

**Investigation into the circumstances surrounding the  
death of a man at Fazakerley Hospital whilst in the custody  
of HMP Altcourse, Spring 2008**

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

**July 2009**

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Altcourse at 1.00am. Nursing staff attempted to resuscitate him and a pulse was re-established. He was then moved by ambulance to the local hospital, Fazakerley, where he was put on a life-support machine. The decision was made to remove the machine two days later and he died at 12.35pm in the presence of his family. He was only 21 years old.

The man had arrived at Altcourse just a week earlier as a remand prisoner facing a very serious charge. If convicted, he would have been given a long custodial sentence. He was ambivalent about having vulnerable prisoner status and, at his own request, in the evening, six days later he gave it up and moved briefly to the prison's Induction Unit. However, some of the other prisoners there were aware of the charges the man faced and he was assaulted, sustaining minor injuries. Staff immediately escorted him back to the First Night Centre, where he resumed vulnerable prisoner status. Less than six hours later, he was discovered hanging. I offer my sincere sympathy and condolences to his family and friends for their loss.

The investigation was undertaken by two of my investigators. A clinical review of the healthcare provided to the man was commissioned by Liverpool Primary Care Trust and I am grateful the review. I would also like to express my thanks to the Director of HMP Altcourse and his staff for their co-operation, in particular the then Head of Safer Custody, whose assistance was invaluable to my investigators.

I make five recommendations covering healthcare issues, family liaison and the procedure for moving a vulnerable prisoner onto normal location. This investigation, like many before it, also draws attention to a failure in information sharing. Information about the man's risk of self-harm was in the hands of the police but not entered on a Prisoner Escort Record. It was not, therefore, available to staff at HMP Altcourse.

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

**July 2009**

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## SUMMARY

The man was remanded in custody charged with rape. It was his second time in HMP Altcourse. He requested vulnerable prisoner status, and this was granted. He remained on the First Night Centre whilst waiting for a vacancy in the Vulnerable Prisoners' Unit.

At the initial risk assessment, the man told staff that he had no history or current thoughts of suicide or self-harm. He described himself as having a short temper and as getting angry and frustrated very quickly. Over the next few days, staff submitted a referral to the Mental Health Inreach Team because the man said he was "paranoid" that other prisoners would discover the charges he was facing. Staff also referred him to counsellors because he said that he felt deeply ashamed of his offence. He asked the staff to telephone his mother to let her know where he was, as he was too ashamed to talk to her.

Six days after his arrival, the man asked to be removed from vulnerable prisoner status and signed a disclaimer. He moved to the Induction Unit but was assaulted shortly after his arrival. Staff immediately returned him to the First Night Centre where he was again designated as a vulnerable prisoner. A nurse examined his injuries but none was serious enough to require treatment. A prison custody officer asked the man how he was as she locked him up for the night. He told her that he was fine and to stop worrying about him.

At 1.00am the following morning, a prison custody officer saw that the man's cell light was still on and decided to check on him. The officer saw the man hanging and called for assistance and for the healthcare team. Staff commenced cardio pulmonary resuscitation (CPR) and established a pulse. Paramedics arrived and transferred the man by emergency ambulance to Fazakerley Hospital. Sadly, he never regained consciousness. His life support machine was switched off and he died in the afternoon two days later. He was aged 21.

After the man's death, staff and prisoners were offered support.

I make five recommendations.

## THE INVESTIGATION PROCESS

1. After the man's death, my investigator opened the investigation three days later when she visited the prison. She met the Director, the Controller, the Chairman of the Independent Monitoring Board (IMB), a trade union representative and the prison's family liaison officer. She saw the man's cell in the First Night Centre and was given copies of his prison records. The investigators returned to Altcourse three more times to conduct interviews with wing and healthcare staff.
2. A clinical review of the healthcare provided to the man was commissioned by Liverpool Primary Care Trust. I am grateful for the review.
3. The objectives of the investigation were to:
  - Establish the circumstances and events surrounding the man's death, including the care provided by the prison and relevant outside factors;
  - Examine any relevant health care issues and assess clinical care, together with the National Health Service;
  - Examine whether any change in operational methods, policy, practice or management arrangements would help prevent a similar death in the future;
  - Ensure that the man's family had the opportunity to raise any concerns and that these were taken into account in the investigation and the report;
  - Assist the Coroner's inquest.
4. One of my family liaison officers spoke to the man's family to ask if they had any concerns that they wanted to be included in the investigation. She and an investigator subsequently visited the man's family, during which meeting the family raised a number of issues relating to Altcourse staff's knowledge of the man's emotional and mental health, his cell moves, the family's contact with the man and staff, and events immediately before and after his death. I hope that this report goes some way to answering their questions.

