

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Altcourse on 4 September 2014**

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 hanged in his cell at HMP Altcourse on 4 September 2014. He was 20 years old. I offer my condolences to his family and friends.

One of my investigators carried out the investigation and a clinical reviewer was appointed to review the man's clinical care in prison. The prison cooperated fully with the investigation.

The man was arrested after it was alleged he had falsely imprisoned, assaulted and threatened to kill his girlfriend. He was remanded to HMP Altcourse on 28 August 2014. He had a history of self-harm and a probation officer faxed a suicide warning form to the prison. No one identified him as at risk of suicide and self-harm and only the reception nurse said that she had seen the warning form.

On his first night at the prison, his uncle phoned to alert prison staff to his concerns about the man's state of mind. There is little written evidence about the prison's response to this call. The man went to hospital twice in his first two days in prison for treatment for a testicular problem. On his second day, his girlfriend told him that their relationship was over. Several days later, his offender supervisor told him that he was not allowed to contact her. He appeared to accept this, but agreed to see a counsellor to discuss his relationship problems. The next morning, an officer found the man hanged in his cell.

I am concerned that reception staff did not identify that the man might be at risk of suicide despite his offence and history of self-harm. There was no process to ensure that all the staff who assessed him saw the suicide warning form sent by the probation officer and it does not appear that all the staff understood what risk factors to look for. I am also concerned that staff did not handle information from the man's uncle appropriately and that he was allowed to telephone the victim of his alleged offence numerous times, which should not have been allowed to happen.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2015

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SUMMARY

1. The man was arrested on 27 August 2014 and charged with threats to kill, false imprisonment and grievously bodily harm with intent. He had been in prison before. He was 20 years old and had a history of self-harm. His 17 year old girlfriend was the victim of his alleged offences. He appeared in court the next day and was remanded to HMP Altcourse.
2. A probation officer had faxed a suicide warning form to the prison shortly after he arrived, which included information that the man had cut his arms in 2013. A nurse in reception saw the form but it does not appear that any of the officers saw or considered the warning form. No one in reception staff considered that the man was at risk of suicide or self-harm despite his evident risk factors including his age, the nature of the charges he was facing, his history of self-harm and the suicide warning form. The staff appear to have based their assessment principally on how the man appeared.
3. Although his alleged victim was named on his remand warrant documents, an officer allowed the man to telephone her. Over the next two days, he tried to speak to her 11 times before getting through. She told him their relationship was over and that she would not drop the charges against him.
4. The police later asked Altcourse to prevent the man from contacting his girlfriend and, on Wednesday 3 September, his offender supervisor told him this. He said that he was very upset about this, but had no thoughts of suicide or self-harm. His offender supervisor suggested he might benefit from counselling, and he eventually agreed to this. His offender supervisor told the investigator that she was aware of his history of self-harm and thought that he was low in mood, but she did not think that he was at risk of suicide or self-harm.
5. Shortly after 5.10am on 4 September, a prison officer checking prisoners found the man hanged in his cell and called for help. An officer radioed an emergency and the control room called an ambulance. Officers and nurses attended. It was apparent that the man had been dead for some time and the staff did not try to resuscitate him. Paramedics arrived and, at 5.22am, pronounced him dead.
6. Reception staff who assessed the man's risk of suicide and self-harm relied too much on his personal presentation at the time, rather than his known risk factors, including the charges he was facing and his history of self-harm. We are concerned that only the nurse in reception appears to have seen the suicide warning form and that information from the man's uncle was not fully taken into account. After he arrived at the prison, the man did not receive a secondary general health assessment, which might have provided another opportunity for staff to assess his risk. It was inappropriate that the man was allowed to call the victim of his alleged offence and having to stop him contacting her subsequently, caused him further distress. We make three recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.
8. The investigator obtained the man's prison medical records and relevant extracts from his general prison record. NHS Lancashire Team, commissioned a clinical reviewer to review the man's clinical care in custody. In October 2014, the investigator interviewed staff and prisoners at Altcourse.
9. We notified HM Coroner for Liverpool of the investigation who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted the man's uncle about our investigation. He asked us to clarify why the man had been admitted to the prison's healthcare unit and why he had asked to see a counsellor. He wanted to know whether there was any evidence that he had been bullied or involved in a fight, in the days before he died. (The investigation found no evidence of a fight or that the man had been bullied.)
11. The man's uncle said that he had telephoned the prison twice because he was concerned about the man, who had a history of self-harm and a mental capacity younger than his actual age. He asked us to consider why Altcourse did not start suicide and self-harm monitoring, as they had done when he made a similar call when the man had previously been in prison.
12. The man's family received a copy of the draft report. The solicitor representing them 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&YOI ALT COURSE

13. HMP Altcourse is a local prison in Liverpool which takes 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 remanded adult and young adult men. G4S runs the company that provides primary healthcare services at the prison. Prime Care provides secondary mental health services.
14. Altcourse is made up of seven houseblocks, divided into individual units. These units hold between 60 and 95 prisoners. The man lived on Melling Brown, the induction unit.

