

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Ashcroft a prisoner at HMP Altcourse on 14 November 2014

A report by the Prisons and Probation Ombudsman

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.

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

Mr Darren Ashcroft died after he was stabbed in his cell at HMP Altcourse on 14 November 2014. He was 35 years old. Mr Keir Michael, another prisoner, was convicted of his manslaughter. I offer my condolences to Mr Ashcroft's family and friends.

My investigation into Mr Ashcroft's death was suspended to allow police and court proceedings to take place. The police and CPS considered whether to bring charges of corporate manslaughter against the prison but decided not to. There were also some delays because my initial investigator became unwell. My report findings are therefore somewhat historic.

The exact reasons for the attack on Mr Ashcroft are unclear, although all the evidence suggests that the incident was drug-related. In the days leading to Mr Ashcroft's death, both Mr Michael and Mr Ashcroft had, separately, been involved in violent incidents in their unit. However, there was no intelligence to indicate any issues between Mr Ashcroft and Mr Michael, and no reason for staff to consider that Mr Ashcroft was at risk from Mr Michael.

What is clear though is that the level of violence and assaults at Altcourse was high during 2014. HM Inspectorate of Prisons and the Independent Monitoring Board raised serious concerns about the level of drugs, violence and weapons in the prison. It is very troubling that Altcourse did not take effective action to address these concerns in the months before Mr Ashcroft's death.

In further inspections in November 2017 and November 2021, the Inspectorate found that violence had decreased at Altcourse although there were still some lessons to learn.

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

June 2022

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Summary

Events

1. Mr Darren Ashcroft was transferred to HMP Altcourse on 26 June 2014. He lived in a shared cell in Valentines Green Unit.
2. Mr Keir Michael was transferred to HMP Altcourse in September 2014 and lived in a single cell in Valentines Green Unit from October 2014.
3. In the months before Mr Ashcroft's death, the levels of violence at Altcourse were high, exacerbated by the ready availability of drugs. In November 2014, there was intelligence to indicate that there were at least 20 weapons in Valentines Green Unit, some of which had been made in the engineering workshop.
4. On 11 November 2014, Mr Ashcroft and two other prisoners assaulted another prisoner in his cell. The next day, the victim of the assault assaulted one of the perpetrators (not Mr Ashcroft) in what was considered a revenge attack.
5. On 11 November 2014, Mr Michael was sacked from his job as a wing orderly, although there is no evidence to explain why. Two days later, staff searched Mr Michael's cell and found a weapon and 'hooch' (illicitly-made alcohol). That afternoon, Mr Michael delivered some drugs to Mr Ashcroft's cell. As he did so, two prisoners assaulted him. Another prisoner saw Mr Michael chase his attackers with a piece of sharpened metal.
6. On the morning of 14 November, Mr Michael went to Mr Ashcroft's cell. Mr Michael hit Mr Ashcroft's cellmate with a metal spike, which punctured his cheek and tongue. Mr Ashcroft tried to intervene, and Mr Michael struck him in the chest with the spike. Mr Michael ran out of the cell and downstairs. Staff locked him in his cell. He later passed the weapon to another prisoner to hide for him.
7. Prison staff had heard the sound of an altercation and went promptly to Mr Ashcroft's cell. When they arrived, they saw Mr Ashcroft on the floor in the recovery position. They radioed for emergency assistance, healthcare staff responded promptly and tried to resuscitate Mr Ashcroft. Paramedics took him to hospital, where he died shortly afterwards. The metal spike had punctured one of his lungs and he died from internal bleeding. The police broke the news of Mr Ashcroft's death to his mother.
8. After Mr Ashcroft's death, the police found a number of weapons, drugs and mobile phones in Valentines Green Unit. Mr Michael was later sentenced to life imprisonment for Mr Ashcroft's manslaughter and for wounding Mr Ashcroft's cellmate with intent to cause grievous bodily harm.

Findings

9. The motivation for the assault is unclear. Some prisoners subsequently alleged that Mr Michael attacked Mr Ashcroft and his cellmate on behalf of another prisoner. Others believed that Mr Ashcroft's cellmate had arranged for Mr Michael to be attacked the previous day.