## HMP ALTCOURSE

5. HMP Altcourse is a privately run prison, located on the outskirts of Liverpool. It opened in December 1997 and is managed by G4S Ltd. (At the time of the man's death, it was run by GSL which is now part of G4S.) Healthcare services are provided by Primecare.
6. Altcourse receives both sentenced and remand adult male prisoners from the courts in. It also takes young offenders, on remand, who live alongside adults on all the units other than the Vulnerable Prisoners' Unit (VPU). There are seven house blocks that are named after the fences in the Grand National steeplechase course:
  - Bechers - remand and short term prisoners.
  - Canal - medium to long term sentenced prisoners.
  - Furlong - Induction and Detoxification Units.
  - Melling - short term sentenced prisoners, and voluntary drug testing unit.
  - Reynoldstown - sentenced prisoners carrying out full-time education and vulnerable prisoners.
  - Valentines - medium to long term sentenced prisoners.
  - Foinavon - mixture of prisoners wishing to take part in vocational training courses.
7. A gymnasium, education block, chapel and the Healthcare Centre form a central spine of the prison with accommodation blocks on either side. One side of the prison houses mainly remand prisoners, along with the VPU and prisoners on the enhanced level of the Incentives and Earned Privileges Scheme. The other side holds the Induction Unit and accommodation for sentenced prisoners.
8. All prisoners spend their first night at Altcourse in the First Night Centre. The unit has space for 28 prisoners and staff check the men every 30 minutes while they are there. On the second day, prisoners move to the Induction Unit or the Vulnerable Prisoners' Unit. Induction for vulnerable prisoners is provided on the Vulnerable Prisoners' Unit. The First Night Centre is on the floor above the Healthcare Centre.
9. Altcourse has 16 volunteer prisoner carers who offer support to prisoners who ask to see them. They work in Admissions, the Induction Unit, the First Night Centre and the VPU and may visit prisoners on other units when needed. G4S also employs a team of trained counsellors who provide services to both prisoners and staff.
10. The Independent Monitoring Board's most recent report covers July 2007 to June 2008. The report describes the period as "a dynamic and excellent year". However, of particular relevance to the man's time at Altcourse is the Board's view that:

“... the continued verbal abuse of VP [vulnerable] prisoners whilst in transit between their place of work and residential unit from other prisoners continues to give the Board concerns.”

11. The Board also raises the issue of prisoners remaining in the First Night Centre after their first 24 hours in prison whilst waiting to move to a suitable location. They highlight the efforts to address this issue and the recent opening of a new, Opt-Out Unit to ease the situation.
12. The most recent inspection by HM Chief Inspector of Prisons, Ms Anne Owers, was an unannounced, short inspection carried out from 17 to 19 September 2007. In her subsequent report, Ms Owers commended “the quantity and quality of time out of cell for prisoners at Altcourse, which placed its regime among the best of any local prison in England and Wales”. She also noted, “Altcourse remained an impressively respectful prison, with well maintained and clean accommodation, and very good staff-prisoner relations.” However, she was concerned that:

“Anti-bullying measures had been re-examined and were being actively pursued, but more work needed to be done to challenge those who bullied and to support those who had been the victims of bullying. There had been a worrying increase in levels of violence.”

Like the IMB, Ms Owers noted that the First Night Centre held men who could not be accommodated elsewhere in the prison.

13. The previous two deaths at Altcourse were in 2006. The issues I raised in my reports are different from those surrounding the man’s death.