HM Inspectorate of Prisons

15. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Altcourse in June 2014. Inspectors noted that suicide and self-harm prevention procedures were very good and emergency response procedures were effective. They were concerned that the number of reported incidents of bullying had increased, largely as a result of the availability of new psychoactive substances (sometimes known as 'legal highs').

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year ending June 2014, the IMB noted a dedicated safer custody team had continued to help keep HMP Altcourse a safe prison for both prisoners and staff.

ACCT - Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Altcourse

18. There were two self-inflicted deaths at Altcourse between January 2013 and the man's death. There were no significant similarities with the circumstances of those deaths, except one was also just 20 years old.

KEY EVENTS

19. The man had served several custodial sentences custody, during which he had twice been managed under the Prison Service's suicide and self-harm prevention procedures, known as ACCT. In December 2011, he had harmed himself by punching a wall and in August 2012, while at Altcourse, he made superficial cuts to his arms. During this sentence, he said that he was hearing voices. He saw a psychiatrist several times, but the voices were eventually attributed to his use of drugs. (He said that he had frequently used cannabis in the community.) He was released in May 2013.
20. The man's medical record indicated that he had cut his arms on 14 June 2013, after he was arrested on charges of battery, although he denied doing so when prison healthcare staff spoke to him about this the next day. The man had been released from Lancaster Farms Young Offenders Institution in March 2014, after serving a sentence for kidnapping and assault.
21. On 27 August 2014, the man was arrested and charged with threats to kill, false imprisonment and grievous bodily harm with intent. The offences were alleged to have taken place on or between 24 and 27 August, against his 17 year old girlfriend.

Thursday 28 August

22. On 28 August, the man appeared at South Sefton Magistrates' Court. Merseyside Police completed a person escort record form (PER – which accompanies all prisoners when they move between police stations, courts and prison). An officer noted the man's alleged offences and that he had harmed himself by making cuts to his arms on 14 June 2013. No one noted any substance misuse, medical or mental health risks, or medications on the escort record. Magistrates remanded the man to custody. He was scheduled to appear at Liverpool Crown Court on 11 September.
23. Before the man left court a court custody officer, completed form F2050 for his transfer to prison. This form contained the man's personal details and identified his father as his next of kin. The court custody officer told the investigator that he had no concerns about the man when he spoke to him to obtain the information for the document. He was not aware of any concerns about suicide or self-harm being raised at court.
24. The man arrived at HMP Altcourse at 1.30pm. The warrant charge sheet from the court outlined the three charges against him. The victim of his offence was named in the court document. She was not identified as the man's girlfriend, or that she was under 18, although there was a reference to the Children and Young Person's Act. Documents also recorded that the court had rejected a bail application, partly to reduce the opportunity for the man to contact the victim and other witnesses. Prison reception staff received these documents along with the PER and had access to his NOMIS (prison computer system) record, which showed that he had been identified as a risk of suicide and self-harm in 2011 and August 2012.
25. The admissions manager booked the man in at the reception front desk which he estimated took approximately five minutes. He checked the man's PER,

NOMIS record, court warrant, personal and next of kin details and asked him if he had any physical or mental health concerns. The admissions manager told the investigator that the man did not arrive with a suicide or self-harm notification warning form, and said that he had asked him general questions about his well-being and had had no concerns about him.

