Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Robertson a prisoner at HMP Altcourse on 14 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Peter Robertson died in hospital on 14 May 2018, after being found hanging in his cell at HMP Altcourse one week before. He was 51 years old. I offer my condolences to Mr Robertson's family and friends.

I am not satisfied that Mr Robertson received adequate care for his mental health. He did not have a proper mental health assessment throughout his time at Altcourse, despite having obvious mental health issues. The clinical reviewer found that the mental health care provided at Altcourse was not in accordance with NICE guidelines and the care Mr Robertson received was not equivalent to that which he could have expected to receive in the community.

The investigation also found that there was a delay of four days in Mr Robertson receiving his prescribed medication and staff failed to monitor his physical health conditions as they should have done.

Mr Robertson was monitored under suicide and self-harm prevention procedures for six days when he first arrived at Altcourse in March. We found some deficiencies in the way staff managed those procedures and I am concerned that they were closed before Mr Robertson had received a mental health assessment.

I acknowledge that staff had no reason to consider that Mr Robertson was at heightened risk of suicide in the period leading up to him being found hanging. However, if he had received a mental health assessment and if wing staff had been more engaged with him, they may have had a better understanding of his risk of suicide.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **December 2018**

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Summary

Events

1. On 13 March 2018, Mr Peter Robertson was remanded to HMP Altcourse, charged with criminal damage with intent to endanger life. The alleged victim was his wife.

2. Mr Robertson had a history of mental ill-health and, in the months before he was remanded to Altcourse, had attempted to take his own life on several occasions. He was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) for the first six days he was at Altcourse.

3. On the morning of 7 May, Mr Robertson had an argument with another prisoner. At around 10am, staff returned him and the other prisoner to their cells to calm down. Mr Robertson's cellmate went to see him and said Mr Robertson was crying and wanted to be left alone. At around 11.30am, Mr Robertson's cellmate returned to their cell and offered to collect Mr Robertson's lunch for him but Mr Robertson told him he would not need lunch as he was 'going to do myself'. Mr Robertson's cellmate did not think this was a serious threat and did not tell staff.

4. At around 12.03pm, Mr Robertson's cellmate found Mr Robertson hanging in their cell. Staff resuscitated him and paramedics took him to hospital. However, he did not regain consciousness and at 8.50am on 14 May, hospital doctors pronounced he had died.

Findings

5. Mr Robertson was not being monitored under ACCT procedures when he was discovered hanging. However, we found some deficiencies in the way Mr Robertson's ACCT was managed when he first arrived at Altcourse. Staff closed the ACCT without addressing the issues identified and without a full mental health assessment having been completed.

6. There was a delay of four days in Mr Robertson receiving his medication and staff failed to monitor his physical health conditions as they should have done.

7. Mr Robertson never had a full mental health assessment at Altcourse. There is no evidence the mental health team obtained his community mental health records and there was no review or care plan in place for his antidepressant medication. The primary mental health provision at Altcourse did not adhere to NICE guidelines and the care Mr Robertson received was not equivalent to that which he could have expected to receive in the community.

8. If Mr Robertson had had a full mental health assessment, and if wing staff had been more engaged with him in the days before he hanged himself, staff may have been better informed about his risk of suicide.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that they:

  - ensure case reviews are multidisciplinary, with healthcare staff in attendance where appropriate;
  - set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk, which must be completed before the ACCT is closed; and
  - hold a post-closure review within seven days of closure.

- The Head of Healthcare should ensure all prisoners have an initial healthscreen in reception and in particular:

  - all initial healthscreens are fully and contemporaneously updated on a prisoner's electronic medical record;
  - care plans are created and reviewed for all chronic illnesses; and
  - medication is prescribed as directed for all chronic conditions.

- The Head of Healthcare should ensure that the mental health team:

  - obtain information from community mental health teams;
  - start and review care plans for prisoners prescribed antidepressant medication; and
  - attend, or at least contribute in writing, to all ACCT reviews for a prisoner on their caseload.

