INVESTIGATION INTO THE DEATH OF A MALE PRISONER AT HMP ALTCOURSE ON 4 FEBRUARY 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

JUNE 2005

This is the report of an investigation into the death of a male prisoner at HMP Altcourse. The man apparently took his own life on Friday 4 February 2005, the day he was due in court and with his trial to begin the following Monday. He was charged with the murder of his long term partner and, by the time he took his life, had been held on remand at HMP Altcourse for seven months. I hope that this report will be helpful to the man's family, and also to the prison as they look after other prisoners in his situation.

The loss of a loved one is always distressing, but particularly so for a family which had already experienced such grief and upset. I would like to add my condolences to those already expressed by my Family Liaison Officer, on behalf of the Ombudsman's office.

This investigation has been undertaken by one of my investigators on my behalf. I would like to thank the Director of Altcourse and staff for their participation in the investigation. Merseyside Police provided invaluable information and assistance that is much appreciated. North Liverpool PCT undertook a review of the man's clinical care, and I appreciate their assistance as well.

This published version of the report does not include the original annexes.

Stephen Shaw CBE **June 2005**
Prisons and Probation Ombudsman

CONTENTS

SUMMARY

1 The subject of this report was born on 1 December 1942 and was 62 years old when he died on 4 February 2005. He had been charged with the murder of his long term partner and held on remand at Altcourse since11 August 2004. Between his partner's death and being charged, the man received hospital treatment for loss of consciousness, injuries to his hand and a suspected heart attack. On reception at the prison, he was appropriately placed on their Suicide and Self Harm monitoring arrangements for eight days, in which time no incidents occurred and after which the close observations ceased.

2 Throughout his stay at Altcourse, the prisoner continued to experience chronic ill health and received extensive treatment from the healthcare centre and from outside hospital. He was generally located on one of the prison wings, but had occasional brief periods in healthcare.

3 The man was described by staff as fully compliant with the prison's rules and did not present any problems to the regime. He was older than many on the wing and did not voice any concerns with his personal officer or other staff. Remand prisoners at Altcourse are monitored in the same way as convicted prisoners, but in his case there were omissions to the so-called Weekly Behavioural checks conducted by his personal officer and in the monthly manager's monitoring. These omissions may not have been significant to his decision to take his life, but should be corrected.

4 The prisoner who died was described as a quiet person, such that it was said by one staff member that *you would not know that he was there,* and he did not let staff know that his trial was due to start. The prison had no system which would inform staff of events of this significance, even though they might be considered an obvious source of anxiety for any prisoner. In this man's case, it was particularly significant as, at his trial, he would be confronted with evidence of events of which he had always denied any recollection.

5. The man was found on the morning of 4 February with a bag over his head and a ligature around his neck. Having discovered him, wing and healthcare staff acted promptly in response and medical attention was provided speedily.

6. The investigation report makes recommendations for improvements to Suicide and Self Harm arrangements, to the healthcare centre and the personal officer role.

CONDUCT OF THE INVESTIGATION

7. The investigation into the man's death began on 7 February 2005 with a meeting with the Director of Altcourse and representatives of the Independent Monitoring Board and the GMB, the trade union recognised at the prison. Notices were displayed to announce the investigation and invite prisoners and staff to contact the investigator. In the event, there were no responses.

8. Three prisoners, including the man's cell mate, were interviewed informally on 7 February. Formal interviews were conducted with 13 staff, including those who knew the prisoner when he was alive, those who dealt with the incident on 4 February and those responsible for the running of various aspects of prison life. In addition, the man's solicitor, who spent the day of 3 February with him, was also interviewed.

9. The man's family were contacted by the Family Liaison Officer and commented on the healthcare he received at Altcourse.

10. Prison records, including medical records, were made available together with relevant policies and procedures.

11. A clinical review was undertaken at the direction of North Liverpool PCT.

BACKGROUND

12. The prisoner was born in 1942, and was aged 62 when he died. He had been married and had two adult children, his daughter being named as next of kin. His son was held in custody at the time of the man's death. Before his arrest the man who died had lived for eight years with his partner, who was the victim of the offence with which he was charged.

13. His previous convictions were as a young man and he was last in custody some 40 years earlier.

14. For many years, the man who is the subject of this investigation was reported as having poor health and he had been prescribed pain relieving medication for arthritis.

