

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Jonathan
Crooks, a prisoner at HMP
Altcourse, on 29 February 2020**

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

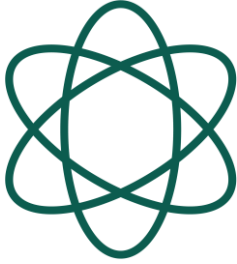
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100



Our vision

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



Our values

We are:

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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 Jonathan Crooks was found hanged in his cell at HMP Altcourse on 29 February 2020. He was 44 years old. I offer my condolences to his family and friends.

Staff monitored Mr Crooks under suicide and self harm prevention procedures (known as ACCT) throughout the 16 days he spent at Altcourse. I am satisfied that staff recognised that Mr Crooks had complex needs and that mental health staff were involved in managing his risk to himself. However, while much of the ACCT process was managed well, I am concerned that staff did not always complete case review summaries accurately or set clear and meaningful caremap actions. I am also concerned that staff did not record why they moved Mr Crooks from a constant supervision cell to a standard cell.

Mr Crooks received a satisfactory standard of healthcare at Altcourse, equivalent to that which he could have expected in the community. However, I am concerned that healthcare staff did not conduct a secondary health screen or clearly record when Mr Crooks was first prescribed his medication.

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

February 2021

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Summary

Events

1. On 29 December 2018, Mr Jonathan Crooks was remanded into custody, charged with assault and criminal damage. He was sentenced to two years and three months in prison on 16 September 2019. He had a history of self-harm, depression, anxiety, personality disorder and substance misuse.
2. On 12 February 2020, Mr Crooks was released on licence from HMP Forest Bank to probation approved premises.
3. On 13 February, Mr Crooks was recalled to HMP Altcourse for breaching his licence conditions. At reception, an officer started suicide and self-harm prevention procedures (known as ACCT) after Mr Crooks said he could hear a voice telling him to self-harm. A nurse conducted an initial health screen and Mr Crooks was placed on constant supervision in the prison's inpatient unit.
4. On 15 February, a locum GP recorded that the prison's electronic medical record would not allow him to add medications and asked that healthcare staff prescribe quetiapine (an antipsychotic). Nurses later recorded that Mr Crooks had taken his medication but medical records show that it was not prescribed until the next day. There is also no evidence that staff conducted a secondary health screen.
5. On 16 February, a first line manager (FLM) chaired an ACCT case review in which several protective factors were identified. As a result, attendees reduced Mr Crooks' ACCT monitoring from constant supervision to five observations an hour.
6. On 18 February, a consultant psychiatrist recorded that Mr Crooks' description of the voice he heard was not representative of a psychotic process. Later that day, staff moved Mr Crooks from a constant supervision cell to a standard cell.
7. On 24 February, an FLM chaired an ACCT case review but the summary of the discussion contained information from a previous review. On 27 February, at an ACCT case review, a prison manager asked Mr Crooks if he had any thoughts of suicide or self-harm. He said, "I wouldn't tell you if I did, as I'm not one who seeks attention." Attendees kept his ACCT monitoring at five observations an hour.
8. At around 9.29pm, on 29 February, a healthcare assistant (HCA) looked through Mr Crooks' cell observation panel and saw him suspended by a ligature. She alerted nearby staff and an officer unlocked the cell while a nurse obtained a medical emergency bag. At 9.30pm, staff radioed a medical emergency code blue. The nurse returned to the cell as the officer was laying Mr Crooks on the floor and started cardiopulmonary resuscitation (CPR). A paramedic arrived and conducted an assessment but at 9.44pm, pronounced that Mr Crooks had died.

Findings

9. Staff recognised that Mr Crooks had complex needs and appropriately managed him under ACCT throughout his time at Altcourse. Mental health staff were involved in managing his risk to himself.

10. However, while staff generally managed Mr Crooks' ACCT well, we are concerned that they failed to accurately complete an ACCT case review summary and did not always set clear and meaningful caremap actions. We are also concerned that staff did not record why Mr Crooks moved from a constant supervision cell to a standard cell.
11. The clinical reviewer concluded that the healthcare that Mr Crooks received at HMP Altcourse was equivalent to that which he could have expected in the community. However, we are concerned that healthcare staff did not conduct a secondary health screen and failed to record clearly when Mr Crooks' medication was first prescribed.

Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
 - consider the most appropriate location for prisoners coming off constant supervision and record their decision in the ACCT record.
 - set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; and
 - accurately record details of case reviews in the ACCT record.
- The Head of Healthcare should:
 - ensure healthcare staff offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050; and
 - accurately record actions and decisions about prisoners' care in their ongoing record.
- The Head of Healthcare should review the contingency arrangements if the prison's electronic medical record is not accessible to ensure that medication is prescribed promptly.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact him.
13. The investigator visited Altcourse on 9 March 2020. He obtained copies of relevant extracts from Mr Crooks' prison and medical records.
14. The investigator interviewed seven members of staff between 16 and 21 July.
15. NHS England commissioned a clinical reviewer to review Mr Crooks' clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the coronavirus restrictions in place.
16. 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.
17. The Ombudsman's family liaison officer contacted Mr Crooks' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Crooks' mother wanted to know what happened in the days leading to his death.
18. Mr Crooks' mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan is annexed to this report.

Background Information

HMP Altcourse

20. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manages the prison and provides primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover. Castle Rock Group provides secondary mental health services.

HM Inspectorate of Prisons

21. 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 that ACCT assessments were generally good, but caremaps were often inadequate.

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 latest annual report, for the year to June 2020, the IMB reported that in the context of the COVID-19 pandemic, prisoners had been treated fairly and humanely. The IMB highlighted that incidents of self-harm had reduced, and that the safer custody team had developed interventions to support prisoners.

Previous deaths at HMP Altcourse

23. Mr Crooks was the tenth prisoner to die at Altcourse and the third to take his life since February 2018. We have previously made a recommendation to Altcourse about the management of suicide and self-harm prevention procedures.

Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce 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 a prisoner anticipating when they will occur. Regular multidisciplinary review meetings with the prisoner should be held.
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 on 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 he moves around the prison. National

instructions on ACCT procedures are set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

26. On 29 December 2018, Mr Jonathan Crooks was remanded to HMP Pentonville, charged with assault and criminal damage.
27. Mr Crooks had a significant history of substance misuse, depression, anxiety and self-harm. He also had diagnoses of emotionally unstable personality disorder (where a person tends to have disturbed ways of thinking, impulsive behaviour and unstable relationships) and dissocial personality disorder (where a person presents as very manipulative and with minimal regard for the consequences of their actions).
28. On 30 December, an officer found Mr Crooks hanging by a ligature. Healthcare staff attended and Mr Crooks was taken to hospital by ambulance. He was treated in intensive care and returned to Pentonville on 4 January 2019. Over the next five months, prison staff monitored Mr Crooks under suicide and self harm prevention procedures (known as ACCT) on several occasions.

HMP Thameside

29. On 3 June, Mr Crooks was transferred from court to HMP Thameside. On 29 July, a prison psychiatrist reviewed Mr Crooks and recorded that he had a history of substance misuse and reported hearing voices. She prescribed quetiapine (an anti-psychotic) and reviewed him frequently. Mr Crooks frequently self-harmed, mainly by cutting, and prison staff monitored him under ACCT procedures.
30. On 16 September, Mr Crooks was sentenced to two years and three months in prison. His mental health deteriorated over the next four months and he spent a significant amount of time in the prison's inpatient unit. Mental health staff explored a transfer to a secure hospital, but the referral was not accepted.

HMP Forest Bank

31. On 11 February 2020, Mr Crooks was moved to HMP Forest Bank for local release. At 5.50pm, a Senior Prison Custody Officer (SPCO), chaired an ACCT case review which a prison manager and a mental health nurse, attended. The SPCO recorded that Mr Crooks said that he intended to take a heroin overdose after he was released.
32. At 11.10am on 12 February, the SCPO chaired an ACCT case review which several members of staff, including a probation officer and the mental health nurse attended. The SCPO recorded that the attendees told Mr Crooks about the plan for his release and that he said that he no longer intended to take an overdose. The mental health nurse noted that probation staff were arranging for him to have a community mental health assessment.
33. Later that morning, Mr Crooks was released from Forest Bank to Bunbury House Approved Premises, Ellesmere Port, Cheshire. Mr Crooks did not have his prescribed medication with him as he had refused to attend a health screen before he was released. A community mental health team visited Mr Crooks to conduct a

Mental Health Act assessment but concluded that he was not detainable under the Act and could be appropriately monitored and treated in the community.

