Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Jordan, a prisoner at HMP Altcourse, on 6 July 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*

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 Jordan was found hanged on 6 July 2018 in his cell at HMP Altcourse. Mr Jordan was 54 years old. I offer my condolences to Mr Jordan's family and friends.

Mr Jordan was appropriately monitored under suicide and self-harm prevention procedures and received good mental healthcare. Prison and healthcare staff cared for Mr Jordan appropriately and created a supportive environment where, if he had chosen to share his distress, he would have been taken seriously. I do not consider that staff at Altcourse could have predicted that Mr Jordan intended to take his own life when he did.

I do, however, have concerns about the way staff conducted roll checks and unlocks the night before and the morning Mr Jordan was found. When he was discovered on the morning of 6 July, he had clearly been dead for some time and there is no evidence that any member of staff had seen him for more than 13 hours.

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 **July 2019**

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Summary

Events

1. On 3 August 2017, Mr Paul Jordan was remanded into custody, charged with the murder of his wife from whom he was separated. It was his first time in prison.

2. On his arrival at HMP Altcourse, staff started suicide and self-harm procedures, known as ACCT, because he had several risk factors indicating he was vulnerable to self-harm. The ACCT was closed on 16 August.

3. Mr Jordan was managed under ACCT procedures again from 23 August, after he seriously harmed one of his arms with a razor blade, until 12 September, and from 18 October to 30 October after he told another prisoner that he intended to cut his throat.

4. On 5 January 2018, staff saw Mr Jordan with facial injuries but he insisted that he had fallen in his cell. He had told two prisoners, however, that he had tried to take his life. An ACCT was opened. On 13 January, Mr Jordan was placed on constant watch after he jumped off the landing onto the floor below. He denied this was an act of self-harm. The ACCT was closed on 27 February.

5. On 3 May, Mr Jordan was convicted of murder and an ACCT was started again to support him because he had expected to be found guilty of manslaughter. He was placed on constant watch. On 21 May, he was sentenced to life imprisonment, with a minimum term of 14 years, which was less than he had expected. The ACCT was closed on 12 June as staff thought he was looking towards the future.

6. At 7.15pm on 5 July, staff locked Mr Jordan in his cell. He was not checked again by a prison custody officer (PCO) that night. On 6 July, another PCO unlocked all the prisoners on Mr Jordan's landing at about 7.30am. He did not look into their cells to check their well-being.

7. At 8.40am, a PCO realised he had not seen Mr Jordan leave the unit for work. He looked into his cell and saw Mr Jordan hanged. Rigor mortis had set in. He summoned help but resuscitation was discontinued as Mr Jordan had clearly been dead for some time.

Findings

8. The investigation found that Mr Jordan's mental healthcare at Altcourse was managed appropriately. There was a lack of clarity in his health assessment during his reception screening about his alcohol misuse history, but this did not have any bearing on his death.

9. The clinical reviewer concluded that the care provided to Mr Jordan was equivalent to that which he could have expected to receive in the community. We agree.

10. ACCT procedures were followed in line with mandatory national instructions and Mr Jordan received excellent support from staff throughout his time at Altcourse.

11. We consider that it was reasonable for staff to have closed the ACCT procedures on 12 June, three weeks after Mr Jordan was sentenced. We are satisfied that there was little to indicate to prison and healthcare staff that he was at heightened or imminent risk in the period immediately before his death. There is evidence that Mr Jordan hid his true intentions from staff.

12. However, we are concerned that the roll checks on the night and morning before Mr Jordan was found dead were not completed to a satisfactory standard. CCTV footage shows that the night officer did not carry out mandatory roll checks and that the officer who unlocked his cell in the morning did not verify whether Mr Jordan was in the cell or in need of help. We understand that, following internal disciplinary proceedings, both members of staff have received final written warnings.

Recommendations

- The Director should ensure that all prison staff are aware of the correct procedures at roll checks and that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no issues that need immediate attention.
- The Director and the Head of Healthcare should ensure that information on the Person Escort Record is fully explored in the first night assessment and reception health assessment.