HMP ALTCOURSE

15. HMP Altcourse is a male Category B local prison with an operational capacity of 1,010. At the time of the man's death, the prison had reduced its numbers from 903 to 600 because one wing was closed for refurbishment. It opened in 1997 and is a privately managed prison, run by Global Solutions Ltd (GSL). The prison has six main house blocks, each divided into two units. Approximately a third of the prisoners are on remand and the remainder convicted and sentenced or awaiting sentence. The full facilities and regime of the prison are available to all. At the time of his death, the prisoner was being held in the Melling Brown unit. The average age of the prisoners on that wing was 29.

16. The most recent inspection of the prison by Her Majesty's Chief Inspector of Prisons was being carried out in the week that this investigation began and no information from the inspection team is yet available. The director of the prison reported that no concerns were identified about the procedures for dealing with suicide and self harm. The previous inspection took place in 1999. It made a number of recommendations regarding suicide and self harm arrangements, some of which have been acted on, and also included a number of examples of good practice.

17. The most recent audit of Altcourse by HM Prison Service's Standards Audit Unit was between November and December 2004. It assessed four discrete areas: Decency and Health, Organisational Efficiency and Effectiveness, Regimes, and Safety and found that it was a high performing prison. The report states that systems for suicide and self harm reduction appeared to be firmly in place, with good identification systems and initial screening. There were three minor aspects of the relevant standards which were not complied with, relating to incomplete records and support plans which were standardised rather than individualised.

18. The prison's week day routine is as follows:

5:00 am	roll check
6:15 am	prisoners attending court are unlocked
7:15 am	other prisoners are unlocked
8:00 am	work, visits, programmes, education etc
12:00 am	prisoners are locked in their cells and a roll check is carried out
12:25 am	lunch
1:00 pm	work, visits, programmes, education etc
5:10 pm	prisoners are locked in their cells and a roll check is carried out
5:25 pm	evening meal
6:15 pm	evening association
8:50 pm	prisoners are locked in their cells
after 9:00pm	roll check

19. The roll checks at 5:00 am and before 9:00 pm are the responsibility of the night staff, and the others are carried out by early and late staff who are

required to check that each prisoner is present. Some day staff begin their duties at 6:00 am as they are responsible for getting prisoners ready for court. The rest of the day staff begin at 7:15 am and both groups work until 1:15 pm. Late staff begin work at 1:00 pm until 9:15 pm and night staff work from 9:00 pm to 7:15 am.

20. The prison has two levels of response to prisoners who may be at risk of suicide or self harm. The first is a local arrangement, the Suicide and Self Harm (SASH) Form A, which is designed for occasions when a prisoner is in a situation which may potentially be stressful, such as receiving bad news from home, but is not actually indicating any intent to harm themselves. The Form A is time limited to 48 hours, after which it must be closed or the prisoner placed on the SASH book. The SASH book is the second local arrangement, identical to the F2052SH used throughout the Prison Service. This is used when there is direct evidence of self harm.

21. A third procedure for observation of prisoners is the First Night Watch for all prisoners when they arrive until 10:00 am on the day after their reception. All three systems include staff observations of the prisoner every 15 minutes throughout the period of the watch. Prisoners on a SASH book are reviewed each Thursday by a standing meeting of multi disciplinary professionals from across the prison, including specialists such as the chaplain and probation as well as representatives from each wing. Approximately 12 staff come to the meeting, not all of whom will know each prisoner to be discussed. The meetings are held in the prison boardroom and prisoners do not attend. These arrangements differ from those in many prisons where review meetings are held when most appropriate for the prisoner, and are attended by the prisoner and staff who know him or her.

KEY FINDINGS

22. The man's partner was murdered during the night of 26 – 27 July 2004. Cheshire Police were called to the house in the morning of 27 July as she did not attend a meeting with a relative. The prisoner who is the subject of this report was found unconscious in an upstairs bedroom and bottles of medication were scattered about. There was a ligature in the house, but Cheshire Police state that it had not been used. The man had an injury to one hand and was taken under police guard to Whiston Hospital for treatment. He remained unconscious for some days, but the blood samples taken by the hospital were unfortunately mislaid, and so the diagnosis was not identified. Whilst he was an in patient at the hospital, the man was suspected of having a heart attack.

