

**Investigation into the circumstances surrounding the death  
of a man  
at HMP Forest Bank in January 2010**

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

**June 2011**

This is the report into the circumstances surrounding the death by hanging of a young man on remand at HMP Forest Bank in January 2010. He had only been in custody for six weeks.

I offer my sincere sympathy and condolences to the man's family and friends for their loss. I must also apologise that 12 months have passed between the man's death and issuing my report. I regret any additional distress that the delay may have caused.

The investigation was carried out on my behalf by one of my senior investigators. A clinical review of the man's healthcare was undertaken by a clinical reviewer on behalf of Salford Primary Care Trust. I am grateful for his helpful report. I would also like to thank the Directors of Forest Bank and Altcourse and their staff for their co-operation and assistance with this investigation.

The man was facing serious charges and the possibility of a substantial prison sentence. He spent the first four weeks at HMP Altcourse on special support measures after threatening to harm himself. He took an overdose of paracetamol pills and twice had to be persuaded to accept treatment. He then assaulted another prisoner and spent two weeks in the Care and Separation Unit (formerly the Segregation Unit) before being transferred to another prison. He appeared to settle down in the Young Offenders Unit at Forest Bank. However, ten days later, staff found him hanging in his single cell at the evening roll count. In spite of resuscitation attempts, he died in hospital.

I make four recommendations, covering familiarisation with the background information when conducting reviews under the suicide and self-harm support procedures, simplifying healthcare emergency codes and accessibility of equipment. I am particularly disappointed that one of my recommendations repeats one made by my office in 2008 which, although accepted by Forest Bank, had not yet been implemented. I also highlight an example of good practice at HMP Altcourse in which staff have developed an innovative process for involving families following instances of self-harm.

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.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**June 2011**

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## SUMMARY

The man died in January 2010. He was remanded into custody at HMP Altcourse on 5 December 2009, charged with serious violent offences.

While in police and court custody, the man was assessed to be at risk of harming himself and this information was passed to the prison. However, during the health assessment which is part of the prison's admission process, he persuaded staff that his mood had improved and he no longer posed a risk to himself. The following evening, (6 December) after completing the induction process, he wrote a letter to his girlfriend in which he told her that he intended to kill himself. Staff withdrew the letter and immediately put in place additional support under the prevention of suicide and self-harm measures.

Staff continued to monitor the man under these provisions for four weeks until 5 January. This included a mental health assessment on 11 December. During the period of monitoring, he insisted during reviews that he was not considering harming himself.

Early on 17 December, one of the prison custody officers on his unit again asked the man if he had thoughts about harming himself, which he denied. Later that morning, another prisoner told staff that the man had taken an overdose of paracetamol. Healthcare staff initially treated him in the prison healthcare inpatient unit, but he was subsequently admitted to hospital as an emergency, for 36 hours, returning on 19 December.

A few days later, on the morning of 23 December, the man told staff that he had received a "bad letter" and was feeling down about the charges he was facing. At lunchtime, he had a fight in which he threw hot, sugared water over another prisoner who received 30 per cent burns as a result. He was taken to the Care and Separation Unit, where he remained until he transferred to Forest Bank on 7 January.

At Forest Bank, the man was considered to pose a risk to cellmates, and so was not suitable to share a cell. When questioned about his mental health and previous overdose, he replied that he had done it to 'wind people up'. The post-closure review of the suicide and self-harm procedures was carried out on 12 January. The man made light of the events leading up to the monitoring. The senior prison custody officer who conducted the review did not have a copy of the relevant documents, but was satisfied from the man's actions and demeanour that it had been appropriate to end the process.

Having spent the first few days at Forest Bank either in or close to his cell, on the day of his death the man spent a lot of time out of his cell. He had several conversations with staff, had his hair cut by another prisoner and was described as smiling and laughing. At around 10.35 that night, an officer conducting a count of prisoners found the man hanging in his cell.

When medical assistance was first called for, there was some confusion as to the nature of the emergency. However, both discipline and healthcare staff quickly attempted cardio pulmonary resuscitation, which was continued by paramedics. The man was taken to hospital where he was pronounced dead.

Staff contacted the man's mother as they were unsure if his nominated next-of-kin was an adult. The prison family liaison officer offered support and invited his family to visit the prison. A hot debrief was held and both staff and prisoners were given support. The prison held a memorial service a few days later.

I make four recommendations, two relating to the handling of the suicide and self-harm prevention procedures. The remaining recommendations concern clinical matters. I have also identified good practice in the development of a document which will enable family members to become involved in the suicide and self-harm management process.

## THE INVESTIGATION PROCESS

1. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. There were no responses.
2. My investigator returned to Forest Bank twice more to interview staff, on one occasion assisted by a colleague. She also visited Altcourse to interview staff. She asked Salford Primary Care Trust (PCT) to commission a review of the clinical care the man received whilst in custody. The clinical reviewer completed the review.
3. One of my family liaison officers contacted the man's family. She and my investigator visited the family to listen to their questions and concerns. The family asked a number of questions about the overdose, suicide and self-harm monitoring procedures, prison regime and living conditions. I hope that this report goes some way towards answering these questions.
4. After reading the draft report, the man's mother provided the following information,

“[The man] made two telephone calls to her on the date of his death. The first telephone call was made about 10 minutes before the second call and in the first telephone conversation spoke to both his mother and one of his brothers. He then made a further telephone call at about 3.30pm or 4pm. He told her that he had only about 2p left on his phone and then said “love you” and ended the telephone call.”

The investigator subsequently asked the prison whether prisoners' telephone calls are monitored as they are made. The answer was that most are not and there would have been no reason for staff to have listened to the man's calls during his conversations.

## HMP ALT COURSE

5. HMP Altcourse is located near Liverpool. It is contracted out by the National Offender Management Service (NOMS) and run by G4S, a private company. It serves the courts in Merseyside, Cheshire and North Wales, and holds up to 1,324 sentenced and unsentenced adults and young offenders. There are seven residential units and a separate healthcare unit.
6. Healthcare services at Altcourse are commissioned by Liverpool PCT and delivered by G4S. An outpatients' clinic is available every weekday, and the inpatients' unit has 24-hour staffing by nurses. Additionally, doctors are on call 24 hours a day for more serious incidents.
7. HM Chief Inspector of Prisons regularly inspects all prisons in England and Wales. The latest inspection of Altcourse was 15-22 January 2010, shortly after the man transferred to Forest Bank. In the report, published in March 2010, the inspectorate concluded:

“Altcourse ... has always had good inspection reports, and this report, following a full unannounced inspection, is no exception. Levels of activity in particular remained exceptionally good for a local prison.

“Altcourse remained an extremely effective local prison, providing prisoners with the kind of opportunities they need to improve skills and employability. In spite of its expansion, it was also a safe prison, buttressed by good staff-prisoner relationships and sufficient activity to keep prisoners occupied.

“Good support was provided for prisoners at risk of suicide and self-harm, particularly during the first days in custody. The overall quality of ACCT [suicide and self-harm monitoring] procedures was reasonably good, with some thorough assessments, but routine initial watches of five an hour was unnecessary in some cases. Entries in ACCTs supported prisoners' views that staff cared for prisoners at risk. Families were encouraged to attend reviews, but they were not always multidisciplinary. Prisoners at risk had good support from counsellors and mental health services.”

