Investigation into the circumstances surrounding the death of a man in December 2008 at hospital while in the custody of HMP & YOI Altcourse

Report by the Prisons and Probation Ombudsman for England and Wales

December 2009

A man was found hanging at approximately 9.52pm in December 2008 in his healthcare cell at HMP Altcourse. Staff and paramedics attempted resuscitation, and he was taken to hospital. Sadly, he did not recover and he died the next day. He was 31 years old.

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

The investigation was carried out on my behalf by my colleague. In addition, a clinical review of the man's healthcare at HMP Altcourse was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful for this review. I would also like to thank the Director of Altcourse and his staff for their co-operation and assistance. Particular thanks go to the liaison officer for his help throughout the investigation process.

The man had been in prison several times before and suffered with drug addiction. He was in Altcourse having been recalled to custody just one week after being released from HMP Hull. His death occurred one month after his recall. He was being monitored under the prison's suicide and self harm monitoring and support procedures (ACCT) at the time.

The man had been prescribed methadone in Hull and was unhappy to find that this could not continue at Altcourse. He staged a protest to try to obtain methadone and was segregated from other prisoners as a result. His emotional and physical health deteriorated and it was then that staff opened an ACCT form. He began to harm himself and was clearly unhappy. He was preoccupied by being unable to take methadone and seems to have relieved his distress by using illicit drugs. His health and state of mind gradually worsened until he was moved to healthcare.

In recent years, I have no doubt that across the Prison Service as a whole the prescription of methadone has helped reduce avoidable deaths while prisoners are detoxifying. Although the exact pattern of the man's prescribed and illicit drug use is not certain, it is disappointing to have to issue a report where the unavailability of methadone appears to be a key issue.

I make six recommendations and highlight one area of good practice.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2009**

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SUMMARY

The man was born on 4 June 1977. Having been released from HMP Hull on 11 November 2008, he was recalled to prison just eight days later. He had been prescribed methadone at Hull and was released with a prescription for methadone in the community.

However, HMP Altcourse (where he was held following his recall to custody) did not at the time prescribe methadone to prisoners. This upset him and he complained of withdrawal symptoms. He was found collapsed several times during the first couple of weeks at Altcourse.

On 2 December 2008, the man climbed up into the roof of the gym in protest at the absence of methadone. Although he had been given medication to deal with the symptoms of his drug withdrawal, he wanted a transfer to another prison that could provide methadone.

He came down from the roof voluntarily and was taken to the Care and Separation Unit (CSU). Suicide and self-harm monitoring procedures were opened the next day as he was reportedly evasive and unclear when asked about self-harming. His time in the CSU was punctuated by removals to the healthcare unit after he harmed himself.

The decision was taken on 12 December to transfer him to HMP Garth.

On an evening in December, 12 days after the suicide monitoring began, the man was found hanging in his cell in healthcare. He was discovered by a nurse conducting suicide monitoring observations and she immediately called for assistance. Cardio pulmonary resuscitation (CPR) started quickly and continued until the paramedics arrived and took over. He was resuscitated and taken to hospital, but sadly he passed away the next day. Prison staff had contacted his family and they were with him at the time.

I make six recommendations in this report relating to managing the ACCT process, caring for prisoners in the CSU, reporting suspected drug taking, and providing defibrillators.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Altcourse on Friday 19 December 2008 to open the investigation. He met senior managers and took copies of the documentation relating to the man. The investigator visited the man's cell and familiarised himself with the geography of the prison. He met a representative from the Independent Monitoring Board (IMB) and discussed their contact with the man. The investigator also took a copy of the CCTV footage of the healthcare unit on 15 December.

2. Notices of the investigation had already been sent to the prison but no one came forward.

3. The investigator wrote to the PCT requesting a review of the man's clinical care while in custody. A clinical reviewer was provided with a copy of the medical records from the prison and relevant interview transcripts.

4. The investigator and a colleague visited Altcourse from 2 to 4 March 2009 to interview staff and prisoners. The investigator and clinical reviewer returned on 17 March to interview further staff. The investigator and an Assistant Ombudsman interviewed a nurse on 12 May 2009.

5. The investigator and a Family Liaison Officer from my office visited the man's family on 11 February to provide them with an opportunity to hear more about the investigation. His family raised various issues including:

    - Why he was not accommodated in a hostel closer to home
    - Why he was sent to Altcourse
    - Why he was on methadone when he arrived at Altcourse
    - How this was managed
    - How he was able to hang himself when he was on an ACCT.

6. I hope this report offers some answers to the family's questions.

HMP & YOI ALTCOURSE

7. 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. Healthcare services are provided by the company Medacs. There is a healthcare unit at Altcourse with space for 12 prisoners.

8. The prisoners live in seven houseblocks, all named after Grand National fences. The man lived in Furlong unit, which is the induction and detoxification unit.

Assessment, Care in Custody and Teamwork (ACCT) process

9. 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.

10. 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. These reviews can be delayed due to the need to establish a multi-disciplinary panel. However, it is essential that the prisoner agrees with this decision. The key questions for each review are listed as:

    - Have the problems that caused the ACCT plan to be opened now been resolved?
    - If not, what needs to be done to resolve them?
    - Have any further problems arisen that are now causing distress and more risk?
    - If so, what action can be taken to address these?
    - Is the person at risk now in contact with friends, family or other support?
    - Does the person at risk now have something in their lives that they feel good about?
    - If not, how can this be improved?

11. Over time, the reviews should also consider other factors such as:

    - Distress – has anything changed to make the person at risk more or less desperate?
    - Resources – has anything changed that makes the person at risk now feel more or less alone?
    - Previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
    - Suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
    - Pattern of self harm – is self harm becoming more or less frequent?

Command suite

12. 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.

Methadone detoxification prescriptions

13. When someone is withdrawing from opiates, they can be given a methadone detoxification prescription. Methadone is an opiate substitute that relieves the withdrawal symptoms. It is available in many prisons but was not, at the time of the man's death, available at Altcourse. Up until the introduction of methadone in January 2009, healthcare staff were only able to prescribe medication to provide relief for the symptoms of drug withdrawal. The introduction of methadone at Altcourse had already been planned, and was not related to the death of the man.

Care and Separation Unit

14. The Care and Separation Unit 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, exceptionally, to protect them from other prisoners. When a prisoner is brought into the Care and Separation Unit certain procedures must be carried out. These include the completion of an Initial Segregation Safety Screen and the beginning of a segregation history sheet. The Care and Separation Unit (CSU) has room for 22 prisoners. It has a permanent staff of eight officers with three on duty any one time during the day.

Carer

15. A carer is a prisoner used by Altcourse to provide emotional support to other prisoners. It is similar to the Buddy system used in other prisons. They do not offer a confidential or counselling service.

Release on licence

16. Prisoners released on licence before the expiry of their sentence are supervised by the Probation Service. They can be recalled to custody at any point until the expiry of their licence if their behaviour gives grounds for concern.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) made up of members of the local community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report from the Altcourse IMB covers the period of June 2007 to June 2008. The

Board's report notes a lack of space in the healthcare unit, but also praises the greater stability in healthcare since Medacs began their contract in 2006. The Board commend the mental health services.

18. The Board comment on the transition to the ACCT system, and praise the approach to safer custody. One key change at Altcourse that the Board greatly welcomes is the plan to introduce the Integrated Drug Treatment Service (IDTS) that provides opiate substitutes to prisoners suffering from drug withdrawal. The Board says it has argued for some form of effective drug treatment for years and notes that the announcement of the introduction of IDTS has had a positive impact on staff morale.