## KEY FINDINGS

14. The man was arrested on suspicion of rape. He told police custody staff that he was suffering from “severe depression and paranoia” and that he had taken 20-25 paracetamol tablets the previous evening. The custody officer referred the man to the police doctor for a medical examination. Prior to the examination, the man was constantly observed by police officers.
15. A police doctor examined the man and assessed that he was fit to be detained and interviewed. After the examination, the man was placed on general observation, set at 60 minute intervals.
16. The man left police custody at 9.00am two days after his arrest. The police officer who completed the Prisoner Escort Record (PER) did not note any of the self-harm concerns they had about the man. The only information box marked was the one that identified him as a drug user. Therefore, the information about the man’s mental health and alleged overdose of paracetamol was not passed on to the GSL staff. Nor were they aware that the police had kept him on constant, then hourly observations. The man was remanded into custody to appear at crown court.
17. When the man arrived at Altcourse, he went through the admissions process during which several staff interviewed him. Staff ask all prisoners on arrival whether they want vulnerable prisoner (VP) status. When the duty Prisoner Custody Officer (PCO) asked the man if he wanted VP status, the man replied that he did. The PCO notified the manager of the Vulnerable Prisoners’ Unit (VPU) of his request and then interviewed the man while he completed the paperwork. The PCO asked the man if he had a history or thoughts of self-harm, to which the man replied that he did not. This is in stark contrast to what he had told the police after his arrest. However, because the police had not put the information on the PER form, the staff at Altcourse had no knowledge of the man’s recent history. The man told the PCO that he did not want to share a cell with a sex offender, which was noted on the form.
18. The duty nurse in Admissions then interviewed the man and completed the First Reception Health Screen. The nurse is a Registered Mental Nurse (RMN) and interviewing and assessing new prisoners is one of his main tasks. He told my investigators that he could not recall the man individually. However, by referring to the forms he completed while he interviewed him, he described their interaction.
19. The man told the nurse that he used drugs socially and listed cannabis, cocaine and “pills”. The nurse explained to my investigators that when a prisoner says his drug use is social rather than a problem, he does not refer him to the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs), the drug counselling service. The nurse recorded that the man said he had no previous history of self-harm and no intention to harm himself. He also said that he had no mental health problems and had no contact with psychiatric services. Finally, the nurse completed the healthcare section of the Cell Sharing Risk Assessment. He asked the man if he had any problems with sharing a cell with

another prisoner. The man initially replied that he had not, but then repeated that he did not want to share a cell with a sex offender.

20. Whilst he was in Admissions, the man waited in the holding area with the other prisoners rather than being put in a separate room as is the case for some of the other VPs. The duty manager of the VPU, arrived in Admissions and interviewed the man in private. She discussed his options of going to the VPU or onto normal location. She set out the risks he faced if he decided to try normal location. The man told her that he had been on normal location in Altcourse on a previous occasion. He said that once a prisoner was in the VPU, the stigma meant that he could not then go onto normal location. He decided not to request VP status and the manager made a note of their discussion and the decision in the man's record.
21. From Admissions, all prisoners move to the First Night Centre which is above the Healthcare Centre. A PCO was interviewing the new prisoners and allocating cells when he read the nurse's note about the man not liking sex offenders. He spoke to the man about his decision not to request VP status. The man said that he was happy with the decision and was content with the cellmate allocated.
22. The following day, the prison doctor assessed the man. The doctor prescribed Aqueous cream for a shaving rash. He noted that the man was a heavy drinker but was not withdrawing at the time. He assessed the man's mental state and concluded that there was no risk of deliberate self-harm.
23. Another PCO interviewed the man to complete an Initial Risk Assessment form, required because he faced a charge of rape. The man spoke about his earlier offence and previous time in Altcourse, but said he could not remember much about the current offences. He gave the PCO some details but told her that his information came from the police. In answer to whether he had any history or thoughts of self-harm, the man replied that he did not. He told her that he was "paranoid" about everybody discussing him and the charges against him. In the section of the form headed "Vulnerability", the PCO wrote "RMN referral". She told my investigators that, after the interview ended, she completed a referral form for the RMN team. However, the form was not in the man's records and there is no record of the referral ever reaching the team.
24. The subject that the PCO and the man spent most time discussing was the VPU. The PCO had worked on the VPU and she discussed the unit, the regime and the opportunities for work and education that would be available to the man. She told my investigators that the man appeared to be interested in learning about the unit on which he would stay in Altcourse.
25. Also on the Friday, the man learned that details of the charges against him had appeared in his local newspaper, to which some prisoners had a subscription. (My investigators were unable to discover how the man had learned of the newspaper article.) He again asked for VP status and the same manager of the VPU interviewed him in the First Night Centre. The man told her that he was "a bit paranoid" and fearful of other prisoners finding out about the offences, as the paper had named him. The manager granted him VP status but, as there was no

space to accommodate him in the VPU, he had to remain in the First Night Centre in the meantime. Several other prisoners in the First Night Centre were also waiting for places in the VPU and staff kept them apart from the other prisoners as far as possible. The VPU manager told the man that, whilst he waited for a space, he could go to the VPU for association and to meet staff and prisoners there.