8. Assessment, Care in Custody and Teamwork (ACCT) provides additional monitoring and personalised support for prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will decide the level of observations/conversations to be carried out at intervals determined by their perceived level of risk. Prisoners should be fully involved in the ACCT process. They first have an interview with a trained assessor, after which an individual care plan is drawn up. They then attend regular multidisciplinary case reviews, where a case manager reviews the care and support they receive. After the ACCT plan is closed, the case manager has

at least one post-closure meeting with the prisoner to discuss how they are coping.

9. An Independent Monitoring Board (IMB) is made up of volunteers from the community in which a prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Justice Secretary annually.
10. The most current IMB report is for the period July 2008 to June 2009. The Chairman concluded:

“Overall, as in previous years, a most satisfactory report in very difficult times. As regards financing, G4S are doing a most commendable job in maintaining regimes and standards at HMP Altcourse.”

The report contains a section on ACCT procedures and standards and states:

“ACCT has been in place at the establishment for more than two years. In the opinion of the Board it is a thorough and effective method of dealing with the most vulnerable. Absolutely all aspects of ACCT have been revisited, reviewed and reinforced.”

## HMP FOREST BANK

11. HMP Forest Bank is a privately managed prison operated by Kalyx under contract. It is situated on the outskirts of Salford. The prison opened in January 2000. It has a certified normal accommodation figure of 1,160, and an operational capacity of 1,424 prisoners.
12. When the man arrived at Forest Bank, he spent a day in the Induction Unit. Then he moved to the Young Offenders Unit on A wing. Young Offender Units accommodate 18 to 21 year olds and the regime and staff focus on meeting the needs of the young men.
13. The cells, both single and double, are a standard size with the same furniture in each, except that single cells do not have an upper bunk fixed to the wall. The windows do not open but ventilation is provided through a long, narrow grill under the window. A sliding metal plate opens and closes to let air into the cell. The report by HM Chief Inspector of Prisons highlighted the poor ventilation in cells in A-F wings and recommended that it is improved.
14. Recently, new wings were opened at Forest Bank. The cells are the same size as the rest of the prison but there is a ventilation grill on each side of the window. However, as the Young Offender Unit remains in the original buildings, the man was not accommodated in one of the new cells.
15. The latest inspection of Forest Bank was an unannounced full follow-up inspection carried out from 29 June – 9 July 2010. The inspectors concluded:

“Forest Bank is a good local prison and a number of improvements were evident since our last inspection [In September 2007] ... For a local prison, prisoners spend a good amount of time out of their cells.”
16. Although the report raises concerns about bullying on the Young Offenders Unit, where the man was located, my investigation did not uncover any evidence to suggest that he had been bullied.
17. The latest IMB report covers the year from December 2008 to December 2009 and raises no issues relevant to the man’s time at the prison.
18. Forest Bank Healthcare has a 20 bed in-patient facility, including two 4 bed wards and a 2 bed observation room. There is 24 hour nursing care and the general practitioner service is provided by a local agency.
19. A Listener scheme is in place for prisoners who are in distress or crisis and need to talk in confidence. Listeners are prisoners who have volunteered for the role and have been trained by the Samaritans.

## **Previous deaths**

20. There have been five previous deaths in Forest Bank since 2004, when my office began investigating deaths in prisons. The only other self-inflicted death was of a man in 2007 and several issues in that investigation are pertinent to this man's time at the prison. I am pleased to note that the medical screening of prisoners in reception has improved, as has the staff response to entering a cell at night. However, the system of emergency codes for summoning medical assistance is still confusing and affected the medical equipment that staff had available to treat the man. I discuss this matter in detail in the Issues section of the report and repeat the recommendation.

## KEY EVENTS

21. The man's parents separated when he was three years old and the following year, his father committed suicide. The man is the middle child, having four siblings.
22. A pre-sentence report, prepared for a court in 2009, noted that the man started offending as a teenager and had been excluded from school on a number of occasions. When he left school, he obtained employment in a local company and his manager spoke well of him. In his spare time, the man socialised with a large circle of friends. He enjoyed playing pool and was a keen fisherman.
23. The man was arrested on 2 December 2009 and charged with two counts of attempted murder and one of GBH. He was on licence at the time, having been released from a YOI two weeks earlier. (Prisoners serving 12 months or more but less than four years are released on licence at the half-way point of their sentence.) Police records showed that he had markers for violence, escape and drugs. He was noted to be at risk of harming himself and the date 16 September 2009 was recorded.
24. On Saturday 5 December, the man appeared at a magistrates' court and was remanded in custody to HMP Altcourse. Whilst at court, he was assessed as being at risk of harming himself. Court staff opened a suicide warning form and made irregular checks of his wellbeing. When he was taken to Altcourse, the escort staff took the form with them and passed it to the prison staff.
25. On his arrival at Altcourse, the man went through the usual admission process. He told staff that he had no thoughts of suicide and the information on the form was not true. An unsigned entry in the Record of Events (F2052A) booklet noted that he had been in Altcourse before and had "no issues being here".
26. Part of the procedures is a health assessment when a nurse completes the First Reception Health Screen form. A registered mental nurse (RMN) interviewed the man. (The RMN has since resigned from G4S to take up other employment and was unavailable for interview. However, his notes of the meetings with the man are comprehensive.)
27. The first entry in the computerised records begins:

"Taken off SASH [suicide and self-harm] form as he now appears philosophical about his situation and certainly did seem to listen to and to respond to positive advice. Good eye contact, posture, body language, facial expression. Good clear, rational coherent speech."

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28. It is unclear from the notes whether it was the RMN's decision to remove the man from the suicide and self-harm monitoring form.
29. The man told the RMN that he had no mental health problems. In reply to a series of questions, he said that he had not been prescribed medication for mental health problems, did have a psychiatric nurse in the community, had not received treatment from a psychiatrist and had never been admitted to a psychiatric hospital. He said that he had never tried to harm himself, either in the community or during previous times in custody. The RMN concluded, "No evidence of mental illness". Nevertheless, the nurse referred the man to the RMN team, which is part of the primary care team.
30. When asked about his physical health, the man said that he had no concerns. He had not seen a doctor during the previous few months and had no outstanding hospital appointments. He described his use of alcohol as "social" as was his use of cannabis and cocaine. The RMN assessed the man as being fit for work and sharing a cell on the houseblocks.
31. The RMN asked the man whether he had any concerns about sharing a cell. When he said that he did "not like Asians", the RMN noted this in the medical records and on the Cell Sharing Risk Assessment (CSRA) form. (The CSRA requires staff to assess whether a new prisoner presents a risk to others, particularly anyone sharing a cell.) The prison custody officer (PCO) in Admissions had completed his part of the form and ticked the box for low risk. However, with the new information about the man's attitude to Asians, the RMN's assessment was of medium risk. The duty manager recorded, "Racially high risk of cell sharing" but decided that he could be put in a double cell.
32. From Admissions, the man went to the First Night and Induction unit in Furlong Green (F2) houseblock. The following day, he took part in the induction process and had a mental health assessment. This was also carried out by the same RMN as the day before, who wrote in the medical record:

"This man does seem settled in manner and behaviour and he certainly did seem to listen to and accept positive advice. He shows good eye contact, posture, body language and facial expression and his speech is clear, coherent, rational, and he displays a good sense of humour. He firmly denies any ideas or intents of SASH [suicide and self-harm]."
33. In the evening, the man wrote a letter to his girlfriend, with "17.55pm" at the top. He wrote that he was "looking at 10 years" and said that he was going to kill himself. When a prisoner writes a letter he passes it to staff with the envelope unsealed so staff can read it before posting it. Staff read the letter the following morning and took the man's threat to kill himself seriously. They did not send on the letter as they judged that it would upset his girlfriend. (Paragraph 7.1 of

Prison Service Order 4411 Prisoner Communications – Correspondence instructs staff to stop letters that will “cause the recipient distress”.)