23. He remained under police guard at the hospital until 9 August when he was fit for release and was taken into police custody. The following day he was charged with the murder of his partner, and he appeared at Warrington Magistrates' Court on 11 August from where he was remanded into the custody of Altcourse prison. The prisoner escort record (PER form) noted that the man was at risk because of his medical condition, and his medication was carried by the escort. He was also assessed as at risk of suicide and self harm, and had tried to self harm in relation to the incident he was arrested for. He made several subsequent court appearances and was seen by Cheshire Police on these occasions, but they did not interview him after this date. The solicitor representing him confirmed that he maintained throughout his arrest and period on remand that he had no recollection of the events of 26 – 27 July.

24. The man who died arrived at Altcourse at midday and went through the standard reception procedures. Reception staff recognised that the escorts had identified him as being at risk and the Security Record (F2058) states that because of this he was admitted to the healthcare centre, where he was referred to a Registered Mental Nurse (RMN). In the induction interview, he disclosed that he had been prescribed temazepam for many years and had retired from work due to ill health. He said that he suffered from arthritis and abscesses and had recently had a heart attack. He went on to say that he had no immediate concerns. He was referred to a counsellor for support.

25. The first reception health screen records that the prisoner said he had not seen a doctor recently prior to his admission at the prison and he was prescribed medication for a heart condition. He had injuries to his left hand. The man told the nurse that he had tried to harm himself in prison previously by hanging, but he did not currently feel like harming himself. He asked to see a doctor but the reason for the request was not recorded. The nurse recorded that the prisoner appeared to be depressed and upset. Because he was identified as having harmed himself before his arrival at the prison, and was charged with a serious offence, the First Night Watch was supplemented by the SASH book which was opened at 15:05 during his interview with the RMN.

26. The forms used to record staff observations are pre-printed with the times every 15 minutes. In interview, the prison's Suicide Prevention Coordinator said that staff do not use the times on the form predictably as this would mean that prisoners would be able to anticipate when they would be observed. However, they do not record the actual time that the observation takes place, although it could be of vital importance to some situations. Observations may take place at any point in a 15 minute period and this should be identified as otherwise a period of just short of 30 minutes may elapse between observations.

The director is recommended to ensure that the actual time of each observation is recorded in the record of all watches.

27. The man remained in the healthcare centre until 13 August when he was seen by a doctor and assessed as fit for normal location, which should be in a downstairs cell with a bottom bunk. This is the type of accommodation which was allocated. Because Altcourse holds remand and sentenced prisoners in the same wings, there is a procedure whereby prisoners are asked whether they consent to sharing a cell with a prisoner of different status. The man who is the subject of this report was asked this on 11 August and agreed to sharing with sentenced prisoners. He was placed on Furlong Green unit, which is the induction wing, until 23 August when he moved to Melling Brown, which was where he died. At the time the man was there, Melling Brown held enhanced sentenced and remand prisoners. Prisoners in the enhanced category are those who comply with the prison's requirements and so have earned additional privileges. In interview, the director of the prison said that holding sentenced and remand prisoners together contributed to a more settled regime which would be beneficial to all. He confirmed that the man was likely to be older than most of the other prisoners on the unit.

28. The SASH book remained open when the prisoner moved on to the wings and 15 minute observations were continued. The watch records do not record the time that the observations actually occurred and the entries are brief. There are more detailed entries in the Daily Supervision and Support record, which is part of the SASH book. These indicate that the man communicated with staff and prisoners alike and there were *no SASH issues.* The first review was held on Thursday 12 August, a day after it was opened, and the record states that it was too early to remove him from it. The support plan merely stated that *staff support* should be given and no details were included as to how that should happen or how it should be made most relevant to the prisoner. It did state that, when managed in normal location, the 15 minute watch should continue and the man should be in a double cell and receive RMN support.

29. The man attended court on 16 August and the observations were continued by the escorting company.

30. The SASH book on the man was reviewed again on Thursday 19 August and the record states that *he has been settled and not self harmed since arrival* at the prison and it was deemed *safe to remove from watch.* The review

meetings followed the standard prison procedures and so were held on a regular day, with the standing members and without the prisoner attending in person. These arrangements differ from those in the public Prison Service and may not provide the best decision making for each individual prisoner and should be reviewed.

