

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in January 2013
at HMP Altcourse**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Altcourse in January 2013. He was 20 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at Altcourse was conducted. The prison cooperated fully with the investigation.

The man was recalled to custody from a previous sentence in November 2012. He was remanded to Altcourse and when he arrived said that he had taken an overdose the previous month. Mental health assessments at Altcourse and Lancaster Farms, where he moved in December, did not identify any concerns about his mental health, or risk of suicide and self-harm. He returned to Altcourse on 21 December after being sentenced. At the end of December, he was identified as being part of a group alleged to have seriously assaulted another prisoner. He was put on a basic regime and moved wings. The next day, he refused to return to his cell and was segregated from other prisoners, although he remained on the wing. He had alleged that some other prisoners had threatened him but gave no indication of distress and prisoners and staff who saw him at the beginning of January said that they had no concerns about him. However, that night, he hanged himself in his cell.

The investigation has found that while there is little to indicate that threats from other prisoners had a part in his death, the prison did not fully investigate the possibility of bullying. The man did not alert staff, other prisoners or his family to any feelings of distress, but I am concerned that in assessing his risk too much emphasis was placed on his presentation rather than his underlying risk factors, such as his recall to prison and his recent drugs overdose. The clinical reviewer has identified that his level of risk and depression was not assessed in line with national clinical guidelines. I am also concerned that at the time of his death he was segregated from other prisoners and on a basic regime with little to occupy him in his cell to distract him when he was feeling vulnerable.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2013

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SUMMARY

1. The man was released from a prison sentence on licence in May 2012 but was recalled to prison on 23 November 2012. He had been found carrying a knife and was later charged with this offence.
2. When he arrived at Altcourse, he disclosed to the nurse that he had recently taken a drug overdose, had regularly seen mental health workers in the community and was taking medication for depression. However, he said that he did not have any thoughts of suicide or self-harm. He was later assessed by a mental health nurse, who did not regard him as a risk of suicide.
3. The man was moved to Lancaster Farms for a period, and no concerns were recorded at another mental health assessment. He returned to Altcourse on 21 December after being sentenced. He did not have a full health screen when he returned.
4. On 29 December, the man was part of a group who allegedly seriously assaulted another prisoner. He was put on the basic prison regime and moved wings. The next day, he refused to return to his cell and said he was being threatened by other prisoners. Staff separated him from other prisoners and kept him in segregation conditions, although he remained on the same wing. His segregation was reviewed in January, and he told the review panel that he was happy with his conditions. Other members of staff and prisoners who saw him that day said that he seemed his normal self and they were not concerned about him.
5. At a roll check the following morning, the man was found hanging in his cell. Staff tried to resuscitate him, but it was apparent that he had died.
6. The investigation found that the initial assessments of the man's risk to himself and of his depression were not conducted in line with national guidelines and have made recommendations about these issues. We also recommend that staff take a prisoner's mental health history into account when deciding if they should be segregated, that prisoners are given access to reading material and a radio when they are segregated, and that all intelligence is considered when assessing allegations of bullying.

THE INVESTIGATION PROCESS

7. Notices were issued at Altcourse announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.
8. The investigator visited Altcourse on 9 January 2013. He spoke to the Head of Safer Custody, and visited the wing and cell where the man lived.
9. The next day, the investigator spoke to Merseyside Police about an allegation that the man had taken part in an assault at the prison on 29 December 2012. They confirmed that there was no outstanding criminal investigation.
10. The investigator interviewed seven prisoners at Altcourse on 17 January. He interviewed nine members of staff on 28 and 29 January.
11. On 18 January, the investigator contacted the safer custody unit at HMP Lancaster Farms who reported that he had not raised any issues while he was there, and had not been subject to ACCT monitoring (the Prison Service process for supporting and monitoring prisoners at risk of harming themselves).
12. A copy of the investigation report has been sent to HM Coroner for Liverpool.
13. One of the Ombudsman's family liaison officers contacted the man's mother in February 2013 to explain the purpose of our investigation and invited her to identify relevant issues which she would like the investigation to cover. She asked the following questions:
 - Had Altcourse properly addressed the man's mental health issues?
 - Why was he on basic level of the Incentives and Earned Privileges scheme?
 - Why was he in a single cell?
 - Why had he been transferred back to Altcourse – where he had told staff he had been involved in a fight – from Lancaster Farms, where he had been settled?
 - Why was he not on suicide or self-harm monitoring, especially after another prisoner died two days earlier?
 - Why had the prison family liaison officer not adequately prepared her for the Coroner's process?
14. We are sorry for the delay in the issue of this draft report caused by staffing difficulties and staffing changes during the course of the investigation.
15. The man's family received a copy of the draft report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP ALTCOURSE

16. HMP Altcourse is a local prison in Liverpool, receiving prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by G4S custodial services and holds up to 1,324 sentenced and remand adult and young adult males. G4S runs the company that provides healthcare services at the prison. There is a 12 bed in-patient facility which provides 24 hour cover.