34. One of the prison managers opened an ACCT plan to put additional support in place for the man. She spoke to him and he denied wanting to harm or kill himself. At 9.30am, she noted on the Concern and Keep Safe form (part of the ACCT plan) that the man “... is angry about being placed on ACCT and refusing to take part in any review at this time.” However, an untimed note in the Record of Events by the unit manager said that the man reconsidered and agreed to talk to the ACCT assessor.
35. One of the duty ACCT assessors then interviewed the man and completed the assessment form. In reply to a series of questions about his problems, mental health and past and present thoughts of self-harm, the man denied any idea of killing himself. He said that he wrote the letter “trying to manipulate staff” and “to upset his girlfriend, who had ceased to have a relationship with him”. The PCO also noted:

“[The man] says he is in good spirit and has got a lot of friends upon the unit. He says he has no bad thought, and seems to be amused by the whole process.”
36. The man told the duty ACCT assessor that he had a large family who were supporting him. He had spoken to them that day and they were booking a visit as soon as possible. However, he said that, although he had no mental health issues, he would like to talk to a mental health nurse.
37. The unit manager completed the Immediate Action plan and set the level of ACCT observations at five per hour with one conversation per shift. He told the man that he could have access to Carers (prisoners who are trained to offer support) and the Samaritans telephone.
38. The next stage of the ACCT process is the first case review meeting which was held at 3.10pm. The unit manager chaired the meeting and the man and the duty ACCT assessor were also there. In his notes of the review, the unit manager wrote that the man, “scoffed at any idea of harming himself”. However, he also noted that the man:

“States he may have anger issues, relationship problems and feels this has resulted in current charges. Admitted he would like some help from Support Services to assist in making sense of it all.”
39. The unit manager observed that the man had not talked about any plans for the future and wrote that he suspected that he was “masking his real feelings”. He referred the man to the RMN and Counsellors teams and set the date of the next review meeting for 10 December.

40. As part of the ACCT process, staff ask prisoners if they want their family to be involved. If they do, the prisoner completes a form, giving the name and number of the person to be contacted. The man said that he would like his mother to be informed and wrote her mobile phone number on the form. A note at the bottom of the form said that, when called at 6.00pm that evening, there was no reply. There is no record of any further attempts.
41. The entries in the On-Going Record of the ACCT plan show that the man spent the rest of the afternoon talking to other prisoners and playing pool. At some point during the day (the time is not recorded), a member of staff interviewed the man and completed an Initial Housing Needs Assessment form. At the bottom of the form is a note saying, "Expecting sentence of 10-15 years advised to liaise with probation when sentenced".
42. The following morning, 8 December, the man told the unit manager that he was concerned about meeting the friends or family members of his victims when he moved from the Induction Unit to a normal houseblock. After a discussion they agreed that the man would move to Reynaldstown Brown, which is the full-time education unit. The prisoners there live and study on the houseblock and only leave to go to the gymnasium or visits hall. The aim was to prevent the man meeting any prisoner who might wish to harm him.
43. The unit manager took the man across to Reynaldstown Brown at 11.40am. However, only minutes after his arrival, the man was approached by a prisoner who spoke about the charges he was facing. Staff took him back to the Induction Unit. The unit manager increased the ACCT observations to the maximum of five per hour after noting that the man was very nervous and anxious, telling staff to be vigilant. An hour later, a member of staff spoke to the man to stress that if he had any fears or any prisoner referred to the charges, he should tell staff immediately.
44. On 9 December, the unit manager again referred the man to the Counsellors Team because he was subject to ACCT monitoring. The team co-ordinator went over to the wing immediately and met the man. She told my investigator that:

"... the session was basically based round trying to identify was he suicidal. Did he have any thoughts of self harm? He was adamant that he didn't ... it was mostly about the letter and I remember saying to him, 'You know that you say you are not suicidal, how might that person [who you wrote to] feel? You know, was this about some kind of emotional response, are you wanting a response?' He just smiled at me."
45. The team co-ordinator from the Counsellors Team said that the man was not willing to discuss the letter to his girlfriend. He said that he was "okay" in the

Induction Unit and did not talk about his brief time on Reynaldstown. She arranged another counselling session for the following week.

46. Also on 9 December, staff in the security department referred the man to the High Security Prisons Group at Prison Service Headquarters. The unit assesses whether prisoners should be given Category A status, which in this man's case was because of the serious charges he faced. On arrival into prison, prisoners are risk assessed and given a category based on their offence or the charges they are facing and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Category A prisoners and those being assessed for Category A must be held in additionally secure cells.
47. The Head of Safer Custody told my investigator that the only suitable category A cells at Altcourse are in the Care and Separation Unit (CSU) formerly the Segregation Unit. The purpose of segregation is to maintain safety, order and discipline. A segregation unit provides temporary accommodation for prisoners that have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners. Prisoners in the CSU spend most of the day in their cells. However, each day, they have the opportunity of an hour of exercise in the open air, 20 minutes for a shower and time for a telephone call.
48. The man moved to the CSU the same day, even though he was on an ACCT plan. Prisoners on ACCT plans should not normally be transferred to the CSU but there were reasons for this man's move. I discuss this issue fully in paragraphs 111-115. The following day another ACCT case review was held. The man told staff that he wrote the letter "to get back at his girlfriend" and that he wanted the ACCT to be closed. However, the case manager and PCO from the CSU decided to keep the ACCT open but reduce the observations to hourly. The next review was set for 14 December.
49. On 11 December, an RMN carried out a mental health assessment as part of the ACCT process. She noted in the record:

"Good eye contact, relaxed talked freely ... Denies any previous or current mental health concerns. States that he has never seen a psychiatrist or taken medication for mental health issues. Denies any history of SASH [suicide and self-harm] ... States that he has no thoughts of SASH at this time. Discussed events leading up to offence, states that he felt his mood 'just changed' and could describe what he meant by this."
50. The registered mental health nurse explained how to ask for a visit by the RMN if the man felt that it would be useful. She then noted that he was "To be seen on a review basis – RMN if necessary". On the same day, the duty Carer spoke to the man and noted that he had no concerns.