- The Head of Healthcare should ensure that mental health assessments comply fully with NICE guidance on the assessment of mental health disorders and all mental health and risk assessment tools are evidence-based.

- The Head of Healthcare should ensure that NICE defined treatment options for patients with common mental health disorders are introduced.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Altcourse, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Robertson's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Robertson's clinical care at the prison.

12. The investigator interviewed nine members of staff and one prisoner at Altcourse on 13 and 14 June. The clinical reviewer accompanied her on 14 June. The investigator asked to interview a prisoner, but he refused. She also wrote to a prisoner who had been released after Mr Robertson's death, but he did not respond.

13. We informed HM Coroner for Merseyside–Liverpool District of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

14. The investigator contacted Mr Robertson's family to explain the investigation. Mr Robertson's family wanted to know if Altcourse had contacted Mr Robertson's GP and if he was prescribed his medication. They wanted to know how Mr Robertson was monitored, what procedures were in place to support him and for how long. Mr Robertson's family also wanted to understand more about an incident on the wing the morning he was discovered, and if he had pressed his cell bell.

15. Mr Robertson's family were received a copy of the initial report, but did not identify any factual inaccuracies.

16. The prison also received a copy of the report and identified one inaccuracy which we have amended. An action plan for the recommendations is annexed to the report.

Background Information

HMP Altcourse

17. 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.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Altcourse was in November 2017. Inspectors noted that there had been three self-inflicted deaths since their previous inspection and the prison had made reasonable progress towards meeting the PPO's recommendations. Levels of self-harm, while still high, were reducing year on year. Inspectors found the quality of ACCT documentation required improvement. ACCT assessments were generally good, but care mapping was often inadequate.

19. Inspectors noted that some aspects of healthcare provision had been disrupted and were not as consistently good as they should have been and that prescribed medication was often delayed. Prisoners waited too long to be seen for an initial mental health assessment, which meant risks might not have been promptly identified.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2017, the IMB reported that the number of ACCTs opened had reduced during the year and there had been a reduction in the number of incidents of self-harm. The Board noted that a new Integrated Mental Health Team had been introduced so that primary care and In-Reach were working as a team rather than in isolation.

Previous deaths at HMP Altcourse

21. Mr Robertson was the 15th prisoner to die at Altcourse since September 2015. Of the previous deaths, three were self-inflicted and 11 were from natural causes. There has been another self-inflicted death since. We have previously made a recommendation about the need for better input from the mental health team at ACCT reviews, which we repeat.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

23. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should

be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

24. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

Key Events

25. On 13 March 2018, Mr Peter Robertson was remanded to HMP Altcourse charged with criminal damage with intent to endanger life. The victim of the alleged offence was his wife. This was not his first time in prison.

26. Mr Robertson arrived at Altcourse around 4.30pm. On his Person Escort Record (PER, a document that accompanies all prisoners when they move between police stations, courts and prisons), court staff recorded on the 'risk indicator' form that Mr Robertson had suicidal thoughts, was known to the mental health crisis team and had been prescribed medication for anxiety and depression. It noted that Mr Robertson took an overdose in October 2017, but there were no specific details recorded. In the ongoing record section of the PER, it was noted Mr Robertson had disclosed that he had recently tried to hang himself but no longer had these thoughts.

27. An officer started Prison Service suicide and self-harm prevention procedures (known as ACCT). He recorded on the 'concern and keep safe' form, that Mr Robertson had arrived with a suicide and self-harm warning form (SASH). He noted, 'not convinced will self-harm but very erratic verbally and not yet had medication. States has no thoughts of s/harm or suicide at this time.'

28. An officer completed the cell sharing risk assessment (CSRA) and recorded Mr Robertson had requested vulnerable prisoner status for his own safety (due to a previous sexual offence) and that he had been placed on an ACCT, but had no current thoughts of suicide or self-harm. He left the question blank on the CSRA form as to whether the healthscreen had been completed. A nurse completed the health assessment section of the form and noted 'none for now' in response to whether there were any factors that might indicate Mr Robertson was at high risk of suicide and self-harm.