26. Officer A, a first night centre officer working in the reception area, interviewed the man and completed a New Admissions pro-forma. He recorded that the man was on remand and was last in prison at Lancaster Farms. The man told him his alleged offences were against his girlfriend and said he did not abuse drugs or alcohol. The officer recorded the man's father as his next of kin. The officer explained the prison rules and the man did not say he had any concerns.
27. Officer A told the investigator that he used the man's PER and NOMIS records as sources of information when they spoke. However, he did not recall seeing any information about the man's previous self-harm history on his NOMIS record. (On the man's NOMIS record, there were two alerts that he had been on ACCT in 2011 and 2012, and another record that he had harmed himself in the community in 2013.) The officer said that the man told him that he had no history of self-harm. Despite the information available to him, the officer did not complete a section at the top of the Admissions pro-forma to show that the man had previously been managed under ACCT procedures.
28. At 3.05pm, a Merseyside Probation Trust probation officer based at South Sefton Magistrates' Court sent a suicide warning form to the reception unit at Altcourse. She had seen a marker on the probation database which indicated that the man was at risk of suicide and self-harm. She noted that she had been unable to access the man's probation records for further information, and that court staff did not have any other information.
29. Officer B completed the man's cell sharing risk assessment (CSRA). (The CSRA is used to determine whether someone would present a risk of violence to another prisoner in a shared cell.) The officer told the investigator that another member of staff had already completed some of the required information on the form, including the man's alleged offences. In the comments section, it was noted that the man was violent and had a history of racist views, bullying, high CSRA assessments and being supported by ACCT.
30. Officer B completed the remainder of the cell sharing risk assessment. The man told the officer that he had no current thoughts of suicide and self-harm and was not worried about being at Altcourse. The officer told the man that he would be given a single cell because of his risk of violence to others.
31. Officer B gave the man a telephone record sheet to complete. The man added the contact telephone numbers of people he intended to call, which included his girlfriend's number. The officer told the investigator that, unless he had received official confirmation that a number was restricted, a prisoner could initially call any number they had identified. (After the reception process, the phone record sheet is sent to the security department where the phone numbers are checked.)
32. At 3.10pm, a mental health nurse, A, saw the man for a reception health screen. At interview with the clinical reviewer, she said that prison staff gave

her the man's prison record along with his warrant, Person Escort Record and the cell sharing risk assessment form. The suicide risk warning form, faxed by the Merseyside Probation Trust probation officer, was inside the front cover of the core record. The nurse recorded the man's weight, height and blood pressure. He told her that he did not drink alcohol but had used cannabis in the previous month. The nurse told the investigator that she would not consider a prisoner's offence as a risk factor when assessing for risk of suicide and self-harm, unless he had been given a life sentence.

33. Nurse A recorded in the man's medical record that he was settled, engaged well and maintained good eye contact. He said that he had used cannabis in the last month. She asked the man about the suicide warning form and he told her that the information related to an incident that had taken place over a year earlier. He said that he did not have any current thoughts of suicide or self-harm. He did not want to see the prison doctor. The nurse said that she did not mention the suicide warning form or discuss it with other staff in reception as she had presumed they were aware of it. She had no concerns about the man.
34. Shortly before 4.00pm, the admissions manager spoke to the man again and reviewed his cell sharing risk assessment. He endorsed the decision that the man should be located in a single cell because of his risk to other prisoners. He noted in his prison record that the man had a history of self-harm, but had no current thoughts of wanting to harm himself.
35. Officer B arranged for the man to have a free two minute phone call, as is standard for new prisoners. The man tried to ring his girlfriend four times but did not get through. There is no evidence that anyone at Altcourse considered the man's alleged offence or the possibility that he might try to contact his victim or a witness in his case when allowing him to make calls.
36. Officer A took the man to the prison's first night centre, the Melling Brown Unit. Another prisoner, A, a trained peer supporter, spoke to the man and gave him information about the unit. Officer C checked that he was okay about being given a single cell and located him in cell number 14. This was around 4.55pm. All new prisoners at Altcourse are observed twice an hour on their first night.
37. Later that evening, around 7.45pm, the man said he had pain in his lower abdomen and Officer C asked Nurse B to examine him. The nurse noted in the man's medical record that she had found him sitting on his bed crouched over in pain. He had tried to climb onto the top bunk but had fallen down because of severe pain in his testicles and lower abdomen. The man told her that he had had the same problem four years earlier, when the tubes in his testicles had twisted and he had a hernia above his pubic bone. Nurse Nesbitt took him to the healthcare unit in a wheelchair for further assessment.
38. At around 8.15pm, the prison doctor examined the man and decided he should be assessed in hospital. To avoid having to wait some time for an ambulance, officers took the man to the local accident and emergency department in a prison vehicle.
39. That night, the man's uncle phoned the prison at 11.47pm and 11.54pm. He spoke to an officer, who was working in the prison's control room. The officer

told the investigator that the man's uncle had asked if his nephew was at Altcourse, said that he was concerned about his vulnerability and that he had a history of self-harm. The officer told the man's uncle that all new admissions into the prison were monitored during their first night but, if he had any further concerns, he could phone back in the morning and to speak to the Safer Custody team. He did not give his uncle any personal details about the man as he was unable to verify his identity over the phone.