51. The following day, the High Security Prisons Group notified Altcourse staff that they had decided not to give the man Category A status, and so he moved back to Furlong Green. One of the PCOs there completed a referral form for the mental health team. She wrote that the man had been asking for “a number of days” to see a psychiatrist.
52. The RMN who completed the man’s First Reception Health Screen form assessed him the next day. He wrote in the medical records:
- “Denies any SH [self-harm]. Claims to be mentally ill but no signs/symptoms. Opinion:- ASPD [anti-social personality disorder] characterised by a lack of any possible emotion, not even self-pity. Follow up as necessary.”
53. The next case ACCT review was held on 14 December as scheduled. The man again asked for the ACCT to be closed, denying that he had any thoughts of harming himself. The case manager had spoken to the RMN before the meeting. He told the man that the next review would be in three days time and he would invite the counsellor and someone from the healthcare team to be there. He would also consult the previous case manager. In the meantime, the ACCT observations were reduced to one conversation morning, afternoon and evening.
54. Two days later, the man again met the counsellor. She told my investigator that the man:
- “... seemed in good spirits. Again I asked him, “Have you got any thoughts of suicide or self harm?” and he said, “No, none at all. Again you know it’s not my first time in prison.” ... I asked him has he had any visitors, was he being supported and he said yes. He said his mum and his girlfriend had come up to visit him that week and he was particularly happy that his mum and his girlfriend had come up.”

When the counsellor asked if he would like to continue the sessions:

“He said, ‘Well I haven’t really got anything to talk about at the moment.’ He said, ‘I’m okay, you know.’ and he appeared to be coping on the unit. He didn’t have any further issues ... I said you can stop me [later on] and ask me. So he said, ‘Yes I think I probably will, you know at a later date because I haven’t got anything to talk about at the moment.’”

### **Paracetamol overdose**

55. At 7.55am on 17 December, the man spoke to one of the unit staff, saying that he hoped that the clothes that had been handed in at the visit the day before would be available to him later that day. When the PCO asked him about self-

- harm, he denied having any thoughts of harming himself. An entry in the ACCT plan at 8.40am, said that the man was at the staff console talking, presumably to the staff there. Another, at 11.05am, noted that he was back in his cell.
56. Half an hour later, the next entry said that a prisoner had told staff that the man said he had taken an overdose of paracetamol. The unit staff informed healthcare staff and the unit manager. Within ten minutes, the unit manager held an emergency ACCT case review attended by the man, one of the unit PCOs and the counsellor. The man admitted taking the pills and produced an empty box from his pocket which had contained paracetamol tablets. As the man had not been prescribed paracetamol by healthcare staff, nor given any by the wing staff, it is not known where he obtained the medication.
57. The unit manager noted in the summary of the review meeting:
- “Discussed visit with Mum yesterday. Stated it was a short visit and his Mum was upset. She is on holiday ... from today and he was meant to be going on the holiday. Feels isolated and low. Stated he took the tablets to ‘pass out’. Stated he was ‘stupid’ for doing so. His answers were vague and failed to fully substantiate why he had such a quick deterioration in demeanour.”
58. The ACCT observations were increased to the maximum level and the unit manager referred the man to healthcare staff for assessment. Shortly afterwards, a nurse measured the man’s blood pressure and pulse. She advised him to see the doctor after lunch. A doctor examined the man at 1.23pm and noted that he was “appropriate in mood and manner”. He admitted him to the inpatients unit in healthcare and prescribed activated charcoal (used to absorb harmful chemicals in the body). He also asked for blood tests to be taken after four hours to measure the level of paracetamol still in the blood.
59. The man spent the afternoon in bed. A nurse spoke to him at 2.10pm and asked how he felt and why he had taken the overdose. He said that he had “got issues on the outside” which was why he took the pills. He said that he had been sick and now felt better and asked to return to Furlong. When the nurse said that he had to wait for further blood tests, he refused to allow blood to be taken. At 6.00pm, he still refused the blood test, signed a disclaimer to that effect and returned to Furlong.
60. Later that evening, staff at outside hospital contacted prison staff with the result of the initial blood test. They advised the prison nurse to send the man to the Accident and Emergency Department immediately. He was escorted to hospital, arriving at 12.20am and he was admitted to the observation ward.
61. The man remained in hospital for the next 36 hours being treated for the overdose. The hospital doctor had to persuade him to complete the treatment

after he initially refused to accept the final bag of fluid that was washing the paracetamol from his system. He returned to prison at 6.30am on 19 December.

62. The following day, a doctor assessed the man. They discussed the reason for the overdose, which the man linked to the visit a few days earlier. He told the doctor he had not suffered from depression in the past, was not currently feeling low and had no thoughts of self-harm. The doctor recorded under "Plan", "Counselled re above" [the impulsive act, ie the overdose]. For the next two days, the man spent a lot of his time out of the cell, talking to staff and prisoners, watching and playing pool.
63. On the morning of 23 December, the man told a member of the chaplaincy staff that he had received a "bad letter from his partner". Shortly afterwards, he spent half an hour talking to a Carer. The Carer completed an interview sheet afterwards, on which he noted:

"Feeling a bit down over looming charges but is managing to deal with it at the moment. Will check on as part of wing visits."

He also ticked the boxes to say that he had no concerns about the man, who was not talking of harming himself.

### **Move to the Care and Separation Unit**

64. At 1.05pm, staff broke up a fight between the man and another prisoner. As they fought, the man threw hot, sugared water over the other man. The other prisoner was examined by healthcare staff and then taken to hospital with 30 per cent burns. The other prisoner told staff that the man had goaded him until he responded. The man later told the Head of Safer Custody that he felt threatened by the other man and decided to strike in self-defence.
65. Staff locked the man in his cell. At 4.10pm, he told a member of staff that he was "upset over a letter he has received" but was not considering harming himself. An hour later, staff escorted him to the CSU, pending police enquiries into the assault. He spent the remainder of his time at Altcourse in the CSU.
66. As the man was in the CSU and on an open ACCT plan, certain procedures were required. The ACCT observations were increased to five per hour and a case review scheduled for the next morning. Staff also asked healthcare staff to complete a mental health assessment of the man.
67. The security manager later emailed Prison Service headquarters with details of the incident. At the time that the email was sent (24 December), the other prisoner was not pressing charges.

68. The ACCT case review the following morning was chaired by the Head of Safer Custody who is the senior manager responsible for the CSU. The man attended as did one of the CSU PCOs and two RMNs. He told the staff that he understood why he was in the CSU and knew what would happen to him. He said that he had no thoughts of harming himself and explained that the overdose was “after a bad visit” (The Head of Safer Custody’s phrase in the review notes). The man said that he was happy without any support from the counsellor. Everyone agreed to reduce the ACCT observations to one an hour and one significant conversation per shift. The next review was scheduled for 4 January 2010.
69. Shortly after the review, one of the prison doctors spoke briefly to the man during his duty visit to the CSU. After lunch, an RMN assessed him and wrote:
- “He has no SASH issues at this time. Has been seen by the RMN team however no further intervention at this time.”
70. Healthcare staff visit each prisoner in the CSU every day. Those who spoke to the man made notes in his medical records, many saying, “no expressed concerns at this time”. The entries in the ACCT booklet show that the man spent a lot of his time in the CSU reading, writing letters and drawing. A number of the entries note that the man asked staff for his ACCT plan to be closed.
71. On 3 January, an ACCT entry notes that managers were looking at the possibility of transferring the man to another prison. The man “was happy with what he had been told no apparent concerns”. The following day, he attended court where he was further remanded in custody until March. The scheduled ACCT review was postponed until the following day.
72. The Head of Safer Custody chaired the review and the man attended along with a PCO, an RMN and a student nurse. The Head of Safer Custody told my investigator:
- “[The man] presented really well, he didn’t present as somebody who had suicidal thoughts, he didn’t present with anybody that had a plan to take his own life and he seemed to be coping well you know with his predicaments. We talked quite openly about the counselling sessions and the RMN sessions and he was happy that they weren’t currently continuing. We talked about...his current location in CSU and why he was being held there ... and he was sort of content with that.”
73. The actions to address the issues highlighted in the Care Map of the ACCT plan had all been completed. The Head of Safer Custody discussed a possible transfer to another prison at the meeting and he noted that the man was happy with this proposal. He told my investigator that the man saw a move as being

positive and an opportunity to return to a normal wing. Everyone at the review agreed that the ACCT should be closed.