26. The following day, a PCO interviewed the man as part of the induction process and completed the Initial Assessment Plan. (A blank copy of the form appears at Annex 3.) He began by asking whether the man had any history or thoughts of harming himself. The man replied that he did not and that his major concern was the embarrassment he had caused his parents. After telling the PCO that he could not remember much as he had taken a large amount of drugs and alcohol, he then provided quite a lot of information. He also said that he had suffered from paranoia and depression in the past but that he currently felt fine. He repeated that he felt ashamed and was concerned about the impact on his family. He said to the PCO that he was “going to go guilty”, which the PCO understood to mean that he would plead guilty to the charges when he returned to court.
27. The PCO asked the man if he wanted to speak to a carer but he did not. However the man agreed to be referred to the counsellors. He also told the PCO that he had not contacted his family since arriving at Altcourse and did not know if they knew where he was. He accepted the PCO’s offer to telephone his mother. After the interview ended, the PCO completed a referral form for the man. Later that evening, he rang the man’s mother. During the call, the man’s mother warned the PCO to be aware that the man was good at “blagging” people. The PCO took this to mean that the man could be manipulative and recorded the information in his wing history sheet. He then told the man that he had made the call and that he might now get some mail from his family.
28. For the next two days, the man remained in the First Night Centre. Around 11.00am on the following morning, a female PCO offered the man the opportunity to go to the VPU for association. He refused, saying he “did not want to do the walk”. He told the PCO that he did not want to be “branded” as a VP, particularly as he knew some of the other prisoners and did not want them to know he was a VP. He said that he wanted to try normal location. It was not a confidential conversation as the man was lying in his bed at the time and his cellmate was present. During the discussion, the cellmate encouraged the man to try normal location. The man was aware of the risks of going to the Induction Unit and then to a normal location unit but he was very keen to make the attempt. The PCO told the man that she was not sure it was a good idea because, as he knew, details of the charges he faced had been featured in the local newspaper. However, he was sure he wanted to try. The PCO said she would speak to a manager about the request but she was unable to do so before her shift ended at 1.00pm.
29. Before the PCO ended her shift, she briefed another female PCO about the man’s request and the need for a manager to decide whether he could move to normal location. The second PCO spoke to the Induction Unit manager, who was unhappy about accepting the man. He told the PCO to get the VPU manager’s

agreement before moving the man. The PCO was unable to speak to the duty VPU manager, until late in the afternoon. When she told him of the man's request, he replied that the decision was for the individual prisoner so long as he signed a disclaimer first. The PCO then arranged with the evening manager on the Induction Unit that the man would move to the Induction Unit that evening.

30. As the PCO escorted the man out of the First Night Centre, she asked if he was sure he wanted to move and whether he understood the implications. He replied that he did, and he wanted to go to normal location as he did not want to be classified as a VP. The man arrived on the Induction Unit around 6.00pm. The prisoners were on association and the unit was busy and noisy. A male PCO gave the man a short briefing about the unit and told him which he was allocated to. The man entered the cell and asked his cellmate which bunk was his. He then put his bag on the bed and left the cell. (The cellmate was released from prison before my investigators arrived at Altcourse so they did not interview him. However, they interviewed the violence reduction manager who spoke to the cellmate over several days after the assault and gathered the following information.) The cellmate, who was on a detoxification programme, went upstairs to collect his evening medication. When he returned to the cell, the man was lying on his bunk. The cellmate went to sleep and was not aware of subsequent events.
31. About 30 minutes after the man's arrival, a female PCO was at the officers' console at the top end of the unit when she noticed a group of prisoners clustered round a pool table. She went to investigate and saw that they were reading a copy of the man's local newspaper. The paper contained a large article about the charges facing the man, as well as his name and a photograph. The PCO took the paper from the men as her male colleague arrived to give her assistance. The male PCO telephoned the manager who told him to move the man back to the First Night Centre immediately.
32. The male PCO and another male colleague then went to collect the man. When they entered his cell, he said, "Boss, I've just been jumped" (a prison term meaning assaulted). The PCO saw red marks on the man's face that he described to my investigators as "reddening, like grazes". He said that the man was "a little bit shaken but more calm than other prisoners who have been assaulted". The cellmate was awake by this time but he denied seeing anything when the PCO questioned him.
33. The man collected his bag, which he had not unpacked, and the two prison custody officers escorted him to the gate leading off the unit. As they did so, they passed a group of prisoners who verbally abused the man. The staff identified one of the prisoners who appeared to be a ringleader and the female PCO locked him in his cell. The unit manager interviewed him later that evening and, after the prisoner admitted swearing at the man, the manager told him that his behaviour was totally unacceptable and punished him. I am satisfied that appropriate action was taken.
34. The male PCO opened the gate leading into the foyer of the unit and the man and a carer moved through the first gate and waited at the second. The PCO

collected the man's file from the office which is off the foyer. The carer had been to the unit to speak to a prisoner and was on his way back to his own unit. As the two men waited briefly in the foyer, the carer said to the man, "Are you okay, lad?" The man replied, "Yeah, I am fine. I am alright." But the carer told my investigators that he thought the man "looked lost" and assumed he was being moved off the unit because he had been bullied.