29. A First Line Manager (FLM - equivalent to a Custodial Manager), completed the ACCT immediate action plan at 6.30pm, noting that Mr Robertson had been seen by healthcare and informed there was 24-hour access to Samaritans or Carers (a peer mentor group). He set a requirement of three observations an hour and a conversation each morning and afternoon until Mr Robertson's ACCT assessment.

30. Mr Robertson declined to have access to the PIN phone and did not make any telephone calls while at Altcourse. Mr Robertson was located on Beechers Green, a residential wing for vulnerable prisoners.

31. On 14 March at 9.48am, a nurse recorded in Mr Robertson's medical record that she had completed his initial healthscreen. This healthscreen should have been completed in reception when Mr Robertson first arrived.

32. The nurse recorded Mr Robertson showed signs of alcohol withdrawal and was a smoker. Mr Robertson told her he had had a heart attack in 2016 but had not taken his medication in recent months, and that he suffered from depression and anxiety. She recorded Mr Robertson was prescribed medication to treat angina and chest pain (GTN spray), blood clots and deep vein thrombosis (rivaroxaban), high blood pressure (bisoprolol), depression (fluoxetine) and stomach problems

(omeprazole). A prison GP prescribed Mr Robertson's medication, although these were not available in the pharmacy until four days later.

33. A nurse noted Mr Robertson had taken an overdose in the past six months and was known to the community mental health team. She referred Mr Robertson to the mental health and substance misuse teams at Altcourse.

34. The well-man screening did not take place. This is typically completed on a prisoner's second day in prison and is designed to capture wider health issues than the initial health screening, such as lifestyle issues and screenings for other conditions such as diabetes and cholesterol levels.

35. A nurse assessed Mr Robertson and noted that he did not show any signs of alcohol withdrawal, but prior to custody drank significant quantities of alcohol. A clinician for the substance misuse team was consulted and Mr Robertson started a seven-day alcohol detoxification programme and was prescribed vitamins and medication to treat the symptoms of alcohol withdrawal.

36. An officer carried out an ACCT assessment at 10.55am. Mr Robertson told him his last attempt to take his own life was a week before, when he tried to hang himself, the trigger being when he separated from his wife. Mr Robertson said he did not know why he attempted suicide and said, 'I just stop myself last minute.' Mr Robertson said he was alcohol dependent, was very tired and did not have any current thoughts of suicide or self-harm. He recorded that Mr Robertson had no family, but got on well with a couple of prisoners he arrived with and wanted to spend time with them. He summarised that family issues and Mr Robertson's medication were his key issues.

37. A FLM was assigned as Mr Robertson's ACCT case manager and chaired the first ACCT review at 2.15pm with a nurse from the mental health team and Mr Robertson. They used the information obtained by an officer during the ACCT assessment. The FLM recorded Mr Robertson said his main concern was getting his medication for detoxifying from alcohol, but that he already had an appointment to see healthcare. She noted Mr Robertson said he suffered with mental health issues and was keen to engage with the mental health team at Altcourse. Staff continued to assess Mr Robertson's level of risk as raised and kept observations at three times an hour. She recorded three issues on Mr Robertson's caremap for action: a doctor's appointment in relation to his alcohol issues (noted as completed as an appointment had already been arranged), a mental health follow-up, and to organise an optician's appointment as Mr Robertson needed glasses. An ACCT review was scheduled for 18 March.

