so VP is unsuitable. No other choice but to keep in CSU."
53. A case review must be carried out within 24 hours of ACCT procedures starting. The review was conducted at 4.10pm, and was chaired by the Head of Safer Custody. It was recorded that, following the visit from his solicitor, he was under the impression he was going to have to spend the rest of his life in prison if he received an indeterminate sentence. After the Head of Safer Custody explained indeterminate sentences to him, he appeared much better. It was noted that the man had no thoughts or plans to harm himself in any way and spoke of leaving the CSU to return to normal location. The ACCT was closed and a post-closure review was scheduled for 24 March. However, there is no evidence a post closure interview was held. PCO E described the man's reaction to the closure of the ACCT:
- "He was happy. He didn't really want to be on it. Like I say, he came across as he had no thoughts of, he held himself well, he wasn't upset in anyway, he didn't say he had any intent, any thoughts of self-harm or suicide."
54. Dr B, a prison doctor, reviewed the man's medication in the afternoon of 17 March. He saw no objective signs of withdrawal from drugs or alcohol and so did not alter his prescribed medications or prescribe any barbiturates (sedatives used for withdrawal).

55. According to an entry in the man's daily history sheet that night, he said he was being verbally bullied and threatened throughout the night. When asked by staff who had been shouting at him, he was unable to identify the perpetrator. No other issues were noted about this or on the preceding days.

The Vulnerable Prisoner Unit

56. The man was transferred to Reynoldstown Blue on 18 March. He had an introductory meeting with PCO F the following day where she explained the expectations of the wing. The man signed the vulnerable prisoners' compact, agreeing to the rules of the wing. She told the investigators that the man was a bit nervous about coming on to a new wing, but he settled well and she never saw him being bullied. PCO G explained that he was originally in a double cell but staff put him in with two other prisoners that he got on well with. She said that he mixed well with the other prisoners on the wing and described the man's behaviour to the investigator during his first two weeks on the unit:

"He was well known to all the staff on there because we have to shout prisoners obviously when they're going to healthcare visits, no matter who you'd shout he would come. He used to think you were shouting at him no matter who we would shout so we all got to know, we'd all say no to the man, we weren't shouting you ... but he was never a problem. He never ever came down while I was on anyway and said anything to me that he needed to move or he wasn't happy. He used the yard a lot with other prisoners; he used to play pool with other prisoners."

57. PCO G said that she spoke to the man on a number of occasions and he never raised any concerns with her. She said that she never heard anyone taunting him or calling him names. PCO H also told the investigators that the man would frequently respond when officers called other prisoners.
58. The man underwent an induction interview with a prison carer. The carer explained to the investigators that the purpose of the induction meeting was to check on the new prisoner's wellbeing, and to see if they have any needs to be followed up. He told the care that he felt able to cope in custody, was not worried about bullying at Altcourse but did feel anxious. He said that he had harmed himself in February 2011, and was aware of the support available in the prison. (This is the only record of the man harming himself so close to his time in custody.)
59. The care told the investigators that the man never spoke to him of bullying while on Reynoldstown Blue, and he never saw anything involving the man. He said that he never had any concerns regarding the man harming himself, and, had he thought the contrary, he would have written the information down. The carer told the investigators that that he helped the man write a letter that day. The following day, the carer read the man a letter from his solicitor and helped him complete his canteen sheet.

60. Another carer told the investigators that he helped the man with a number of applications, and lent him some tobacco. He said that he started to write a letter for him, but did not think it was completed before the man moved to the CSU.
61. On 22 March, the man had a safer custody interview with the prisoner safer custody representative. The prisoner safer custody representative explained to the investigators that he spoke to every new prisoner on the wing and explained how prisoners could complain if they felt intimidated. He recalled that the man told him he had “no concerns at all.” The man said that he suffered from arthritis, did not have any relatives in the prison, and had not ever been bullied. He said that he knew about carers, and the prisoner safer custody representative said that he was not concerned that the man might harm himself. The prisoner safer custody representative wrote on the form:
- “Has been a self-harmer in the past and also suicidal but has said he does not feel that way anymore, he just wants to move forward in life. He seems to have settled down well on the wing, he has no issues at this present time.”
62. The prisoner custody representative described the man as a “jolly” person, and recalled that he mixed well with other prisoners. He explained that he always checked to see if any prisoners were isolating themselves, and this was not true of the man. He told the investigators that the man said that people were calling him names on Reynoldstown Blue, but also said that he suffered from paranoia. The prisoner custody representative said that he never heard anyone call the man names, and never saw the man avoid other prisoners, or isolate himself. The prisoner custody representative told PCO H of the alleged name calling and the PCO asked the man about it. The man said he didn’t know who it was, and then said everyone was shouting. The prisoner custody representative said that the PCO explained that it was difficult to do anything if he was unable to say who was shouting at him. The prisoner custody representative recalled that the man went back to mixing with the other prisoners. However, the PCO made no reference to this conversation in his interview.
63. The carer told the investigators that he spoke to the man on 23 March, as he was upset with how his solicitors were handling his case. The carer advised him to contact them to ask them to try to progress matters.
64. On 24 March, the man had an interview with his personal officer, PCO H. This interview allows staff to gain a bit of background information on the prisoner, and gives an opportunity for the prisoner to be referred to other services should they require it. He told the PCO that he had not experienced any problems while in prison. However, the PCO recalled to the investigators that the man was very concerned about not having his glasses. The PCO referred him to the optician.