Her Majesty's Inspectorate of Prisons

17. HM Inspectorate of Prisons conducted an unannounced short follow-up inspection of Altcourse between 15 and 17 October 2012. Inspectors found that there were excellent staff-prisoner relationships, and that Altcourse was fundamentally a safe prison in which prisoners at risk of self-harm received good support. However, inspectors did not think that anti-bullying procedures were sufficiently robust. While arrangements for managing prisoners who were on the basic level of the incentives and enhanced privileges scheme had improved, inspectors considered that the landing for basic status prisoners was too punitive and the regime did not address their behavioural issues.

Independent Monitoring Board (IMB)

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In the IMB annual report for 2011-2012, the IMB considered that the general healthcare provided in the prison met the standards which prisoners could reasonably expect in the community. The IMB was concerned that an influx of prisoners with severe mental health problems was disturbing for other prisoners in the inpatient unit who were unwell, particularly those who were there for palliative care.

Previous deaths in custody

19. There have been two self-inflicted deaths at Altcourse since 2011. The second of these was two days before the man's death. In the first death, we made recommendations about the use of the segregation unit for prisoners subject to self-harm monitoring. He was subject to segregation conditions and said that he was being threatened by other prisoners, but we do not consider that the circumstances are similar.

KEY EVENTS

20. The man was first convicted of theft in 2005. He had been convicted of a further 26 offences by 2011, and had spent time in custody. On 4 November 2010, he was remanded to HMP Altcourse.
21. On 6 November, a nurse carried out a mental health assessment. He told her that he had harmed himself five years earlier, when he had cut his wrists, but said that he had only done this to seek attention. She thought that he engaged well, and he said that he did not have any thoughts of suicide or self-harm or history of mental health issues. She explained to him how he could access mental health services at the prison.
22. The man was involved in a fight with another prisoner on 4 March 2011. He said that he had hit the prisoner after he called him a “grass”. He injured his knuckle and healthcare staff treated the wound.
23. On 25 March, the man was convicted of offences including robbery, damaging property and intimidating a witness, and given consecutive prison sentences of 18 months and 15 months. After his court appearance, he was taken to HMYOI Lancaster Farms.
24. When he arrived at Lancaster Farms, the man had another health screen. He said that he had no thoughts of self-harm or suicide. He was treated for the knuckle injury he sustained at Altcourse. During the remainder of his time in Lancaster Farms, he was treated for a variety of minor ailments but did not access mental health services or report feelings of suicide or self-harm.
25. The man was released on licence from Lancaster Farms on 4 May 2012. As part of his licence conditions, he was required to be well behaved and not commit any offence.
26. On 21 November 2102, the man was arrested for carrying an eight inch kitchen knife with a serrated blade in a public place. He appeared at a Magistrates’ Court on 23 November, where he pleaded guilty. He was remanded in custody for sentencing on 21 December.
27. While at court, custody staff noted that they had information that the man had previously been regarded as being at risk of suicide or self-harm, and had cut his wrists in 2005 and taken an overdose four months earlier in 2012. Probation staff had also noted this in their application for his licence to be revoked.
28. When the man arrived at Altcourse on 23 November, a mental health nurse noted that his community GP records showed that he was being treated for depression in the community, and received 50mg of sertraline (an anti-depressant) daily. He said that he had taken an overdose on 22 October 2012 (his GP records suggest that this was in fact 21 October). He said he had been sacked from his job on the same day that both his partner and ex-partner had undergone planned abortions. He told the nurse that he had used

cannabis in the previous month and drank occasionally. The nurse referred him to the mental health team.