40. The officer who was working in the prison's control room did not record his contact with the man's uncle anywhere, but he phoned the night duty operations manager and told him about the conversation. The night duty operations manager told the investigator that he knew that the man had been taken to hospital and he contacted the escort officers to check on him. There is no record of this on the escort log. He told the investigator that both officers had said that, although the man was in pain, they did not have any concerns about his mood or demeanour. No one informed staff on Melling Brown Unit that the man's uncle was concerned about his state of mind.

Friday 29 August

41. At 2.40am, the man came back to the prison from hospital. Doctors had diagnosed orchitis (an inflammation of the testicle which is caused by an infection) and had given him antibiotics. The man told Nurse C that he was not currently in pain and was happy to go back to his cell.
42. The night duty operations manager said he had spoken to the man after he got back from hospital and was satisfied that there was no need to be concerned about him. The man told him he was okay, but was tired and wanted to go to bed.
43. In the morning, as part of his induction, staff explained more prison rules and procedures and the man saw staff from a number of agencies who work in the prison, including someone for the chaplaincy team and a peer supporter. He had an induction to the gym. No one recorded any concerns about him.
44. Between 1.27pm and 2.29pm, the man made seven telephone calls to his girlfriend and one to his father. All the calls went to voicemail. At 2.29pm, the man managed to speak to his girlfriend. Transcripts of the calls show that the man was upset and believed his girlfriend would end their relationship. He asked her to drop the charges against him and to say that her injuries had been self-inflicted. The man's girlfriend told him that she could not have snapped her own jaw in two places and that there was nothing she could do about the charges against him. The man said he loved her and believed they could still make their relationship work.
45. A resettlement officer saw the man for about five minutes at about 2.30pm to check if the man had any housing or employment concerns. The resettlement officer said that the man gave him all the information he needed and he did not have any concerns about him. The man did not mention that he had spoken to his girlfriend.
46. The man phoned his girlfriend again at 2.34pm. She was upset, said she did not love him and told him that she was not allowed to speak to him. She told

the man to plead guilty. The man said they could make their relationship work. His girlfriend told him that their relationship was over and she would not support him any longer. She told him that her mother had phoned the police to tell them that he had contacted her. The man was upset and again begged her to say that her injuries were self-inflicted. She refused.

47. The reception nurse automatically refers prisoners to the primary mental health mental health team who arrive with a history of mental health problems or self-harm. A mental health nurse, C, recorded in the man's medical record at 3.14pm that she had tried to assess the man, because of the suicide warning form. The man was polite but would not engage with the assessment and said that he had no history of deliberate self-harm and had no immediate concerns about his mood or mental health. The nurse recorded that she had reminded the man of the prison's support networks and how he could access the mental health team if he felt his mood was deteriorating.
48. At 4.45pm, a police officer from the Sefton Vulnerable Persons' Unit (an agency to support victims of domestic abuse) sent an urgent email to the prison intelligence department. The email noted that the police had just left the man's girlfriend's home, and that she was distressed by his action and being called by him. The email asked for some action to be taken.
49. Later that evening, the man again experienced pain in his testicles. A nurse arranged for him to go to hospital and he left Altcourse at around 10.20pm.

Saturday 30 August

50. The man was discharged from hospital and arrived back at Altcourse at 2.35am. As the escort vehicle went through the prison gate, the man told staff that he felt unwell. When he got out of the vehicle he was unsteady and vomited. Nurse C took the man to the healthcare centre. He told her that the hospital had given him some strong pain relief (ibuprofen) and he had not eaten for a while. The night duty operations manager spoke to the man on the way to the healthcare unit. He said that the man was in pain but laughed about his situation.
51. The man stayed in the healthcare centre overnight for observation. At 6.48am, Nurse C noted that he had had a settled night and had not experienced any further nausea, vomiting or pain.
52. At 8.31am, the prison's police liaison officer, replied to Sefton Vulnerable Persons' Unit for further information about his alleged victim so that the prison's security department could take action.
53. At 1.22pm, Nurse D recorded that the man had not passed urine since the previous evening. He was still in discomfort and had vomited in the morning. She referred him to see the prison doctor.
54. Dr A saw the man shortly afterwards and told healthcare staff that they should continue to give the man pain relief. Nurses used a chart to monitor his fluid balance and said that he would not be able to go back to his unit until he had passed urine. He did so, shortly afterwards and at 2.14pm, Nurse E recorded that the man was fit to return to his cell.

55. Prison Service instructions state that in the 72 hours after the first reception every prisoner should be offered a general health assessment. There is no record that the man was offered an assessment.