65. According to the record of the personal officer interview, the man said that he was in contact with his brother and sisters who he expected to visit him. He said that, before he came to prison, he usually drank and smoked cannabis everyday. He said that he was low in mood, had suffered from depression and had tried to harm himself previously. He said that he did it to gain attention. He ended by saying that he did not have any outstanding issues. PCO H said that the man did not say he had thoughts of harming himself at that time, but if he had, then he would have started ACCT procedures. The PCO said to the investigators that the man was "totally compliant" during the time he knew him on Reynoldstown Blue, and he never brought any issues to his attention. The officer told the investigators that his impression was that the man was glad to be on the wing as he had pointed out how small he was. The man explained that staff thought he might be bullied if he stayed on normal location.
66. The man also had a mental health assessment that morning with Nurse A. The man seemed angry as he had no glasses with him in custody and said he needed to see the optician as soon as possible as he was wearing someone else's glasses. The nurse recorded that he presented with poor coping skills. The nurse prioritised his appointment with the optician. The man said he had been in prison before and had no undue anxieties. He had harmed himself a year ago, but had no thoughts or intents of that nature at that time. When later asked by Nurse F on 31 March why he had not seen an optician prior to coming into custody he said that he had not needed to as his sister had done everything for him. Nurse F explained that the optician only came in every couple of weeks and that he would be seen on their next visit.
67. Over the next week, the man stayed on Reynoldstown Blue in the three man cell. There is no record that he raised concerns with staff or spoke to a carer about problems with other prisoners. The man attended education classes during this time.

Saturday 2 April to Sunday 3 April 2011

68. When the prisoners were unlocked in the morning at about 8.15am on 2 April to get their breakfast, the man left his cell and climbed over the bars on the first floor landing. He threatened to jump from the railings, which would have meant a fall of one storey or approximately two to three metres. PCO G explained that it was shouting by other prisoners that alerted her and her colleague, PCO E, to the man's actions. To enable them to speak to the man, the officers locked all the other prisoners back behind their doors. When they approached the man he said that people had shouted at him all night but did not mention anyone specifically. He said that he could not stay on the wing, and agreed to climb back over the railings when staff said they would move him off the wing.
69. Once he had climbed back over the railing, the man went to an activity room with PCO G and the unit manager. He repeated that people had shouted at him all night and called him insulting names. (The PCO said that if there had been shouting at night, she would have expected the night staff to relay this to

the day staff. To her recollection, nothing was mentioned that morning in the handover.) The PCO began ACCT procedures by filling out the initial pages of the document at approximately 8.20am.

70. At 8.30am, staff told the man that he could be moved to the CSU, which he accepted. They told him that prisoners would be allowed out of their cells again, but he could be locked behind his door if he wanted to while he waited his transfer to the CSU. However, he said that he did not want that and remained in his cell with the door open while other prisoners associated on the wing.
71. Nurse C was asked to see the man that morning. (PCO G said that the nurse was asked to meet with the man as he had said that he thought he might be paranoid and also seemed a bit contradictory regarding whether he wanted to leave the wing or not. It was also to ensure that moving him to the CSU was suitable.) The nurse went to the wing, and saw the man in his cell, who told her that he was being bullied on the unit. She noted that he appeared anxious and worried about being in segregation and being bullied. He said that he got on well with his cellmates, but did not say who had called him names.
72. However, the nurse told the investigators that the man engaged well in conversation and gave rational responses to questions asked. He said he had mentioned the name calling to staff and carers but felt nothing had been done about it. The nurse told the investigator that the man told her: "I wasn't going to jump but that is the only way I could make a cry for help." She noted that his behaviour could be impulsive, however his last act of self harm had been over a year previously. She said to the investigator: "I was quite happy with his mental health, mental state, at that time." She went on to describe their conversation:
- "I said do you actually want to jump, do you actually want to kill yourself, he said never, I don't, I don't want to kill myself, it's a means to get their attention because if I stay there and say I'm going to do it, they will come, they will listen to me."
73. Nurse C told the investigators that she understood someone in the man's situation would normally be transferred to the CSU for their own safety. He said that he did not want to go to the CSU as he believed that the name-calling would continue even if he was there. However, she said that he needed to be removed for his safety as he had made an allegation of name-calling:
- "... we have to take you to seg for your own safety which he quite agreed, he agreed at that point in time, because I did explain to him."
74. Although he was anxious about being moved to the CSU, Nurse C deemed him fit to be transferred there. She said that she did not feel that there was anything in his presentation that suggested that a period in the CSU would result in any deterioration in his mental health.