10. Whatever the exact motivation, there was intelligence to suggest that both Mr Ashcroft and Mr Michael were involved in the supply, distribution and use of drugs at Altcourse, and it seems likely that the assault was related to drugs or other contraband items.
11. Although Mr Michael had a history of violence, there was no intelligence at the time to indicate that Mr Ashcroft or his cellmate were at risk of being attacked by Mr Michael, or that there were any specific issues between the men.
12. Nevertheless, it is clear Altcourse was not doing enough in general to reduce the levels of violence, weapons and drugs in the prison at the time of Mr Ashcroft's death. HM Inspectorate of Prisons had visited Altcourse in June 2014 and recommended that the prison take urgent action to address the levels of violence and the related problem of the ready availability of drugs.
13. Altcourse did not inform Mr Ashcroft's partner of his death promptly and they should have liaised with her after his death.
14. After Mr Ashcroft's death, a new team took over the management of the prison, and Altcourse revised their Violence Reduction Programme and Drug Strategy in 2015. HMIP, in their subsequent inspections, found that levels of violence have fallen at Altcourse.
15. Mr Michael assaulted Mr Ashcroft and his cellmate with a piece of metal with a sharpened end. It is likely that this weapon was made in the prison's engineering workshop. Altcourse revised their security risk assessment for the workshop after Mr Ashcroft's death, increasing the level of staff supervision and the type of searches carried out on prisoners.

Recommendations

- The Director should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are appropriately supported and protected.
- The Director should ensure that there is an effective Violence Reduction Strategy, including that reasons for increasing violence are investigated and effective action taken as a result.
- The Director should ensure that the named next of kin and any other person, who might reasonably be included, are informed of a death in custody and contacted by a family liaison officer.

The Investigation Process

16. In November 2014, an 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.
17. The investigator obtained copies of extracts from Mr Michael's and Mr Ashcroft's prison and medical records.
18. In accordance with the Ombudsman's terms of reference, the investigation was suspended while Merseyside Police carried out a criminal investigation into Mr Ashcroft's death. The police considered whether to charge HMP Altcourse with corporate manslaughter but did not proceed with these charges.
19. We resumed our investigation in February 2018 and another investigator took over the investigation because the original investigator was unwell. The police shared witness statements and other evidence with us.
20. NHS England commissioned a clinical reviewer to review the clinical records of Mr Ashcroft and Mr Michael. He carried out some interviews with the original investigator on 8 July 2015.
21. We informed HM Senior Coroner for Liverpool and Wirral of the investigation and have given him a copy of this report.
22. One of the Ombudsman's family liaison officers contacted Mr Ashcroft's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider.
23. The family liaison officer and original investigator met Mr Ashcroft's partner on 16 July 2015. Mr Ashcroft's partner wanted to know why she was not told what had happened when she rang the prison on the day that Mr Ashcroft was killed to book a visit. She also asked for more details about the emergency response.
24. We issued an initial report in September 2018, which we shared with Mr Ashcroft's family. The solicitor representing Mr Ashcroft's family wrote to us raising a number of questions. We have provided clarification by way of separate correspondence with the solicitor.
25. We have subsequently reviewed the findings of our initial report and, in March 2022, issued this revised initial report.
26. We shared the revised initial report with HM Prison and Probation Service (HMPPS).
27. We also shared the revised initial report with Mr Ashcroft's family. They did not make any comments.

Background Information

HMP Altcourse

28. HMP Altcourse is a local prison in Liverpool, which takes prisoners from the courts in Merseyside and Cheshire. It holds over 1,100 sentenced and remanded adult and young adult men. G4S custodial services manages the prison. G4S also ran the company that provided primary healthcare services at the prison at the time of Mr Ashcroft's death.
29. The prison is divided into seven units. Valentines Green Unit is a two-storey wing, which could accommodate up to 90 prisoners serving medium to long sentences.

HM Inspectorate of Prisons

30. Inspectors visited Altcourse in June 2014. They noted that the levels of assaults against prisoners and staff were high, as were the number of incidents of bullying and fights. They noted that there had been 38 serious assaults in just four months before the inspection. They concluded that gang issues and the availability of drugs, particularly psychoactive substances, contributed significantly to the violence, and had resulted in regular hospital admissions.
31. The inspectors found that the prison's response to the increasing violence had been inadequate. There was little support for victims and a failure to take prompt, firm action against perpetrators.
32. The inspectors recommended that Altcourse should urgently adopt a strategic and co-ordinated approach to reduce the levels of violence, bullying and anti-social behaviour, and that the security strategy should be reviewed and provide a more sophisticated and rigorous response to the linked issues of drug availability, gangs and violence.
33. Altcourse has since addressed these issues and when inspectors inspected the prison again in November 2017, they noted the decrease in violence. The Chief Inspector noted that "there was much here from which others could learn".
34. In November 2021, inspectors completed another inspection of Altcourse. They found that recorded levels of violence had reduced from their previous inspection but were still too high. All violent incidents were investigated, but the response to incidents was not swift or effective enough. Inspectors reported that Challenge, Support and Intervention Plans were used effectively to manage perpetrators of multiple assaults. They also found that fewer prisoners than at comparator prisons said that they had ever felt unsafe.