Her Majesty's Chief Inspector of Prisons

19. Altcourse was inspected by Her Majesty's Chief Inspector of Prisons in 2005, and a short follow-up visit was conducted in September 2007. In the most recent report, Altcourse is described as "one of the most impressive of its type" and "reasonably safe, with improved suicide prevention arrangements". Its cleanliness and good staff-prisoner relations are praised and healthcare services are described as "generally satisfactory". The Chief Inspector particularly notes the excellent quantity and quality of time out of cells for the prisoners.

20. However, concern is raised regarding an increase in violent incidents, and in drug misuse. The report also points out a need for strengthening anti-bullying arrangements.

21. In 2005, the Chief Inspector had recommended that prisoners should be involved in their own suicide and self-harm reviews. The more recent report confirms that Altcourse had introduced ACCT procedures and that "in the documents we checked, prisoners had been involved in their reviews". The 2007 report also notes the successful implementation of an earlier recommendation that carers should be available in the admissions area of the prison. The Chief Inspector notes that the earlier recommendation that "case entries in self-harm files should be regularly monitored to ensure that they describe the level of contact made and the prisoner's current demeanour" had been only partially achieved. However, the prison was taking steps to remedy this.

22. Another 2005 recommendation was that prisoners should be allocated to other prisons on the basis of their individual needs. This too was partially achieved by 2007:

> "Prisoners' needs were taken into account when deciding on allocations but the limited number of vacancies because of crowding meant that allocations were often driven by available spaces."

23. The Chief Inspector's 2007 report provides a concise summary of the problems arising from the lack of methadone:

"… prisoners admitted directly from the courts, transferred in from other prisons or who were registered drug users on methadone prescriptions in the community were unable to continue their treatment at Altcourse. This was causing serious difficulties for prisoners and those managing them. One such example involved a prisoner who was a registered drug user on methadone who had been remanded in police cells, went to court and was brought into the establishment, where his methadone treatment was stopped. Health services staff were willing to provide maintenance treatment, but were powerless to do so. If he had been sent to HMP Liverpool, he would have received appropriate methadone treatment. We were told that the prison was not funded to provide methadone maintenance."

24. In her 2007 report, the Chief Inspector recommends that all staff should carry anti-ligature knives. She also recommends that contact with the PCT should be improved, and that the healthcare contract should be revisited to ensure that any outdated practices were reviewed. The report ends by praising the mental health assessment that all prisoners undergo when arriving at Altcourse.

KEY FINDINGS

25. The man was born on 4 June 1977 and had a brother and a sister. He described himself as having had a difficult childhood. He was expelled from school at the age of 12 and began using drugs at the same time. His drug use had become significant by the age of 15, by which time he had already committed several offences.

26. He spent a considerable time in custody which inevitably affected his ability to keep a job. Despite his problems, he frequently expressed a desire to better himself and establish what he called a "normal lifestyle". While in prison he spoke of his supportive family. He had a child with his former partner and fervently wished to become a good father to his child.

27. I understand that the man had suffered from numerous health problems, particularly concerning his stomach. He had told his probation officer that he had a history of harming himself dating back to his childhood.

28. In May 2004, he was sentenced to seven years imprisonment for two robbery offences. He was at HMP Hull when released on licence on 11 November 2008. By the time of his release he was being prescribed 85mls of methadone a day. He was also prescribed 100 mg a day of Amitriptyline (an anti-depressant medication).

29. On release on licence, the man went to live in an Approved Premises (hostel) in Ellesmere Port. After a few days, he returned to Crewe for a short period to see his family. However, by leaving the hostel as he did, he had breached his licence conditions. When he returned to the hostel on 19 November 2008, he was recalled to prison.

30. The man arrived at Altcourse at approximately 10.30am on 19 November. The Prisoner Escort Record form which was handed to Altcourse staff referred to concerns about suicide and self-harm, medical and mental health conditions, violence and weapons issues, and drug and alcohol history.

31. Just before 1.00pm, the man was seen by Registered Mental Health Nurse (RMN) A for his initial health assessment. The RMN wrote that he was fit for normal location, work and any cell occupancy. Three referrals were made. The first was to a doctor regarding his substance misuse; the second was to a nurse as the man had requested human immunodeficiency virus (HIV), Hepatitis B and sexually transmitted disease (STD) tests, and for a mental health assessment; and the third was to the drugs service. (The RMN explained in interview that the referral for a mental health assessment was a result of the man's substance misuse history and because of his behaviour at the time.) The RMN wrote "no evidence of mental illness". He noted that the man was concerned about his drug usage and methadone prescription and asked for detoxification treatment.

32. The RMN wrote that the man appeared "settled and untroubled" and did not give him any cause for concern. During interview with my investigator, the

RMN said that the man answered the questions freely and co-operated throughout the interview.

33. A Cell Sharing Risk Assessment (CSRA) was carried out by Prison Custody Officer A who noted that there had been previous F2052SHs (this was the former method of monitoring prisoners at risk of suicide or self harm, now replaced by ACCT). The PCO wrote that the man suffered from psychosis and used methadone. He recorded his concerns about the man's detoxification, but was unable to judge his risk as he had been diagnosed with an anti-social personality disorder. The man told the PCO that he had no concerns about being at Altcourse as he had been there before. The PCO told my investigator that the man did not raise any concerns about being refused methadone and he had no particular concerns about his welfare.

34. The man was placed in cell F1-27, which is in the First Night Centre. Different first night arrangements are made for recalled prisoners as they may experience additional stress. He was offered a bed in the healthcare care suite, which he declined. At Altcourse the care suite is normally reserved for people who require further emotional support, rather than prisoners suffering from physical conditions. Medical Officer A at Altcourse described the purpose of a care suite as:

> "… [it is] a cell that is based on the healthcare unit that we use to assess patients who are feeling low or have ideas of self harm in some cases, it's a cell which has more than one bed so that the person can be in the presence of carers … it's a cell where the individual would have a greater degree of observation perhaps than other cells … "

35. The man agreed to share a cell with a carer during his first night. The carer told my investigator that:

> "When I met him he was quite agitated and he explained to me that he'd been on a three day bender. He'd left his hostel and he'd gone to Crewe for three days and he'd been on drugs and alcohol."

36. The carer completed a First Night Centre observation sheet and noted that the man did not sleep well due to the pain of withdrawing from methadone. The paperwork completed by carers is put into the prisoner's file. He told my investigator that:

> " … he was very agitated. He was, one minute he was sleeping on the floor, well trying to sleep on the floor, he had the shakes and he kept moving around the cell trying to find a comfortable position."

37. However, the carer also noted that, during the night, the man had talked positively about trying to turn his life around. He told him that he wanted to get a job and provide for his children.

38. On 20 November, the man moved into a shared cell with a friend on the detoxification wing, Furlong Red, which he was apparently pleased about.

(He stayed in this cell until his removal to the Care and Separation Unit (CSU).) Prison Custody Officer B was assigned as his personal officer. (Each prisoner has a personal officer assigned to act as a first port of call for any concerns. The personal officer is also responsible for recording their interactions with the prisoner and monitoring how well they settle into prison life.)

39. Later that morning the man met a CARATs worker. (CARATs stands for Counselling, Assessment, Referral, Advice and Throughcare, and the team works with prisoners with drug problems.) He recorded the man's details and asked whether he wanted to be involved with the CARATs service. The man signed the confidentiality form but the assessment was not completed as he felt unwell. The CARATs worker told my investigator that the man was clearly withdrawing from drugs and was keen to access support from CARATs.