75. In response to the investigators' question, Nurse C explained that if staff felt that someone would be unable to cope with the restricted regime of the CSU, they could be located in the healthcare department. She said she was consulted on this issue but was content for the man to be taken to the CSU. In interview for the investigation, the nurse explained why she did not pursue a move to the healthcare department for the man:
- “I had no concern for him to go to segregation. If we feel segregation will act as a deterioration into his mental health or mental state he would be placed in healthcare and at that point in time I had no concern about him moving to segregation.”
76. Nurse C said that it was not overly unusual for prisoner to be transferred to the CSU while subject to ACCT monitoring procedures. She said that prisoners would be reviewed under the ACCT system, but also as part of the segregation review boards. The nurse said that she thought she discussed the man with the ACCT assessor before the ACCT assessment interview took place. However, PCO G (who completed the assessment) said that conversation did not occur.
77. The immediate action plan of the ACCT specified five observations per hour and one conversation recorded each morning, afternoon, evening and night. The immediate action plan also required the man to be moved to the CSU. The unit manager completed the caremap section of the ACCT. (A caremap is a chart of a prisoner's problems with actions recorded alongside them to manage the issues and support the prisoner.) Name calling was identified as one of the man "issues" on his caremap and the unit manager recorded that the man was to "ignore it".
78. The ACCT assessment interview took place at approximately 11.45am with PCO G. This process is designed to gather as much information as possible about the prisoner's state of mind at that time. The PCO told the investigator that the man claimed that the name calling had gone on for a number of nights, despite neither staff nor his cellmates hearing anything. The man told the PCO of his history of harming himself, but said that his actions were a cry for help and he did not intend to take his life.
79. The man was taken to the CSU at 12.20pm. A 'Prisoners in CSU on ACCT form' filled out which said: "Prisoner [illegible] was located on VP unit R/Blue – no other suitable location available." He asked for a television in his cell at 1.10pm. A segregation safety algorithm was completed by Nurse B at 1.30pm to assess the safety of the man which recommended that he could cope with a period of segregation. The nurse acknowledged the man's previous ACCT, but authorised the segregation. However, given that the nurse only mentioned the old ACCT it is unclear whether the nurse understood that the man was on an ACCT on 2 April.
80. A case review was held at 1.40pm with the man, the unit manager, PCO D and PCO G. PCO D told the investigators that the man appeared very

relaxed and happy during the review. Nurse B said she was not present as she was not in the prison at that time but, as she had already spoken to the ACCT assessor, she felt that her comments would be taken into account. The man said he was happy to be in the CSU, and his eye contact and body language were noted as “appropriate”. The man told the staff that the name calling had immediately begun again in the CSU. However, PCO D pointed out that he had been on the unit all the time the man had and he had not heard anything. PCO G recalled that the man had then suggested that perhaps he was “paranoid”. She told the investigators that the man had said that he had not really wanted to leave Reynoldstown Blue because he was enjoying the education classes. He was told that he would be able to return to the unit for the classes even if he was not a resident on the wing, which he was pleased about.

81. PCO D told the investigators that the man had told them that he never intended to jump from the landing: “He said I had no intentions of doing it, he said I had no intentions of ever jumping.” The man was referred for a further mental health assessment because of his suggestion that he may have been paranoid.
82. The observations were reduced from five to two per hour and one recorded conversation per unlock shift. PCO G recalled that this was done because he seemed content on the CSU, and was looking forward to continuing his education. She said that the man did not think that the ACCT monitoring procedures needed to continue at all as he had not actually harmed himself. On the ACCT form, his risk of harming himself was marked as ‘low’. PCO D recalled that the man was asked about returning to Reynoldstown Blue and reducing the level of observations:

“He said ‘I’ll have to go back on there’, he said ‘I’ll have to just get on with it and just do it’ and then we said ‘well we can’t put you back on there today, you’ll get a review on Monday’ which he had and we’ll take it from there so he said ‘sound, that’s great’, and the unit manager asked him if he was happy to be reduced on his obs, you know, if he was feeling okay, and he said ‘yes, I don’t really need to be on an ACCT’ he said but he understood why he was put on one.”
83. According to the ACCT on-going record, the man was quiet and without issues during the evening and night. PCO D told the investigators that he had no concerns regarding the man that evening.
84. It was agreed that the man was to have daily visits and support from the Duty Director, healthcare, PCOs and the mental health team. The man signed to say he did not wish members of his family to be notified of his recent actions on Reynoldstown Blue.
85. The man confirmed that he would like to make a telephone call on 3 April. He asked PCO C to dial the number for him and the PCO agreed. According to the daily history sheet, he made the telephone call in the afternoon. The man’s sister said that she spoke to him that afternoon and he told her that he

was worried he would be assaulted. He said that other prisoners were calling him a 'grass' (an slang term for an informant), although he did not mention who was involved.

86. A PCO made an entry in the on-going record of the ACCT document was made at 1.40pm that the man wanted to be moved back to Reynoldstown Blue as he did not like it in the CSU and wanted to continue his education classes. PCO D explained during interview for this investigation that the man realised he had gone about the situation on Reynoldstown Blue the wrong way, and should return to the unit. He said to the investigators that his impression was that the man did not like the confined nature of the CSU, and preferred to be somewhere he could leave his cell more. The man also saw the Duty Director, a member of the healthcare team and a member of the chaplaincy team in accordance with the requirements of the segregation review board.