The Investigation Process

13. 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. One prisoner responded.

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

15. The investigator interviewed 14 members of staff and three prisoners at Altcourse between November and December 2018.

16. NHS England commissioned an independent clinical reviewer to review Mr Jordan's clinical care at the prison. The clinical reviewer was present for 12 joint interviews with the investigator.

17. We informed HM Coroner for Liverpool and Wirral of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. The investigator contacted Mr Jordan's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Jordan's daughter wanted to know whether her father received the mental health care he needed and asked why he was under suicide and self-harm procedures for only a week after he was sentenced. Mr Jordan's son and daughter were provided with a copy of the initial report. They did not comment on its contents. HMPPS also received the report, they did not raise any issues on its factual accuracy.

Background Information

HMP Altcourse

19. HMP Altcourse is a local prison and holds up to 1,164 men. It serves the courts of Merseyside, Cheshire and North Wales. It is managed by G4S Care and Justice Services. Healthcare is provided by G4S Health Services UK.

20. The prison has seven colour-coded residential units. Foinavon Red is a unit for 60 prisoners on the enhanced regime of the Incentives and Earned Privileges Scheme. It has single cell accommodation.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Altcourse was in November 2017. Inspectors found that the prison had been proactive in addressing levels of self-harm which, although high, were decreasing. Prisoners vulnerable to self-harm told inspectors that they were well cared for and staff/prisoner relationships were very good. Inspectors found that the prison had an appropriate range of accessible healthcare services and a small highly motivated team of nurses provided a reasonable range of primary mental health services.

Independent Monitoring Board

22. 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 annual report to June 2018, the IMB reported that the work of the safer custody team had contributed to a reduction of violence and self-harm. Prisoners told the IMB that they felt safer at Altcourse than at other comparable establishments.

Previous deaths at HMP Altcourse

23. Mr Jordan's death was the fifth self-inflicted death at Altcourse since 2015. There were no similarities between Mr Jordan's death and previous self-inflicted deaths at the prison.

Assessment, Care in Custody and Teamwork (ACCT)

24. 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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. 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. 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.

Key Events

26. On 3 August 2017, Mr Paul Jordan was remanded into prison custody at HMP Altcourse, charged with the murder of his wife from whom he was separated. This was Mr Jordan's first time in prison.

27. When Mr Jordan arrived at the prison, a nurse started suicide and self-harm procedures, known as ACCT, due to the risk factors highlighted in his Person Escort Record (PER), which accompanied him from police custody to court. The PER recorded two previous incidents indicating a risk of suicide or self-harm. (In March 2016, Mr Jordan had walked along a train line and threatened to throw himself in front of a train. On 2 August, after he was charged with murder, he said he would strangle himself.)

28. Mr Jordan was tearful and told the nurse that he was an alcoholic and had relapsed recently after being in recovery for 15 months, and that a close friend had recently died. The nurse made a referral to the primary mental health team, although Mr Jordan said that he was not on medication for his mental health.

29. A Prison Custody Officer (PCO) completed a first night assessment on Mr Jordan to gauge whether all important outstanding issues that might raise his risk of self-harm had been identified. Mr Jordan told her that he had attempted suicide in the past but would not do so in custody. The PCO wrote, wrongly, on the assessment that Mr Jordan did not have alcohol issues and that an ACCT had not been opened.

30. The frequency of his ACCT observations was set at four times an hour, but on 5 August, this was increased to five times an hour after Mr Jordan's cellmate told staff that Mr Jordan had wrapped the lead of his television aerial around his neck and said that he wanted to kill himself. Mr Jordan was supported by a multidisciplinary team of staff under ACCT procedures with regular case reviews and supportive conversations.

31. On 5 August, a prison doctor carried out a mental health assessment. Mr Jordan told him that he felt lost and low when he arrived at Altcourse as he had expected to be remanded on bail, not custody, and that he did not know how to manage himself in prison. The doctor wrote in his clinical record that Mr Jordan denied current thoughts of suicide and showed no evidence of bizarre behaviour. He referred Mr Jordan for counselling, which began on 7 August. On 10 August, Mr Jordan asked to be referred to the substance misuse team.