40. The man also saw Medical Officer B that morning. A urine test was carried out and it tested positive for amphetamines but not opiates. He told my investigator that methadone would have been identified by the test. (However, my investigator was later told that at the time of the man's test, the test used at Altcourse would not have identified the presence of methadone in the urine. Altcourse does now prescribe methadone and has a system to test for the presence of methadone in urine.)

41. However, Medical Officer B noted that the man wished "to be prescribed DFs" as he was complaining of withdrawal from methadone. (This refers to Dihydrocodeine which is a drug that provides pain relief for the symptoms of drug withdrawal, although it is not licensed for the management of drug dependence.)

42. The docot rdecided to prescribe a 14 day Dihydrocodeine detoxification prescription because of his drug withdrawal symptoms. The doctor also reduced the dose of Amitriptyline and replaced it with Fluoxetine (Prozac), a different anti-depressant, as Amitriptyline can be a dangerous drug if taken in excess. He wrote that the man exhibited "no signs of alcohol withdrawal as such". He explained to my investigator that this would be normal considering that he had only been drinking for a few days following his release from Hull.

43. The following day, the man had an interview with the carer during which he disclosed his self-harm history and fear of bullying. The carer arranged to follow up his concerns.

44. The man also underwent an Initial Risk Assessment with a Probation Officer in the mid-to-late afternoon. She wrote that the man was severely withdrawing during the interview. She described him as shivering and fidgeting.

45. She told my investigator that she was sufficiently concerned about his condition to call the detoxification wing (Furlong Red) to see if they were aware. She was told that the amount of methadone that he had been formerly on was known to the staff. She wrote in his core record that she had referred

him to the Mental Health In-reach Team. She asked him if he was thinking about harming himself, which he denied. In interview, she remembered that his priority seemed to be dealing with his withdrawal.

46. Prison Custody Officer B wrote in the man's core record that at 3.40pm he was seen on his bed by another prisoner and appeared to be having a seizure. She called for assistance from healthcare staff. In interview, she recalled that he:

> "… appeared to be fitting at first but then I know after that over the time he was just really shaky and going hot and cold, he was really white. He looked like you know like a grey colour."

47. PCO B remembered that, almost as soon as the healthcare staff arrived to assess the man, they were called away to treat another prisoner who had seriously harmed himself. She and a colleague stayed with him throughout. He told them that he felt ill because he could not get any methadone.

48. Nurse A arrived at the man's cell about an hour later and saw him lying on the floor shaking. He was able to hold a conversation and he told her that he was withdrawing from methadone and alcohol. She told him to try to sleep for 30 minutes and then she would assess him again.

49. Nurse B returned at 5.16pm and noted that the man appeared orientated. He repeated that he was withdrawing from methadone. The nurse offered to take him to healthcare but he refused stating that he would feel better when he had his medication.

50. A note in the man's core record for the next day said that he had had another seizure and felt extremely unwell. He was unable to digest any food or drink. PCO B made a note in his record that said:

> "The man has not been eating since 20/11/2008. Stays in his cell a lot. He states that he is 'rattling' really bad from methadone ... "

51. Wing staff asked Nurse C to check on the man when he dispensed the medications that evening. He had had a seizure and they were concerned about how he was. Staff also wondered whether he had taken illicit drugs. He had been seen in the showers three times that afternoon with another prisoner which was unusual. During interview with my investigator, PCO B said:

> " … he was in the shower a lot - must have gone in the shower about three or four times prior [to his seizure] ... and it was a bit strange for him to have so many showers."

52. Nurse C noticed that the man appeared pale and slightly unsteady on his feet, but he said that it was due to his methadone withdrawal. In interview, the nurse said that although the man was lethargic there did not seem to be any reason for him to receive urgent assistance. He refused to give him any more

medication until he could review him properly and wanted to see him at the wing gate. Once at the gate, the man denied taking any illicit drugs and appeared to the nurse to be orientated. He said that he was taking 85mls of methadone a day outside prison and wanted to have his medication. The nurse recalled that he became agitated at the thought that he might not receive his medication and was very keen to receive it. The nurse checked his blood pressure which was recorded as 156/96 with a pulse of 98. He told my investigator that he considered these readings acceptable, and thus gave him the Dihydrocodeine. He said that, despite his agitation, "… he wasn't clearly expressing withdrawal symptoms …". The nurse asked him specifically about self-harm and suicide and he denied having any thought of either.

53. At 2.37am on 24 November, Nurse D was called to the man's cell as his cellmate had told staff that he had collapsed while walking to the toilet. He told the nurse that he felt unwell, had been retching, had not eaten for a week, and was unable to drink enough fluids. He appeared pale and his blood pressure reading was 153/113 with a pulse of 87bpm which appeared to the nurse as quite high.

54. Nurse D told my investigator that the man appeared drowsy and unwell, but she could not identify with that was wrong with him.

55. The nurse wanted to move him to healthcare, which he agreed, but the only bed available in the healthcare unit was cell 12 (a care suite) which was unsuitable.

56. Instead, she told wing staff to watch his physical well-being. She explained to my investigator that, had he been more acutely unwell, she would have brought him to healthcare and tried to find space by assessing other patients and moving one of them. She noted that she would return to check on him later in the morning. The substance abuse nurse was to be informed as she thought that he might have taken illicit drugs.

57. At 3.50am, the man's cellmate discovered him collapsed on the floor again. This time, he was taken to healthcare and located in cell 12. Nurse D explained that cell 12 was used because of her concerns about his health. He was unsteady on his feet and was to be monitored every hour. He first told her that he had not taken any illicit substances, but later admitted taking Subutex that afternoon. (Subutex is a drug prescribed to treat people withdrawing from opiates. It was not prescribed to prisoners at Altcourse.) She told my investigator that, in her opinion, his health problems may have been caused by, or exacerbated by, taking Subutex.

58. The man was assessed at 5.00am by Healthcare Assistant (HCA) A who noted that he still felt sick and weak in his limbs. He was advised to rest and told that he would see a doctor later. Medical Officer A saw him at 9.00am who said that he was vomiting up his meals and had a history of hiatus hernia (the protrusion of part of the stomach through the diaphragm). The doctor added Maxalon to his medication to counter the nausea and told staff that he

could now leave cell 12. At 11.30am, he signed a medical disclaimer and left the healthcare unit. There is nothing to suggest that anything else of note happened on 25 November.

59. The man was seen by his CARATs case manager on 26 November. He recorded that the man was feeling better but was worried about the length of time he might have to serve.

60. The carer explained the changes that he saw in the man between his arrival in prison and the end of November:

> "I just believe that when he was on the Detoxification Wing he was able to get hold of drugs and he was using them. Because he was no longer talking about being positive and I could just see it in his eyes and his actions … The withdrawal symptoms seemed to have abated when I saw him a couple of days later … he seemed happier, you know he wasn't worried about getting his methadone. When he first came in he was, he said you know I need my methadone prescription and I don't think the prison were doing methadone when he came in … He told me that he was able to get the drugs …"

2 December

61. At 2.10pm on 2 December 2008, the man climbed up from the first floor balcony onto the rafters in the gym and positioned himself in the roof space on the pipes and ducting. Staff arrived and he told them that he was in possession of a knife and would slash them if they approached. He explained that he was protesting about being refused methadone and wanted to transfer to another prison where he could have it.

62. The Command Suite was opened and negotiators were called in from the North West Area Office. The man said that he felt that his health had deteriorated since he had been at Altcourse. He threw a disposable razor blade down to the floor at 4.50pm, but continued to demand a transfer to a prison with a methadone treatment programme. He also said that he wanted to see a doctor. He was told that a transfer could not be guaranteed. If he came down, he would be seen by the Duty Director, Healthcare and the IMB, and taken to the Care and Separation Unit (CSU).