74. After an ACCT plan is closed, the case manager must arrange a “post-closure interview” when the interviewer will check that the prisoner is coping without the ACCT support. The Head of Safer Custody set the date for this interview as 8 January.
75. The Head of Safer Custody and a manager at HMP Forest Bank in Manchester discussed transferring the man and for a prisoner from Forest Bank to move to Altcourse in return. The managers arranged the transfer which took place on 7 January, two days after the ACCT was closed.

### **Transfer to HMP Forest Bank**

76. The man arrived at Forest Bank in Manchester at approximately 11.30am. The reception officer completed sections one and two of the Cell Sharing Risk Assessment. He noted that the ACCT plan had been closed two days earlier and that the man had assaulted another prisoner. The man said that he would be prepared to share a cell but not with an ethnic minority prisoner, as he had once had a “bad experience”. The PCO assessed the man’s risk to others as “medium”, meaning that the risk level had to be reviewed regularly.
77. The next part of the reception process was the healthcare assessment. The Healthcare Assistant (HCA) told my investigator that, before speaking to the man, he collected the medical records from the staff who had escorted him to Forest Bank. As the man was a transfer prisoner and not newly in custody, the HCA did not complete a First Reception Health Screen. He asked the man if he had any physical or mental health issues to which he replied that he did not. The man also said that he had never seen a psychiatrist or been prescribed medication for mental health problems.
78. The HCA asked about the overdose at Altcourse. The man replied that he had done it “to wind people up” and had no intention of killing himself. The HCA noted no sign of mental issues. The HCA recalled in interview that, at one point, the man laughed at something he said and appeared to be in a good humour.
79. However, in view of the man’s stated reason for taking the overdose, the HCA asked the duty RMN to come to reception to assess the man. Although the duty RMN went to reception and the HCA briefed her, there is no record of her findings in the medical records.
80. When staff completed the Cell Sharing Risk Assessment, they based their decision to put him in a single cell on two pieces of information. Firstly, staff at Altcourse had passed on details of the man’s assault on another prisoner and secondly the man repeated that he did not want to share a cell with an ethnic

minority prisoner. When asked why, he said that he was “not racist but had a bad experience with ethnic people in the past”.

81. From reception, all prisoners go to either the First Night Centre on G wing or the Detoxification Unit on H wing. The man went to G wing, where he completed the induction process.
82. The induction officer told my investigator that he gives new prisoners their induction booklets first thing in the morning after their arrival. He told the man which forms in the booklet he had to complete to have his PIN (telephone) credit and cash transferred quickly. The man said that he had been transferred after assaulting another prisoner. He had felt threatened and had attacked first, before he was attacked. He added that he was happy to be at Forest Bank as it was “a fresh start”.
83. The man completed the induction process on the afternoon of 8 January and moved to a cell on the upper floor of A1 wing, the Young Offenders Unit. A clerk in the custody office completed an “At Risk of Suicide and Self-harm” form after seeing information about the ACCT and a self-harm warning on the PER form. He then contacted the prison’s ACCT clerk and a member of A1 wing staff to pass on the information, “Self-harm marker on PER. Was on ACCT book at Altcourse”.
84. On 12 January, a Senior Prison Custody Officer (SPCO) met the man to complete the ACCT post-closure assessment. The man said that he felt “okay” and did not have any issues. He explained that he had threatened to self-harm as “messaging about to try and get a smoker’s pack”. He said that he had telephoned his family since arriving at Forest Bank but had not yet had any visits.
85. The SPCO told my investigator that, when asked why the ACCT was opened, the man laughed and said that he had been “messaging about”. He was very dismissive about the process. The SPCO got the impression that the ACCT had been opened in the CSU at Altcourse and had been in place for about a week. When asked by the investigator whether the man spoke of harming himself in the letter to his girlfriend or his overdose of paracetamol, the SPCO said that he had not.

### **The Day of the Man’s Death**

86. On the day of the man’s death the prisoners had the normal weekend periods of association from 8.00 to 11.00am, 12.00 to 4.30pm and 4.45 to 5.15pm. (Association is the time that prisoners are out of their cells and make telephone calls, take part in other wing based activities and talk to each other.) A PCO told my investigator that he saw the man several times during the day and had a number of conversations with him. He said that, until the Sunday, he had been

quite quiet on the wing, generally keeping close to his cell. He attributed this to the man being new and taking time to settle in to life on the wing.

87. However, on the day of his death, the man spent a lot of time out of his cell. The PCO told my investigator:

“I specifically remember [the day of the man’s death] ... he was really approachable and he was coming up to us [staff] and he seemed a lot more confident.”

88. The PCO recalled having two conversations with the man. The first was in the wing office in the morning and revolved round the man’s wish to do his laundry. The second was later in the day when the PCO showed him how to use the washing machines. As they stood at the machines, the PCO said that the man was smiling and laughing. Also during the day, he had his hair cut by another prisoner. The PCO noticed that he was chatting to the prisoner cutting his hair and another man standing nearby.

89. At 4.30pm, the men returned to their cells and were locked in for the roll count (a physical count of the number of prisoners on each wing) before the evening meal. The food is served at 4.45pm and the prisoners are locked up for the night at 5.15pm, when there is another roll count.

90. The last time the PCO saw the man was when he checked his cell during the roll count at 5.15pm. He said in interview:

“I opened the observation panel of cell 56 ... and his light was on, so everything was clearly visible. And he was lying on his bed watching television and ... he turned around and looked at me through his panel and then he just turned his, sort of like nodded, turned his head and just carried on watching telly. And there was nothing untoward in his cell ... All his bedding was flat on top of his bed, all his duvet was just laid flat and he was laid on top of his bed and he wasn’t under the quilt, he was lying on top of it.”

91. Once the roll count is correct, the day staff go off duty, leaving one PCO on each wing. He or she patrols the wing until the night staff arrive between 8.00pm and 8.30pm. At 9.00pm, the prison went into night patrol state. The prison operates at night with a reduced staff. The Night Orderly Officer carried the radio call sign Oscar 1 and was the most senior person on duty in the prison.

92. During night patrol state, only Oscar 1 carries a full set of keys to unlock all gates and cells. Oscar 2 and the duty nurse have keys that allow movement through the prison but do not carry a cell key. Wing staff do not have access to keys to allow free access around the prison and have to be escorted. The PCOs are each issued with a cell key in a sealed pouch for use in emergencies. The

instructions are that, during the night state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.