Monday in April 2011

87. The daily history sheet noted that the man had breakfast, exercised and saw the duty director, a member of healthcare and a member of the chaplaincy team. The morning report noted no issues.
88. At 10.10am, PCO C made an entry in the on-going record that he had asked the man if he had any issues. The man replied that the person in the cell next door had called him a 'nonce' (a slang term used for a sex offender). The PCO explained that he knew the prisoner next door well and it was not in his nature to call someone else names. The man replied 'well he's been calling me a nonce anyway'. The PCO noted that he was not in the best of spirits, but there were no further concerns at that time. When the investigators spoke to the PCO he said that, although he did not believe the prisoner in the cell next to the man had called him names, other prisoners in the CSU may have taunted him due to his stature. Neither of the PCO's colleagues that the investigators interviewed suggested this, and there is no further evidence in the prison documents, beyond the man's comments about the prisoner next door, regarding taunting.
89. A segregation review on the day the man died was chaired by the Head of Residence and attended by Mental Health Nurse C, the manager of the CSU and a member of the IMB. It was held in a separate office in the CSU. (A review has to be undertaken within 72 hours to assess whether it was still suitable for the man to be held in the CSU.) The man also attended the meeting. It was noted that the man was currently subject to ACCT procedures and was fully compliant in the CSU. The review form documented that the man fully understood the reasons why he was in the CSU. The nurse recalled that the man was happy to go back to Reynoldstown Blue, and said that he did not intend to harm himself. The nurse recalled the man's presentation at the meeting:

" ... he had no concern, he had no issue about his continuing stay in segregation and I remember I did ask him about his upcoming court

case any concern, any worry, he said he has no concern, he has no worry. There was no symptoms of anxiety or low in mood or any mental health deterioration in the way he presents to me.”

90. The review board decided the man should stay in the CSU until there was space on Reynoldstown Blue and the next review would take place on 15 April. (It was also noted that he should be transferred to another establishment, but the Head of Residence confirmed to the investigator that this was a mistake and there was no intention to transfer the man.)
91. An ACCT review followed the segregation board, and was held at 12.20pm. It was the same personnel as the segregation board but was chaired by the CSU manager. The man repeated that he had no current thoughts of self harm. It was noted that, as discussed in the segregation board, he was to be located back to Reynoldstown Blue when a space became available. There was no change made to his current observations and conversations requirements. The Head of Residence recalled his presentation during the meeting:

“He was quite chatty in that meeting. He talked, he didn’t sit there, he wasn’t subdued or anything. He was asking about his canteen, when he was getting his canteen and things like that as prisoners do. He didn’t show any concerns whatsoever.”
92. However, on the ACCT review paperwork, the man’s level of risk was marked as ‘raised’, when it had been ‘low’ in the previous review. When asked during this investigation, Nurse C and the Head of Residence were unable to recall why the man’s risk had changed to ‘raised’. The next review was scheduled for 11 April.
93. At 1.05pm, the man was due to make a telephone call. However, PCO C recalled that he did not actually speak to anyone as he had not got his pinphone code. The man was given his canteen at 1.45pm. (This is the process for prisoners to buy or order goods, each week, to a limited value.) He had asked about it in the morning as he wanted more tobacco.
94. At 2.15pm, the duty director, saw the man. He confirmed in his statement to the police that the man was safe and well when he saw him. He wrote in his statement that the man asked him about moving out of Altcourse, and he replied that a transfer would be considered after his trial was complete.
95. PCO E and PCO D came on duty at 1.30pm. PCO E explained initially he completed some work in the office while the prisoners were locked in their cells. At approximately 2.30pm he left the office to undertake ACCT checks and to have a conversation with the man.
96. When PCO E reached the man’s cell, he looked through the observation panel. He saw the man lying under the sink. He had tied shoelaces around his neck and attached them to the sink. The man appeared purple in colour with blood around his mouth. He shouted for help and went into the cell.

PCO E called a first response emergency alert on his radio. (This is an emergency alert that blocks the airwaves and stops other members of staff using their radios.) PCO C and PCO D were also in the CSU and ran to assist PCO E. PCO E used his anti-ligature knife to cut the noose. He turned the man onto his back and started chest compressions. He then asked PCO C to call a code one on his radio (a code to alert staff to a medical emergency), but PCO C was unable to get through because the radio system was still disrupted after the emergency alert. PCO D left the CSU to open the gates to allow access for healthcare staff and the ambulance.