Monday 1 September

56. On the afternoon of 1 September, Officer D completed the man's induction. The officer told the investigator that the man did not raise any concerns with him. Induction officers at Altcourse are required to complete a form for the public protection unit with the details of victims in cases of potential domestic violence. The investigator could not find a copy of this document in the man's prison records. The officer told the investigator that he could not remember if he was aware that the man's girlfriend was the victim of his alleged offence. He thought that reception staff normally initiated the form, when a prisoner first arrived.
57. At 7.29pm, Officer C contacted Nurse F as the man said he had accidentally cut himself trying to get onto his bunk bed. The officer told the investigator that she saw nothing to suggest that this was not an accident, and that they found a razor sharp piece of metal, which the man had known nothing about, concealed in the mattress. The man was taken to the healthcare unit where staff dressed a cut on his right forearm.

Tuesday 2 September

58. That afternoon, the security department barred any outgoing prisoner phone contact to the man's girlfriend's telephone number. The prison had her address to screen the man's and any future cellmate's mail, in case the man tried to contact her indirectly. That evening, Nurse G gave the man his paracetamol and noted that he appeared settled and was trying to sleep.
59. At about 9.00pm, the man was taken to the healthcare unit again, suffering from severe abdominal pain. Dr B gave him paracetamol through an intravenous drip and asked nurses to observe him every four hours. The night duty operations manager also checked the man. The night duty operations manager said that although the man was uncomfortable, he was polite and raised no concerns and showed no signs of being at risk of suicide or self-harm.

Wednesday 3 September

60. Healthcare staff observed the man throughout the night. They did not record any problems and said he appeared settled and slept well. At around 5.00am, Nurse H examined the man and took his clinical observations (temperature, oxygen saturation level and blood pressure). The man said that he was in pain and had to be supported to get to the toilet so that he could give a urine sample. At 5.15am, he was given more paracetamol intravenously. He then became more settled.
61. Nurse C and Dr B saw the man between 10.00am and 11.00am. The nurse had told the doctor that the man's presentation was inconsistent and that he appeared to be in pain only when he was directly observed. At other times, he

appeared free from pain, and nurses had seen him walking around the healthcare unit talking to other prisoners. The man told the doctor he wanted to return to his cell on Melling Brown. The doctor recorded in the man's medical record that he was fit to move and he went back to the unit that day.

62. On 3 September, the man's offender supervisor, reviewed his OASyS report (an assessment of risk and needs completed by the Probation Service). She contacted his community probation officer and established that he had previously been convicted in 2013 for assaulting his girlfriend, who was 16 years old at the time. His current charges were against the same girlfriend.
63. The man's offender supervisor told the investigator that she did not know that the man had called his girlfriend or that the security department had subsequently barred telephone contact with her. She saw him that morning and told him that he should not contact his girlfriend, by phone or by letter and made sure he understood this. The man said he had already received a letter from his girlfriend. He did not say that he also phoned her since he had arrived in prison. (There was no copy of a letter from his girlfriend in the man's records that we received.)
64. The man's offender supervisor completed an initial risk assessment form and noted that the man was subject to harassment procedures and that the prison's Offender Management Unit had not received the man's phone record sheet. The man was not happy about the contact restriction but told her that he understood the reasons. The man said that he felt gutted but could cope in prison. He said that, although he had harmed himself in the past (by cutting his arms), he did not have any current thoughts of suicide or self-harm.
65. The man's offender supervisor told the investigator that she assessed the man while she interviewed him and she had no concerns that he would self-harm. She reminded him that he could get support from Carers (prisoner peer supporters), the Samaritans and counsellors if he found it difficult to cope. After initially declining, the man asked her to refer him to the prison's counselling services, which she did. He said he would not want to share any personal information with another prisoner. The man's offender supervisor noted on the referral form that the man's mood was low because of his relationship issues and he was anxious at not knowing how long he might have to spend in prison. When interviewed, she said that the man did not appear low, but she thought that he might go away and struggle later on. However, she said that there was nothing in the interview to make her think she needed to open an ACCT.
66. Officer E told the investigator that she spoke to the man several times when he was in the healthcare centre and Melling Brown Unit. He did not mention any thoughts of suicide or self-harm and was generally friendly. He had asked her several questions about the prison, including how the telephone and mail systems worked. He talked about his alleged offence and his girlfriend. He was also concerned that he was waiting for some money to be sent in to him, so that he could buy some items from the prison shop and anxious about his possible sentence. The officer told the man that he would be paid some money when he completed his prison induction.
67. On 3 September, Officer E said that the man had appeared okay. He had mixed with other prisoners in the afternoon, and played table tennis. Prisoner

A, the prisoner peer supporter, told the investigator that the man seemed normal and happy that afternoon.