93. A PCO was on duty on A wing that night. After he arrived, he went round the wing and checked that each cell door was locked but he did not look into the cells. He then completed paperwork until told, via his radio, to carry out the 10.30pm roll count. He checked all the cells on the ground floor before going to the cells on the upper floor. He started at the opposite side to the man's cell and worked round the landing.
94. When the PCO arrived at the man's cell at around 10.35pm, he opened the observation hatch in the door and looked in. The cell light was on and he saw the man hanging from the light above the desk, facing the wall. He called for medical assistance over the radio and added that it was an emergency. The man appeared to have burned two holes in the Perspex panel covering the light fitting, then threaded a strip of bed sheet through the holes and tied a knot.
95. An SPCO was on B wing when he heard the call, "Code Yellow 1 on Alpha 2", which was quickly amended to, "Code Yellow 2 on Alpha 1". This code meant that the emergency was a prisoner who was not responding. The SPCO went immediately to A wing, which he estimated took him a few seconds. On his arrival, the PCO who first spotted the man hanging took out his cell key and opened the door. Both men went into the cell and the SPCO supported the man while the PCO cut the ligature. They laid the man on the bed and the PCO cut the noose from his neck.
96. The duty nurse was in the healthcare centre when she heard the Code Yellow 1 call, which indicates that someone is bleeding. She collected the emergency bag but did not take the defibrillator or oxygen, as she would have for a Code Yellow 2 emergency. She told my investigators that she did not hear the call amended to Code Yellow 2, although she was aware of the location being changed to Alpha 1.
97. As the duty nurse walked to A wing, she met the Oscar 1. The nurse went into the cell and examined the man to find his pulse but did not find one. She asked for an ambulance to be called. Then she and the SPCO began cardio pulmonary resuscitation (CPR). The duty nurse had left the emergency bag outside the cell and did not take the time to collect a mask from it but immediately began giving mouth-to-mouth resuscitation. The nearest defibrillator was in a cupboard on the hub, which had to be opened with a medical key. The duty nurse was the only person carrying a medical key but she decided that it was more important to continue with CPR.
98. The Oscar 1 told the communications room to call an ambulance and then he and a PCO went to the main gate to wait for it. When the ambulance arrived, they took it round the inside perimeter to the end of A wing. This process took 11

minutes. The paramedics treated the man in the cell before moving him to the ambulance. Three officers accompanied him to outside hospital, where a doctor confirmed his death at 11.37pm.

99. When the man went into prison, he had named his girlfriend as his next-of-kin. After his death, staff were reluctant to contact her as they did not know how old she was. Given that the man was only 18 years old, they could not be sure that his girlfriend was over 18 and therefore an adult. Instead, they contacted his mother and the prison FLO offered her and the family support. The family were invited to visit the prison, to see the man's cell and meet staff and prisoners, which they later did.
100. The following morning, staff told the prisoners on A wing of the man's death. The Deputy Director and the Safer Custody SPCO held case reviews for the prisoners who were being monitored under the ACCT procedures. Staff identified one prisoner who needed additional support and placed him on an ACCT plan. The chaplain and the unit manager spoke to each prisoner individually to offer support. The Director visited the wing on a number of occasions and talked with prisoners and Listeners were available for peer support.
101. The night staff came into the prison later that morning and attended a hot debrief. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. Managers arranged for other staff to cover the night shift that night.
102. On 22 January, a memorial service for the man was conducted on the unit. Association period was given directly after the service to allow staff, chaplaincy and Listeners to provide further support to prisoners. The man's funeral was held on 29 January and the prison FLO attended.

## ISSUES

### Health

103. The clinical reviewer in his review of the clinical care the man received, raises a number of issues that concern him. However, he highlights the man's medical records being "clear, legible and in chronological order" as good practice.

#### *Lack of a psychiatric assessment*

104. Whilst at Altcourse, the man was assessed by an RMN on several occasions. The RMN suggested that the man had an anti-social personality disorder but did not refer him to a psychiatrist. The clinical reviewer concludes:

"He did not have any psychiatry report at any point. Given the nature of his [alleged] crime and his behaviour whilst at Altcourse this would have been useful."

105. In less than three weeks at Altcourse, the man threatened to kill himself, took a paracetamol overdose and seriously assaulted another prisoner. Throughout the period, he insisted that he had no thoughts of harming himself and asked for the ACCT plan to be closed. His young age is also noteworthy and the clinical reviewer notes:

"Young adult males are often very reluctant to discuss health concerns especially mental health concerns."

I agree with the clinical reviewer's conclusion. When a prisoner, particularly a young prisoner, demonstrates a series of violent behaviours (and self-harm is violence against himself) mental health staff should consider referring him for a psychiatric assessment.

#### *Exchange of medical information between prisons*

106. The clinical reviewer is critical of the exchange of information between healthcare staff when the man was transferred. He concludes:

"I do have concerns that the transfer of medical care between Altcourse Prison and Forest Bank was suboptimal [not as good as it might have been]. Communication of recent mental health concerns could have been much better."

He suggested that it is not:

"... acceptable just to pass the medical records from one team to another. A more direct approach such as a medical personnel member from

Altcourse speaking directly on the telephone to Forest Bank would have been better or even a printed summary going along with this prisoner.”

107. He points out that matters should improve when prison medical records move onto SystemOne (electronic medical records computer system). This will allow information to be passed immediately between prisons electronically.

### **Sharing a cell**

108. The man’s assault on the prisoner at Altcourse meant that staff correctly considered that he presented a risk to other prisoners. Therefore, he was given a single cell. The clinical reviewer suggests that consideration should have been given to having the man share a cell, as he had recently been supported by the ACCT procedures. Very often, prisoners on ACCT plans do share a cell as it provides someone to talk to during the long hours when locked up. However, on balance, I agree with the staff assessment that the man presented too much of a risk to other prisoners to put in a double cell.

### **Paracetamol overdose**

109. On 17 December, the man told wing staff that he had taken an overdose of paracetamol tablets. He was admitted to the healthcare centre as an inpatient to monitor his symptoms and have blood tests. However, the man was unwilling to stay in healthcare and have the second blood test. He signed a disclaimer and returned to the wing.
110. In the early hours of the following morning, the man was admitted to outside hospital and given bags of fluid intravenously to wash the paracetamol from his system. After two units of fluid, the man refused the final bag. Only after speaking to a doctor, was he persuaded to complete the treatment.
111. The question of where the man obtained the paracetamol remains unanswered. Staff regulate the number of pills they give to prisoners. Wing staff can give two paracetamol pills to a prisoner who says he has headache, toothache etc. When doing so, staff should complete the wing paracetamol log, noting the date, time and the prisoner’s name and prison number. My investigator obtained a copy of the log for the time the man was on the wing but his name is not listed.
112. Prisoners can also be prescribed paracetamol by healthcare staff. The pills are in a box of 16, which is a two-day course of the medication. When staff issue the tablets, they should make an entry in the prisoner’s medical record. The man’s medical record contains no such entry. There is no evidence that the man obtained the paracetamol from a member of staff. Generally, it is not unknown for prisoners to sometimes trade medications with each other. However, there is no evidence that the man obtained the pills in this way.