Independent Monitoring Board

35. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report for the year to June 2014, the IMB was concerned about the levels of violence.

Previous deaths at HMP Altcourse

36. Mr Ashcroft's death was the first homicide at Altcourse since the Ombudsman started investigating deaths in custody in April 2004. There have been no further homicides at Altcourse.

Key Events

Mr Darren Ashcroft

37. On 8 April 2013, Mr Darren Ashcroft was remanded to HMP Altcourse. On 18 October 2013, he was sentenced to three years and three months in prison for drug offences. There was intelligence that Mr Ashcroft was linked to drugs being brought into prison through visits.
38. On 7 April 2014, Mr Ashcroft was transferred to HMP Risley, where he was put on a Tackling Anti-Social Behaviour Scheme after drugs were sent to him by post, and again after he assaulted a prisoner. There was also intelligence that Mr Ashcroft had assaulted another prisoner to retrieve drugs. Staff received an anonymous telephone call to say that they had concerns for Mr Ashcroft's safety at Risley.
39. On 26 June 2014, Mr Ashcroft was transferred back to Altcourse for security reasons (he had been re-categorised from a Category C to B prisoner).
40. In July 2014, a review board considered that Mr Ashcroft was likely to reoffend and decided that he was unsuitable for release under the Home Detention Curfew scheme. This meant Mr Ashcroft would remain in custody until his conditional release date of 22 November 2014.
41. There was intelligence to suggest that Mr Ashcroft was involved in the supply, distribution and use of drugs at Altcourse, and on 23 September, drugs were found in some mail that was addressed to him.
42. At the time of his death, Mr Ashcroft lived in a cell in Valentines Green Unit, which he had shared with another prisoner for about a month.
43. Mr Ashcroft's cellmate said that they had got on well. He said Mr Ashcroft did not appear to have any issues on the wing and described him as more of a peace maker than a fighter. He said that the atmosphere in Valentines Green Unit had "always been hostile", fights regularly broke out over trivial matters and drugs were easily accessible.

Mr Keir Michael

44. On 13 November 2012, Mr Michael was recalled to HMP Chelmsford (having been released on 5 October 2012). He had been sentenced to 14 years in prison on 31 October 2003 for possession of a firearm and attempted robbery. Mr Michael served time in a number of prisons before he was transferred to HMP Altcourse on 2 September 2014 for security reasons. Intelligence indicated that Mr Michael was involved in prison drug culture.
45. Mr Michael had several warning markers on his record – violence, hostage taker, weapons (knives and firearms), threats to staff, gang culture and damaging prison property. He had spent a lot of his time in custody in segregation. Mr Michael was never diagnosed with a mental illness and consistently refused to engage with mental health staff.

46. On 9 September 2014, a substance misuse worker wrote an intelligence report which said that Mr Michael had told him that because he was not being given Subutex (a heroin substitute), “his patience could wear out” and “because he feels he is being mentally tortured by the system, he may cause harm to prisoners or staff as he has nothing to lose”.
47. On 14 September 2014, staff found a homemade weapon in Mr Michael’s cell.
48. About three weeks before Mr Ashcroft’s death, Mr Michael moved to a single cell in Valentines Green Unit.