35. Once the carer went off to his unit, the PCO asked the man who had assaulted him. The man replied that he would not tell him because he did not want to be seen as "a grass" (informant). The PCO said that if the man gave him the names of those responsible, he would start the procedures to have the men punished. He told my investigators that the man replied, "I knew this would happen, but I thought I would give it a go - coming to normal location. I deserve it anyway." In the First Night Centre, The PCO put the man in a cell on his own and then briefed the manager, who was in the unit at that time. The PCO told my investigators that nothing that the man said or did indicated that he should have opened an Assessment, Care in Custody and Teamwork (ACCT) plan for him. (ACCT is the arrangement used throughout prisons in England and Wales to support and monitor prisoners thought to be at risk of suicide or self harm.)
36. The manager spoke to the man in an interview room and asked how he was. The man said that he was "fine". He refused to give the names or descriptions of his attackers, telling the manager, "I'm not a grass." He also refused to give any details about the attack and said that he did not want the police informed. The manager asked the man if he felt like harming himself and the man said he did not feel like that. The manager told my investigators that the man appeared quite calm and composed. He accepted that he had to return to VP status.
37. The female PCO who had escorted the man to the Induction Unit spoke to him once he had returned to the cell. She saw bruising on his nose and a scratch on his arm. The man said he had been in his cell when some other prisoners came in with a newspaper. There had been too many of them for him to fight off. She took him downstairs to the Healthcare Centre where a nurse examined him. The nurse noted a mark on his cheek and asked if he had any other injuries. The man said his head, so she examined his scalp behind the ears. She asked him to remove his shirt and noted red marks across his shoulders and arm. The skin was not broken and the nurse's opinion was that he would be bruised the following morning. The man also told the nurse that he had bitten the inside of his cheek so she examined his mouth. None of the injuries needed medical treatment. Although, the nurse noted the man's manner and behaviour, she did not carry out a formal mental health assessment.
38. The nurse asked the man what had happened and he told her he had been hit. He said he did not see his attackers. He appeared fairly calm and sat quietly during the examination. The nurse told my investigators that his manner gave her no cause for concern. The man returned to the First Night Centre and the nurse transferred her notes to the medical computer system. The computer automatically added the time of the entry as 7.37pm.

39. The man was allocated a double cell, although he was on his own. (His former bed space had been allocated to a newly arrived prisoner when he moved to the Induction Unit, so he could not return to the same cell.) The PCO gave him fresh bedding and again asked if he was alright. The man replied, "Yes, Miss. Stop worrying about me. I'll be alright." He refused painkillers. He spent the rest of the evening lying on his bed watching the television. Later, he collected some hot water and returned to his cell. As the PCO locked him up for the night, he told her to "stop fretting".
40. At night, all prisons operate with a much reduced staff. During night patrol state, only the duty operational manager (codenamed Oscar 1) carries a full set of keys to unlock all gates and cells. Staff who are designated as Oscar 2 have keys which allow movement through the prison. Wing staff and nurses do not have access to keys allowing them free access around the prison and have to be escorted. However, prison custody officers are each issued with a cell key in a sealed pouch for use in emergencies. The staff instructions are that during the night state, a cell may only be unlocked by a single member of staff where there is, or appears to be, immediate danger to life.
41. The First Night Centre is a small unit and at night only one member of staff is on duty there. The night PCO began his shift at around 8.45pm and was briefed by the staff going off duty. They told him about the man's move to the Induction Unit, the assault and his return to the First Night Centre. The night PCO checked all the prisoners on the unit at around 9.30pm and, although in interview he could not recall what the man was doing, he noted that he seemed fine.
42. At 1.00am, the night PCO checked the occupant of the cell next to the man's cell. As he passed the man's cell, he realised that the light was still on, so he looked through the observation hatch. He saw the man hanging by a sheet from the rung of the ladder at the end of the bunk beds. The PCO pressed the emergency button on his radio and told the prison custody officer in the control room that there was a Code 1 medical emergency. He then began to take his cell key from the sealed pouch. The control room officer alerted the duty operations manager and other staff of the emergency by radio.
43. The duty operations manager was in his office when he heard the message. He and another PCO arrived at the cell while the night PCO was still removing the key from the pouch. The manager opened the door with his key, went in and lifted the man up. As the night PCO entered he took out his anti-ligature knife, intending to cut the sheet. However, the whole sheet was twisted round the man's neck and was too thick to cut through. He helped lift the man while he and the others removed the sheet and then they laid the man on the floor.
44. Two nurses were in the Healthcare Centre when they heard the Code 1 call. They took the emergency equipment bags and ran up the stairs to the First Night Centre. The discipline staff had opened the doors so they were not delayed. They arrived just as the prison custody officers were putting the man on the floor. The female nurse assessed the man, who appeared unconscious and she began to give oxygen through a mask. The male nurse noticed a letter lying on the desk addressed to the man's family and passed it to the manager. The nurses began