## Location in the Care and Separation Unit

113. The man spent two periods of time in the CSU at Altcourse whilst subject to ACCT monitoring. Prison Service Order 1700 – Segregation states that:
- “Segregation should be used only as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners, this does include prisoners on an open ACCT plan, but only when 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.”
114. The first period was from 9 to 12 December, which was while the High Security Prisons Group decided whether to give the man category A status. When someone is flagged as potentially a Category A prisoner, they must be treated as if they are Category A. The Head of Safer Custody told my investigator that the only secure cells for Category A prisoners are in the CSU. The only alternative is to transfer the prisoner to an establishment with suitable cells. When asked what would have happened if the man had been reclassified as Category A, the Head of Safer Custody said that managers would have transferred him to HMP Manchester.
115. For the man who was on an ACCT plan, being in the restricted regime of the CSU, was not ideal. However, a transfer to another prison, only a few days after his arrival at Altcourse, would have meant having to adapt to a new regime, staff and prisoners. As it was, after three days, the man was able to return to the Induction Unit as he was not judged to be a category A prisoner.
116. After the man assaulted another prisoner, he was moved back to the CSU while the matter was referred to the police. He remained there for two weeks and was then transferred to Forest Bank. The Head of Safer Custody explained the additional support that is available for all prisoners in the unit:
- “Everyone in CSU will see a member of healthcare everyday and they do have the support of the CSU staff and education is provided. You know there’s already a sort of regime in place in that area ... The duty director speaks to everybody every morning, the chaplain visits everybody every day, a member of the healthcare will see everybody every day, a doctor will see everybody at least three times a week ... The IMB will visit everybody in CSU on a rota visits and that is at least once a week.”
117. In the circumstances, I judge that the man’s transfers to the CSU and the care that he received to have been reasonable. Prison staff had to balance the man’s risk of harming himself with the possibility that he would be categorised as a category A prisoner and with the risk to other prisoners. In these circumstances, I believe that the decision to locate the man in the CSU was appropriate.

## Management of the Assessment, Care in Custody and Teamwork procedures

### *Opening the ACCT plan*

118. The man arrived at Altcourse on 5 December and the following evening wrote to his girlfriend. He said that he was “looking at 10 years” and threatened to hang himself. When staff read the letter the next day, they opened an ACCT plan. When they explained why they opened the plan and what it meant, the man reacted angrily and, at first, refused to co-operate. He explained his actions as “only messing” and, throughout the time the ACCT plan was open, he repeatedly asked for it to be closed.
119. Once an ACCT plan has been opened, staff must complete certain procedures within specific time limits. All the actions were completed well within the timescales. A prison manager opened the plan at 9.30am. The next step was for a trained ACCT assessor to interview the man to discuss the issues that led to the ACCT being opened. The man refused to take part in the assessment, agreeing only after persuasion by the prison manager. A PCO completed the assessment at 10.40am. The unit manager completed the Immediate Action Plan at 1.30pm. A case review meeting must be held within 24 hours of the ACCT being opened. The unit manager held the man’s review within six hours. After discussing the man’s issues, the unit manager made appropriate referrals.

### *Family involvement*

120. PSO 2700, Suicide Prevention and Self-harm Management, states, “*After consultation with the prisoner, the nominated next of kin must be notified ...*”. The unit manager asked the man if he wanted his mother to be contacted and he replied that he did. Included in the man’s ACCT plan is a document designed by staff at Altcourse entitled “ACCT Family Involvement” that sets out clearly that he wanted his mother to be informed.
121. The document gives clear guidance to case managers about how to involve family members in ACCT plans. It states in the section to be completed by the prisoner:

“I wish that a member of my family or partner be contacted and notified of my recent self-injury/suicidal intent/issues and my current ACCT status and informed of the reason why I am currently being supported by an ACCT Plan. I understand that he/she will be contacted before or after every review and kept up to date on my progress. I understand that the Case Manager may decide that my family member/partner should attend the review in person and accept that it is the Case Manager’s decision.”

**I commend the prison managers for producing the guidance to enable better family involvement when a prisoner harms himself, which if followed, may add another dimension to the support given to the prisoner.**

122. However, in this man's case, the necessary action was initiated but not followed through. A note at the bottom of the form said, "Telephoned 18:00 07.12.09. No answer." There is no evidence that any other attempts were made to contact the man's mother. I think that making one telephone call falls short of the procedures set out in the local document and meant that the man's mother was denied the opportunity to be involved in supporting her son. Given that the man had asked for his mother to be involved in the ACCT process, it is disappointing that this did not happen. Case managers should persevere until contact has been made and then follow through on the undertaking to keep the family member informed of the prisoner's progress.

**The Director of Altcourse should remind all ACCT case managers to follow the guidance set out on the local ACCT Family Involvement form.**

*Closure of the ACCT monitoring*

123. PSO 2700 states:

"The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so, i.e. that the problems that caused the ACCT Plan to be opened have been resolved or reduced, the prisoner is able to cope with any remaining difficulties, they have access to and are making use of at least some positives, e.g. friends, family, counsellor, member of chaplaincy team, hobbies, education/employment, and they know who to contact (and how) should they need support in the future."

124. When the unit manager completed the Care Map, he identified five issues of concern. Three were dealt with by the RMN and Counsellor teams working with the man. One was resolved by the man making contact with his family and friends and having visits from them. The final issue was to move him to a suitable location after completing the induction process. As described earlier, a move to another wing was unsuccessful and he remained on the induction unit until his removal to the CSU. The plan to transfer him to Forest Bank, and so on to normal location, completed that part of the plan.
125. The Head of Safer Custody told my investigator that everyone at the final case review agreed that the ACCT plan should be closed. He then set the date for the post-closure review. PSO 2700 states that ACCT case reviews should be multi-disciplinary with staff attending from departments involved in the prisoner's care, not just wing staff. Apart from the first two, the man's reviews were attended by

mental health nurses and once by a counsellor. The consistency of the multi-disciplinary reviews was commendable.

### *Transfer after ACCT closure*

126. After the man assaulted another prisoner, he was taken to the CSU. He remained there until his transfer to Forest Bank on 7 January. My investigator interviewed the Head of Safer Custody and discussed the transfer with him. He said that transfers are not unusual and can be a fresh start for the prisoner. He said that he talked to the man about moving to Forest Bank. He said in interview:

“He was looking forward it. He was more than happy to go. It gave him a fresh start again. It meant that he wouldn’t be located in CSU. When you move prison you go on to standard regime so it’s just, it’s just like you are walking back in the door from, you know, fresh off the street. So yes we weren’t aware of any problems that he would face at Forest Bank. He wasn’t aware of any potential issues, you know, people knowing about his offence and stuff and it gave him the opportunity to get on with a little of bit normality with his prison life whilst he was preparing for his trial.”

127. PSO 2700, Suicide Prevention and Self-harm Management states:

“ACCT Plans must not be closed (or where already closed and in the post-closure phase of ACCT, the prisoner must not have the final post-closure review) within the 72 hours before a known transfer.”

The man’s ACCT plan was closed on 5 January and he transferred to Forest Bank two days later. However, when the Head of Safer Custody closed the ACCT, he did not know when the transfer would take place. I agree with the Head of Safer Custody’s assertion that it was better for the man to move to Forest Bank as soon as possible. That way, he could return to the normal wing regime rather than continue in the CSU.