29. A cell sharing risk assessment form was completed. Because one of the man's previous offences was racially aggravated, he was assessed as a high risk for cell sharing and should not share with anyone from a black or ethnic minority background.
30. The same day, a prison GP noted in his records that the man did not want to see a GP, and had said that he had no thoughts of suicide or self-harm. The doctor offered to see him at any time, and prescribed sertraline in line with his community GP.
31. The man completed his induction on 26 November. A nurse carried out a mental health assessment. She described him as being pleasant in mood and manner, relaxed and making good eye contact. He said that he was fine and just wanted to get on with his sentence. She did not note any concerns about him.
32. On 30 November, an officer (the name is not clear) submitted a security information report (SIR) saying that the man had told him that he had been threatened by another prisoner who had moved into his cell on Melling Brown unit after returning from the care and separation unit (the segregation unit at Altcourse). It appeared that the prisoner wanted to share with another prisoner, and not the man. He was moved to a different cell.
33. On 4 December, the man told a nurse that he felt depressed. He explained why he had taken an overdose in October, and said that he was feeling stressed about some relationships outside prison and was also down because he was in prison.
34. The man moved to Lancaster Farms on 11 December. In reception he told an officer that he had no thoughts of self-harm, but might have problems with some other prisoners from Liverpool. During the reception health screen, he told a nurse that he had no thoughts of deliberate self-harm. He had 13 tablets of sertraline from a box of 28, and he was allowed to keep these to administer himself.
35. The same day, a nurse from the prison mental health in-reach team, assessed his mental health. He said that he had been referred for counselling in the community, but had been arrested before he could begin. He said that he had tried to commit suicide because of his girlfriend's abortions. However, he said that he did not want support in prison as he did not think that it was the best place to explore his emotions, and would wait until he was out of prison before he sought counselling. He said that he had no thoughts of suicide or self-harm. She said that she would refer him to the mental health team, with a view to probable discharge as he did not want their support. She also explained how he could contact the team in the future.

36. Over the next few days, the man was treated for a tooth abscess. On 17 December he was given two warnings under the Incentives and Earned Privileges scheme (IEPS, which uses a system of rewards and sanctions to promote good behaviour) for misuse of his cell bell during the night and threatening an officer. On 18 December, the mental health team discussed his case and agreed to discharge him from the list as he did not want their support.
37. On 20 December, a further prescription for sertraline was arranged. An "in possession" assessment was completed, and a doctor was not prepared to issue the medication for him to keep himself. This meant that he would need to collect his medication each day.
38. On 21 December, the man appeared at Crown Court. He was sentenced to six months' detention and taken to Altcourse, the main prison which takes young people from the Crown Court. When he arrived, he saw a nurse, although it does not seem that a full health screen was completed. He completed his induction on 23 December.
39. The man was given a cell on Melling Brown unit, which he shared with another prisoner.
40. On 25 December, the man called his mother. They discussed their plans for Christmas. He said that he would do everything he could to stay at Altcourse and not be sent back to Lancaster Farms, particularly as it was further for his mother to travel.

29 December 2012

41. At 10.30am, a member of staff (who completed, but did not sign, a witness statement giving an account of what happened) noticed a lot of activity outside cell 16 on Melling Brown. The officer noted that a group of prisoners, including the man, were outside the cell and, because one of them was being monitored as a suspected bully, went to investigate. The officer saw a prisoner in the cell with facial injuries. A prison cleaner told the officer that the prisoner had been assaulted in his cell. Staff locked prisoners back in their cells and the officer went to view CCTV footage while another officer spoke to the injured prisoner.
42. The CCTV footage showed several prisoners, including the man and his cellmate, going in and out of the cell for approximately 15 minutes. The injured prisoner told the officer that the other prisoners had punched him, poured boiling water on his backside and then tried to insert something into his anus.
43. The two officers reported this to the unit manager. The unit manager discussed the incident with the duty Director, who decided that the man, his cellmate and a third prisoner (described by the victim as the instigator of the assault) should be put on the basic regime of the incentives and privileges scheme in Valentines Green unit. They were moved into a cell together.

44. The induction officer opened an anti-social behaviour scheme booklet to monitor the man as a suspected bully. No entries were made in the booklet after 29 December.