The director is recommended to review the standing arrangements for SASH review meetings to ensure that they promote individualised decisions and that prisoners can participate.

31. The man was not subject to either the SASH Form A or SASH book during the rest of his time at Altcourse. There is no indication of any actions by him which should have led to either of the arrangements being reinstated.

32. It is standard procedure at Altcourse for all prisoners, whether remand or sentenced, to be allocated a personal officer. The procedure is designed as a means for prisoners to have a named individual officer to deal with any requests and for the officer to focus on any poor conduct. The aim is that the prisoner builds up trust with a member of staff which should assist custody planning. The personal officer should also complete a Weekly Behavioural, which is a face to face discussion to consider any conduct matters. The Weekly Behaviourals are monitored by a monthly Management Review. The records of the weekly and monthly checks are held in the prisoner's F2058 but in this case many are missing. In the months between his arrival at Altcourse and his death, there are only four records of Weekly Behaviourals and two Management Reviews. I conclude that the system for monitoring prisoners did not operate properly as far as the subject of this report was concerned.

The director should remind all staff that the routine for personal officers to carry out weekly checks and for managers to monitor them each month is to be implemented according to the prison's policy.

33. The arrangements for allocation of personal officers changed during the man's time at the prison, but for most of the time he had the same personal officer. In interview, his personal officer said that he did not think he had received sufficient training for the role, that he was not in the practice of introducing himself to prisoners and that the prisoner concerned had not approached him with any issues.

The director should review the training offered to personal officers to enable them to carry out the role properly.

34. Another standard Altcourse procedure is for all prisoners, whether remand or sentenced, to have a Custody Plan Review. These should be held each quarter and should be attended by the prisoner, the personal officer if they are on duty, the wing manager and the probation officer. The purpose of the meeting is to look at any issues raised in the weekly and monthly checks and make plans, for example, to attend offending behaviour courses. In the case of the man who died, reviews took place as required and were held on 9

November 2004 and 10 January 2005, but different staff chaired each meeting and his personal officer attended neither.

35. In interview, one of the managers of the Melling Brown unit, who also chaired the Custody Plan Review of 9 November, described the prisoner as a quiet, unassuming older man who attended education and never presented a problem to wing staff. As an example, he said that the man was always ready at the gate and never had to be reminded to get ready for appointments.

36. The Custody Plan Review of 9 November commented perceptively that the prisoner *may become distressed when the evidence is presented to him* in court *because he maintains he has no recollection* of the offence. Regrettably, it was not apparent that these comments informed subsequent arrangements for the man, and in interview neither the personal officer nor the manager of the Melling Brown unit said that they were aware that his trial was about to begin. The man who later died had not told them, and there was no other means which would have given them the information - even though an imminent trial might well be a factor which increases the risk to prisoners. All staff receive annual Suicide and Self Harm Awareness training which covers risk factors such as trigger points. But this is of limited benefit if information about individual prisoners is not available.

The director should review ways of informing wing staff and personal officers of events that might increase the risk to prisoners.

37. The second Custody Plan Review on 10 January was brief. It recorded that the man had no issues with his family. There is a section of the form entitled Expected Outcome, which enquires about a possible sentence plan for prisoners who are expecting a custodial sentence. In this case, that section of the Review is marked *N/A.*

38. It is also standard procedure at Altcourse that prisoners facing the possibility of a life sentence are interviewed by either a probation officer or Lifer Manager soon after they are received at the prison. Subsequent interviews are only arranged for specific purposes or at the request of the prisoner. The man's interview took place on 17 August with a probation officer at the prison, who recorded on the F2058 that the lifer process was explained to him but he refused an information booklet. An internal audit by the Lifer Manager subsequently discovered that their record of the interview had been mislaid and so the interview was repeated at a later date.

39. Throughout the man's time at Altcourse he made extensive visits to the healthcare centre. His requests were recorded in out dated terminology, such as "attended special sick" and reported for "sick parade". Terms such as these contrast with the usual interaction between staff and prisoners at Altcourse, which is positive, respectful and individualised. The Director may wish to review the use of terms such as these, and consider how they can be replaced with ones which are more appropriate.