32. On 12 August, a nurse conducted another mental health assessment with the aim of helping Mr Jordan to adapt to prison. She did not see evidence of low mood, anxiety, psychotic symptoms or suicidal intent. Mr Jordan was advised how to contact the mental health team in the future. On 16 August, his ACCT document was closed, when it was agreed he was future-oriented.

33. On 23 August, a staff incident report said that Mr Jordan had been asking other prisoners what was the best way to commit suicide. Mr Jordan was found in his cell by an officer with four deep cuts to his left arm. He was taken to hospital by ambulance and was returned to the prison the same day after treatment. (The wounds were so deep that he subsequently returned to hospital for surgery.)

34. ACCT procedures were recommenced. Mr Jordan told a nurse he was unable to cope with the thought of being in prison for life and had cut himself with a razor blade. The nurse wrote in his clinical record that Mr Jordan showed signs of depression and she asked for a GP to prescribe him some anti-depressant medication. She arranged for two prisoner carers to stay with Mr Jordan in a care suite in the healthcare centre, rather than in his cell.

35. On 24 August, a nurse in the mental health team saw Mr Jordan, and again on 28 August. She wrote in his clinical notes that although he appeared to have recovered from his serious self-harm incident, given the seriousness of his offence and the impulsivity of his previous hanging attempt, his denials should not be taken at face value. Mr Jordan remained in the care suite until 30 August, and was gradually re-integrated back on to his residential unit. He continued regular contact with the nurse and on 12 September, his ACCT was closed.

36. On 18 October, ACCT procedures were reinstated when Mr Jordan said that he would kill himself. He insisted that he had been misunderstood however, and he said that he was feeling frustrated. The ACCT was closed on 30 October.

37. On 20 November, Mr Jordan was seen by an independent psychiatrist as part of his trial preparation. The psychiatrist diagnosed that Mr Jordan might have been suffering from psychosis when he committed his offence. Mr Jordan agreed that he was experiencing emotional difficulties but denied that he was psychotic.

38. On 2 December, Mr Jordan stopped taking his anti-depression medication. On 27 December, officers contacted a nurse when Mr Jordan appeared low, tearful and did not attend work. The nurse saw him in his cell and they discussed resuming his medication as he agreed his mood had deteriorated.

39. On 5 January 2018, Mr Jordan appeared to have facial injuries and a bruised eye. He told officers that he had fallen in his cell. He was given medical treatment by a nurse and told her he had fainted in his cell. However, a prisoner who worked in Altcourse's recycling centre told staff that Mr Jordan had handed him a bag containing a blood-stained broken broom handle and overalls and asked him to hide it in the rubbish. The prisoner said he had asked Mr Jordan if he was okay and he replied that he had tried to hurt himself but "it had gone wrong". Mr Jordan also told another prisoner that he had tried to hang himself.

40. Staff checked CCTV to ensure that Mr Jordan had not been assaulted and began ACCT procedures because they were concerned that his injuries were self-inflicted, although Mr Jordan denied any thoughts of self-harm.

41. On 8 January, Mr Jordan told his counsellor that he no longer wanted to continue with counselling. On 12 January, Mr Jordan jumped from the upper landing of his residential unit to the floor below. He appeared unhurt and told staff that he was not in pain. He denied that it was a suicide attempt and insisted that he had "slipped" and it was an accident.

42. Staff were not convinced, and arranged a constant watch, which meant Mr Jordan was under close supervision, 24 hours a day, in the healthcare centre. (A PCO told the investigator that Mr Jordan had jumped off the landing in "a diving

motion".) The PCO spoke to Mr Jordan later that evening for an hour and a half. Mr Jordan cried and said that he felt so low he wanted to die.

43. On 15 January, Mr Jordan told a nurse that he did not jump off the landing on purpose and that although he had tied a ligature around his neck, he was "messing about". Staff continued to support him through the ACCT process, constant supervision and regular visits from the nurse.