38. On 18 March at 11.30am, the FLM chaired the ACCT review with an officer and Mr Robertson; no-one from the mental health or healthcare team attended. She recorded that Mr Robertson said 'he has come a long way since we spoke the other day, his main issue, which has been resolved was getting Librium for alcohol detox. He says this has settled him immensely. he states he gets on well with his cell mate… he tells me that he has no current thoughts of self-harm and if he did he would speak to staff'. The caremap was reviewed and updated. Next to both outstanding actions - 'mental health RMN follow ups' and 'optician appointment' - the actions were noted to have been completed 'awaiting appointment'. Staff considered Mr Robertson's risk of suicide or self-harm had

reduced to low, and closed the ACCT. A date for the post-closure review was not recorded on the ACCT document, but was completed on 27 March.

39. There are three entries on Mr Robertson's prison record between 27 March and 7 May. None were made by wing staff. An officer noted on 8 April, that Mr Robertson had an excellent attitude in the light assembly workshop. He noted on 10 April, that Mr Robertson had to return to his cell as he had accidently been hit in the face by some debris brushed off the roof; closed circuit television (CCTV) showed this was an accident. The final entry was made by someone from the substance misuse team, on 11 April, when he recorded he and Mr Robertson discussed his issues around alcohol.

40. On 2 May, Mr Robertson moved to cell 30. A prisoner, told the investigator that Mr Robertson had been sharing with a Polish national and had asked to move as he was not able to communicate with him. He said he and Mr Robertson had become friends and often chatted on the wing and he had asked him to share with him instead.

Monday 7 May

41. On Monday 7 May, Mr Robertson did not go to work as it was a Bank Holiday. During the morning he was observed by staff to be arguing with another prisoner. Mr Robertson's cellmate said the argument started because the other prisoner owed Mr Robertson some vape cartridges. A FLM told the investigator that an officer spoke to him and explained what had happened between Mr Robertson and the other prisoner. They agreed that they should both be locked behind their doors and could not associate for an hour, in order for them both to calm down. The officer locked both men in their respective cells around 10.00am.

42. Mr Robertson's cellmate said he had been associating on the wing and asked an officer if he could go and see Mr Robertson after his argument with the prisoner. The officer let him into their cell. He said Mr Robertson was sitting on his bed and they chatted for about 10-15 minutes. He said Mr Robertson was depressed and crying, but said he just wanted to be on his own, so he left. He said that he was not unduly concerned as Mr Robertson had often been low before, and he assumed that he just needed some space.

43. Mr Robertson's cellmate returned to their cell at around 11.30am, to get his plate for lunch. He used his key to unlock the door and Mr Robertson was still sitting on his bed. He encouraged Mr Robertson to come out of their cell and collect his lunch, and offered to collect it for him, but Mr Robertson said, 'No I won't need it.' He asked him what he meant and he said, 'I'm going to do myself.' He said he left the cell to get his lunch, but did not consider telling staff about his conversation with Mr Robertson. He said comments such as these were common in prison and he took what Mr Robertson said, 'with a pinch of salt' and thought 'it was just words'. After his lunch, he went back to their cell to check on Mr Robertson.

44. CCTV shows Mr Robertson's cellmate returned to the cell at 12.03pm. He attempted to open the door but was prevented from doing so as Mr Robertson's body was behind it. He shouted for staff, along with other prisoners, and two officers responded immediately. They all entered the cell. He supported Mr

Robertson's body while one officer removed the ligature. Another prisoner helped the officer to radio a code blue medical emergency, indicating it was a life-threatening situation.

45. Staff started cardiopulmonary resuscitation (CPR) immediately, and Mr Robertson was brought out of his cell onto the landing so they had more space. An officer also responded to the code blue and collected the emergency medical equipment. A defibrillator was attached to Mr Robertson and staff continued CPR.

46. North West Ambulance Service records show they received a request for an emergency ambulance at 12.04pm. Paramedics arrived at the prison at 12.07pm and assisted staff. By 12.19pm, Mr Robertson had been resuscitated but he remained unconscious. He was taken by ambulance to the hospital where he remained on life support until he died at 8.50am on 14 May. Restraints were never applied.

Contact with Mr Robertson's family

47. On 7 May, the prison appointed a family liaison officer (FLO) and his deputy. Mr Robertson's family were informed that he had been admitted to hospital and were provided with ongoing support by the FLO and his deputy. The prison contributed towards the costs of Mr Robertson's funeral, in line with national policy.