40. The Registered General Nurse (RGN) was interviewed for this investigation as she attended the man on his death. She also knew him when he was alive and described him as a quiet and amenable individual, who always had genuine clinical complaints and whom she recognised because of his age and because he had been at the prison for a long while. On approximately 30 occasions he attended for dressings to the injury to his left hand. As well, he made at least 12 requests to see the doctor because of various complaints, including pains to the arm and hip and, on two occasions, complaints of chest pain. On four of these occasions, he was admitted overnight to the healthcare centre and on 21 October he attended Fazakerley Hospital as an out patient. The clinical record does not state the purpose of this appointment but it does contain a letter from the Department of Pain Relief which proposes specific medication.

41. The man's healthcare is assessed more thoroughly in the clinical review carried out by North Liverpool PCT. But this investigation attempted to explore whether there were any arrangements for a holistic review of the needs of a patient who presented at healthcare so frequently. In interview, the healthcare manager said that the doctor would have the patient's full clinical record to hand at each appointment and could arrange such a review. However, the healthcare manager thought it likely that the frequency of appointments was due to him suffering a long term chronic condition. The Registered General Nurse also said that she did not think the frequency of appointments was unusual for a man of the prisoner's age and condition.

42. The man remained on Melling Brown, in a ground floor cell and sleeping in the bottom bunk. The wing observation books for his period on the wing contain no entries about him, other than one entry about the need to locate a record after a court appearance.

43. On 17 November, the prisoner successfully applied for level 4 status, which is the highest level in the prison. It means that the prisoner is fully compliant with the demands of the regime and that they are entitled to enhanced privileges such as extra visits and cash.

44. On 10 January 2005 the man had a physiotherapy appointment, and reminded the physiotherapist that six months had elapsed since he injured his hand. At the time of the injury, he had been advised to wait until six months after his heart attack, and then seek advice about reconstructive surgery. The physiotherapist informed the prison's doctor of the man's request, and the next day a letter was sent to the orthopaedic surgeon at Fazakerley Hospital. The man had a further physiotherapy appointment on 31 January.

45. In Paragraph 37 of this report, I say that the internal audit carried out by the Lifer Manager identified that the record of the man's interview as a Potential Life Sentence Prisoner had been mislaid and so, rather than have a gap in the records, she decided to repeat it. The interview was carried out on 2 February and is recorded on form LSPO. The Lifer Manager said that she introduced herself and her role. She described the prisoner as well informed about the legal processes, saying that there were medical reasons which his

legal team were looking at which he hoped would get him off the charges. The record of the interview states that the man said that *his head was cabbaged* when he was admitted to the prison, but that by this time he was thinking and feeling straighter. The Lifer Manager said that he used the word 'cabbaged', which she had heard previously from prisoners charged with serious offences to describe coming to terms with what they have done. She asked whether he felt like harming himself, and the prisoner said that he would have done so in the early days at the prison but would not do so now. She informed him of the various sources of support within the prison, but said that the man replied he was fine.

46. The following day (3 February), the man had an all day meeting with his solicitor, his counsel and clerk. In interview, the solicitor said that he had known the subject of this report since he was charged with the murder of his partner. The solicitor was aware at their first meeting that the man was under constant surveillance by the police and suspected that this was because he was considered to be a suicide risk. The solicitor himself said that he considered this possibility at the beginning of their acquaintance and subsequently. The solicitor stated that there was no occasion when he considered that he needed to alert the prison of specific risks, and the man never suggested that he was likely to harm himself. However, he also said that he assumed that Altcourse would be monitoring the situation because they were aware of the nature of the charges and that the trial was approaching.

47. The man's solicitor said that he was aware of the man's physical condition and that he raised it with the prison. He described the man's physical and mental health in the early stages of their relationship as being at a low ebb, but that he seemed to get stronger as time went by. He complained of poor sleep and lack of medication, but not to the extent that the solicitor was asked to write to the prison. He described him as having a degree of physical disability but that his gait improved and his arm injury was healing.

48. The solicitor said that he had a number of meetings whilst the man was remanded in custody. Throughout them the man said that he had no recollection of the night of 26 – 27 July. The solicitor said that this made it difficult to advise how he should plead and so a trial was inevitable. In order to investigate the man's claim of lack of memory he arranged for a report by a consultant neurologist to be prepared as well as the routine psychiatric report prepared for all offences of this nature. Neither of these reports have been made available to this investigation.