68. Prisoners are locked in their cells at around 5.10pm for an evening roll check and then are unlocked again at 5.45pm for the evening meal and association period. Officer C started to lock prisoners into their cells for the night at 6.28pm. Just before she locked the man in his cell, Officer E had to deal with another prisoner who had refused to go into his cell. The man had asked if she was okay and then went into his cell. Officer E had no concerns about him.
69. Officer C did a further roll check at around 8.00pm. She told the investigator that the man was sitting on his bed at the time and there was nothing to indicate any concern. Officer F and Officer G began a night shift on the unit at about 8.30pm.

Thursday 4 September

70. The man did not use his cell bell during the night. At 5.10am on 4 September, Officer F began a roll check on the first landing. In a statement for the police, he said that he had opened the observation panel on the man's cell door at 5.13am. It was dark, so he shone his torch into the cell. He saw the man hanging with one end of a curtain tied around his neck and the other end tied to the window. He was in a sitting position facing towards the cell door and was fully dressed. The officer shouted to Officer G for help.
71. Officer G told the police that he arrived at the man's cell door in seconds and radioed a code one emergency, which indicates circumstances such as when a prisoner is unconscious or not breathing and should alert the control room to call an ambulance immediately. According to their log, the control room called an ambulance at 5.13am. For security reasons, prison staff on residential units do not usually carry keys at night, but have a cell key in a sealed pouch for use in an emergency. The officer broke the seal on his pouch, unlocked the cell and he and Officer F went in. He cut through the curtain with an anti-ligature knife while Officer F supported the man's body. Officer G and Officer F (who were both first aid trained) said that the man looked as if he had been dead for some time. He was not breathing and showed no signs of life. His blood had started to pool on his skin and his body was stiff.
72. The night duty operations manager, Nurse H and Nurse I responded to the code one. Nurse H and the night duty operations manager brought the medical emergency response bag to the man's cell. (The bag contained a defibrillator, oxygen and other medical equipment). They arrived at the cell within a minute.
73. Nurse H examined the man. He had no pulse, his skin was blue and mottled and he was cold and stiff. The nurse concluded that the man had died and that it would be inappropriate and futile to attempt resuscitation. Nurse I had arrived at the cell within two minutes with additional emergency equipment. She also did not find any signs of life and agreed with Nurse H that it would be inappropriate to attempt resuscitation.
74. Two ambulances arrived at the prison gate, at 5.16am and 5.19am respectively. At 5.22am, paramedics pronounced the man had died.

After the man's death

75. At 7.00am, the Director of Altcourse and the duty director debriefed the staff involved in the emergency and offered them support. Members of the staff care team attended. No concerns were identified. The unit manager on Melling Brown, spoke to every prisoner on the wing, with Officer C and a prison chaplain, to tell them what had happened and to offer support. Staff checked prisoners subject to ACCT monitoring in case they had been adversely affected by the man's death.
76. The prison's family liaison officer, and the chaplain, visited the man's father at 8.55am to break the news of his death and offered condolences. The prison contributed towards the cost in accordance with Prison Service guidance. The man's funeral was held on 18 September. A memorial service was held in the prison chapel on 22 September.
77. On 9 September, the prison's security department received information from unknown source that, the day before the man's death, an unidentified prisoner had given the man some drugs (possibly black mamba, a new psychoactive substance) because his mood was low. There is no other evidence of this.

Post-mortem

78. The post-mortem examination found that the cause of the man's death was compression of the neck as a result of hanging. The toxicology report indicated that the man had taken cannabis, although the toxicologist could not determine how recently.

ISSUES

Assessing risk of suicide and self-harm

79. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, first time in custody, being charged with a violent offence, in particular against a family member, substance misuse, relationship instability and a history of mental health problems. New prisoners must be interviewed in reception so that staff can assess their risk of suicide or self-harm. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including opening an ACCT if necessary. The PSI clearly states that information received should be shared and acted upon appropriately.
80. The man had been charged with seriously assaulting his girlfriend, falsely imprisoning her and making threats to kill her. He was also young, only 20 years old, had just arrived in custody and had a history of self-harm. These factors were significant indicators of a heightened risk of suicide and self-harm.
81. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we identified that, too often, assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. The members of staff we interviewed at Altcourse who spoke to the man after he arrived, all said that they were not concerned about his presentation. Nurse A, who interviewed the man on the day he arrived, told the investigator that she did not consider a prisoner's offence as part of her consideration of risk unless they had been given a life sentence. In a Learning Lessons Bulletin of July 2014, in which we looked at issues arising specifically from the self-inflicted deaths of 18 to 24 year old prisoners, we again noted that risk assessments too often relied too heavily on a prisoner's presentation and their own assurances that they had no thoughts of harming themselves. We consider that staff should have begun ACCT suicide and self-harm monitoring procedures when the man arrived at Altcourse.
82. The probation officer at court, sent a suicide warning form which arrived shortly before the man saw Nurse A. The form was attached to the man's prison record before this meeting. It is not clear who attached it but it must have been another member of staff in reception. Nurse A asked the man about the information on the form and he said that it referred to events over a year previously and that he had no thoughts of suicide or self-harm. The nurse did not discuss the form with officers as she assumed that they had already seen it.
83. Prison Service Instruction (PSI) 74/2011, about early days in custody, sets out mandatory reception procedures and requires reception staff to examine the 'Person Escort Record (PER) form that must accompany each new prisoner, and any other available documentation...to identify any immediate needs and risks already recorded'. Although the suicide warning form from the probation officer at court did not arrive at the same time as the man, it reached reception while he was still there. There is no evidence that any officer used this information when assessing the man's risk of suicide and self-harm and we are