63. The man began to make his way down at 6.15pm while continuing to demand a transfer to another prison. He told staff at 6.40pm that he was coming down and he was safely on the ground by 6.45pm. He was taken to the CSU under Rule 53 (which meant that he awaited an adjudication hearing) where he was visited by a member of the IMB. He was calm and explained that he found the medication for his drug withdrawal ineffective. She told my investigator that: "He seemed agitated and upset … He was regretful for the, you know, for the trouble he'd caused basically." She praised the way he had been treated by staff and said that he "was fully compliant and satisfied that he'd been fairly treated".

64. An Initial Safety Segregation Screen was undertaken by Nurse E at 6.50pm. No healthcare intervention was needed at the time and the man was assessed as clinically fit for location in the CSU. (The nurse told my investigator that she had not received any training in the completion of this form.) According to her, he did not show acute signs of withdrawing from drugs at the time. She gave him his evening medication and told him that he would see a doctor the following day.

65. The man was observed five times an hour during the night and seemed to sleep well throughout. (This level of observations was not standard practice and reflected the extra support that staff thought he needed.)

66. The records show that the man was to be offered showers, use of the telephone and exercise daily. He was also allowed access to the library, education and religious services.

3 December

67. According to the CSU daily history sheet, the man was seen by the Duty Director, healthcare and chaplaincy staff on 3 December. He was quiet and polite and mainly concerned with transferring to a different prison.

68. The man's CARATs case manager wrote in his record that he was unable to see him due to his issues with methadone.

69. An adjudication hearing was opened following the man's protest of 2 December. It was conducted by the Head of Safer Custody. The man did not plead to the charge but explained that he had been on methadone for eight months and his "head had gone". He said that he had first thought of harming himself but then realised that the situation had gone too far. He said that it would not be repeated. The hearing was adjourned because he claimed that the protest was a form of self-harm.

70. The Head of Safer Custody explained to my investigator that the prison would not continue an adjudication hearing if there was a self-harm element. The hearing was suspended pending an investigation into whether self-harm had been present in the man's actions. (My investigator was told that the investigation concluded that the protest was an act of defiance rather than self-harm. However, the adjudication had not been resumed before his death.)

71. The Head of Safer Custody told my investigator that the man did not behave during the hearing in a way that caused him any concern for his well-being. He also explained that it is common to consider transferring any prisoner involved in an incident at height in order to show that their behaviour will not be tolerated.

72. The Manager of the CSU thought that the man was down and uncommunicative and so she opened an ACCT form at 11.05am on 3 December. In interview, she said that he was evasive or non-responsive

when asked about self-harm so she thought that ACCT monitoring would minimise the risk to himself. She remembered that he appeared agitated and said that he was struggling, although she did not think that he was clearly withdrawing from drugs.

73. She filled out the ACCT Immediate Action Plan. It sets out the actions which were to be carried out with regard to his location, staff support, telephone access and access to Listeners. She wrote that he was currently in the CSU but this was to be reviewed later. He was to have five staff observations per hour, and staff should attempt to hold a conversation each morning, afternoon and evening. He should also have access to the telephone and to a carer.

74. The man was visited by a second carer at approximately 2.00pm. He reported in the Carers Interview Sheet:

> "Needs methadone treatment, is going through a bad time after being taken off. Is having feelings about self-harming and suicide. Wants a transfer to another jail so he can get methadone treatment ASAP. Wants to be back in normal location, can't do with being on his own."

75. He told my investigator that the man said he was thinking of cutting himself to relieve his stress. He also spoke of possibly taking his life. They talked about other things he could do to relieve the pressure instead of harming himself, and he agreed to visit him again the next day.

76. At 4.51pm, the man saw Medical Officer B who said that his mood and manner were appropriate with no evidence of psychosis. He wanted to be given methadone but the doctor told him that it was not prescribed. A note was made in his ACCT document at 6.30pm:

> "Attempted to carry out assessment at 18.30hrs on 3/13/2008. The man could not participate due to feeling unwell due to detox. Agreed to try again tomorrow."

4 – 14 December

77. The ongoing record shows that the man was seen by the doctor at 7.40am on 4 December and given his medication. The first ACCT case review was carried out at approximately 9.00am with the man, manager of the CSU, Head of Safer Custody, the RMN and the Duty Director. An ACCT assessment interview had not taken place beforehand, although it is a necessary part of the process as it provides much of the detail of the prisoner's condition. The ACCT document states that it should be carried out within 24 hours of concern being raised unless circumstances are exceptional, e.g. prisoner admitted to outside hospital and too ill to be interviewed.

78. The man told the staff that he did not want to be on ACCT monitoring. He also said that he would commence a dirty protest if he was not transferred from Altcourse. As he had not yet had an ACCT assessment interview, it was decided that he would be asked every day whether he would agree to an assessment to allow staff to manage his risk. Five observations an hour continued and he was to be seen by healthcare staff and the Duty Director each day.

79. In interview, the Head of Safer Custody explained the man remained on five observations an hour because they were unable to assess his level of risk as the assessment interview had not taken place.

80. After the ACCT case review the man told staff that it was a "waste of time". He was described as being very low, and said to be uncooperative as he denied any thoughts of self-harming yet made threats to do so. No changes were made to the ACCT observations as had not undertaken the assessment interview. He told the RMN that he did not wish to stay at Altcourse as he thought he would be more likely to get methadone at a different prison.

81. The man was seen by the Duty Director at 7.29am on 5 December. He later saw a nurse and again complained about withdrawing from methadone. A Separation Under Prison Rule 45 review was held on 5 December. No specific healthcare concerns were raised, and it was decided that he would remain in the CSU until he was transferred to another establishment. He also appeared to give his consent to an ACCT assessment interview.

82. He tested positive for heroin and benzodiazepines at 3.55pm. The test was carried out after consultation with a doctor as he complained of withdrawal from methadone. Medical Officer A explained to my investigator that Dihydrocodeine shows as heroin in the urine and so the results do not necessarily show that the man was illicitly using heroin. He saw the doctor at 4.44pm and again asked for an extended detoxification programme. He was given medication to relieve his detoxification symptoms.

83. At approximately 8.00pm that evening, Nurse F was called to the CSU as officers had found the man on the floor behind his door. She did not think that he had had a seizure. Later that evening, Nurse D was called to the CSU as he was complaining of vomiting all day and was now bringing up blood. He

told the nurse that he had not passed urine for 48 hours and had not had a bowel movement for two weeks. She noted that he did not appear dehydrated, although there was some yellow fluid, which could have been bile, on the floor.

84. Shortly afterwards, Nurse D was recalled to the CSU as the man had made superficial cuts to his left arm, stomach and face. She cleansed his cuts and he was moved to cell 8 in healthcare. (Cell 8 is a cell with a Perspex door that allows greater observation of the prisoner.) He kicked the door and became verbally abusive to staff. He had told the nurse that he harmed himself because his "head fucked up". She completed a F213SH form and recorded that he would continue to self-harm until his demands were met. (A F213SH form is used to record injuries following incidents of self-harm.)

85. During interview, Nurse D said that she thought his demands related to receiving methadone, but she could not fully recollect their conversation. At 1.15am on 6 December, she had recorded in the Continuous Clinical Record that he had told the Healthcare Assistant (HCA) that he had taken Subutex two days earlier from another prisoner.