HMP Altcourse

34. On 13 February, Mr Crooks was recalled to HMP Altcourse for breaching his licence conditions by threatening staff at Bunbury House. He arrived at 2.30pm.
35. At 3.00pm, a Prison Custody Officer (PCO) started ACCT procedures after Mr Crooks said he could hear a voice telling him to self-harm. At 3.30pm, a SPCO completed an immediate action plan and noted that Mr Crooks required five observations an hour and two conversations a day.
36. At 4.10pm, a nurse conducted an initial health screen and noted that Mr Crooks initially refused to engage with a Black nurse and stormed out of the room three times. Mr Crooks eventually calmed down, told the nurse that he was prescribed quetiapine and zopiclone (a sleeping tablet) but had lost them. He also said that he intended to hang himself that evening. The nurse saw that staff had already started ACCT procedures and advised a prison manager that Mr Crooks required a constant supervision. She also made a mental health referral and requested a GP review.
37. At 5.00pm, prison staff moved Mr Crooks to a single cell on the induction wing. Shortly afterwards, the prison manager phoned a nurse and asked her to admit Mr Crooks to the inpatient unit as he had told staff that he intended to take his own life. Staff moved Mr Crooks to the inpatient unit at 7.55pm and placed him in a safer cell (a cell specifically designed to minimise ligature points) on constant supervision.
38. At 9.20am on 14 February, a PCO visited Mr Crooks to introduce himself as his keyworker but Mr Crooks was abusive and refused to engage. At 11.30am, a mental health nurse saw Mr Crooks for a mental health assessment and he told her that he would like to re-start his medication. He also said that a voice in his head was triggering his thoughts of suicide and that he would hang himself if staff took him off constant supervision. The mental health nurse referred Mr Crooks to the secondary care mental health team for a psychiatric review.
39. At 11.56am, a mental health nurse from the secondary care mental health team, contacted the healthcare department at Forest Bank for up to date information on Mr Crooks as a technical issue was preventing the electronic medical records from merging.
40. At 1.00pm, a PCO completed an ACCT assessment and recorded that although Mr Crooks refused to engage, he said that he was “always suicidal and always will be”. Immediately afterwards, an FLM, tried to conduct a first ACCT case review which a prison manager, the mental health nurse and a nurse attended. However, Mr Crooks refused to participate. Attendees assessed him as a high risk of suicide and decided that he should stay on constant supervision. Two actions were recorded on the caremap: a medication review and a psychiatric assessment.
41. At 11.01am on 15 February, a locum GP recorded that the prison’s electronic medical record would not allow him to add medications and requested that staff

prescribe quetiapine. However, there is no record that this took place or that healthcare staff conducted a secondary health screen.