44. On 4 February, the nurse devised a care plan with a view to reducing Mr Jordan's level of observations to five times an hour, a gradual return to work, and moving back into a normal cell on the healthcare unit, as a first step to his eventual return to Foinavon Red unit with the support of two carers.

45. On 25 February, Mr Jordan said that he was being more honest with staff about his feelings and he was glad that he had not died when he jumped off the landing. He said that he felt supported by other prisoners and staff, and he had re-engaged with a different counsellor. (She was not interviewed as she no longer works at Altcourse.) The ACCT was closed the same day.

46. On 16 April, Mr Jordan's trial started. On 1 May, ACCT procedures were started again as a support measure although Mr Jordan denied any thoughts of self-harm.

47. On 3 May, Mr Jordan was convicted of murder. He told a nurse on his return to the prison from court that he had expected to be found guilty of manslaughter instead of murder. He was not happy that a constant watch had been arranged and he said that he wanted to be left alone. Mr Jordan agreed that two carers would spend the night with him and that the situation would be reviewed the next day.

48. On 4 May, an ACCT review took place. Staff explained that due to Mr Jordan's change in circumstances, a constant watch was appropriate as his level of risk was higher. Mr Jordan said that he did not have any plans to self-harm and talked about appealing against his conviction, and said that he was looking forward to the birth of his first grandchild. Daily ACCT reviews continued.

49. On 8 May, Mr Jordan said that he did not find being constantly watched helpful and it was agreed that his supervision would gradually be reduced and his friends would be able to visit him so he could socialise as part of the re-integration process. His level of risk was lowered from high to raised as he was making a transition towards moving from the healthcare centre back to Foinavon unit but he was still considered to be at risk.

50. On 12 May, Mr Jordan told a nurse that he was expecting a minimum sentence of 25 years, but that focusing on his daughter and unborn grandchild would be positive and a protective factor. Mr Jordan told a prisoner, however, that he did not want his daughter to bring his grandchild to see him in prison and her pregnancy was something that caused him stress.

51. On 20 May, an ACCT review was held in recognition that Mr Jordan would be attending court the next day for sentencing. He said it would be a difficult day but he was prepared for the outcome. He said that he felt well supported and

although suicide had crossed his mind recently, it was a fleeting thought and he did not have a plan.

52. On 21 May, Mr Jordan was sentenced to life imprisonment, with a minimum tariff of 14 years. On his return to prison he told a nurse that he was happy with the sentence as he was expecting 18 years, and he was relieved the court process was over.

53. At the ACCT review on 22 May, Mr Jordan spoke about which prison he would like to progress to and about identifying appropriate offending behaviour courses. He said that it was difficult and off-putting being on ACCT as he needed to be escorted by an officer for activities away from his residential unit. Staff considered that his level of risk remained as raised.

54. On 29 May, an ACCT review took place. Mr Jordan spoke about his plans for the future, which included appealing against his conviction, reconnecting with his son and having regular counselling sessions. The summary of the case review said that his level of risk was reduced to low as there were a lot of protective factors in his life and he had built good relationships with staff and other prisoners. Mr Jordan asked for the ACCT plan to be closed as he said it was hindering his movement around the prison. His request was discussed at the review but staff decided to keep it open and arranged another review for 11 June.

55. On 11 June, Mr Jordan told staff at the ACCT review that being on an ACCT was destroying his day-to-day life as he needed to be escorted by an officer if he wanted to leave his unit and staff were not always easily available. He was annoyed because his daughter's visit the previous weekend had been delayed while an escorting member of staff was sought (although he had still received a full length visit). The summary of the review said that Mr Jordan was angry and frustrated with the ACCT process. Mr Jordan said that he would talk about how he was feeling from now on and would not hide things as he had done in the past. The staff present agreed that the ACCT was detrimental to Mr Jordan and given that he had made progress and counselling had been beneficial, the ACCT document would be closed.