Events leading to the death of Mr Ashcroft and the wounding of his cellmate

49. At the trial for Mr Ashcroft’s murder, the jury heard evidence that suggested that Valentines Green Unit had serious problems with drugs, drug dealing and the use of makeshift or improvised weapons and mobile phones.
50. On 4 November, the substance misuse worker saw Mr Michael about his clinical and non-clinical support plan for substance misuse. Mr Michael wanted to be stabilised on Subutex before his parole review and said that if he did not get a positive outcome at the review, he planned “something that would get him into a High Court as he had nothing to lose”. The substance misuse worker submitted an intelligence report about this. (We do not know why Mr Michael thought that he was due to have a parole review as his release notification showed that, because he had been recalled, he was not due for release until March 2017.)
51. An intelligence report on 4 November suggested that new prisoners in Valentines Green Unit were being bullied by at least six prisoners. It was thought that there were at least 20 “shanks” (home-made blades) on the wing hidden in mattresses and that some of these had been made into serious weapons.
52. An intelligence report on 5 November said that some prisoners had made weapons in the engineering workshop and taken them back to Valentines Green Unit. The intelligence report gave cell numbers of the prisoners thought to be involved (which did not include those occupied by Mr Ashcroft or Mr Michael).
53. The next day, an intelligence report noted that illegal items were held in a number of cells in the unit and asked for cell searches to be completed. It was agreed that the unit manager and the Heads of Residence, Security and Industries should be informed, and that staff should be advised to be vigilant. We do not know whether this happened and have seen no evidence to suggest that cells were searched before Mr Ashcroft’s death.
54. On 7 November, a prisoner asked to be moved from Valentines Green Unit. He gave staff a piece of sharpened metal and said that it was for his own protection. The prisoner would not say who had given it to him nor who was threatening him. He said that the metal had come from the engineering workshop.

11 November

55. At 11.30am on 11 November, Mr Ashcroft, his cellmate and a third prisoner went into another prisoner’s cell on Valentines Green and assaulted him. At the murder trial, Mr Ashcroft’s cellmate said that he and Mr Ashcroft had gone to the

cell to take a mobile phone from a prisoner who owed money for drugs. He said that an unnamed prisoner had told him to get the phone.

56. Mr Michael, who lived in the cell next door, later told police that he had heard the assault. An officer said that he heard banging and went into the cell, where it was clear that there had been an altercation.
57. Mr Ashcroft and the other two prisoners were put on an anti-bullying programme. Mr Ashcroft and his cellmate were reduced to the basic level of the Incentives and Earned Privileges (IEP) scheme (which limited their time out of their cell and prohibited them from leaving their cell during association periods).
58. The intelligence assessment about the assault said that the prisoners would be separated and moved around the prison. However, Mr Ashcroft and his cellmate were not moved
59. An officer made an entry in Mr Ashcroft's records to say that he had discussed the assault with the duty director, and that Mr Ashcroft would remain in his cell until the Safer Custody team had investigated the incident.
60. Also on 11 November, Mr Michael was sacked from his job as and given a warning for being verbally abusive to an officer.

12 November

61. On 12 November, the victim of the 11 November assault punched one of the perpetrators (not Mr Ashcroft). This was thought to be a revenge attack. Mr Ashcroft's cellmate heard the commotion, came down from the upper landing and tried to kick another prisoner, but staff prevented him, restrained him and led him away. An officer said that she and a colleague had not been told that those involved in the previous day's assault should not have been unlocked that morning.
62. The officer said that she spoke to Mr Ashcroft afterwards, but he did not express any concerns for his safety or ask to be moved from the unit. She said that Mr Ashcroft and his cellmate wanted to stay on Valentines Green. She said that Mr Ashcroft told her that an officer had told his cellmate and him that they would get stabbed. The officer told the police that she did not know which officer had allegedly spoken to them about this and we have no further information to corroborate whether such a conversation took place. In any event, she said that she did not have any concerns for the safety of Mr Ashcroft or his cellmate because the victim of the assault had been moved to a different unit.
63. A prisoner who was due to be released the following day (13 November) told staff that Mr Michael had threatened him and wanted his property. He told staff that Mr Michael had several bladed weapons and had wounded other prisoners on the wing. Staff searched Mr Michael's cell and found seven litres of a fermenting, alcoholic liquid (hooch) and a piece of metal, described as "capable of inflicting a nasty injury". Mr Michael denied the items were his, even though he lived in a single cell. (He later admitted to the police that he regularly brewed hooch to sell to other prisoners.) The manager of Valentines Green Unit was told about the search and Mr Michael was put on the anti-bullying programme and downgraded to basic IEP level.