86. The man handed over a sharp piece of metal to nursing staff at 4.30pm. He later apologised to Nurse D for the way he had spoken to her. In interview, she said:

> "… he said to me a couple of nights later 'Can I just have a word?' and I said 'Yes' and he said, 'Miss I'm very sorry about what I said the other night, I wasn't right in saying that to you and will you accept my apology?' And I said, 'That's a handsome apology; let's just leave it now, that's fine. I knew it wasn't personal, I don't take things personally, that's fine.' And he said thanks for that … I did say to him, 'You don't know what you're actually taking do you, from these people?' and he said 'No'. And I said, 'Well you know it could be something that's making you unwell' because he was saying, 'I keep feeling sick all the time'. And I said, 'It could be that that's making you unwell you know, you do have to be careful what you take' and he said, 'Yes, I know …"

87. The first carer told my investigator that the man repeatedly asked him to procure drugs for him while he was in the CSU and healthcare unit. He refused and decided to stop seeing him. He told healthcare staff why he would no longer see the man.

88. Also on 6 December, at 1.06pm, HCA B wrote in the man's medical file that he had been quite demanding that morning and had asked for a second shower. He had eaten and drank normally and was awaiting a bed in the CSU. It was written in his medical file at 7.54pm that he was moved to cell 6, and at the same time had asked for a carer. He spoke to the carer at approximately 8.30pm. Throughout the night he was seen to retch but not vomit by Nurse D. She told my investigator that she was concerned about sustained vomiting. She said:

> "I was more concerned that he might have an underlying medical condition, something like maybe a bleeding ulcer. He had already had detox but I was concerned that it was an underlying medical problem."

89. The man spoke to another carer at approximately 6.30pm the next day. The second carer said in interview that the man was in a bad way and was unable to drink properly. He had told him that "his head was completely gone".

90. At 1.04am on 8 December, the man was found lying awake on his floor and complaining of nausea. He was offered two paracetamol pills but refused. Nurse D monitored him over the next three hours and, at 4.03am, noted that she had seen him vomit twice. Although he looked pale, he did not appear dehydrated but there was a plastic bag by the toilet that appeared to contain blood-stained vomit. She decided that he was to be reviewed by a doctor. It is unclear why he had a plastic bag in his possession although items such as this would not routinely be removed from a prisoner, even if they were subject to ACCT monitoring procedures. Prison Service Order (PSO) 2700 states:

> " … removing personal belongings from a person who is feeling hopeless and depressed (especially items of clothing, belts or shoelaces) can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Fear of losing their normal possessions can discourage prisoners from disclosing suicidal feelings. And removal of some items in possession (such as pens) can deprive the individual of access to creative activities which might distract them from their painful feelings. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so … *Staff must not remove items from at-risk prisoners as a matter of course.*"

91. A Separation Under Prison Rule 45 review was held on 8 December. No specific healthcare concerns were raised and it was noted that the man was to be transferred to another establishment. He was not present as he was in healthcare. It was also decided that, should he be fit for normal location, he would return to the CSU.

92. According to the ACCT form, an assessor undertook the ACCT Assessment Interview at 11.00am on 8 December. The man said that he felt very ill due to withdrawing from methadone. He described the incident in the gym as a 'complete blur' and was feeling low as he did not cope well with isolation. He explained that, when he harmed himself, his mind went blank but he was not aiming to kill himself. He said that, although he had self-harmed since childhood, he had not done so for many months and regretted having done so now. He also said that he had never attempted suicide and did not feel that he ever would as he had "too much to live for". He explained that he had a son and a 14 year old stepson, and also had the support of his parents.

93. With regard to his current mental state, the man told the assessor that he felt much better than he did when he had harmed himself, but was still not eating

or sleeping well. He felt as though his "head has gone" but did not say that he had any mental health concerns.

94. At 2.12pm, HCA B made a note that the man was frustrated as he was still in the healthcare unit.

95. Shortly afterwards, at 2.50pm the man's ACCT case review was carried out. He told the staff that he regretted acting the way he did and expressed the desire to share a cell with someone and find an activity to focus on. He wanted to come off "the watch" but said that he would harm himself if he was made to return to the CSU. His risk was described on the form as "raised".

96. A Care Map was filled out. They agreed to consider the most suitable location for the man, to arrange activities once this was established, and to try to provide him with information about his sentence.

97. Three hours later, at 5.50pm, the man was seen lying on his cell floor. A senior nurse checked that his pupils were reactive to light but she was unable to rouse him. She left to speak to the doctor and, when she returned, spoke to him who told her that he wanted to sleep. He slept well overnight with no apparent problems.

98. Medical Officer B saw the man at 9.06am the next morning (9 December). He wanted to be prescribed sleeping tablets. The doctor refused this request.

99. The man was maintained on the CSU regime and was monitored under the ACCT procedures. He spoke to a carer again at 6.30pm.

100. Upon waking on 10 December, the man was noticed by staff to vomit into his toilet. He was seen at 8.53am by Medical Officer B who prescribed Movicol sachets to try to help his constipation.

101. It seems that the man was also seen by a member of the IMB. In interview, she described him as calmer and much better. She said that, "he gave us … the impression that he would actually quite like to be clean and not to be taking drugs and to look forward to the future."

102. The penultimate note in the man's CARATs Case Record noted that he was in healthcare under segregation. The note said:

> "Not yet interested in CARATs due to being stressed about bang up. To visit once on normal location."

103. An ACCT Case Review took place at 3.30pm before the man's discharge from healthcare. He agreed to return to the CSU that evening as he thought that did not need a healthcare bed. He was reassured that his medication and ACCT observations would remain the same.

104. However, later that afternoon the man refused three direct orders from officers to return to the CSU and he was restrained using control and restraint

techniques. He did not receive any injuries and was returned to the CSU at 8.45pm to cell 17. An Initial Segregation Safety Screen was undertaken by RMN B shortly afterwards. The RMN noted that no healthcare intervention was required.

105. The man was seen by the doctor at 7.55am on 11 December. He complained of stomach pains and of being unable to sleep. Nurse G was called to the CSU at 10.29am to see him as he had superficially cut his left cheek. He told her that he had used a piece of glass. It is recorded in the medical file that officers searched him and removed some items from his possession. The nurse cleaned the cut, but he opened it again and so she had to repeat the cleaning. At 10.55am, Medical Officer B saw him who complained of abdominal pain. The doctor asked for an ultrasound scan of his abdomen.

106. At 11.46am, Nurse C was called to the CSU as the man had cut his face again. The nurse reported that the cuts were slightly deeper than before and he seemed low in mood.

107. The man told the nurse that he had taken a piece of glass from a coffee jar and had secreted it. He was determined to continue cutting himself, and would wound himself more seriously if he was left as he was. The nurse explained to my investigator that he thought the man should be moved to healthcare.

108. Because of the man's self-injuries and his comments, Nurse C contacted RMN C who supported the decision to transfer him to cell 8 in healthcare. Nurse C was sufficiently concerned to take him over to the healthcare unit personally:

> "… I was aware that the man was expressing such behaviour at that point in time, that he was clearly in need of observation, and I stayed with him until and actually took him over to healthcare with the officers and actually took him to cell 8 where he was going to be continuously monitored so from the point of seeing him there he wasn't left at all he was actually escorted over and I accompanied him over to healthcare to make sure …"

109. The man was searched by an officer who found a piece of glass wrapped in tissue, which they suspected had been used by him to cut himself. Nurse C thought that this occurred in the CSU. The nurse told my investigator that he told RMN A of the potential mental health implications of the man's behaviour, and of his move to cell 8 in healthcare.

110. An ACCT case review was carried out at 12.00noon. Although Nurse C was listed as present, the manager of the CSU explained that the review used information from Nurse C before the start of the review. She told my investigator that much of the information had been provided in the CSU, rather than at the review.