56. On 18 June, the ACCT case manager carried out a post-closure interview with Mr Jordan. He concluded that there were no outstanding issues to be resolved and Mr Jordan had supportive people he could turn to at the prison and within his family if he needed to. Mr Jordan said that he had been well supported and cared for by staff.

Events of 5/6 July

57. On the morning of 5 July, Mr Jordan did not go to work as he said he had a migraine. A nurse gave him pain relief medication and a sick note for one day. He was advised to let a member of healthcare staff know if his symptoms persisted or got worse.

58. CCTV footage shows that Mr Jordan went into his cell at 7.02pm. At 7.15pm, PCO A checked that he was in his cell by looking through the observation panel. PCO B double checked that Mr Jordan's cell door was locked at 7.35pm, but did not look into his cell. PCO B told the investigator that he did a handover PCO C,

who was on night duty. CCTV does not show PCO C conducting any roll checks on Foinavon Red unit during his shift, as he was required to do. He was seen answering a cell bell near to Mr Jordan's cell at 12.09am.

59. At 7.34am on 6 July, CCTV shows PCO A unlocking cells on the lower level of Foinavon Red unit. He unlocked Mr Jordan's cell at 7.35am, but he did not look through the observation panel to see if he was inside and well. PCO D unlocked the upper landing of Foinavon Red unit while PCO A did the lower level where Mr Jordan's cell was.

60. At about 8.30am, PCO D began to mark prisoners off a roll board as they left the unit to go to work, a process that normally takes up to 15 minutes. He noticed that he had not seen Mr Jordan that morning and asked a prisoner whether he had seen him because he knew they were close friends. The prisoner said that he had not.

61. PCO D went straight to Mr Jordan's cell, opened the observation panel flap and saw him hanging from a ligature which was attached to the wall mounted television bracket. At 8.40am he radioed an emergency code blue (indicating that a prisoner has breathing difficulties or is unconscious and that an ambulance should be called immediately). He went into the cell and cut the ligature with a specialised tool that all officers carry. Control room staff telephoned for an ambulance at 8.41am and it arrived at the prison at 8.49am. Mr Jordan's body fell onto a mattress that had been placed against the inside of the cell door.

62. A prisoner who was standing opposite Mr Jordan's door dragged the mattress with Mr Jordan on it, onto the landing. PCO D began CPR and four healthcare staff arrived within minutes. A paramedic employed at the prison arrived at the unit at 8.45am. She told the investigator she asked the staff present three times what time Mr Jordan had last been seen but did not receive a definitive reply. She asked staff to stop their resuscitation attempts as Mr Jordan was not breathing, did not have a pulse, was cold and rigor mortis was clearly present. At 8.45am, the paramedic confirmed that Mr Jordan had died.

63. After Mr Jordan's death, his friend said that Mr Jordan had told him that he had no intention of serving his sentence and that he would say to other prisoners that he would not see another Christmas. He had not shared this information with staff.

Contact with Mr Jordan's next of kin

64. A PCO was appointed as family liaison officer (FLO). At 1.00pm on 6 July, the FLO and the Deputy Director went to Mr Jordan's daughter's home to inform her of her father's death. The FLO remained in contact with Mr Jordan's daughter.

65. The prison offered a contributed to the cost of Mr Jordan's funeral in line with national prison service instructions.

Support for prisoners and staff

66. After Mr Jordan's death, a senior manager debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues and to offer support. The staff care team also offered support.

67. The prison posted notices informing other prisoners of Mr Jordan's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Jordan's death.

Post-mortem report

68. The post-mortem gave Mr Jordan's cause of death as compression of the neck due to hanging.

Findings

Management of ACCT

69. We are satisfied that ACCT procedures were followed in line with mandatory national instructions and Mr Jordan received excellent support from staff during his time at Altcourse. Prison and healthcare staff worked effectively to create a genuinely multidisciplinary, supportive and effective network by including his carers and close friends. The frequency of ACCT reviews was stepped up at potential trigger points such as after his conviction and before he was sentenced. Staff were open to implementing a mix of actions such as constant watches, changes of location or shared cells where required.