97. PCO I came into cell and took over chest compressions. PCO E took out the resusci aid from his pouch and started to give rescue breaths. (A resusci aid is a small plastic device used to protect contamination between the patient and the first aider in mouth to mouth resuscitation.) PCO E asked where the nurse was so PCO C asked PCO J for his radio and again called a code one. He repeated that an ambulance was required. This time he was able to get a response. (The paramedic's statement to the police says that the paramedics were informed at 2.37pm.) The staff continued cardio pulmonary resuscitation (CPR) until healthcare staff arrived.
98. From approximately 2.38pm, numerous healthcare staff arrived with emergency equipment. (The incident debrief notes indicate that the lack of an emergency code initially delayed the arrival the emergency equipment.) The first nurse on the scene took over breaths while PCO E carried on the chest compressions. Second nurse on the scene arrived shortly after and took over chest compressions. The man was turned on his side to clear his airway of vomit. The defibrillator was applied but it advised staff not to shock and so CPR continued. (Defibrillators deliver a brief electric shock to the heart, which can enable the heart's natural pacemaker to regain control and establish a normal heart rhythm.) A prison doctor and the first response paramedic arrived at 2.40pm. The rapid response paramedic took over the situation and the ambulance arrived shortly after at 2.50pm. (The paramedic's statement to the police says that the ambulance arrived at the prison at 2.46pm.)
99. At 3.04pm, the man was taken to the ambulance on a stretcher. The paramedics continued resuscitation. The ambulance left Altcourse at approximately 3.12pm and arrived at Fazakerley hospital at 3.18pm. The man was recorded as having a very weak pulse. He was given further adrenaline by hospital staff which strengthened his pulse. At 4.23pm, the critical care service assessed him and judged that he had no reflexes and was being kept alive by drugs.
100. The man's next of kin was informed and travelled to the hospital. At 5.32pm, the prison called to receive an update on the man's condition. The ventilator had been switched off, and the man was breathing unassisted. The man's brother and sister had arrived and chaplaincy and the prison family liaison officer spoke with them at 5.37pm. The family requested that the man be given his last rites at 6.47pm. The man's death was confirmed at 7.13pm by a hospital doctor.

101. The prison paid for the cost of the funeral and returned the man's property to his family. The man's family were offered an opportunity to visit Altcourse, which they accepted.

Support for prisoners

102. All offenders on the CSU were individually spoken to by the prison family liaison officer and were all offered councillor or carer support. All prisoners subject to ACCT procedures were reviewed and offered support.

Support for staff

103. After the man was taken to hospital, the staff on duty were debriefed before being sent home. A further debrief was held and the care team was available for all staff who needed it. PCO E spoke of the care offered to him:

“I've been involved in incidents before and the support you get has always been quite good. ... it was nice to get support, especially from the senior management team and even the Governor, that was nice.”

104. The other members of staff involved in the morning of 4 April that the investigators spoke to were also positive about the support offered.

ISSUES

Clinical care

105. The clinical reviewer, explored the clinical care received by the man. He writes with regard to the man's physical health:

"It appears that at the initial entry to HMP Altcourse there was an adequate discussion relating to [the man's] physical health. He was noted to be cigarette smoker but no physical illness related to this are noted in the records. His history of substance misuse is noted and appropriate referral was made in relation to this."

106. With regard to the man's mental health, the clinical reviewer writes: "I am also persuaded that [the man] did not have a recognised (or treatable) mental illness." The clinical reviewer provides the following overview of the man's care:

"My view is that plans to meet [the man]'s healthcare needs were sufficiently comprehensive and robust. [the man] had a history of substance misuse and history of self-harm. He was seen by the substance misuse team and also by the mental health team. He was treated in an appropriate manner for the latter."

107. The clinical reviewer makes no recommendations and concludes with regard to equitability of care:

"I take the view that [the man] received care of a standard which was equivalent to the care which he would have received had he seen healthcare professionals in the community setting. I take the view that he received care of a satisfactory standard."

Assessment, Care-in-custody and Teamwork procedures

108. Prison Service Orders were long-term instructions intended to last for an indefinite period. Prison Service Order (PSO) 2700 says:

"The Case Manager must enter in the record of the final Case Review why the Case Review Team feel it is safe to close the ACCT Plan, and enter the date closed and date for a post closure interview. The date of the first post closure interview is a matter for the case review team to decide but must be within 7 days of closure."

109. The man was briefly subject to ACCT procedures on 16 March following his concerns about his sentence. At the case review involving the prison FLO and PCO E, the ACCT was closed and a post-closure review was scheduled for 24 March. However, there is no evidence that a post-closure interview took place. The interview is a vital part of the ACCT process as it enables the prison to assess whether the closure of the ACCT was appropriate, and ensure that the prisoner is sufficiently supported. Although the ACCT was only open for a matter of hours, this makes the extra safeguard of the post-closure review particularly important as it offers an opportunity to check that the ACCT was not closed too quickly.

The Governor and the Safer Custody Manager should remind ACCT case managers of the importance of post closure interviews.

Possible threats against the man

110. The man was concerned that other prisoners were taunting or threatening him throughout his time in custody. This worry culminated in the man threatening to throw himself from the landing on Reynoldstown Blue on 2 April if he was not removed from the wing.
111. The man told staff he believed that other prisoners were shouting about him on Reynoldstown Blue, but there is little evidence to substantiate his belief. Several of the staff the investigator spoke to mentioned how the man would come to staff when they called for different prisoners. This was one example of the man mistakenly believing that shouting was directed at him. He also acknowledged to the carers on the wing that he suffered from paranoia.
112. Further evidence of this possibility was provided by his cellmates during his time on Reynoldstown Blue. Despite the man claiming that the shouting was frequent, none of his cellmates ever heard any taunting directed at the man. Following his death, the Head of Residence, was asked by the Director to investigate the allegation of name calling. He told the investigators:

“ ... there’s no supporting evidence for the name-calling. The only way that people have become aware of the name-calling is through the man ... no one actually seen, witnessed or physically seen anybody calling him names. ... One of his pad mates, [a slang expression for cellmate] states that the man was having a cigarette at the window one night and he was saying that other prisoners were calling him names so he muted the telly but it was just prison banter, prisoners shouting to each other out the windows, but he believed it was directed at him.”