cardio pulmonary resuscitation (CPR) and the manager called for an ambulance. The control log timed the call at 1.03am and the ambulance arrived at the prison gate seven minutes later. The general duties staff had opened the internal gates to allow the ambulance to move through the prison to the First Night Centre as quickly as possible.

45. As the female nurse set up the defibrillator (a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart), the paramedics arrived. She briefed them and they took over the man's treatment. They succeeded in establishing a faint heartbeat. Once they had stabilised him, they strapped him into a support chair and took him to the ambulance where they continued to treat him. The manager arranged for two prison custody officers to escort the man in the ambulance, which left the prison at 1.40am and arrived at the hospital at 1.42am.
46. Any prisoner required to remain in hospital, who has not been released from custody on temporary licence, is escorted and monitored by prison custody officers under the 'Bedwatch' procedures. This usually means that two officers remain at the prisoner's bedside and record any significant changes or events. Subject to a risk assessment process, the Director decides whether the prisoner should be handcuffed and the number of officers required to stay with him. The duty director instructed staff not to handcuff the man after the paramedics told him that the man was unlikely to survive.
47. Members of the Care Team offered support to the staff who had been involved in finding and resuscitating the man. Managers ensured that all carers were on duty over the next few days and the Inreach Team and counsellors were also assigned to the units. Case managers reviewed all prisoners on open ACCT plans and provided additional support where required.
48. The prison's family liaison officer contacted the man's family at 7.30am, having tried for several hours to get in touch. He met them at the hospital later in the day. The man remained in a coma on a life-support machine for two days. He was taken off the life-support machine and died at 12.35pm with his family at the bedside.

## ISSUES

### Health

49. When the man arrived at Altcourse, the Admissions nurse assessed his health needs. The man told him that he had never harmed himself, nor had any contact with psychiatric services. The following day, the doctor examined the man and assessed his mental state as being at “no risk of deliberate self-harm or attempted suicide”. The doctor also noted that, although the man was a heavy drinker, he showed no symptoms of withdrawing from alcohol. He prescribed cream for a dry skin.
50. Five days later, after the assault, the man was examined by a nurse in the Healthcare Centre but his physical injuries did not need treatment. However, the clinical reviewer notes that no mental health assessment was carried out after the assault.

**The Head of Healthcare should ensure that a brief mental health assessment is completed and the findings recorded after a prisoner has been assaulted.**

### Missing mental health referral document

51. When a PCO interviewed the man in order to complete an Initial Risk Assessment form, she discussed suicide and self-harm with him. The man denied having harmed himself in the past and said he had no thoughts about self-harm at the present time. However, he did talk about being “paranoid”, thinking that everyone was talking about him and the offences he was alleged to have committed. The PCO noted the information on the form and, after the interview she completed a referral form to the Mental Health Inreach Team. However, although she remembers putting the referral into the internal post, there is no trace of the form in the man’s records. Had the referral reached the team, there is no guarantee that the man would have been assessed by the time he died, as the following two days were the weekend.

**The Director and Head of the Mental Health Inreach Team should review the referral process to ensure that all forms reach the team.**

### The telephone conversation between a PCO and the man’s mother

52. A different PCO interviewed the man and completed the Initial Assessment Plan. During their conversation, the man said that he had not contacted his family since arriving at Altcourse. Later that evening, the PCO telephoned the man’s mother. He told my investigator that she had said that he man could be manipulative, which he then noted in the wing record.
53. When the man’s mother discussed her conversation with the PCO with my staff, she said that she had not said any such thing. She had told the PCO that the man was very good at hiding his feelings and wanted the staff to be aware of that. She had also urged them to watch him.

54. Clearly, the two descriptions of the telephone call are at odds. There is no third-party account of the conversation. I have, therefore, set out both statements but can offer no further comment on what occurred.