13 November

64. During the afternoon of 13 November, Mr Michael went to Mr Ashcroft's cell to deliver some drugs to Mr Ashcroft's cellmate. As he did so, Mr Michael was attacked by two other prisoners, one of whom is thought to have hit Mr Michael over the head with a homemade weapon (a tin of tuna in a sock). CCTV showed Mr Michael initially running away with two prisoners chasing him, but then turning and chasing them along the landing to the top of the stairs. (It is unclear why this attack took place but it seems likely that it was linked to drugs.)
65. Another prisoner saw Mr Michael chasing two prisoners along the landing, holding a metal spike. He said that Mr Michael then put this metal spike inside in his top. The prisoner gave evidence at the trial that he had heard the altercation was a result of a debt that Mr Michael owed to another prisoner.

14 November

66. On 14 November, an officer was working in Valentines Green Unit. He and another officer unlocked all the prisoners (except those on basic regime) at around 7.20am. At 7.50am, some prisoners left the wing for work or education, while the others were locked back in their cells. At around 10.00am, an officer unlocked the 14 prisoners on basic regime, including Mr Ashcroft and his cellmate, and Mr Michael. CCTV footage showed Mr Ashcroft's cellmate talking to two prisoners in the laundry at 10.15am, and Mr Ashcroft going into the laundry at 10.30am. They both then returned to their cell.
67. CCTV footage showed Mr Michael going into their cell at 10.51am. At the trial, Mr Ashcroft's cellmate said that he did not have a problem with Mr Michael who sometimes had coffee with them in their cell. He said that Mr Michael supplied him with drugs. (He said that Mr Michael did not supply Mr Ashcroft with drugs, although Mr Michael said that he supplied both of them.)
68. Mr Ashcroft's cellmate said that when Mr Michael went into their cell, they spoke about Mr Michael being attacked the day before. He said that Mr Michael said something about never knowing who you could trust. Mr Michael then struck him twice with a metal spike. He said that the second blow pierced the left side of his cheek and went into his tongue. Mr Ashcroft's cellmate said that Mr Michael also hit his forehead.
69. Mr Ashcroft's cellmate said that Mr Ashcroft got off the bed and tried to stop the attack by getting between them, was struck with the spike and fell to the floor. He said that he tried to help Mr Ashcroft by putting him into the recovery position. He could see some blood coming out of his mouth.
70. A prisoner who was outside the cell heard the toilet door in the cell "bang". He said that this was a sign that a fight was going on. He looked inside the cell and saw Mr Ashcroft fall to the floor. He said that Mr Michael was trying to get out of the cell and Mr Ashcroft's cellmate was trying to stop him. He saw Mr Michael come out of the cell. (CCTV footage showed that this was at 10.53am.) He said that Mr Michael was carrying something that looked like a piece of steel about seven and a half inches long, with one end sharpened. The prisoner said that he

did not know about any issues between Mr Michael and Mr Ashcroft and had not heard any shouting or arguing while the three men were in the cell.

71. Mr Michael gave the police a different version of events. He said that he had gone to Mr Ashcroft's cell to get some sugar to brew hooch. Mr Michael said that he was telling Mr Ashcroft's cellmate about the incident the day before, when the cellmate suddenly attacked him without warning. He said that Mr Ashcroft took out a weapon and Mr Michael grabbed the weapon from him. He said that Mr Ashcroft's cellmate hit him with something. (He said that he thought it was a can of something in a sock.) Mr Michael said that he pulled Mr Ashcroft to the side. He said that they were all struggling. Mr Michael said that he was scared and under attack. Mr Michael said eventually got himself free and ran out of the cell. He said that Mr Ashcroft's cellmate must have stabbed Mr Ashcroft.
72. Two officers heard banging from Mr Ashcroft's cell. Officer A saw Mr Michael come down the stairs, noticed that he had red marks on his face and asked him if he had been fighting. He told her that he did not know. She locked him in his cell and made her way to Mr Ashcroft's cell, where Officer B had already gone.
73. After Officer A locked Mr Michael in his cell, CCTV footage at 10.56am showed a prisoner walking to Mr Michael's cell, leaning down and taking something from under the door. Other prisoners said that Mr Michael said, "I've done him, get rid of this for me". The prisoner took the spike that had been pushed under the door and hid it behind the toilet in his cell. (He was subsequently convicted and sentenced to two years in prison for assisting an offender.)
74. Officer B said that when he arrived at Mr Ashcroft's cell, the cell door was closed, and he had to kick it open. He found Mr Ashcroft on the floor in the recovery position, and his cellmate at the sink, washing himself. He bent down to check Mr Ashcroft, who was not moving and did not respond when he shouted at him. When Officer A arrived, Officer B asked her to radio for assistance.
75. Officer A radioed a medical emergency code at 10.55am. The control room called the emergency services at 10.59am, and the North-West Ambulance Service despatched an ambulance which arrived at Altcourse at 11.03am.
76. Mr Ashcroft's cellmate told Officer A that Mr Michael had come into his cell and hit him. She checked Mr Ashcroft, saw blood on his face and moved his head and shoulders. She applied a towel to Mr Ashcroft's wound, and told the police that she intended to apply pressure to the wound. She said that he was struggling to breathe and going blue around his cheeks. Officer B said that a number of prisoners were standing outside the cell, so he left the cell to move them. As he did so, the medical staff arrived.
77. Nurse A arrived at Mr Ashcroft's cell at 10.58am and found Officer A with Mr Ashcroft. She told him that she thought that Mr Ashcroft had been stabbed and had stopped breathing. The nurse found no pulse, no response and Mr Ashcroft had dilated pupils. They moved him out of the cell and onto the landing.
78. Nurse B began cardiopulmonary resuscitation (CPR). Nurse A said that there was no obvious external bleeding but they saw a small puncture wound on the left side of Mr Ashcroft's chest when his clothing was removed to attach the