113. The man also complained that the person in the cell next to him in the CSU had been calling him a 'nonce' during the night of 3 and 4 April. PCO C knew the prisoner in the cell and considered it highly unlikely that he would have been shouting at the man:

"He was kind of saying overnight to the person in the cell next to the man was shouting through you're a nonce but you know, I know that didn't happen. ... I said the person in the cell next to the man wouldn't do that, he's not like that. He said well someone's shouting at me, someone's shouting at me a nonce. I said well I can guarantee you it won't be him and he was kind of taken aback a bit so I don't know whether he was hearing it from above."

114. However, when the investigators spoke to PCO C he acknowledged that there probably was name calling in the CSU during the man's second time there:

"Now I don't know whether other people were shouting around, you know, upstairs above him and around the unit were shouting at him because he was obviously, you know, the size of him and the stature, he was very vulnerable like."

115. PCO C explained that such behaviour was quite common in the CSU; "it's just the way they are." He said that it could be difficult for staff to know where the shouting was coming from, which made it difficult to challenge the behaviour directly. The PCO commented that the people in the CSU are often bored and this can fuel their actions. However, none of the PCO's colleagues said that people were shouting at the man in the CSU.

116. While the man may have been subject to other prisoners' abuse in the CSU, there is no recorded evidence of the man suffering any taunts while he was on the vulnerable prisoner unit. Rather, he was considered to have got on well with the other prisoners on Reynoldstown Blue. However, it is clear that the man continued to feel threatened throughout his time at Altcourse. Despite this concern, it is not considered that the prison acted inappropriately with regard to the alleged name calling. They removed him from the alleged site of the bullying but were unable to act more directly as the man was unable to indicate who had been taunting him.

Prisoners in the CSU subject to ACCT procedures

Were alternative arrangements sought?

117. The PSO regarding segregation says:

"A prisoner on an open ACCT plan must only be kept in segregation under exceptional circumstances where by they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate."

118. PSO 2700 also requires:

“Location of an at-risk prisoner in the Segregation Unit must be authorised by the Duty Governor, who must record in the ACCT document that this has been done and the reasons it was considered necessary” [Italics in the order indicate a mandatory instruction.]

119. The investigation has uncovered evidence that there are a significant number of prisoners segregated while subject to ACCT procedures. Altcourse’s 2011 CSU Monitoring Report revealed that in January of this year nine out of an average of 15 prisoners in the CSU were subject to ACCT procedures. In February it was four from 21 and in March 10 from 20.

120. PCO D said he thought that it was increasingly common for prisoners to be in the CSU while subject to ACCT procedures. He said that prisoners in this situation used to go to healthcare but this does not happen as frequently anymore. He also said that they used to go to healthcare but this has stopped now, and it is difficult to manage the other prisoners in the CSU, when there are some on ACCTs:

“We ask for help and nine times out of 10 you’re told there is no one, kind of get on with it.”

121. If a prisoner has been identified as at risk of harming themselves, safeguards are put in place to support the individual and manage their risks. Such safeguards are difficult to deliver in the restricted regime of a segregation unit, which is often a more isolated and potentially more volatile environment than a residential unit. In a previous fatal incident investigation report on a death in a segregation unit, the Ombudsman’s office has commented that: “The effect of segregation on an already vulnerable person’s state of mind can be severe.”

122. The man was twice subject to ACCT monitoring procedures while in the CSU. Altcourse staff understood that the man’s second stay in the CSU was under exceptional circumstances. The Head of Residence explained:

“If I get a call to say that somebody needs to go to the block [a slang term used for the CSU] and he’s on an ACCT book I will fill in an Exceptional Circumstances because I will have looked at all alternative places to put him whether that be the healthcare ... alternative units, an alternative regime on the unit that he’s on, it would be the last resort to put the person in there.”

123. An exceptional circumstances form was completed for the man on both occasions that he was in the CSU on an ACCT. In both cases, the justification for the man’s presence in the CSU was because no other location was suitable. The forms did not make clear what, if any, other locations (such as healthcare) were considered, and why they were deemed unsuitable. Nurse C explained to the investigators that had she been concerned about the

man's wellbeing in the CSU, she would have recommended he be located in the healthcare unit.

124. No apparent consideration was given to additional safeguards such as CCTV or safer cells. (A safer cell is a cell designed to reduce the number of ligature points available to the prisoner.) Further, there was no documented evidence of the particular attributes the man had (small stature, paranoia, fear of bullying) that should have made this decision more than a formality. A segregation safety algorithm was completed, but it is unclear whether the nurse understood that the man was subject to ACCT procedures at that time. (This issue is returned to later in the report.)
125. The man's location on the CSU with an open ACCT document was not an isolated incident. Against the explicit instructions of the PSO, Exceptional Circumstances forms appear to have been completed as a matter of routine. The form in the man's case was completed briefly and with no additional information about how to keep him safe.
126. The regime is more restricted in the CSU. As the man was there, both times, for his own protection he was able to exercise and receive education materials. However, this would not have been suitable for him because he could not read or write without support.
127. It is against the mandatory requirements of the PSO to accommodate prisoners subject to ACCT procedures on the CSU. Operational reasons may exceptionally demand it, but the evidence made available to this investigation suggests that such arrangements were increasingly becoming the norm rather than an exception. No additional resource has been allocated to the CSU to safeguard vulnerable prisoners. The investigation found no evidence of the consideration of a long term solution to the management of prisoners subject to ACCT who could not be accommodated with the general prison population. It is strongly recommended that the Director reviews the resources available to him to ensure that alternative measures are used for prisoners in the man's situation.