111. The manager of the CSU had been the Case Manager when the man was in the CSU and now handed over to someone else. The review noted that he

had been moved to cell 8 following acts of self-harm, and the level of risk was raised to high. He told staff that he did not like being isolated and did not understand why he had been separated. He told staff that he would continue to harm himself and would even cut his jugular vein given the chance. It was decided that he should remain in cell 8 until he was seen by the doctor.

112. The decision was made on 12 December to transfer him to HMP Garth. A note in his core record stated:

> "Following discussion with the Director it has been agreed to carry out a staged unlock [gradual increase in time unlocked] until transfer. This will begin with a 1 hour association this evening, providing he behaves. Duty Director will decide what escalation he will be permitted each day."

113. The person who wrote the note thought that the man was very happy about the opportunity to go to Garth and willingly agreed to the transfer. The transfer would probably have occurred at some stage in the following week. During interview, the person related his interactions with the man during this time:

> "He had mood swings but you know sometimes he was happy, sometimes he was sad. He was never, he was never particularly violent or angry or cross towards me but I think that's probably just to do with the fact that I don't raise my voice, I talk to people on a one-to-one basis, you know … I don't recall him being in discomfort. You know there are a couple of times when he might have been angry but not distressed."

114. The staff who undertook the man's ACCT observations reported that he had slept well through the night and, following a review with Medical Officer A at approximately 2.00pm, had been moved to cell 10. (Cell 10 is a standard prison cell.) He was allowed out of his cell for an hour to associate with the other prisoners in the early evening. On 12 December, the man telephoned his mother at 6.40pm and was apparently fine.

115. On 13 December, the man was reported to be settled, and seemed much happier after being out of his cell at lunchtime. However, at approximately 9.35pm he pressed his cell bell to complain of abdominal pains. He spoke of his constipation and was given a suppository but it had no effect. He was given Losec (to relieve excess stomach acid) and Movicol, but continued to complain of stomach pain. The doctor advised staff to give him an injection of Voltarol (an anti-inflammatory and pain relieving medicine) and some Metoclopramide (to relieve nausea). Having taken the medication, he spent an unsettled night reportedly retching on several occasions.

116. Medical Officer A wrote in his file on 14 December that the man should consume eight sachets of Movicol in one litre of water to treat the constipation. The rest of the day was quiet. It was recorded in his ACCT that he told a member of staff that he felt a bit better that morning.

15 and 16 December

117. The man was seen retching again during the night and was given paracetamol at 6.50am the following morning (15 December). Medical Officer A saw him at 9.00am and described their conversation as follows:

> "… I think the thing that sticks out most in my memory is that he was unhappy that we hadn't managed to treat his constipation properly, I don't recall he had anything suspicious of low mood or depression or anything else at that time. He also mentioned I think at that interview that he was suffering with his chest and we assessed that at the same time again in terms of his mental health. There was nothing specific that came out of that interview really … there was no mention, no further mention of his drug withdrawal …"

118. At 11.40am, a note was made in his ACCT ongoing record:

> "Had a chat with the man earlier. Stated that he still felt unwell and that this was 'wrecking his head'. Has been seen by Dr this morning and said that he is happy with treatment prescribed by Dr. Stated no thoughts of DSH [deliberate self-harm] at this time."

119. At 3.00pm, the senior nurse made a note in the man's ACCT ongoing record that his case review was to be deferred until the following day to ensure the attendance of staff who had had input into his care. She noted that he had agreed to this decision.

120. From 9.00pm that evening, the day staff began to hand over responsibility to Nurse D and HCA A who were the night healthcare staff. The nurse explained to my investigator that the handover took a long time and she needed to leave the office while it was ongoing in order to carry out the ACCT observations. At 9.15pm, a record was made in his ACCT by the nurse saying that he appeared to be sleeping on his right side.

121. The man was next seen again when Nurse D went to his cell at approximately 9.50pm to make another ACCT check. She saw him sitting on his bed with a ligature around his neck. The ligature was made out of two socks and linen and was tied to a wall-mounted light above the bed.

122. The nurse called a Code 1 alarm on her radio to indicate a medical emergency. Night nursing staff do not carry keys but have a cell key in a sealed pouch which is to be used in emergencies. HCA A came to help her and opened the cell using the key. They cut him down using a ligature knife. In interview, the nurse described the ligature as feeling wet. They placed him on the floor and immediately began cardio-pulmonary resuscitation (CPR). Other staff arrived within 30 seconds. Officer A brought the oxygen and defibrillator from the nurses' station. Nurse D told my investigator that the first defibrillator that the staff brought was not working so she left the cell to get another one.

123. Officer B ordered an ambulance via the control room. An oxygen mask was put on the man and the defibrillator attached. It instructed staff not to shock him. (A defibrillator verbally tells staff whether to shock the patient or not.) CPR continued until the ambulance arrived at approximately 10.04pm. The paramedics asked Nurse D and HCA A to continue CPR while they administered adrenaline and atropine. The man's heart rhythm changed and he was given a shock from the defibrillator. A pulse was established at approximately 10.12pm.

124. The man was taken to the ambulance at 10.25pm and then to hospital. He arrived at 10.32pm and was admitted to the critical care unit. Officers C and D accompanied him to the hospital and remained until 6.45am when they were relieved by the day bed-watch staff. The man was not restrained at any point.

125. After the man was taken to hospital the Duty Operations Manager double-locked the cell to preserve any evidence. The care team were informed and were available to offer support any staff that needed it.

126. The incident commander telephoned Prison Custody Officer C at his home at 11.15pm to appoint him as Family Liaison Officer (FLO) and to ask him to contact the man's parents. PCO C was given the contact details by the incident commander and then telephoned the man's parents at 11.30pm. There was no answer so he left a message asking them to call him back. At the request of the incident commander, the PCO also telephoned the man's partner at 1.10am. There was no answer either so again he left a message. Following these unsuccessful attempts, the incident commander decided to ask the police to contact the family.

127. The police went to the man's parents' house at approximately 1.50am and told them that their son was in hospital. The Duty Operations Manager arrived at the hospital at 4.40am in order to meet the family. The man's aunt, uncle and sister arrived at 5.20am and went to his bedside. At 6.45am, PCO D introduced himself to the family. The FLO, PCO C, went to the hospital at 9.10am with the chaplain and introduced himself to the family. The family asked various questions and told him that the decision had been made to turn off the life support machine. They said that the man's partner and son had not been contacted but his brother who was in HMP Ranby had been informed.

128. It was decided that a computerised topography (CT) scan would be carried out in the morning to check on the condition of his brain. At 9.45am, the chaplain attempted to arrange a phone call between the man's brother and sister. However, the idea had been abandoned by 10.30am in favour of attempting to arrange a compassionate visit for his brother.

129. At approximately 11.55am it was decided that the man would have the CT scan at 4.00pm. At 1.05pm, his parents arrived at the hospital. PCO C and the chaplain returned and met his parents. His brother arrived at 4.18pm and went to his bedside.

130. The man died at approximately 4.45pm. His parents left the hospital at 5.15pm and spoke briefly to PCO C as they left. He expressed his condolences and promised to call them in the morning.

131. The Head of Safer Custody and the Head of Residence, carried out two hot debriefs on 16 December. The first was with staff who had found and resuscitated the man. The second was with Nurse D and HCA A as they were unable to be relieved from duty during the first debrief. The Head of Safer Custody told my investigator that both debriefs were valuable and considered helpful by the people involved. The care team were available at both meetings.