30 December 2012

45. At about 12.00pm on 30 December, the man and his cellmate refused to return to their cells for a roll check. The duty Director noted that he thought that their non-compliance could escalate and result in further incidents so he decided to segregate them under YOI Rule 49, which allows prisoners to be kept separate from others for reasons of good order and discipline. They remained in their own cells on Valentines Green unit, but had exercise, showers and telephone calls in the segregation unit, known as the care and separation unit (CSU) at Altcourse.
46. Later that day, the man and his cellmate told staff that they felt threatened by other prisoners. There is very little mention of these threats in the prison records we have seen. In his statement, the duty Director recorded that they said that they felt under threat but that "there was no evidence to support this". After the man's death, the Violence Reduction Manager produced a note for the Head of Safer Custody, setting out the information they had about this incident. The initial segregation paperwork mentioned that he "is under threat" but contained no further details. He noted that the Valentines Green handover book (which we have not seen) contained an entry that the two prisoners said they were under threat but had not said who from.
47. The Violence Reduction Manager recorded in his note that he spoke to the cellmate (it is not clear when). The cellmate told him that he felt threatened by another prisoner, but that he did not know if the man had received any threats. He thought that his issue might have been that some items had been stolen from his cell. The Manager noted that this information was not recorded anywhere.
48. The cellmate told the investigator that he thought that other prisoners had been discussing an alleged theft committed by the man when he was living on Melling Brown. He said that he did not know the details but thought that, in retaliation, some prisoners had gone into their cell and taken items such as tobacco, toiletries and a box he had made. After this, he said that he and the man asked to be moved to a different wing but instead they were moved to separate cells. The cellmate said that he felt under threat because other prisoners knew that he had been his cellmate.
49. The man received a visit from his mother that afternoon.
50. All prisoners who are subject to segregation should be assessed by healthcare staff to ensure that there are no health reasons why they should not be segregated. A nurse saw the man at 5.00pm and recorded that he did not require any healthcare intervention and was fit for segregation.

31 December 2012

51. The man was taken to the CSU in the afternoon for a shower and to spend some time in the open air in the CSU exercise yard. At 3.21pm, he spoke to his mother on the telephone for just over two minutes. They discussed their respective plans for New Year's Eve. He said that he was "flying" and seemed happy. The duty director and a member of healthcare staff both saw him as part of routine segregation checks and no issues were reported. He then returned to the Valentines Green unit.

1 January 2013

52. The man was taken to the CSU for exercise and a shower in the morning. During exercise, he was in one of three fenced exercise areas, each of which holds a single prisoner. In the others were the cellmate and another prisoner, who was in the middle. The cellmate told the investigator that he had spoken to the man and they had a normal conversation. The man passed him a cigarette lighter via the prisoner. The prisoner, who had not met the man before, said that they talked about why they were in Altcourse and the CSU. He described him as an "all right geezer", that he sounded normal and that he did not say anything about feeling low.
53. A Security Manager, who was duty Director that day, chaired a segregation review with the man. A PCO who worked in the CSU, the suicide and self-harm prevention co-ordinator, and a nurse also attended. The Security Manager noted on the review form that the man indicated that he was happy to be on basic following the allegation of assault, and to continue the CSU arrangements. They discussed the threats that he had reported, but the Manager said that he was not very specific. He said that he did not want to be unlocked while on basic regime but that he was happy to be living on the Valentines Green unit. The nurse, a trained mental health nurse, noted on the review form that she did not have any concerns at that time.
54. The review panel concluded that the man should remain segregated until 14 January. The arrangements for him to remain on the Valentines Green unit were kept in place. At interview, he explained that this meant that the man was not kept on the CSU, and that he hoped that he would get used to the surroundings on the Valentines Green unit and that he might feel that he was no longer under threat, so they could expand his regime. The Manager also told the investigator that if the man had identified the prisoner who was threatening him, they would have looked into his concerns and possibly moved him to a different wing. (An entry dated 30 December 2012 in his intelligence record gives the names of two prisoners who the man and his cellmate had issues with but staff dealing with him seemed to be unaware of this. The source of the information is not recorded.)
55. The cellmate spoke to the man while they were waiting to go back to their respective wings from the CSU. When interviewed, the cellmate said that the man appeared to be his usual self and that he did not think that he was down.