The Director should ensure that prisoners on an ACCT are located in the CSU only in exceptional circumstance and that appropriate alternative accommodation is made available, in line with the requirements of PSO 2700.

Further support for prisoners

128. If prisoners are exceptionally located in the CSU while subject to ACCT procedures there are further safeguards that should be put in place to protect them. PSO 2700 requires:

“A mental health assessment must be undertaken by Healthcare/Mental Health In-Reach staff of all prisoners on an open ACCT (or in the post-closure phase of ACCT) who are placed in a segregation unit or awarded a period of cellular confinement in another part of the establishment. This must take place within 24 hours.”

129. The man received a mental health assessment while he waited to be taken to the CSU on 2 April. Nurse C told the investigators:

“I had no concern for him to go to segregation. If we feel segregation will act as a deterioration into his mental health or mental state he would be placed in healthcare and at that point in time I had no concern about him moving to segregation.”

130. PSO 2700 goes on to require:

“Where prisoners who are at risk of suicide or self-harm are exceptionally located in the segregation unit, or have been located in a segregated setting elsewhere in the establishment, the additional safety mechanisms outlined in PSO 1700 / PSI 2006/17 - segregation special accommodation and body belts must be put in place. In summary, this is:

- Detailing on the Initial Segregation Safety Screen the reasons for the segregation of an at-risk prisoner
- ACCT case review at the earliest opportunity and certainly within 24 hours
- Observations/conversations to take place no less than 5 times per hour at irregular intervals until the Initial Segregation Safety Screen and the Mental Health Assessment take place (or more frequently if stipulated on the ACCT Plan)
- Accommodation in a safer cell, wherever possible; consideration of use of CCTV. Note that paragraph 7.30 of PSO 2000 – Adjudications requires prisoners undergoing cellular confinement to be accommodated in an ordinary cell set aside for the purpose (this should not be interpreted as disallowing use of a safer cell), and makes clear this need not be in the segregation unit.”

131. The initial segregation safety screen does not include the reason for the segregation of the man. In addition, it seems that the nurse did not realise that the man was on an ACCT at that time, as reference is only made to the previous ACCT. Therefore, the initial segregation safety screen was not completed fully or accurately. This is particularly concerning given the vulnerability of the man at the time he was segregated.

The Director should ensure that the nurse completing the initial segregation safety screen is fully informed of the details of the reason for segregation and any risks relating to that individual.

132. The case review took place within 24 hours. The observations only reduced once the man had undergone an initial segregation safety screen and mental health assessment. There is no evidence that a safer cell or CCTV was considered. This issue is covered in the previous section about appropriate location.

The management of the CSU.

133. The CSU holds some of the prison's most difficult prisoners. Some will be there as a punishment, some for security reasons and a significant proportion, as the investigation has learnt, for their own protection. However there are also a growing number subject to ACCT procedures while in the CSU. This puts added pressure and responsibility on the staff working there. The investigators were told that there were frequently only two members of staff working there, which made it difficult to successfully manage the unit. This was particularly true when there were several prisoners subject to ACCT monitoring procedures in the CSU.
134. One PCO was concerned that the duty director who visited the CSU changed each day so there was little continuity of governance, and prisoners became frustrated as their requests had to be repeated each day to the different duty director. It is for the Director to determine the adequate staffing levels in each area of the prison, but this assessment should be considered in light of the need to avoid locating prisoners in the CSU while subject to ACCT procedures.

The use of prisoners as carers and representatives on Reynoldstown Blue

135. The investigators spoke to a number of carers and representatives on the unit and, while it is clear they work hard to help their peers, one raised concerns that he had not undertaken the carer course despite acting as a carer for a number of months. The carers told the investigators that they can share information with staff if they feel it is in the prisoner's best interest.

136. The same carer who had not completed the training recorded that the man had harmed himself in February 2011 which is, if accurate, a more recent episode than that recorded elsewhere in the man's records. However, the carer did not feel it necessary to ask the man about the details of the event or bring it to the attention of staff. It is unclear if his lack of training played a role in this decision, but if prisoners are to undertake such important roles on the wing, they should be properly trained and supported in that role. There should also be a clear understanding about when information should be shared with staff.

The Director should ensure that prisoners acting as carers undertake appropriate training as soon as possible.

The man's shoelaces

137. The man used his shoelaces to make a ligature. Staff would not routinely remove objects from prisoners unless they had a specific reason to do so. Although the man was subject to ACCT procedures at the time of his death, would only remove property from prisoners in exceptional circumstances. PSO 2700 states:

“However, removing personal belongings from a person who is feeling hopeless and depressed ... can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so.”