concerned that this information was not used effectively to help assess the man's risk.

84. When the man arrived at Altcourse, he had several risk factors which should have alerted staff that he was at risk of suicide and self-harm, irrespective of the suicide warning form. It is a serious concern that processes designed to highlight risk for newly-arrived prisoners were not followed and staff responsible for assessing prisoners did not see all the relevant information about the man's risks. It does not appear that all the reception staff fully understood what risk factors to consider and did not balance these risks against his personal presentation. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Ensure that all sections of the reception and first night risk assessments are completed during the reception process when prisoners are first received into custody.**
- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**

85. Five days after he arrived at Altcourse, the man's offender supervisor, told him that he could not communicate with his girlfriend, the victim of his alleged offence. The man was upset but said he could cope with being in prison. He agreed to see a counsellor, at the offender supervisor's suggestion. The offender supervisor said that she considered the impact of the break in contact on the man and continually assessed his mood when she spoke to him. She knew about his history of self-harm. She reminded him of the support services that were available to him with in the prison and did not consider that the man was at risk of suicide or self-harm. She told the investigator that she saw no reason to open an ACCT.

86. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. Although we consider that there was sufficient reason for the offender supervisor to have opened an ACCT (he had been given bad news, had a history of self-harm and was low in mood), this was a judgement call. The fact that the man had agreed to counselling suggested that he was looking to the future at the time and the man's offender supervisor did not have the benefit of all the information that should have been available about the man's risk at the time, such as his uncle's concerns about his state of mind. We are satisfied that the man's offender supervisor assessed the man's risk in the round and used the information available to her, before making her judgement.

Handling information from families

87. The man's uncle telephoned Altcourse because he was concerned about him on his first night in prison. The officer he spoke to said he passed on the man's uncle's concerns to the night duty operation manager. At the time, the man was in hospital and the night duty operation manager said that he contacted the escorting officers to check how he was. The night duty operation manager told us that he spoke to the man when he returned from hospital to ensure he was okay. There is no written record of the telephone call from the man's uncle, no note of any of these conversations in the man's prison record, and no evidence that anyone passed on the information to staff at Melling Brown Unit. It is not clear that anyone explicitly discussed with the man his risk of suicide or self-harm at the time.
88. Prison Service Instruction 64/2011, which contains guidance on safer custody, states that:

All staff who receive information, including from concerned family members ... must communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan. [The italics denote that this is a mandatory instruction]

The instruction goes on to say:

Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form.

89. We do not consider that the prison dealt with the man's uncle's concerns appropriately. Information from families is very important and needs to be taken seriously as they are the people who know the prisoner best. While the control room officer appropriately passed on the information to the night duty operation manager, there is nothing to indicate that anyone considered whether to open an ACCT as a result of the information, as the PSI requires should happen. There is also nothing in his prison record to note his uncle's concerns. This meant that this information was not available to other staff if they needed it. We make the following recommendation:

The Governor should ensure, in line with PSI 64/2011, that staff report any concerns from families about a prisoner's state of mind to an appropriate manager, consider whether to open an ACCT and record the information and action taken in the prisoner's record.

Clinical care

90. The clinical reviewer concluded that the man's clinical care was comparable to that which he could have expected in the community. He noted that the man did not receive a secondary health screen as he should have done under Prison Service Order (PSO) 3050 (continuity of healthcare), which states that

every prisoner should be offered a general health assessment within the 72 hours following the first reception. Although this should have happened, we are satisfied that the man had appropriate contact with healthcare staff after his visits to hospital and admission to the healthcare centre. Although he did not engage, a mental health nurse assessed him on 29 August.