42. At 2.00pm, the FLM chaired an ACCT case review which prison staff and a mental health nurse, attended. The FLM noted that Mr Crooks engaged well and said that he was willing to take his medication and to see a psychiatrist. However, he also said, "I will do myself in the first chance I get", "I don't care about myself and I don't care if I die". Attendees decided that he should remain on a constant supervision as he posed a high risk of suicide.
43. At 5.42pm, a nurse recorded that she had attended an ACCT case review, where Mr Crooks presented as unkempt and low in mood. She also noted that Mr Crooks had accepted his prescribed medication that evening without concern. At 7.23pm, a nurse recorded that Mr Crooks had been fairly calm all day and had complied with his medication. However, there is no record that his medication had been prescribed.
44. At 9.27am on 16 February, a prison GP visited Mr Crooks to conduct a review but he refused to cooperate. Electronic prison medical records show that at 12.09pm, the prison GP prescribed quetiapine.
45. At 2.00pm, the FLM chaired an ACCT case review which several members of staff attended, including a prison manager and two nurses. The FLM noted that Mr Crooks said he wanted to re-build his personal relationships and did not report any thoughts of self-harm. Attendees also identified several other protective factors, such as Mr Crooks displaying an interest in purposeful activity and agreeing to take his medication. They assessed his risk of suicide as high but reduced his ACCT monitoring to five observations an hour and two conversations a day. However, there is no record that staff updated the caremap.
46. On 17 February, the FLM visited Mr Crooks to conduct an ACCT case review but he refused to engage and threw a food tray at the door. There is no record that she considered going ahead with the review in his absence.
47. At 11.57am on 18 February, a consultant forensic psychiatrist assessed Mr Crooks who said that he had had a voice in his head since childhood and that he had been suicidal 'on and off' for his whole life. The consultant forensic psychiatrist recorded that Mr Crooks' description of the voice he heard was not representative of a psychotic process and that his paranoia most likely arose from childhood adversity. He noted that he agreed with the decision not to detain Mr Crooks under the Mental Health Act and increased his quetiapine.
48. At 4.29pm, a nurse reviewed Mr Crooks in response to a medical emergency code red (indicating that a prisoner is bleeding) and noticed that he had re-opened four previous self-harm injuries on his arms. He initially refused treatment but allowed her to clean and dress the wounds around 30 minutes later. At 9.18pm, another nurse recorded that Mr Crooks cut his arms shortly after staff moved him from the constant supervision cell to a standard cell.
49. At 2.45pm on 19 February, a FLM visited the inpatient unit to conduct an ACCT review but decided not to proceed because Mr Crooks was displaying abusive and threatening behaviour. The FLM postponed the review until the following day when

one action was added to the caremap: for Mr Crooks to refrain from refractory behaviour.

50. At 10.41am on 20 February, the FLM chaired an ACCT case review which a member of prison staff and a nurse attended. He noted that despite an initial reluctance to engage, Mr Crooks participated in the review and showed an interest in getting a prison job. The nurse noted that Mr Crooks reported thoughts of suicide but did not have a clear plan. Mr Crooks told attendees that he did not like the number of times he was being monitored and they explained that these observations had to stay in place for his safety. At 11.19am, the nurse completed a mental healthcare programme approach assessment and a care plan.
51. At 9.50pm on 24 February, a PCO visited Mr Crooks and conducted a keywork session through his cell observation panel. He recorded that Mr Crooks appeared very paranoid and confused. The PCO spoke to Mr Crooks about going to the main unit to interact with other prisoners but he refused. A FLM chaired an ACCT case review at 3.00pm but the text box entitled 'summary of review' on the case review form contains the same wording as case review two. An action was added to the caremap for Mr Crooks to complete the induction process.
52. On 27 February, an operational manager (OM) chaired an ACCT case review which two FLM's attended. Healthcare staff did not attend but provided a verbal update. The OM asked Mr Crooks if he had any thoughts of suicide or self-harm and he said, "I wouldn't tell you if I did, as I'm not one who seeks attention." The OM recorded that Mr Crooks was waiting to see the psychiatrist again and attendees decided that he remained at substantial risk of suicide. Mr Crooks level of ACCT monitoring remained at five observations an hour, with two daily conversations.

Events on 29 February

53. At 11.00am, a PCO recorded that he had had a conversation with Mr Crooks who had said he was fine. He noted that Mr Crooks maintained good eye contact, did not report any thoughts of suicide or self-harm and appeared to be in a reasonable mood.
54. At 5.15pm, a PCO recorded that he had spoken to Mr Crooks in the garden during exercise. Mr Crooks told him that there had been some confusion about his vapes (electronic cigarettes) that had caused him to feel frustrated but the problem had been resolved.
55. Between 8.10pm and 9.22pm, a Healthcare Assistant (HCA) carried out seven ACCT observations on Mr Crooks. On each occasion, she recorded that he was lying on his bed and appeared asleep.
56. At around 9.29pm, the HCA looked through Mr Crooks' cell observation panel to conduct an ACCT observation and saw him suspended from the window by a ligature made from bed sheets. She shouted out to a PCO and a nurse, who were just leaving the unit. The PCO looked through the observation panel and entered the cell while the nurse went to collect a medical emergency bag. The PCO checked Mr Crooks' pulse and shouted for staff to raise the alarm while he cut the ligature. Control room records show that a medical emergency code blue

(indicating that a prisoner is unconscious or has breathing difficulties) was received at 9.30pm, but it is unclear who made the call.