132. Prisoners were informed of the man's death by notices put up in the wings.

133. At 12.30pm on 17 December, PCO C spoke to the man's sister. He explained the involvement of the Coroner and provided details of the Coroner's officer. He also spoke about the man's property and the investigation that the Ombudsman's office would undertake. He offered up to £2,500 for funeral expenses and assured her that she could contact him at any time with any further questions.

134. On 18 December, PCO C confirmed with the Director that a letter of condolence had been sent to the man's parents. He visited the man's parents on 22 December to return his property.

135. PCO C returned from leave on 7 January 2009 and rang the funeral directors to enquire about the funeral date. They told him that it was at 12.00 noon that day. The date and time had not been known to the prison and so no flowers were sent and the family were not consulted about staff attendance.

136. PCO C contacted the family again on 9 January to ask about the funeral and to offer a visit to the prison. The family debated whether to visit but decided against it. The prison paid their contribution towards the funeral expenses.

ISSUES

Good practice: use of carers

137. My investigator was told by one of the Altcourse carers that it is the prison's policy for recalled prisoners to share a cell with a carer on their first night. This provides emotional support during a night which may be quite distressing. A prisoner may have been recalled fairly quickly after release – as was the case with the man – or it could be after many years, and the policy acknowledges the difficult situation that recalled prisoners face. This is followed with another meeting with the carer to allow the opportunity for the recalled prisoner to relate their feelings and express any concerns about their situation. I am pleased to highlight this area of good practice.

Managing the man's drug withdrawal

138. At the end of his period in custody at Hull, the man was taking 85mls of methadone daily. He was released on 11 November and it is unclear whether he continued to take methadone subsequently. However, my investigator was told by a prison carer that the man had said that he had taken a number of other drugs during the week he was at liberty. As we have seen earlier, he was recalled to prison on 19 November having breached the terms of his licence. Thereafter, he consistently requested methadone and complained about his poor health which was characterised by collapsing, seizures, vomiting and constipation.

139. At the time when the man was received at Altcourse, the prison did not offer methadone to any prisoner. This has now changed and methadone has been prescribed since mid-January 2009. There was some confusion over whether the urine test used would have identified the presence of methadone. However, since Altcourse was unable to prescribe methadone at that time it appears that his treatment was not affected. He was still prescribed Dihydrocodeine for his drug withdrawal symptoms. This drug can counter some of the symptoms of drug withdrawal, although it is not licensed for this purpose and does not alleviate the addiction.

140. I note that the clinical reviewer comments on the healthcare received by the man:

> "[The] healthcare the man received (accepting prescription of methadone was not allowed at the time) was generally to the standards one would expect …"

Use of illicit drugs

141. It appears very likely that the man was taking illicit drugs while in Altcourse and this may have exacerbated his physical problems. He confessed to illicitly taking Subutex and asked several carers to try to procure drugs for him. This might help explain his constant ill health and changeable mood. The CARATs worker explained that the man's desire for methadone should have lessened fairly quickly after entering Altcourse.

142. No prison is wholly immune from illicit drug-taking, and I am confident that the Director and his staff take the matter very seriously. Nevertheless, in support of the Director, the Director of Offender Management for the North West will wish to assure herself that all reasonable actions are taken to prevent the ingress of drugs into Altcourse.

143. The first carer told healthcare staff that the man had asked him to obtain drugs on his behalf. Healthcare staff were also told by him himself that he had consumed illicit drugs. Furthermore, his personal officer suspected he might have been taking drugs. Despite all this, my investigator found no Security Information Reports (SIRs) relating to this issue. This is surprising and disappointing.

The Director should remind staff of the need to pass all information regarding illicit drug use to the security department via an SIR.

Segregation Safety Algorithm

144. When a prisoner enters the CSU a document called the 'Segregation Safety Algorithm' must be completed. The purpose is to check whether the prisoner is clinically able to cope with being in the CSU. The algorithm in the man's case was undertaken by Nurse E. She deemed him able to cope with the CSU and that no healthcare intervention was required. However, she told my investigator that she had had no training in the filling out of the form.

145. The algorithm is not a complicated document but it was not filled out in the manner one might expect. None of the boxes on the pathway was ticked, meaning that the form was potentially ambiguous.

146. The problem was replicated in the form filled out by RMN B on 10 December. It is not clear which route was followed on the flow-chart and the form does not appear correctly completed. It is unfortunate that the staff tasked with completing this role did not clearly understand the process involved. This is a matter that can be remedied quickly.

The Director should ensure that the staff tasked with completing Segregation Safety Algorithms are appropriately trained in the purpose and completion of the forms.

147. The man was removed to the Care and Separation Unit following his protest in the gym. I am content that this decision was correct given his behaviour.

148. When a prisoner is taken into the CSU it is important that they are able to spend their time in a manner not likely to damage their mental health. The man had access to the library, education and an hour's exercise a day. Association with other prisoners was not possible, although it appears that he did have time out of his cell when he was moved to the healthcare unit.

Transfer to HMP Garth

149. The man wanted to be prescribed methadone. It was not available at Altcourse and he told staff that he wanted to move to another prison that was able to prescribe methadone. His request was refused. Staff explained that there were many prisoners in the same situation as the man who had come into Altcourse on a methadone prescription, but which was stopped immediately. There was no reason to transfer him any more than any other prisoner. In addition, he might not have been eligible for a methadone prescription in another prison because there was no methadone in his urine.

150. My investigator asked whether there was a medical reason to transfer the man. He was told that there was nothing particular about him that meant he required special treatment. Ultimately, the decision to transfer him was because of his protest in the gym. Senior management explained to my investigator that prisoners involved in incidents at height are regularly transferred.

151. Although it is highly probable that the man would have been more comfortable at another prison, I do not criticise Altcourse for their approach to his request for a transfer. It is clear that he was not alone in finding the lack of methadone at Altcourse uncomfortable and unsettling. The logical extension of his transfer would have been the wholesale transfer of potentially hundreds of prisoners. The fundamental problem, as the IMB acknowledged, was the absence of methadone prescribing at Altcourse at that time.

Assessment, Care in Custody and Teamwork (ACCT)

152. The man was placed on an ACCT on 3 December to monitor and protect him. When an ACCT is opened there are a number of requirements that should be carried out.

Assessment interview

153. One of the key processes after the ACCT is opened is the assessment interview. This discussion with the prisoner records their state of mind and enables the prison to properly assess the risks. The ACCT book states that the interview should be carried out within 24 hours, unless circumstances are exceptional such as the "prisoner/trainee admitted to outside hospital and too ill to be interviewed". Staff attempted to carry out the interview with the man on the evening of 3 December and again the following morning (4 December). Both attempts were unsuccessful as he was either unwilling or not well enough to participate.

154. Strict interpretation of the ACCT requirements is that Altcourse did not fulfil the expectation to hold an assessment interview within 24 hours. However, I am satisfied that this was not due to any failings on their part. Further attempts to carry out the interview were made before it was eventually completed on 8 December. Crucially, the prison maintained the observations at the original frequency (five per hour) as they did not have sufficient information to reduce them. I consider this to have been an appropriate way of dealing with a difficult situation.

ACCT case reviews

155. The ACCT requires case reviews (the exact number depends on how long the ACCT is open and the events that take place) to be held with staff and the prisoner. The man went to a number of reviews. I am pleased to see that they generally involved a multi-disciplinary group of relevant and senior staff.

156. However, the paperwork for the review on 11 December records several people including Nurse C as present (the word 'attended' is written next to his name). In interview with my investigator, he denied any knowledge of the review and expressed ignorance of ever attending any reviews.