Support for prisoners and staff

48. A hot debrief was not held following the emergency response on 7 May, although staff said they felt well supported. The Duty Director held a debrief for prison staff who were at the hospital when Mr Robertson died.

49. The prison posted notices informing other prisoners of Mr Robertson's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Robertson's death. On 14 June, a memorial service was held in the prison chapel.

Post-mortem report

50. A pathologist concluded that Mr Robertson had died from lack of oxygen, due to hanging. A toxicology report found no substances in Mr Robertson's blood at the time of his death, other than those prescribed.

Findings

Assessment and management of Mr Robertson's risk of suicide and self-harm

51. Prison Service Instruction (PSI) 64/2011 - *Safer Custody*, lists a number of risk factors and potential triggers for suicide and self-harm. Mr Robertson had several risk factors: a history of self-harm and suicide attempts, mental health illness and substance misuse issues, and he was also charged with a serious offence against his wife. Prison staff appropriately started ACCT procedures when Mr Robertson arrived at Altcourse, which they continued for six days.

52. We found some deficiencies in the way the ACCT was managed. Prison staff started ACCT procedures when Mr Robertson arrived at Altcourse on 13 March, because of the information contained in the PER. At the first ACCT review on 14 March, an action was added to the Caremap 'Alcohol issues – Doctor's appointment'. At the same time, the action was marked as completed, as an appointment had been made, although Mr Robertson had not yet attended the appointment. Two other issues were recorded: 'Mental health – RMN follow ups' and 'needs glasses – optician appointment'. At the next review on 18 March, both actions were marked as completed despite both being noted as 'awaiting appointment', and the ACCT was closed.

53. PSI 64/2011 makes it clear that ACCT procedures should not be closed until all caremap actions have been completed. We consider that in this case, the caremap actions were not completed because Mr Robertson was still awaiting appointments. In particular he was still awaiting an assessment by the mental health team. In addition, the decision to close the ACCT was taken even though no-one from the mental health team attended the review. Neither a nurse nor the clinical lead were able to explain why they did not attend and there is no evidence that they provided any feedback for the ACCT review to consider.

54. Given Mr Robertson's history of mental ill-heath and recent suicide attempts in the community, we consider that the ACCT should not have been closed until he had received a mental health assessment.

55. Mr Robertson's ACCT was closed on 18 March, but the post-closure review did not take place until 27 March, nine days later. PSI 64/2011, Chapter 5 states: 'The date of the first post closure interview is a matter for the case review team to decide but must be within 7 days of closure'.

56. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular staff should:

- **ensure case reviews are multidisciplinary, with healthcare staff in attendance where appropriate;**
- **set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk, which must be completed before the ACCT is closed; and**

- **hold a post-closure review within seven days of closure.**

57. We recognise that there was no reason for staff to consider that Mr Robertson's risk of suicide had increased in the hours or days before he was discovered hanging on 7 May. However, we are concerned that there is no evidence that any wing officers engaged with Mr Robertson in the 10 days before he hanged himself. If Mr Robertson had had a full mental health assessment, and staff had been more engaged with him, it is possible that staff may have been better informed about his risk of suicide.

Clinical care

58. PSO 3050 – *Continuity of healthcare,* states all prisoners that arrive in prison custody should have an initial healthscreen while in reception, and if appropriate, be referred to the doctor to assess their physical and mental health needs, including any medication they may be prescribed.

59. The clinical reviewer concluded that the management of Mr Robertson's physical and mental health needs and the subsequent care he received was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community.

60. The clinical reviewer noted the emergency response was at the very least equivalent to that which would have been received in the community. Three staff were nominated by Altcourse for a recognition award because of their efforts in resuscitating Mr Robertson.