57. The nurse returned to the cell just as PCO Ferry was laying Mr Crooks on the floor and started cardiopulmonary resuscitation (CPR). Prison staff then took over so that she could issue oxygen to Mr Crooks and attach a defibrillator. The defibrillator did not detect a shockable pulse and advised staff to continue CPR.
58. At 9.43pm, a paramedic arrived and conducted an assessment. At 9.44pm, after establishing that staff had conducted CPR for 25 minutes, the paramedic pronounced that Mr Crooks had died.

Contact with Mr Crooks' family

59. A short while later, a prison manager arrived at the prison to support staff. She told the investigator that Mr Crooks had not named a next of kin and that despite checking all his prison records, they were unable to find any contact details. She said that she told the police officers who had responded to the incident and that they said they would check their records and be in contact.
60. At 7.30am on 1 March, the prison appointed a FLM as the family liaison officer (FLO). The FLO went through Mr Crooks' records again and recorded that he had not made any phone calls since arriving at Altcourse. At 1.45pm, the Director contacted HMP Thameside to see if they had next of kin details for Mr Crooks but they had none.
61. At 1.54am on 2 March, Merseyside Police contacted an OM and gave him a contact telephone number for Mr Crooks' mother. At 9.45am, the FLO emailed Merseyside Police requesting an address for Mr Crooks' mother as they would not provide this information by phone.
62. At 10.50am, the FLO received a phone call from Mr Crooks' mother. She told him that two officers from Humberside Police had visited her at 5.00am on 1 March and had broken the news. The FLO explained the next steps and offered support.
63. The FLO continued to provide ongoing support to Mr Crooks' mother until Mr Crooks' funeral, which took place on 29 March. The prison contributed towards its cost in line with national guidelines.

Support for prisoners and staff

64. Following Mr Crooks' death, the prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
65. The prison posted notices informing other prisoners of Mr Crooks' 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 Crooks' death.

Post-mortem report

66. The post-mortem report established that Mr Crooks died from hanging. Routine post-mortem toxicology tests identified therapeutic levels of quetiapine in his system.

Findings

Management of Mr Crook

67. For the most part, Altcourse managed the ACCT process well. The case reviews indicate that staff made concerted efforts to work with Mr Crooks to reduce his risk of suicide and self-harm and that healthcare staff were frequently involved in the process. Staff were aware that Mr Crooks had a complex mental health history and managed his aggression appropriately. Despite this positive work, we have identified some areas for improvement.

Caremaps

68. Prison Service Instruction (PSI) 64/2011 on safer custody states that completing a caremap is an integral part of the ACCT process and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. The caremap should set time-bound actions and be aimed at reducing the risk the prisoner presents to themselves. Caremap actions should be updated at future case reviews, with new actions added when appropriate.
69. Although the caremap appropriately identified the need for a psychiatric assessment and a medication review as actions to progress while Mr Crooks was subject to constant supervision, staff failed to record an action outlining how he would participate in purposeful activity, as mandated in PSI 64/2011.
70. At an ACCT case review on 19 February, staff recorded that Mr Crooks must 'refrain from refractory behaviour'. They did not record what the behaviour was, nor did they make any additions to the caremap to set out how they would support him. We do not consider that this was an appropriate or meaningful caremap action. A FLM told us that an officer subsequently showed Mr Crooks how he could order food and phone credit as they thought that may cause him frustration but there is no record of this. We consider that it would have been more meaningful if staff set out in the caremap how they planned to support Mr Crooks to change his behaviour.
71. At an ACCT case review on 20 February, the FLM recorded that Mr Crooks was interested in applying for a prison job but did not add this action to the caremap. He told us that the plan was to start small and to build up to applying for a job, but with hindsight, he recognised that he should have recorded it in the caremap.