56. The man spoke to his mother on the telephone at 12.23pm, for almost eight minutes. They wished each other a happy New Year. He told her that he did not have a television. He said that he would speak to her later. He did not express any concerns.
57. A PCO walked the man back to Valentines Green unit. He told the investigator that there was nothing to suggest that he was uncomfortable or unhappy, that he appeared to be his usual self and that they had chatted about everyday things. He said that he had no concerns which would have led him to open an ACCT.
58. A PCO was on duty on Valentines Green unit on the afternoon of 1 January. She told the investigator that she had not met the man before, but was introduced to him as he returned from the CSU. His regime was explained to her. She took him a meal at 2.15pm (after other prisoners had returned to the wing from the gym). At interview, she recalled that they had joked about the meal, which was curry and rice. He had asked for some bread, and they had discussed whether he was going to make a curry butty with it.
59. The man had his evening meal at approximately 4.00pm. The unit orderly (another prisoner) who gave him this meal told the investigator that he seemed fine. A PCO returned to his cell at around 5.30pm to give him (and other prisoners) hot water. She recalled that he used the hot water to make noodles. She did not have any concerns.
60. Later in the evening, the man pressed his cell buzzer. A PCO responded, and he asked her for a book. As they were in night state by then (when officers are not allowed to open cell doors without authority), she told him that he would have to wait until the morning. At interview, she told the investigator that he accepted that.
61. Several prisoners spoke to the man that evening. Prisoner A, who was in the next cell to him (there was a cupboard in between the cells), told the investigator that the man had asked him if he could borrow a radio in return for some tobacco. He told him that he could not give him the radio as he had borrowed it from another prisoner, but offered to turn it up so he could hear it through the window until he went to sleep. The prisoner told the investigator that the man passed him some tobacco. He said that he did not detect any problems with him, and later heard him laughing and chatting with another prisoner.
62. Prisoner B was in the cell next to the man on the Valentines Green unit. He told the investigator that the man had spent much of the evening telling him how to "throw a line" between their cells, so that they could pass tobacco. Although the prisoner said that prisoners often used lines to pass drugs, he was adamant that he only used the line to receive tobacco that night from him. He said that he was surprised that he did not know how to throw a line, and laughed, and called him a "muppet". The prisoner said that this was just after a search team had come onto the wing, and removed a prisoner who they

believed had a mobile telephone concealed. He said lots of prisoners, including the man, were laughing as they knew what the truth was.

63. The prisoner said that it took him nine attempts to throw the line. The man told him to throw another one to make sure he could do it, and then said that if he needed any more tobacco, he should bang on their shared cell wall. He told the prisoner that he would see him in the morning. The prisoner said that he had difficulty sleeping and banged on the wall several times about an hour later. However, the man did not respond and he assumed he had gone to sleep. The prisoner told the investigator that he had no concerns about him and that he had been laughing and joking with him all evening.
64. At approximately 5.15am, PCO 1 was conducting the morning roll check on the Valentines Green unit (which is done to ensure that staff can account for all the prisoners in the jail). When he got to cell 44, the man's cell, he opened the observation panel and saw him hanging from a ligature that had been tied to the bedframe. The PCO thought that the ligature had been made from a bedsheet. As a towel had been hung over the bottom bunk he was not sure if there was another prisoner in the cell. He called a code 1 emergency on the radio (a code used when someone is found not breathing) and ran to the office to check who was in the cell.
65. As the PCO arrived back at the cell, he tried to break into the pouch holding his emergency cell key (staff on nights do not hold keys, but have a sealed pouch containing a cell key that they can use in emergencies). Another officer, PCO 2, used his key to open the door. (He estimated he was at the cell less than a minute after the emergency call.) PCO 1 gave him his anti-ligature knife and took the man's weight while the other PCO cut the ligature. However, the ligature was too big for the knife. PCO 3 helped PCO 1 lift the man and PCO 2 untied the ligature from his neck. Another PCO who had also arrived helped PCO 3 to lay him on the floor.
66. A nurse was working in the inpatient unit. When he heard the emergency call, he collected an oxygen bottle and went directly to Valentines Green unit. He estimated that it took him at most two minutes to get to the cell. He told the investigator that the man's face was purple, there was a deep ligature mark to his throat, his tongue was protruding and his jaw was clamped. His legs were bent (PCO 2 said that he was found in a kneeling position, although his knees were not on the ground), but when the nurse tried to straighten them, he found that they were locked solid. He was cold to the touch and the nurse said that he could not find a pulse. He said that, although he did not think that it would make a difference, he began cardiopulmonary resuscitation.
67. An ambulance was called from the control room at 5.18pm. Records from the North West Ambulance Service show that paramedics arrived in the cell at 5.24am. The nurse estimated that he had completed eight rounds of 15 chest compressions in this time.
68. The paramedics recorded that they could not find a pulse, that the man's temperature was below 32°C, and there were signs of rigor mortis and

hypostasis (where the blood pools in the lower limbs as there is no circulation). At 5.30am, they pronounced that he had died.