### **Decisions about Vulnerable Prisoner status**

55. As each prisoner arrives at Altcourse, the manager in Admissions asks if he wants vulnerable prisoner (VP) status. The man said that he did, so the duty manager of the Vulnerable Prisoners' Unit, spoke to him whilst he was still in Admissions. After a discussion about the implications of being a VP, the man said he would try normal location. However, the following day, after a further discussion with the same manager, the man asked for VP status. Having made sure that the man understood the consequences of being a VP, she granted it.

56. Unfortunately, the care and individual attention that the female manager gave the man was not mirrored when he asked to come off VP status. The man asked to try normal location six days after his arrival. A PCO discussed it with him whilst he was in his cell with his cellmate present. Thereafter, both she and a second PCO telephoned managers to obtain permission for the man to move to the Induction Unit. The VPU manager that day was a man. He did not think it was necessary to speak to the man who died, but focussed on ensuring that the man signed a disclaimer accepting the risk.

57. At interview, the male manager accepted that it would have been better if he had interviewed the man face-to-face before allowing him to move to the Induction Unit. The male manager told my investigators that he has now changed his procedures and will always speak personally to a VP who requests a move to normal location. The Director has now stopped the practice of men having to sign a disclaimer as it has no legal standing or usefulness.

**The Director should ensure that all prisoners requesting to move from the VPU to normal location are interviewed by a manager before a decision is taken.**

### **The impact of the charges on the man's risk of self-harm**

58. The man arrived at Altcourse on remand, having been charged with rape. Prison staff were aware of the charges, particularly as they were at the centre of why the man asked for VP status. The health screen form that the duty nurse completes in Admissions lists a number of offences that trigger an automatic referral for a mental health assessment. The offences with which the man was charged were not on the list, so no referral was made at that point. However, it is good practice for all staff to be aware of offences that may increase a prisoner's risk of self-harm and monitor those prisoners more closely.

### **The man's changes of mind over being a Vulnerable Prisoner**

59. When he arrived in Altcourse, the man asked for VP status and then changed his mind. The following day, he again asked for VP status and changed his mind five

days later. He understood that if the prisoners on normal location knew of the charges he was facing, they might make life difficult for him. He had been in prison before and knew how other prisoners often regard VPs. He told a PCO that he “did not want to do the walk” to and from the VPU that would identify him as a VP. He told another member of staff that he did not want to be “branded” a VP. Because of the charges he was facing, the man had the dilemma of needing VP status but wanting very much to be on normal location.

60. The female VPU manager told the man the day after his arrival that his arrest and the charges against him had been reported in his local newspaper. When a PCO discussed trying normal location before he moved to normal location, he told her that he did not want to be identified as a VP. Knowing all this, the man still wanted to try normal location and staff agreed to the move.

61. It appears that he spent less than an hour in the Induction Unit before returning to the First Night Centre. During that short time, some of the other prisoners assaulted him physically and made threats. He once more asked for and was given VP status. Afterwards, a nurse examined the man in the Healthcare Centre and noted red marks on his face, shoulders and arms, although none required treatment. In addition to the physical consequences, the man was faced with the psychological blow of knowing that it was impossible for him to be on normal location for the foreseeable future. Furthermore, if convicted, he faced the prospect of serving a lengthy sentence.

62. Once a prisoner has VP status, it is difficult for him to move to normal location. Even if he is transferred to another prison, he may well meet men who knew he was a VP at his previous prison. An alternative can be to move the VP to a prison in a different part of the country. However, this makes it more difficult to maintain family links, an important part of the resettlement process.

63. When the man arrived at Altcourse, he told two members of staff in Admissions that he did not like sex offenders and did not want to share a cell with one. Many of the men in the VPU are sex offenders, and only a minority are there for other reasons. While the man waited for a place on the VPU, he had the opportunity to go to the unit for exercise and association. He refused, preferring to make do with the more restrictive regime in the First Night Centre. However, that was only a temporary location and he knew that he would move to the VPU as soon as there was a space for him. He would then be living and working alongside other VPs, many of whom would be sex offenders. From what he said in Admissions, this would have been very unwelcome.

### **Prisoners in the First Night Centre awaiting places in the VPU**

64. When the female VPU manager gave the man VP status, there were no places available on the VPU. The man, along with several other VPs, remained in the First Night Centre waiting to be transferred to the VPU once there was space for him. This meant that the First Night Centre accommodated both normal location prisoners and VPs, and staff had to keep both groups separate. Whilst my investigators were in the prison, the First Night Centre also held prisoners who were too vulnerable to be accommodated elsewhere, even the VPU.