The code system

138. When the man was found, PCO E entered the cell to attempt to assist the man. Altcourse uses a code system for staff to alert their colleagues to emergency situations. However, instead of using the code system, he pressed the emergency response button on his radio. Although this does request assistance, it does so by a sound that blocks the radio net so no other messages can be passed. Healthcare staff still responded to the alert but were unaware of the nature of the emergency, and this impacted on the equipment they initially took with them. He told the investigators that his actions were confused due to a desire to try to help the man:

“I just wanted to make sure people were coming and for me the fastest way to do that was to hit me first response button because all I had in my head was do CPR, do CPR, you know, if there was any chance I could save him.”

139. PCO E responded to a difficult and stressful situation and, although using the code system would have been preferable, it is clear that he attempted to save the man, and staff responded quickly. However, it is appropriate to repeat a recommendation made in a previous investigation at Altcourse:

The Director should remind staff of the need to use the appropriate code when responding to an emergency situation

Liaison with the man's family

140. The investigation's family liaison officer and the investigator met with the man's family to discuss the terms of this investigation. At this meeting, they raised a number of issues, most of which are addressed in the investigation report. Nevertheless, the following two issues remain.

The clothes worn by the man

141. The man's family were concerned about some clothing that the man was seen wearing in prison. They were told that he was wearing red clothes, and his solicitor suggested that these clothes are reserved for people with mental health problems. The investigators spoke to prison staff who said that this is not accurate. PCO C explained that anyone in the CSU for reasons of punishment wears red clothes. The most recent Inspectorate of Prisons report confirms this. The man needed to borrow clothes while he was in the CSU as he was waiting for more clothes to come in, and that was why he wore red clothes for the visit with his solicitor.

Bedwatch behaviour

142. The man's family were concerned about the behaviour of the bedwatch staff when they visited the man in hospital. They felt their attitude was flippant and unprofessional. Whether officers meant to offend the family or not, it is a matter of concern that their behaviour could be perceived as inappropriate at such a sensitive time. It is to be expected that the Director will note this and remind escort staff of the importance of maintaining a professional attitude at all times.

CONCLUSION

143. The man was vulnerable, not least because of his stature. Regardless of the cause, it is clear that he felt unsafe in custody and spent a lot of time expressing the fear that people were verbally targeting him. However, there is little evidence to support this. The man appeared to be the only person who heard the alleged taunting, although PCO C did mention some shouting in the CSU.
144. Altcourse responded to his moments of crisis and correctly began suicide prevention measures on two occasions. However, the investigation has highlighted a significant concern over the increasing practice of placing such prisoners in the CSU. Prison Service policy is clear that this should only ever be in exceptional circumstances, and is particularly relevant in the case of the man with his specific vulnerabilities. While there is no evidence that Altcourse have been inattentive or dismissive of the man, the recommendations in this report seek to help Altcourse avoid the weaknesses of approach identified and, in particular, ensure prisoners at risk of self-harm are held in the most appropriate location.

RECOMMENDATIONS

1. The Governor and the Safer Custody Manager should remind ACCT case managers of the importance of post closure interviews.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

“Notice to case managers issued 22nd November 2011.”

2. The Director should ensure that prisoners on an ACCT are located in the CSU only in exceptional circumstance and that appropriate alternative accommodation is made available, in line with the requirements of PSO 2700.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

“Prior to any prisoner being located within the CSU on ACCT, Duty Director to explore all other alternatives within the establishment and only locates within the CSU in exceptional circumstances and alternatives should be recorded. These exceptions should be for those prisoners demonstrating refractory behaviour or pose a threat to others on normal location. All prisoners located on ACCT in CSU will within 24hrs have a case review completed and other alternative accommodation will be considered. Three cells within the CSU to be made into safer cells with CCTV for high risk offenders located within the CSU. Head of Safer Custody to explore a permanent solution within current accommodation therefore ensuring compliance with PSO 2700.”

3. The Director should ensure that the nurse completing the initial segregation safety screen is fully informed of the details of the reason for segregation and any risks relating to that individual.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

“Safety Algorithm completed by nurse, detailing all relevant information regarding reasons for segregation, which includes a medical review of Systemone. Weekly audit checks are conducted by Senior Nurse to ensure compliance. Procedures have been reinforced to all staff. ACCT offenders clearly marked on rule 45/53 paperwork.”

4. The Director should ensure that prisoners acting as carers undertake appropriate training as soon as possible.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

“Carer training is now conducted under supervision of the Safer Custody Department, therefore ensuring adequate initial training and refresher training is given. Training to include the following :-

- Mental Health Awareness training
- Listening Skills
- Suicide & Self-Harm Awareness
- The Carers – The Do’s and Don’ts

All new carers initially shadow experienced carers, they are reviewed by Safer Custody for suitability prior to commencement. Regular meetings are held with the carers so that any trends and lessons learnt are passed on appropriately.”

5. The Director should remind staff of the need to use the appropriate code when responding to an emergency situation.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

“A notice to staff re-enforcing the code call procedures has been issued. The procedures are reinforced via safer custody training.”