157. My investigator spoke to the Head of Safer Custody about this issue and he provided the following comments:

> "I have spoken to the CSU manager who informed me the member of healthcare named on the handover review was present in CSU and was jointly responsible for the decision to relocate the man to healthcare. During the decision process all aspects of the case were discussed with the member of healthcare, they then took him to healthcare where she again went over the case with the healthcare manager …"

158. Although this misunderstanding causes me some concern, I am impressed that the handing over to the healthcare manager included the CSU manager who chaired the initial case review when the man moved to healthcare. This is a good example of the different areas of the prison working together to ensure that relevant information is shared effectively. However, as a housekeeping point I encourage the Director to ensure that documents are filled in accurately, so that it is clear whether someone is present or merely provides information before the meeting.

ACCT observations on the evening of 15 December

159. The man's ACCT book stipulated that he should be checked five times an hour. The responsibility to undertake the checks was handed over to Nurse D and HCA A at 9.00pm on 15 December, and indicated by the stamp in his ACCT booklet signed by Nurse D. The Head of Safer Custody explained to my investigator that a correctly managed handover should include a check on the prisoner concerned. From the CCTV footage, it can be seen that there was a check at 9.15pm and another at 9.52pm when he was found with a ligature around his neck. If the handover is included, three checks were carried out between 9.00pm and 9.52pm.

160. Nurse D explained to my investigator that she believed that the ACCT observations should be random without any maximum gaps between them. She said that did not do anything different to her usual routine and was confident she would perform the required checks in the hour.

161. The ACCT guidance does stipulate that the checks should be random (for example, not every ten minutes exactly) and do not state the maximum gaps between checks. Nurse D mentioned a situation where she returned to a prisoner two minutes after her previous check and found him tying a ligature around his neck. There is certainly merit in that type of random check. However, there evidently needs to be a balance between checks in close proximity and sufficient checks for the rest of the hour.

162. I accept that the ACCT procedures leave a grey area in this regard, but I am struck by a 37 minute gap in observations intended to be five times an hour for a man who had recently harmed himself. It is impossible to know whether the man would have survived had a check occurred at, for example, 9.30pm, but it is reasonable to assume that his chances of survival would have been higher.

163. Nurse D and HCA A both explained that the lengthy handover from the day staff complicated matters in the first hour of their shift. However, the nurse left the handover to complete the checks at 9.15pm. In addition, she told my investigator that she did not do anything differently from previous evenings and chose to undertake the checks at the times she did.

164. I was also disappointed to learn that Nurse D was unaware that the signed stamp in the ACCT booklet meant that she and HCA A had taken over responsibility for the man from the day staff. Their lack of knowledge, coupled with the issue of the observations, suggests that further ACCT training may be advisable. (It should be noted that the nurse and the HCA no longer work at Altcourse.)

165. The ACCT checks on the man from 3 December to the time of his death were generally regular and impressive.

The NOMS Safer Custody and Offender Policy Group should consider whether further guidance should be offered on the balance between regular but random observations for those subject to ACCT monitoring.

The Director should ensure that sufficient training is provided on ACCT procedures to all relevant staff.

The Director should ensure that the need to undertake ACCT observations as required by the individual document is understood and implemented by all staff.

Resuscitating the man

166. When Nurse D found the man hanging, support arrived very quickly from HCA A and other staff. The clinical reviewer has raised no issues about the resuscitation attempt. However, I am concerned to learn from the nurse's evidence that one of the defibrillators kept in the healthcare unit was known to be broken. As chance would have it, this was the one brought to the man's cell. The nurse had to leave the cell and go and fetch a working one. It appears that CPR was maintained and the second defibrillator advised staff not to shock him. However, this would clearly not be the case in every situation and non-functioning defibrillators should be immediately replaced.

The Director and Head of Healthcare should ensure that all defibrillators in the prison are checked and, if any are found to be not working correctly, replacements should be purchased.

Liaison with the man's family

167. The prison's family liaison officer, PCO C, attempted to contact the man's parents on the evening of 15 December, but was only able to reach their answer machine. Consequently the local police were asked to break the news to them. Although this was a great shock, I consider it appropriate that the prison sought to alert them as soon as possible to their son's condition and thus enable them to go to the hospital.

168. It was unfortunate that PCO C was not aware that the Night Operations Manager had gone to the hospital in the night to meet the family. While I do not think it necessary to make a recommendation in this case, the Director should ensure that the prison FLO is provided with all the information relating to contact with the family. This will help prevent professional embarrassment and ensure that the FLO does not look ignorant in front of the family.

169. PCO C was on leave over the Christmas period and returned to work on 7 January 2009. While he was on leave, the telephone number of the Head of Safety Custody was given to the family to use in the interim. No contact was made during this time. Upon his return to work, the PCO discovered that the funeral was the same day. The prison was therefore unable to send either a representative or send flowers.

170. I am not critical of the lack of contact between the prison and the family while the PCO was on leave. The family had the Head of Safer Custody's number and so had easy access to a senior manager. However, I am critical of the fact that the PCO was the prison's only Family Liaison Officer at the time of the man's death. If there had been more than one FLO, a trained member of staff could have taken over contact with the family while the PCO was on leave. I would have made a recommendation in this regard, but have been pleased to learn that the recruitment of additional FLOs has already been undertaken.

CONCLUSION

171. The man was unhappy throughout much of his time at Altcourse. This seemed to stem largely because of the absence of prescribed methadone. As his distress and ill health became more pronounced, he became difficult to manage. He harmed himself and complained of becoming more unwell. I believe that the staff tried to help him and began the ACCT process to try to protect him.

172. It appears likely that the timing of the ACCT observations on the evening of 15 December 2008 gave the man the opportunity to hang himself. My recommendations reflect the importance of maintaining effective monitoring of those most at risk of harming themselves.

RECOMMENDATIONS

1. **The Director should remind staff of the need to pass all information regarding illicit drug use to the security department via an SIR.**

   The Prison Service accepted this recommendation:

   > "Staff undergo annual security refresher training that covers this subject. This will be reinforced to all staff."

2. **The Director should ensure that the staff tasked with completing Segregation Safety Algorithms are appropriately trained in the purpose and completion of the forms.**

   The Prison Service accepted this recommendation:

   > "Head of Healthcare will deliver training to all Healthcare staff responsible for this area."

3. **The NOMS Safer Custody and Offender Policy Group should consider whether further guidance should be offered on the balance between regular but random observations for those subject to ACCT monitoring.**

   The Prison Service stated that this recommendation is already in place:

   "PSO 2700 requires the following "The frequency of conversations and observations (day and night) must be appropriate to the individual's assessed level of risk, including their perceived intent and individual need". It is re-enforced through training why the observations should be carried out at irregular intervals (so the prisoner cannot determine a pattern of observation which may offer a window of opportunity) and that these should be spread over the full hour period."

4. **The Director should ensure that sufficient training is provided on ACCT procedures to all relevant staff.**

   The Prison Service accepted this recommendation:

   > "A programme of foundation training and annual refresher training is in place. The importance of ACCT observations has been reinforced with all staff."

5. **The Director should ensure that the need to undertake ACCT observations as required by the individual document is understood and implemented by all staff.**

   The Prison Service accepted this recommendation:

   > "Regular checks are completed on emergency equipment. Equipment found to be faulty will be replaced or repaired swiftly."

6. **The Director and Head of Healthcare should ensure that all defibrillators in the prison are checked and, if any are found to be not working correctly, replacements should be purchased.**

GOOD PRACTICE

7. **The use of carers at Altcourse for prisoners who have had their licences revoked is an example of good practice.**