Physical health

61. Although Mr Robertson's physical health needs were identified appropriately during the initial healthscreen, the reception screening was recorded the day after he arrived at Altcourse. Mr Robertson arrived around 4.38pm on 13 March, when all staff were still in reception. A nurse who made the entry on Mr Robertson's medical record on 14 March, was unable to explain why the assessment had been recorded or completed a day late and had no recollection of any interaction with Mr Robertson.

62. The clinical lead told the investigator she had never known an initial healthscreen not to be completed in reception. She said that an experienced agency nurse had completed the CSRA form and would almost certainly have completed the healthscreen in reception when Mr Robertson arrived. She said she had tried to investigate what had happened but was unable to provide any explanation or evidence for what went wrong.

63. There were no care plans in place on Mr Robertson's medical record for his chronic physical problems and the National Institute for Health and Clinical Excellence (NICE) pathways for management of heart disease and hypertension were not followed. A second day well-man screening was not completed.

64. Mr Robertson did not receive his prescribed medication for four days (except his alcohol withdrawal medication). In Mr Robertson's medical record the reason was recorded as 'unavailable', but no further explanation was provided. As he had a number of chronic conditions, this delay was unacceptable. We make the following recommendation:

The Head of Healthcare should ensure all prisoners have an initial healthscreen in reception and in particular:

- **all initial healthscreens are fully and contemporaneously updated on a prisoner's electronic medical record;**
- **care plans are created and reviewed for all chronic illnesses; and**
- **medication is prescribed as directed for all chronic conditions.**

Mental health

65. Mr Robertson was appropriately referred to the mental health team by a nurse after his initial healthscreen but his mental health was not assessed correctly and no formal evidence-based risk assessment on his state of mind was ever completed.

66. A nurse attended Mr Robertson's initial ACCT review. Mr Robertson told the review he had suicidal thoughts, but denied immediate intent or plans. He said that in the community he had received input from the Primary Care Mental Health Team and the Crisis Team, but there is no evidence that this was followed up. She could not recall if she had made contact with the community teams.

67. The nurse recorded that Mr Robertson would be allocated to the mental health team caseload and that he would be discussed at the joint referral meeting (attended by mental health, primary care, substance misuse and counselling services). She told the investigator that she considered the ACCT review as an informal assessment of Mr Robertson's mental health needs, but accepted that she did not undertake a comprehensive mental health assessment.

68. The investigator requested minutes of the joint referral meeting from the clinical lead along with any other pertinent records held separately that might indicate any input from the mental health team at Altcourse into Mr Robertson's care. Nothing was provided. (The minutes were provided after we published our initial report).

69. Mr Robertson was prescribed antidepressant medication (fluoxetine) before arriving at Altcourse, which was continued by the prison GP. There is no evidence that this treatment was monitored, or that Mr Robertson had a care plan.

70. The Primary Care Mental Health model at Altcourse does not adhere to NICE Pathways and Guidance on the identification and treatment of common mental health disorders, in Mr Robertson's case, depression. Improving Access to Psychological Therapies (IAPT) is not available at Altcourse, but is a standard intervention for anxiety and depression in primary care in the community.

71. The lack of a stepped care model, comprehensive evidence-based mental health assessment and appropriate treatment options shows a gap in service compared to that available in the community. While counselling is available at Altcourse, it is commissioned separately and the staff interviewed from the mental health team were not sure whether the counsellors routinely accessed or recorded on a prisoner's electronic medical record or who supervised them.

72. The clinical reviewer concluded that the mental health care that Mr Robertson received at Altcourse was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that the mental health team:

- **obtain information from community mental health teams;**
- **start and review care plans for prisoners prescribed antidepressant medication; and**
- **attend, or at least contribute in writing, to all ACCT reviews for a prisoner on their caseload.**

The Head of Healthcare should ensure that mental health assessments comply fully with NICE guidance on the assessment of mental health disorders and all mental health and risk assessment tools are evidence-based.

The Head of Healthcare should ensure that NICE defined treatment options for patients with common mental health disorders are introduced.

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