65. Both the IMB and HM Chief Inspector of Prisons have raised concerns about prisoners, other than newly arrived men, being in the First Night Centre. For the man who died, it meant that he was in a unit where he spent most of the day in his cell, rather than being in the VPU where the men spend much more time unlocked. My investigators raised the issue with the Director when they met to brief him on their findings. The prison has now opened a new unit called the Opt-out Unit that has freed up space in a number of other parts of the prison. The First Night Centre now only accommodates men who are newly arrived at Altcourse. Like the IMB, I welcome this development and urge the Director to ensure that the First Night Centre remains focussed on its specific role.

### **The assault on the man**

66. The other prisoners on the Induction Unit identified the man almost immediately. They had a copy of the newspaper which contained an article about the charges facing him. Information from the man's family indicates that there were also men from his home town in Altcourse at that time knew of the charges.

67. One of the prisoners in the Induction Unit later told staff that he had told the man that he had better get off the unit. The prisoner maintained that he said this by way of advice. However, depending on the tone of voice he had used, it could have just as easily been taken as a threat. Several prisoners went into the man's cell and assaulted him. The man did not name his attackers, staff did not see other men entering his cell and there is no closed circuit television footage available. His cellmate was detoxifying and appears to have taken his evening medication and then slept through the incident.

68. As the man could not, or would not, identify his attackers, the Violence Reduction Manager investigated the assault. He and another manager spoke to a number of prisoners who were on the wing that evening. Several provided information but nothing that could prove who had committed the attack. The Violence Reduction Manager described his enquiry in detail when my investigators interviewed him. The transcript can be found at Annex 20.

69. As staff escorted the man out of the unit, a crowd of prisoners shouted abuse at him. A PCO heard one particular phrase and identified the prisoner who had 'advised' the man to leave the unit as being the person who said it. Although the prisoner denied using the words reported by the PCO, he did admit to using a different phrase. (Both phrases were abusive.) It is little wonder that the carer described the man as looking lost. However, in the letter to his family found in his cell, the man did not refer to the assault or his time in Altcourse. His focus was the charges he was facing and the impact on himself and his family.

### **Family liaison issues**

70. After the paramedics told staff that the man was unlikely to survive the duty director began the procedures for a death in custody. The process includes a list of people and units that must be informed. At 3.30am the prison's family liaison officer (FLO) received a telephone call asking him to take on the role of family

liaison officer for the man's family. Staff provided him with two telephone numbers so that he could telephone the family and inform them that the man was in hospital. The FLO rang both numbers but neither was answered. The FLO went into the prison and continued to try to contact the family. When the man arrived at Altcourse, he had said he lived at his mother's address and this was noted in his records. Directory Enquiries might have been able to provide a landline number for the address. At 7.30am, the FLO managed to contact man's father, who said that he would inform the rest of the family.

71. The family's immediate concern was to be with the man in the hospital. Before they could break the news to their own extended family, other prisoners had passed the information to their own relatives. This meant that the news spread round the community very quickly. When the Prison Service press office released a statement, as is normal practice, the local media featured the news prominently. The man's family were upset that, because of the speed with which the news became public, they were unable to break the news personally to all their relations. It would be helpful for next of kin to be advised at an early stage that a press notice will be issued and, as details may appear in the press and media, to suggest that they might want to contact other family members quickly.

**The Director should include in the Family Liaison policy a requirement for the FLO to inform the family that the Prison Service press office will release a statement.**

72. Talking to my investigators, the FLO said that it was the first time he had carried out FLO duties when the prisoner was still alive. His FLO training from the Prison Service had not covered the special circumstances nor did the FLO policy contain procedures for deciding whether to break the news to the family by telephone or in person. He also identified the need for the FLO to have detailed information about recent events in the prisoner's life as soon as possible so that it can be passed onto the family. I agree with his assessment of the need for clear procedures to cover the specific circumstances surrounding the man's death.

**The Director should expand the FLO policy to include procedures for liaising with the families of prisoners in hospital who are not expected to survive. (The NOMS Safer Custody and Offender Policy Group may also wish to consider if there is a need for national guidance on this issue.)**

## **Conclusion**

74. The man who died was a young man facing a charge of rape. He knew that if he was convicted, he would receive a long sentence that he would probably have to serve as a vulnerable prisoner. Many VPs are sex offenders. The man told staff that he did not want to share a cell with such offenders but was facing the prospect of many years living and working alongside them. His dilemma was that he needed vulnerable prisoner status for his own safety but wanted very much to be on normal location. He moved to normal location in the Induction Unit but was only there for a very short time before he had to leave for his own safety. A few hours later, he took the action that led to his death.

75. Information about the man's risk of self-harm was in the hands of the police. This information was not contained in the Prisoner Escort Record and was not therefore available to staff at Altcourse.