defibrillator pads. The defibrillator machine gave a total of five shocks between 11.00am and 11.13am, with CPR continuing between shocks.

79. The first ambulance arrived at the prison gates at 11.03am and was escorted to Valentines Green Unit. A prison GP tried to insert a cannula which would allow Mr Ashcroft to receive intravenous drugs, but he was unable to do so because Mr Ashcroft's veins were shutting down. Paramedics arrived on the wing at 11.14am. They intubated Mr Ashcroft and tried to insert a cannula but were also unable to do so.
80. An advanced paramedic arrived at 11.25am and an intra-ossial (IO) infusion was established (an advanced procedure where an infusion is placed through the hard exterior of the bone into the bone marrow to allow direct access to the vascular system). Four doses of adrenaline were given, with continued CPR.
81. At 12.00pm, Mr Ashcroft was taken by ambulance to Aintree University Hospital. The ambulance reached hospital at 12.15pm. Mr Ashcroft could not be resuscitated and his death was pronounced at 12.16pm.

Contact with Mr Ashcroft's family

82. A family liaison officer (FLO) was appointed and was told that there had been a life-threatening assault on Mr Ashcroft. The prison's Deputy Director decided that Mr Ashcroft's mother should be the first person to be told but that his partner should also be informed as his prison records listed her as Mr Ashcroft's next of kin. We were told that this decision was taken because in a previous death at Altcourse, the Coroner and police had not accepted a girlfriend as a next of kin and had liaised with the parent of the deceased.
83. The FLO and a chaplain were told to wait at the prison while a police escort was arranged to accompany them. While waiting for the police escort, the FLO was told that Mr Ashcroft had died. The police decided that they would break the news of Mr Ashcroft's death to his family and told the FLO not to accompany them. The prison's family liaison log does not say when the police broke the news to his family.
84. At 1.56pm, Mr Ashcroft's partner telephoned the prison to arrange a visit. She did not know what had happened and Altcourse processed and booked the visit without telling her.
85. On 20 November, Mr Ashcroft's sister telephoned the prison and the FLO spoke to her. She said that several prisoners and ex-prisoners had been in touch with her to say that Altcourse was unsafe and violent.
86. On 21 November, the FL and the chaplain visited Mr Ashcroft's sister.
87. On 27 November, the FLO spoke to Mr Ashcroft's partner on the telephone. She said that she was Mr Ashcroft's next of kin. He explained that the prison was treating Mr Ashcroft's mother as the next of kin. Mr Ashcroft's partner was very unhappy about this.
88. Altcourse paid for Mr Ashcroft's funeral in line with national instructions.