69. The duty director was called at home and arrived at the prison at about 6.00am. He ensured that the Director, police and coroner were all informed. He held a debrief for all staff who were present at the man's cell before they left the prison, to ensure that the staff were OK and to see if there was any practice that needed to change. Prisoners who were on ACCTs were reviewed in case they had been adversely affected by his death, and the care team was available to both staff and prisoners on Valentines Green. The former cellmate told the interviewer that he was told of the death individually in an office as staff were aware that he knew him.
70. At 8.43am, the family liaison officer (FLO) and the chaplain left Altcourse, accompanied by the police, to inform the man's family of his death. They went to his mother's home and informed her and her partner. The FLO arranged to meet the family at the hospital that afternoon so that they could identify him, but when they arrived they were told that identification could not take place until after the post-mortem the next day. The FLO apologised to the man's mother for this by telephone later that afternoon.
71. The next day, the FLO called the man's mother again to tell her that the post-mortem had not been completed and that the family would not be able to view his body until the next day. The man's mother was upset and told the FLO that he had built up her expectations and not delivered.
72. On 4 January, the FLO spoke to the man's mother at 8.30am. He offered a contribution to funeral expenses. She was unhappy that the Coroner's Officer had told her that some tissue samples had been retained but that she had not been told about this by the FLO. Later that day, the man's mother and father viewed his body separately. The man's mother visited Altcourse on 8 January, and attended a service in the chapel which was conducted by a chaplain. She met the Deputy Director, and her son's property was returned to her.

ISSUES

Clinical care

73. The clinical reviewer had access to the man's community GP records when conducting his review. He noted that he had taken an overdose of someone else's medication, dosulepin, on 22 October 2012. This is primarily used as an anti-depressant. He noted that the National Institute of Clinical Excellence (NICE) guidelines for the longer-term management of self-harm, state that an episode of self-harm made it 50-100 times more likely that the person will attempt suicide in the next year.
74. The NICE guidance gives several recommendations as priorities for implementation. These include offering a psychosocial needs assessment, to include coping strategies, recent and current life difficulties, mental and physical health issues and the need for psychosocial, support or drug interventions. The guidelines also recommend that an assessment of risk is completed. This assessment should include:
- methods and frequency of current and past self-harm
 - current and past suicidal intent
 - depressive symptoms and their relationship to self-harm
 - any psychiatric illness and its relationship to self-harm
 - the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
 - specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
 - coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
 - significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
 - immediate and longer-term risks.
75. The clinical reviewer notes that a mental health assessment took place on 23 November 2012, when the man returned to prison. This assessment covered many of the factors in the NICE guidance and, for example, noted that he had taken an overdose and the reasons behind the overdose, that he had had help with mental health from when he was 13 or 14 years old, and that he took cannabis and alcohol. He was observed to be emotionally settled. However, his depressive symptoms and coping strategies were not documented in detail.
76. The clinical reviewer concludes that the risk assessment was not comprehensive. In turn, this led to the conclusion that the man was not at risk. However, he also comments that on three occasions it was noted that he did not have any suicidal ideation. On 1 January 2013, he was seen by a

mental health nurse, and did not raise any concerns. He comments that he cannot conclude that had NICE guidelines been followed then his suicide could have been prevented. Indeed, as part of this investigation, we have interviewed most of the staff and prisoners who interacted with him on the day before he died, and none of them had any idea that he was planning to take his own life. We have also listened to the telephone conversation with his mother and do not believe that he raised any concerns about his mental well-being during this conversation.

77. While the personal presentation of a prisoner will always need to be taken into account when assessing the risk they pose to themselves, static risk factors such as their age, previous experience of custody and history of self-harm must also be viewed objectively and given due weight. We have interviewed many members of staff and prisoners who saw the man the day before he died, and it is clear that they did not notice any signs that he might harm himself. However, as the clinical reviewer has noted, the initial risk assessments did not fully take into account his pre-existing level of risk.
78. The clinical reviewer also examined the management of the man's depression while he was in prison. He noted that his community GP had prescribed sertraline and offered him counselling. His mental state was noted several times between November 2012 and January 2013. On 26 November, he was described as pleasant in manner and said that he felt fine. However, by 4 December, he said that he felt down as he was in prison, was not sleeping well and had some family issues. He said that he did not have any suicidal thoughts. On 11 December, he saw the mental health in-reach team but said he did not want any help as he did not think that prison was the right place to deal with his emotions. He said that he had no thoughts of suicide. On 18 December, he was discharged from the in-reach team caseload. On 1 January, he saw a mental health nurse, who did not note any concerns.
79. The clinical reviewer notes that a validated depression assessment tool was not used to monitor the man's mental health. He also notes that his depression was not treated in line with NICE guidelines, which set out the amount of contact a person who is on anti-depressants should have. As he was under 30 years old, according to the guidelines he should have been seen after one week and "frequently thereafter" until the risk (of self-harm) was no longer considered clinically important.
80. The clinical reviewer concludes that neither the assessment of risk nor the man's depression was managed in accordance with NICE guidelines. It is clearly important that the management of these issues is in line with national standards. We make the following recommendation:

The Head of Healthcare should ensure that assessment of risk of self-harm and the management of depression are in accordance with NICE guidelines.