Location of at-risk prisoners

72. PSI 64/2011 states that case managers and case review teams must base their decision on where to locate an at-risk prisoner against the risk they present and the benefits the location may afford them.
73. Staff moved Mr Crooks from the constant supervision safer cell to a standard cell on 18 February. The Acting Head of Safer Custody told us that there was another safer cell in the inpatient unit and that the process would be to try to move the prisoner coming off constant supervision into that cell. However, he said that this would depend on availability and an assessment of the risk involved in moving another high-risk prisoner out of a safer cell.

74. While we appreciate that capacity can be an issue in prisons and that Mr Crooks was subject to five observations an hour, we are concerned that there is no record that staff considered moving him to the other safer cell or that they assessed his risk against that of another prisoner. At interview, a FLM told us that she could not remember which cell Mr Crooks went to or when the decision was made. We consider that as Mr Crooks presented a significant risk of suicide, staff should have at least recorded why they located him in a standard cell.

Recording ACCT case reviews

75. PSI 64/2011 also states that staff must make a detailed and accurate record of the case review. We are concerned that the content of the 'summary of review' section of the case review form completed on 24 February contained the same wording as that documented in the second case review. A FLM told us that although she could not fully recall what had happened, she said that she must have used a previous case review form as a template and not saved the changes. We consider it important that staff completing ACCT review records take the time to ensure that the content accurately reflects what was discussed, so that those involved in the next review have the most recent information about a prisoner's risk available to them.
76. We make the following recommendation:

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

- **consider the most appropriate location for prisoner coming off constant supervision and record their decision in the ACCT record;**
- **set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each review; and**
- **accurately record details of case reviews in the ACCT record.**

Clinical care

77. The clinical reviewer concluded that the overall care that Mr Crooks received at Altcourse was mostly equivalent to that which he could have expected in the community. Mental health staff carried out appropriate assessments, contributed to the ACCT process, provided structured support and arranged for a psychiatric review. He did, however, identify aspects of Mr Crooks' care that required some improvement, namely that staff did not complete a secondary health screen and that they failed to record when Mr Crooks medication was first prescribed.
78. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that newly arrived prisoners should be offered a general health assessment in their first week. This did not happen. While we appreciate that Mr Crooks was being monitored in the inpatient unit and that the constant supervision might have limited the opportunity to conduct a secondary health screen, it was important given his presentation that he had a secondary review. The clinical

reviewer considered that healthcare staff should have at least recorded a reason for not conducting it.

79. We are concerned that healthcare staff appear to have issued quetiapine to Mr Crooks before it was prescribed. A prison pharmacist told the clinical reviewer that the prison's electronic medical record shows that a prison GP prescribed quetiapine on 15 February but that it was not dispensed until the following day, due to issues merging his medical record with the one from Forest Bank. She said that a paper prescription could have been issued as an interim measure on 15 February but there is no evidence that this happened. The Head of Healthcare, told us that she spoke to the two nurses but that they were unable to clarify what happened. We consider it likely that the medication was issued on 15 February, but we cannot be certain. While the delay in Mr Crooks receiving his medication did not impact on the outcome, in other cases, it could be critical.
80. We are satisfied that, overall, Mr Crooks received a satisfactory standard of clinical care at Altcourse. However, we make the following recommendations:

The Head of Healthcare should ensure healthcare staff:

- **offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050; and**
- **accurately record actions and decisions about prisoners' ongoing care in their medical record.**

The Head of Healthcare should ensure that there are contingency arrangements to ensure that medication is prescribed promptly if the prison's electronic medical record is not accessible.

Emergency response

81. The HCA responded promptly after she noticed Mr Crooks hanging and alerted a nurse and a PCO who appropriately entered the cell. The HCA told the investigator that she could not remember who called a medical emergency code blue as everything happened so quickly. However, the nurse told us that the HCA radioed a code blue straight after she alerted the PCO and her. Although we have not been able to establish who radioed the code blue, we are satisfied that staff swiftly radioed the correct code and that the control room called an ambulance immediately, in line with national policy.
82. The clinical reviewer concluded that the resuscitation efforts were carried out in line with best practice guidelines.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100