49. During the meeting on 3 February, the solicitor said that they went through the likely events of the trial, the possible length of sentence and the benefits of pleading guilty. The prisoner had previously refused to have legal papers in his possession, but at the court hearing of 13 January he had requested a copy of a forensic report which set out the evidence and made it clear to him that no one else could have been involved in the crime.

50. The meeting between the man and his solicitor ended at about 4:30 pm and the latter said that he would see him in court the next day, with a further meeting arranged for Saturday 5 February. The man then returned to the wing where he had his evening meal and evening association, and where he was locked up for the night by one of the wing officers. The night roll checks were carried out by another prison officer. The records of this period are routine and do not contain anything untoward in respect of the man who died. In interview, the officer who carried out the night roll checks described the 5:00 am check on 4 February, saying that all the prisoners appeared to be in their beds and at 5:50 am he passed the head count information to the control room. He said that he could see a shape on the bottom bunk which he took to be the prisoner sleeping there.

51. According to this officer, at 6:00am he began to wake the prisoners for court. They included the man who is the subject of this report and so he knocked at cell 6. He saw the prisoner on the top bunk lift his head and he assumed that this was the man. One of the day staff had been asked to go to another part of the prison but called first to Melling Blue to look for a colleague. He was on the wing at 6:10 am and volunteered to take the court prisoners off the wing, the officer who conducted the night roll checks having told him that he had got a response from all the cells and all the prisoners were awake. He used his keys and at about 6.30 am unlocked cells 2 and 5 before reaching cell 6 on the ground floor about five minutes later. The day officer said that he did not notice anything when he first opened the cell, but then saw the prisoner in a kneeling position on the floor, partly obscured by clothing hanging from the top bunk, and with a white bag on his head. He noticed that his knuckles were white, but his first thought was that the prisoner was going to jump up at him.

52. The day officer was not carrying a radio so he called to the prison officer who carried out the night roll check to join him and he called code 1 at 6:42 am, which is the Altcourse code for a serious incident and summons all staff including healthcare. He took the bag off the man's head and saw a ligature round his neck, attached to the rail of the top bunk. The officer responsible for the night roll check was carrying a ligature knife and had been trained to use it. He used the knife to remove the ligature, whilst the day officer lifted the prisoner by the elbows to take his weight. They laid the man on the cell floor and the cell mate was sent out of the cell into the dining area. The prison officer who conducted the night roll check said that he, like all staff, was first aid trained, and so was able to check the vital signs of pulse and breathing. He said that he was able to recognise that the vital signs were missing because the prisoner's face was discoloured and his tongue was swollen. As a consequence no attempt at resuscitation was made. The cell was locked with the man who died inside.

53. At 6:45 am the control room telephoned for an ambulance.

54. The cell was reopened when the Night Duty Operations Manager arrived. He said that on arrival he took charge of the incident and attempted first aid. The on-site Registered General Nurse said that she heard the code 1 at about

6:40 am and went to the wing, followed by a Healthcare Assistant, who carried the grab bag with resuscitation equipment. The Night Duty Operations Manager and the Healthcare Assistant lifted the prisoner on to the floor outside of the cell so that there was more space for them to work on him. The Registered General Nurse began CPR and placed the defibrillator pads on the man. She checked with the Night Duty Operations Manager that he had already telephoned the control room to call for an ambulance, and carried on attempting to resuscitate the man who later died.

55. The ambulance arrived with the paramedics at the prison at 6:50 am, and they were escorted to Melling Brown where they took over from healthcare staff. They applied their own pads before one of the paramedics said that he did not think they were achieving anything. The on-site Registered General Nurse said that the paramedics and healthcare staff agreed that CPR should cease and the man was pronounced dead at 7:10 am.