Public protection

91. The man was charged with a violent offence against his girlfriend. The court did not apply a restraining or harassment order against him contacting his girlfriend, but he was refused bail because of the seriousness of his alleged offence and to prevent any possible intimidation of witnesses. This information was contained on the warrant that accompanied him to Altcourse.
92. We are concerned that the man was able to contact his girlfriend by telephone after he arrived at Altcourse. While there was no clear instruction from the court, his alleged victim was named on the warrant and, as there was a reference to the Children and Young Person Act 1933, it should have been apparent to reception staff that she was under 18 years. We discussed this issue with the policy lead at NOMS, who told us that there are three relevant prison instructions, PSI 46/2011-Tackling Witness Intimidation by Remand Prisoners (Paras. 1.6, 3.2, 3.4 and 3.7), PSI 49/2011 - Prisoner Communication Services (Paras. 6.1 and 6.2) and PSI 74/2011- Early Days in Custody (Para. 2.42). The policy lead told us that, in her opinion, the fact that there was some relevant information available to staff on the warrant that should have made staff consider the policy in PSI 49/2011 at para. 6.2; when deciding who the man should have been allowed to call. This paragraph of PSI 49/2011 states:

"If the prisoner is subject to, or likely to be subject to, public protection restrictions (including an identified risk of intimidating victims or witnesses) ... a member of staff should make the [telephone] call on the prisoner's behalf, checking that the recipient is willing to receive the call in the first instance".
93. The Admissions Manager told the investigator that reception staff would normally not allow a prisoner to contact someone identified at risk by the police or court. Officer B told us that unless he received confirmation that a prisoner should not contact a specified individual, he would allow them to call anyone identified on their phone record sheet.
94. Although the court warrant did not specifically identify the man's girlfriend, we consider that there was enough information for officers to have prevented the man from calling her. When he eventually spoke to her, it caused her great distress, which we believe could have been avoided had officers followed the provisions of PSI 49/2011. There needs to be clear guidance to reception officers about this. Preventing the man from contacting his girlfriend from the time he arrived might also have been less distressing for him than imposing this restriction five days later, after his girlfriend had, understandably, made her feelings towards him clear. We make the following recommendation:

The Director should ensure that reception staff review all documentation and consider any possible public protection issues before allowing a new prisoner access to the telephone.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:
 - Ensure that all sections of the reception and first night risk assessments are completed during the reception process when prisoners are first received into custody.
 - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
2. The Governor should ensure, in line with PSI 64/2011, that staff report any concerns from families about a prisoner's state of mind to an appropriate manager, consider whether to open an ACCT and record the information and action taken in the prisoner's record.
3. The Director should ensure that reception staff review all documentation and consider any possible public protection issues before allowing a new prisoner access to the telephone.



Action Plan: Roy Hoey – HMP/YOI Altcourse

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:</p> <ul style="list-style-type: none"> ▪ Ensure that all sections of the reception and first night risk assessments are completed during the reception process when prisoners are first received into custody. ▪ Have a clear understanding of responsibilities and the need to share all relevant information about risk. ▪ Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from 	Accepted	<p>The existing local guidance and procedures will be reviewed and reinforced to all staff in particular reception and first night staff.</p> <p>The Safer Custody team will provide a series of micro-teaching sessions to capture all staff involved in the 'early days' functional departments.</p> <p>A plan for this will be completed by 24 April and all training will be completed by 31st May 2015.</p> <p>The Safer Custody team will complete a 10% weekly check of CSRA documentation for all new receptions, which will be incorporated into the Directors weekly compliance meeting.</p>	<p>May 31st 2015 Head of Safer Custody</p>	

Action Plan: Roy Hoey – HMP/YOI Altcourse

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	suicide and self-harm warning forms and PERs.				
2	The Governor should ensure, in line with PSI 64/2011, that staff report any concerns from families about a prisoner's state of mind to an appropriate manager, consider whether to open an ACCT and record the information and action taken in the prisoner's record.	Accepted	The existing local procedures will be reviewed and reinforced to all staff via a 'Notice to staff'. Information from families should be directed to the Safer Custody team and in their absence calls/other sources of information regarding concerns about a prisoners state of mind should be directed to the Duty Operations Manager/ Duty Director.	30 April 2015 Head of Safer Custody	
3	The Director should ensure that reception staff review all documentation and consider any possible public protection issues before allowing a new prisoner access to the telephone	Accepted	The Reception Managers will ensure that all staff who work in Reception understand the importance of reviewing all documentation and considering any possible public protection issues before allowing a new prisoners access to the telephone. Guidance will be issued to staff by the Head of Security.	30 April 2015 Head of Security	