Events and criminal proceedings after Mr Ashcroft's death

89. Immediately after Mr Ashcroft's death, the police searched Valentines Green Unit and found a number of weapons, 9 separate quantities of drugs and 42 other prohibited items, including mobile phones.
90. A prisoner told police that Mr Michael had been asked to collect debts from prisoners on behalf of another prisoner. Mr Ashcroft's cellmate told the police that neither he nor Mr Ashcroft were working for anyone else in the prison and were not part of a drug-dealing gang.
91. Mr Ashcroft's cellmate told the police that he had not been warned that they were in danger of being stabbed. He said that if they had known, they would have asked to be locked in their cells for their own protection.
92. Mr Ashcroft was found to have a knife in his shorts when he was taken to hospital after the stabbing. His cellmate said that Mr Ashcroft used it to cut his tobacco.
93. Mr Ashcroft's cellmate said that he did not think that Mr Michael was an enforcer or debt collector for another prisoner. He said that Mr Michael was dependent on drugs and brewed hooch to sell on the wing to fund his drug habit. He said that he had seen Mr Michael carrying a weapon a few weeks before Mr Ashcroft's death.
94. One prisoner interviewed by the police said that Valentines Green Unit was "probably the worst wing of the jail... people are fighting every five minutes...". Others referred to a "bad atmosphere".
95. On 15 May 2015, Mr Michael was sentenced to life imprisonment, with a minimum tariff to serve of eight years, for Mr Ashcroft's manslaughter and for wounding Mr Ashcroft's cellmate with intent to cause grievous bodily harm.

Post-mortem report

96. The post-mortem examination found that the stab wound to Mr Ashcroft's chest had penetrated his lung, and that he had died from internal bleeding. The report also identified two defensive wounds to Mr Ashcroft's forearm.
97. Toxicology results showed a therapeutic dose of diazepam in Mr Ashcroft's bloodstream. Mr Ashcroft was not prescribed diazepam at the time of his death and it is reasonable to conclude that he obtained this drug illicitly within the prison.

Findings

Violence, assessment and management of risk

98. During 2014, the level of violence in Altcourse was high. In November, there were 11 recorded serious assaults on prisoners. There is evidence to suggest that drugs were easily available at the time of Mr Ashcroft's death.
99. Although the assault on Mr Michael on 13 November suggested that he was under threat from other prisoners, we have seen no evidence to indicate the motive for his attack on Mr Ashcroft or whether Mr Michael intended to attack Mr Ashcroft's cellmate alone, or both of them. The police found no evidence of an "obvious and serious risk" that Mr Michael would kill Mr Ashcroft.
100. Valentines Green Unit was a violent and dangerous place, but there was no specific information that Mr Ashcroft or his cellmate were at risk of attack from Mr Michael. Mr Michael denied stabbing Mr Ashcroft and his cellmate, and offered no explanation for the attack to the police, prison or our investigators. We do not know if he was acting alone or on behalf of someone else.
101. We know that Mr Michael had made previous threats of violence (to his substance misuse worker) and that he had weapons, but we know of no specific threat towards either Mr Ashcroft or his cellmate. In fact, Mr Ashcroft's cellmate said that they were "friendly" and that Mr Michael would sometimes drink coffee with them in their cell. Mr Michael said that he had supplied drugs to both men. Mr Ashcroft's cellmate said that neither he nor Mr Ashcroft were in debt or in trouble with anyone in the unit.
102. We accept therefore that the prison had no reason to consider that Mr Ashcroft or his cellmate were specifically at risk of violence from Mr Michael at the time of his death.
103. However, as we have set out in our report, there was considerable intelligence linking Mr Ashcroft, his cellmate and Mr Michael to violence. While staff took some action in relation to this – such as placing all three on anti-bullying programmes and the basic IEP level – there is no evidence that any of the incidents in which they were involved were investigated to determine the underlying causes or whether there were any ongoing threats associated with them.
104. At the same time, we do not consider that Altcourse was doing enough generally to address the very troubling levels of drugs and violence in Valentines Green Unit around the time of Mr Ashcroft's death. Prisoners were seemingly able to obtain drugs and weapons with ease, and some recommended actions to address this – such as cell searches and cell moves – did not happen.
105. In January 2015, Altcourse introduced a new Violence Reduction Strategy, with the aim of reducing the number of violent incidents and to bring the figure in line with the average that occurs within comparative establishments. HMIP's most recent inspection report in November 2021 indicated that the level of violence had decreased, although there were still some lessons to learn around investigating violent incidents and analysing safety data.

106. Managers must, however, remain vigilant to ensure that they do not allow a culture of violence and drug use to build. We make the following recommendations:

The Director should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are appropriately supported and protected.

The Director should ensure that there is an effective Violence Reduction Strategy, including that reasons for any increases violence are investigated and effective action taken as a result.