The man's return to Altcourse on 21 December

81. The man's family have asked us to establish why he returned to Altcourse after his court appearance on 21 December 2012 rather than Lancaster Farms. Altcourse is the main prison for young adults serving the courts in Merseyside. We do not have any concerns that he returned there. Although he alleged that he had a fight at Altcourse before transferring to Lancaster Farms in 2011, he did not mention this when he returned to Altcourse on remand on 23 November 2012. In a telephone call to his mother on 22 December, he said that he did not want to return to Lancaster Farms, and was considering putting in an application to make sure he stayed at Altcourse for as long as possible.

Response to the assault on 29 December

82. After a prisoner alleged that he had been assaulted on 29 December 2012, the man was quickly identified as being one of the potential perpetrators. He was identified both by an officer on duty and from CCTV footage as being likely to have been involved.
83. Altcourse has an Incentives and Earned Privileges (IEP) scheme which is described as providing a "scheme of structured incentives based on prisoner behaviour and a willingness to co-operate, whilst maintaining the requirements of security, control and safety". There are four levels under the scheme (numbered 1, the lowest, to 4, although level 1 is often referred to, including in official documentation, as the basic regime).
84. Section 6.4 of the scheme deals with demotion from one level to another. One of the reasons given for a possible demotion is set out as follows:

"Any prisoner who commits an assault against a member of staff or prisoner will be demoted to the Managed Regime Level 1 after an investigation has taken place regardless of the current IP level and previous pattern of behaviour under the zero tolerance set out by G4S and NOMS".
85. It is clear that, under the scheme, the incident which took place on 29 December would be of sufficient severity to meet this criteria. The investigator spoke to a security manager at Altcourse about decisions to demote a prisoner under the scheme. He explained that being involved in an alleged assault is considered under the anti-social behaviour policy and, even if the victim decides not to press charges or withdraws their allegation, action can still be taken using the IEP scheme. He gave examples of evidence as CCTV footage and seeing prisoners coming out of another prisoner's cell (as happened in this case) as being enough to trigger action under the scheme.
86. We have considered whether the decision to reduce the man to Level 1 under the IEP scheme was appropriate. He did not contest this decision, and there was evidence from both the officer and CCTV to suggest that he was involved in some way. We appreciate that schemes such as this, which promote

safety in prisons, are important in maintaining discipline and acceptable standards of behaviour. However, in this case there seems to be very little documentation detailing the evidence for the decision, or any evidence that he was given any chance to give his version of events. We are surprised that a disciplinary charge was not laid for either the assault or his refusal to return to his cell. These hearings would have given him a chance to explain his actions. However, we believe that the decision to place him on level 1 was appropriate.

87. Nevertheless, we are concerned that the effect of this was to leave the man without any occupation in his cell. As a result of being on the basic level he had no TV, which he mentioned as an issue to his mother in his telephone call of 1 January. That evening he requested a book which would indicate he had no reading material to distract him. He was unable to get one as the prison was in night state. It is also apparent that he had no radio as he attempted to borrow one from another prisoner. Although he had not been identified as at risk of suicide and self-harm, it is a concern that a young person should be locked in a cell for long periods, particularly during the holiday season without any means to distract themselves at times when they might be feeling vulnerable. We make the following recommendation:

The Director should ensure that prisoners on the basic level of the Incentives and Earned Privileges Scheme and those segregated under Prison Rule 45/YOI Rule 49 have reading materials and a radio to occupy themselves in their cells.

Response to accusations of threats on 30 December

88. The man and his cellmate refused to return to their cell on 30 December. The man said he was being threatened, although he refused to give any further details when pressed. However, because of their refusal, both prisoners were segregated under YOI Rule 49 (good order and discipline) but were not charged with any disciplinary offence. At his review on 1 January, he was recorded as saying that he was happy with this arrangement. There was no indication at the review that he was considering harming himself.
89. There does not appear to have been any consideration of the man's previous history of depression and mental health issues when deciding to place him under CSU conditions, or during the review. Although he said that he was fine with the arrangements, they necessarily meant that he was more isolated, which in itself would be a factor suggesting increased risk for self-harm. We believe that the decision to place him in CSU conditions should have been taken while fully considering his history of depression and his relatively recent suicide attempt. This is largely the responsibility of healthcare staff, to ensure that the authorising officer is fully aware of mental health issues. We make the following recommendation:

The Director and Head of Healthcare should ensure that the mental health history of a prisoner is taken into account when making decisions to segregate under Prison Rules.