56. The man was placed back into the cell and placed on the bottom bunk. The on-site Registered General Nurse said that she attended to the prisoner who died to preserve his dignity, straightening his limbs and trying to shut his eyes, before the cell was double locked for security by the Night Duty Operations Manager. By this time, the Healthcare Assistant had gone to the wing office to attend to paperwork and other staff on the scene were dealing with the other prisoners who were locked in their cells. The dead man's cell mate was placed in a different cell with a friend. He was placed on a Form A watch at 9:47 am and was given support by the chaplain and others. He was spoken to informally as part of this investigation and has subsequently been released from prison. In his statement to the police, the man's cell mate said that he and the man went to bed as usual but that the latter gave him the television remote control instead of keeping it himself as was their routine. He said that he did not hear anything during the night and first became aware of his cell mate's death when he was woken by staff the next morning.

57. The Duty Governor of the day was notified of the incident at 6:45 am as she drove to work. She made sure that the prison's contingency plans were being followed and, on arrival at the prison at 7:15 am, took charge in the command suite which had already been set up. She ensured that the police, prison director, GSL head office and other relevant people were informed as required.

58. The contingency plans designate the duty chaplain as the family liaison officer. She was paged at 7:10 am when she was on her way to work and went straight to the command suite to get the necessary information. Because she was concerned that the man's family might be leaving home to accompany him in court, she took the decision to notify them of his death over the telephone rather than in person and this was done at 8:10 am. She was aware that the man's son was in custody and checked with the family how they wished him to be informed. Later that day, both she and the Duty Governor visited the man's daughter to offer condolences and provide information.

59. The wing manager came on shift at 7:15 am, by which time he said the incident on the wing had largely been dealt with. He placed an officer on duty outside the cell and the other prisoners remained locked up instead of being unlocked for breakfast, unless they were escorted for appointments. In interview, he said that the other prisoners were respectful of this arrangement and the atmosphere on the wing was quiet.

60. The police arrived at the prison at 7:32 am and were escorted to the wing by the Night Duty Operations Manager. They took responsibility for informing the coroner of the death as the prison had been unable to get through on the telephone.

61. As some staff had been relieved of their duties and had left the prison, the Duty Governor decided she would divert from the contingency plan and would not hold a hot debrief meeting for all those involved in the incident. Whilst this is understandable, it meant that some staff were unaware of the role played by others and did not have the opportunity to receive feedback on their actions.

The director should remind senior colleagues that a hot de-brief should take place after any death in custody in order that staff can participate and lessons can be learnt.

62. Later in the morning, the Duty Governor briefed the wing manager, and he identified the man's body before it was released to the undertaker at 11:30 am. The wing manager said that he undertook this task because he felt it right to take responsibility. The command suite was closed at 11:59 am.

63. All staff interviewed for the investigation spoke highly of the support offered to them individually by colleagues and senior managers as well as receiving letters from GSL to offer external counselling support.

64. Immediately after the incident, GSL commissioned an internal review of the events in order that any lessons could be learnt. In addition, the Lifer Manager has decided to make three changes to the way her office. Future interviews with potential lifers will be carried out jointly by herself and the probation officer so that both staff will know the prisoner, and afterwards all such prisoners will be put on a Form A watch in recognition of the potential for distress from the subject of the interview. Additionally, she is exploring how information about court dates can be shared and consideration given to whether a prisoner should be placed on a watch.

65. The changes in procedures introduced at Altcourse are to be welcomed. However, given the circumstances described in this report, I do not believe that the man's death could have been predicted by staff. Prisoners who have committed violent acts within the family are an at-risk group. However, for many months after first reception at Altcourse, the man who died had presented a quiet and placid demeanour despite his many medical needs.

RECOMMENDATIONS

Local Recommendations

SASH procedures

1 The Director should ensure that the actual time of each observation is recorded in the record of all watches.

2 The Director should review the standing arrangements for SASH review meetings to ensure that they promote individualised decisions and that prisoners can participate.

3 The Director should explore ways of informing wing staff and personal officers of events which might increase the risk to prisoners.

4 The Director should arrange for a hot de-brief to take place after any death in custody in order that staff can participate and lessons can be learnt.

Personal Officers

5 The Director should ensure that the routine for personal officers to carry out weekly checks and for managers to monitor them each month are implemented according to the prison's policy. He should also provide training to enable all personal officers to carry out the role properly.

Healthcare

6 The clinical review makes four recommendations to the prison and Veritas Limited, provider of healthcare, to improve the provision of healthcare for prisoners.

GOOD PRACTICE

1 The prison is to be commended for making the personal officer arrangements available to all prisoners, including those held on remand.