### *Post-closure review*

128. Once an ACCT plan is closed, a post-closure review must be held within seven days. When a prisoner is transferred shortly after an ACCT has been closed, the review must be held by the receiving prison. This allows the staff there to decide whether the prisoner has settled sufficiently for the ACCT process to be ended.
129. An SPCO held the ACCT post-closure review at Forest Bank on 12 January, a week after the closure and four days after the man’s arrival at the prison. He told my investigator that he did so because he was the manager on duty that day. He did not know the man very well and contrasted this with carrying out a post-

closure review where the prisoner had been on the unit while the ACCT was open.

130. The SPCO did not have a copy of the ACCT plan at the meeting and had not read a copy before beginning the review. Therefore, he did not know when and why the plan had been opened. Instead he relied on the information which the man gave him. The SPCO asked the man and, from the reply, understood that it had been opened while he was in the CSU in Altcourse and had remained open for about a week. The man did not tell him about threatening to kill himself or the overdose. The SPCO was therefore unaware of the seriousness of the man's self-harm.
131. It would have been sensible for the SPCO to have had the full picture of the man's attempts to harm himself before doing the post-closure review. Reading the Care Map and the case review records would have provided a great deal of accurate information, rather than relying on getting accurate details from the man.
132. However, if the SPCO had had all available information, it might not have altered his decision to end the ACCT process. He told my investigator that he ended the interview "convinced that he [the man] was fine". The Head of Safer Custody had also been satisfied enough with the man's actions and demeanour to feel confident about closing the ACCT plan a week earlier. However, one of the strengths of the ACCT process is the detailed information that it provides on the prisoner, his issues and means of resolving them. All staff should be encouraged to make as full use of this as possible.

**The Director of Forest Bank should remind staff who conduct ACCT case and post-closure reviews to familiarise themselves with the information in the ACCT plan before holding such reviews.**

### **Emergency codes and equipment**

133. In 2008, in an investigation report into a previous death at Forest Bank, the following recommendation was made by this office:

"The Director should consider introducing a simplified and effective system for summoning assistance in an emergency."

The prison's response was:

"Accepted – Implementation of system of CODE RED for bleeding and CODE BLUE for breathing issues to be discussed with SMT and COMMS meeting."

However, Code Red and Code Blue were not adopted for use in summoning medical assistance. When the man died, the prison was still using Code Yellow 1 for prisoners who are bleeding and Code Yellow 2 for those with breathing difficulties.

134. When an officer calls for medical assistance, he or she gives the appropriate code and then the location. The wings are identified by a letter and then either "1" or "2", indicating whether it is the upper or lower unit.
135. A PCO called for assistance by saying, "Code Yellow 1 on A2", indicating that a prisoner was bleeding. He corrected himself in a second call but not all the staff heard him change both the location and type of emergency. The inclusion of two numbers in an emergency call is an opportunity for confusion, as it was on this occasion. The result was that the nurse did not take the necessary equipment to the cell. The nurse only heard the change of location and therefore took the bag for an emergency involving bleeding. Had she known that she was attending a prisoner with breathing difficulties, she would also have taken oxygen and a defibrillator.
136. I am disappointed that the Director did not change the emergency codes in response to my previous recommendation. Many other prisons use Code Red and Code Blue as it is a system that is clear and easy to use. I again urge the Director to change the codes to ones that are unambiguous and memorable and repeat my recommendation here.

**The Director and Head of Healthcare of Forest Bank should put in place clear and memorable medical emergency codes and ensure that all staff are trained in their use.**

137. The confusion over the type of emergency led to the nurse not taking oxygen and a defibrillator to the man's cell. At interview, she explained that the nearest machine was in a medical cupboard on the hub but it needed a medical key to open the door. She was the only member of staff on night duty with a medical key. However, she judged it more important to continue with CPR rather than stop to collect the defibrillator from the cupboard.
138. While understanding the need to keep the machines secure, they need to be readily available in an emergency. This is especially the case at night when fewer staff are on duty. The defibrillator on the hub should either be kept in a cupboard that does not need a medical key to open or at least one other member of staff (perhaps the night orderly officer) should carry a medical key. Emergency equipment, such as defibrillators, is only useful if it is readily accessible.

**The Director and Head of Healthcare of Forest Bank should arrange for defibrillators to be accessible to all members of staff.**

## CONCLUSION

139. The man who died was a young man who had been remanded for very serious offences and was subsequently advised of further grave charges. Although identified in both police and court records as at risk of self-harm, he repeatedly denied any thoughts or intentions of harming himself. However, it quickly became apparent from a letter written the day after his admission that he intended to kill himself. He made an attempt to do so by taking an overdose of drugs 11 days later.
140. Staff put in place the suicide and self-harm prevention procedures as soon as the contents of the letter came to light and the man was given additional support for a month. However, throughout this time and after the monitoring was stopped, he persisted in making light of his actions, appearing to mask his true feelings. Five days after the ACCT post-closure review, the man took his own life. Given the effort it would have taken to burn holes in the light fitting to which he attached the ligature, this seems to have been a deeply considered action on the part of the man.
141. In line with the suicide and self-harm provisions, I am satisfied that staff at both prisons took positive steps to help protect the man from harm and, when he was found, to preserve his life. I judge that, generally, the staff were thorough and professional in managing him. I have identified two areas of the ACCT process that would benefit from improvement, as well as ensuring the accessibility of medical equipment. Regrettably, I also repeat a recommendation previously made by the office regarding the need for a clearer emergency code system. Nevertheless, I concur with the clinical reviewer's view that these improvements would not necessarily have led to a different outcome for the man.

## **RECOMMENDATIONS**

### **HMP Altcourse**

1. The Director of Altcourse should remind all ACCT case managers to follow the guidance set out on the local ACCT Family Involvement form.

The recommendation was accepted. The prison response was,

“All case managers have been reminded to contact family members should the at risk person request their involvement”

### **HMP Forest Bank**

2. The Director of Forest Bank should remind staff who conduct ACCT case and post-closure reviews to familiarise themselves with the information in the ACCT plan before holding such reviews.

The recommendation was accepted. The prison response was,

“Safer Custody Manager to ensure the safer custody policy contains information to those who conduct post closure reviews to familiarise themselves with the information in the ACCT plan before holding the review.”

3. The Director and Head of Healthcare of Forest Bank should put in place clear and memorable medical emergency codes and ensure that all staff are trained in their use.

The recommendation was accepted. The prison response was,

“Emergency codes will be changed to follow National standards of red for bleeding and blue for unresponsive. A roll out programme will be developed for implementation on the 4<sup>th</sup> July 2011.”

4. The Director and Head of Healthcare of Forest Bank should arrange for defibrillators to be accessible to all members of staff.

The recommendation was accepted. The prison response was,

“We have 4 defibrillators one located in healthcare, one in A/F hub, one in reception and one G/H hub. They are easily accessible to all staff in the event of an incident”

**Good practice**

I commend Altcourse managers for producing the guidance to enable better family involvement when a prisoner harms himself, which if followed, may add another dimension to the support given to the prisoner.