90. We have considered whether staff at Altcourse should have done more to investigate the threats that the man said he had faced. When interviewed about the CSU review on 1 January, the Security Manager said that he had asked him about the threats, but that he had given him very little detail. The cellmate has given two different accounts of who he felt was threatening him and the man (to the Violence Reduction Manager and to the investigator). However, there was an intelligence report which suggested that there were two named prisoners involved in threatening the man. This information does not seem to have been shared with those responsible for his care, or investigated further. While there is no evidence that the threats contributed to his death this could have caused him some anxiety. It is clear that there was enough information held by the prison for staff to have investigated the threats further. We make the following recommendation:

The Director should ensure that all intelligence relating to potential bullying is shared and investigated appropriately.

Family liaison

91. The man's mother asked us to establish why she had not been properly informed of the Coroner's procedures. It is clear from the family liaison officer's records that there was confusion about arrangements for viewing his body at the hospital. However, the family liaison officer was acting on information that he had received from the police. While this was unfortunate, we believe that he acted appropriately.
92. The man's mother also asked why she had not been told that tissue samples might be retained. She thought that the FLO should have explained this to her. We have referred to the Prison Service policy which deals with liaison with families following a death in custody, chapter 13 of PSI 64/2011. The policy states that family liaison officers should refer matters about the inquest to the Coroner's Officer, and suggests that the family liaison officer should prepare families for what they might see when they view a body. However, there is no guidance about informing families about post-mortem procedures. In this case, therefore, we do not consider that the FLO acted inappropriately in not informing the family that tissue samples might be retained, about which he was unlikely to be aware. However, the Director might wish to consider liaising with the Coroner about what information should be given to families and by whom about post-mortem procedures.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that assessment of risk of self-harm and the management of depression are in accordance with NICE guidelines.
2. The Director should ensure that prisoners on the basic level of the Incentives and Earned Privileges Scheme and those segregated under Prison Rule 45/YOI Rule 49 have reading materials and a radio to occupy themselves in their cells.
3. The Director and Head of Healthcare should ensure that the mental health history of a prisoner is taken into account when making decisions to segregate under Prison Rules.
4. The Director should ensure that all intelligence relating to potential bullying is shared and investigated appropriately.

ACTION PLAN: The Man - HMP Altcourse

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that assessment of risk of self-harm and the management of depression are in accordance with NICE guidelines.	Accepted	<p>The Head of Healthcare will ensure processes and protocols are in place to allow clinical staff to manage all offenders that require assessment for both self harm and depression effectively and in accordance with NICE guidelines.</p> <p>Processes and protocols available include referrals for both mental health and ACCT concerns, GP appointment and assessment for suitability for medication, counselling interventions, referral to In-reach Services and psychiatrist.</p>	1 st October	
2	The Director should ensure that prisoners on the basic level of the Incentives and Earned Privileges Scheme and those segregated under Prison Rule 45/YOI Rule 49 have reading materials and a radio	Accepted	<p>Additional radios will be purchased and made available for use with those offenders separated within the Care and Separation Unit and for those prisoners on basic regime who do not have one in their possession.</p> <p>All prisoners will be offered access to reading materials.</p>	1 ST November	

	to occupy themselves in their cells.				
3	The Director and Head of Healthcare should ensure that the mental health history of a prisoner is taken into account when making decisions to segregate under Prison Rules.	Accepted	Prior to completion of safety algorithm, the nursing staff will check system 1 records and any history of mental health will be noted on the algorithm. Any concerns will be raised with Duty Director.	1 st October 2013	

4	The Director should ensure that all intelligence relating to potential bullying is shared and investigated appropriately.	Accepted	<p>All intelligence relating to potential bullying is shared via a security action plan. This is then issued to the Safer Custody Team or the relevant Residential Manager who will investigate any concerns appropriately and feedback accordingly.</p> <p>On completion of the investigation appropriate action, if necessary will be taken as required within Anti-Social Behaviour Strategy, this will be documented in the prisoners ASB booklets.</p> <p>All prisoners now placed on ASB complete a questionnaire which is returned to Safer Custody and forms part of their individual ASB booklet</p> <p>A multi-disciplinary team now meets weekly to review progress of each offender on the ASB strategy.</p> <p>Prisoner identified will attend an ASB course.</p>	Complete	
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