70. It is clear from reading the detail in the ACCT documents, the number of staff involved with Mr Jordan and their evident knowledge of his situation, that a considerable amount of work was carried out from the beginning of Mr Jordan's period in custody to create an environment around him that he could rely on if he needed to.

71. We have considered whether Mr Jordan's ACCT document should have been closed three weeks after he was sentenced.

72. We are satisfied that at times of crisis, staff did not simply take Mr Jordan's word that he would not harm himself at face value, but also considered his known risk factors. Although he pushed for the ACCT to be closed, staff did not initially agree to close it. However, when his life sentence tariff was lower than expected, Mr Jordan gave the impression that he was focussing on his future in a positive way and we do not consider that it was unreasonable for staff to have closed the ACCT three weeks later

73. Officers said when interviewed that they believed Mr Jordan deliberately hid his intention to take his life from particular staff he had a good rapport with. The pattern and methods of his earlier instances of self-harm suggest that there may have been a degree of planning, as does his insistence that the ACCT be closed. Although Mr Jordan had some risk factors for suicide and self-harm, we are satisfied that there was little to indicate to prison and healthcare staff that he was at heightened or imminent risk in the period immediately before his death. We make no recommendation.

Roll check and unlock procedures

74. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells, but it is also an opportunity for any concerns about prisoners' safety to be identified and addressed.

75. According to CCTV recordings covering the night and early morning of 5 and 6 July, PCO C does not appear to have checked whether prisoners were in their cells or alive. It is a cause for serious concern that an officer tasked to complete a roll check did not ensure that all the prisoners were in their cells. Unless that is done, the roll check is meaningless.

76. Altcourse's security manager carried out a fact-finding investigation into the events leading to the discovery of Mr Jordan in his cell. Altcourse have provided us with a summary of the investigation. PCO C told the security manager that 5 July was his first night on duty in a residential unit and he was unaware what checks needed to be done. He said that he did not know he had to physically count the prisoners before submitting the roll on his unit. We did not interview PCO C as he was on sick absence during the investigation.

77. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual says:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

78. Prison Service Instruction 75/2011 'Residential Services' says:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner has died. This is not acceptable …
>
> "[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock … Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process."

79. Altcourse's Director issued Notice to Staff 54/2018 on 12 June 2018, about welfare checks. It says:

> "Staff are reminded of the need to gain a response from prisoners during the main am, pm and evening unlock process. This process also requires you to see each prisoner as you unlock them. This process is important, if it is not followed thoroughly there is a risk that prisoners in distress could be missed and the opportunity to help then is also missed. Residential managers will carry out spot checks on the CCTV system to make sure this notice is adhered to."

80. The Notice to Staff was issued only just over three weeks before Mr Jordan died but neither PCO A nor PCO D complied with it. PCO D said he was pressed for time and PCO A told Altcourse's security manager that he did not know he should get a response from prisoners when unlocking them. This suggests that the practice is not sufficiently embedded. PCO A and PCO C were given final written warnings following a disciplinary investigation.

81. There were several missed opportunities to check on Mr Jordan. We know that he was alive at 7.15pm on 5 July. We are concerned that staff did not see Mr Jordan again until he was found hanged at 8.40am the next morning. We note

that Mr Jordan had been dead for some time. If effective roll checks and an unlock check had been carried out, he should have been found sooner. We make the following recommendation:

The Director should ensure that all prison staff are aware of the correct procedures at roll and wellbeing checks and that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no issues that need immediate attention.

Clinical care

82. The investigation identified no concerns with Mr Jordan's mental healthcare at Altcourse. The clinical reviewer concluded that the care provided to Mr Jordan was equivalent to that which he could have expected to receive in the community. We agree.

83. However, but there was a lack of clarity about Mr Jordan's alcohol misuse history in his clinical records. The information in the first night assessment about alcohol use was incorrect despite his PER saying he had a history of alcohol misuse. Nevertheless, we make the following recommendation:

The Director and Head of Healthcare should ensure that information on the Person Escort Record is fully explored in the first night assessment and reception health assessment.

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