Security measures

107. The weapon that Mr Michael used to stab Mr Ashcroft was a piece of metal with a pointed end which was most likely made in the engineering workshop.
108. The workshop risk assessment at the time of Mr Ashcroft's death was dated November 2011, and required a staff supervision level of two to three staff for 40 prisoners. It required staff to give prisoners a rub-down search when they left the workshop. This did not include removing prisoners' shoes or checking them with a hand-held metal detector wand.
109. The investigator was told that all prisoners should have been checked with a metal detector and given a rub-down search before leaving the workshop and that there was also a metal detector portal to walk through before leaving the area. We have seen no evidence to indicate whether these searches took place or whether the metal detector portal worked.
110. After Mr Ashcroft's death, Altcourse revised the security risk assessment for the workshop and changed the supervision level to two staff for 25 prisoners. The procedures were also changed so that all prisoners are given a rub-down search, including a check of footwear, a metal detector check with a wand and metal detector portal check. We therefore do not make any recommendations.

Emergency response

111. The clinical reviewer considered that the emergency response was efficient and professional and that the paramedic response times were very good, and we agree.
112. However, at the time of Mr Ashcroft's death, Altcourse was not using medical emergency codes in line with national instructions (Prison Service Instruction (PSI) 03/2013). According to the recorded timings, there was a delay of four minutes in calling 999 after the initial radio message from Officer A at 10.55am.
113. We also note that it took 11 minutes for the paramedics to be escorted to Mr Ashcroft's side from the gate area.
114. The medical emergency code system had been introduced and implemented by the conclusion of our investigation, and we therefore make no recommendation.

Clinical care

115. Mr Michael's medical record showed a history of long-term chronic pain in his hands, for which he had historically been prescribed gabapentin (a painkiller for nerve damage). However, at the time of Mr Ashcroft's death, he was not receiving any medication for hand pain.
116. Mr Michael had a lengthy history of substance misuse in the community, and had smoked cannabis, heroin, cocaine and crack cocaine daily. Mr Michael had completed detoxification programmes using methadone, Subutex and buprenorphine but always said that he had no intention of ending his drug use.
117. Mr Michael strongly denied any mental health issues and said that he claimed to have a history of overdoses and self-harm in order to manipulate a change in his prison regime. Mental health services had previously tried to engage Mr Michael as there were concerns about possible paranoid ideation. However, from the limited engagement he had with mental health professionals, there was no evidence of any major mental illness.
118. Mr Michael had previously threatened healthcare staff and had spent a lot of time in segregation because of his unpredictable and violent behaviour. When he was transferred to HMP Altcourse in September 2014, he was unhappy with his medication and asked for Subutex. (This had previously been stopped as he was found to be selling it on the wing.)
119. Mr Michael continued taking his prescribed buprenorphine (a non-opioid drug used to relieve symptoms during opioid detoxification) but was sometimes abusive and threatening to staff. On 29 September 2014, a nurse wrote in Mr Michael's SystemOne record that he had threatened to "pull her head through the bars" if she smirked at him, and that he was willing to escalate his behaviour as he was not getting Subutex. After his arrest, Mr Michael gave a urine sample which tested positive for the presence of opiates.
120. The clinical reviewer concluded that the care Mr Michael received was equivalent to the care that he could have expected to receive in the community. He concluded that there was no evidence to suggest that the involvement of healthcare services could have prevented the stabbing on 14 November.

Family liaison

121. PSI 64/2011 provides instructions and guidance on required actions after a death in custody. It states that, following a death in custody, prisons must promptly notify the next of kin and any other person the prisoner has reasonably nominated to be informed. It says that prisons must approach the deceased's family in accordance with individual needs and may include providing different members of the family with the same information.
122. Mr Ashcroft's prison records noted that his partner was his next of kin. Although we understand that the police decided to break the news of Mr Ashcroft's death to his mother, we are concerned that the prison did not do more to ensure his partner was informed quickly.

123. While we recognise that Altcourse liaised with Mr Ashcroft's family after his death, they should have provided a similar service to his partner as she was listed as his next of kin.
124. Mr Ashcroft's partner called the prison on the day of Mr Ashcroft's death and booked a visit, but the news of his death was not broken to her then. We accept that the administrative staff she spoke to may not have known of his death at the time. However, the prison would have gone some way to remedy the situation if they had contacted her shortly afterwards to break the news to her.
125. We make the following recommendation:

The Director should ensure that the named next of kin and any other person, who might reasonably be included, are informed of a death in custody and contacted by a family liaison officer.

**Prisons &
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