The death in custody of a man at HMP Altcourse in July 2005

Report by the Prisons and Probation Ombudsman for England and Wales

March 2006

This is the report of an investigation into the death of a man in HM Prison Altcourse. He was found hanging by his cell mate in the early hours of 29 July 2005. Sadly, the attempts to resuscitate him were unsuccessful. The man was 30 years old.

I would like to extend condolences on behalf of my office to all the man's family and friends and those touched by his death.

The investigation was led by one of my Assistant Ombudsmen. An independent review of the man's medical care in prison was commissioned from the Director of Prison Healthcare, North Liverpool Primary Care Trust. Clinical advice was given by a doctor. I have not had access to the post mortem report.

I would like to thank the management and staff at HMP Altcourse for their assistance and co-operation during the course of this investigation. Particular thanks go to the prison liaison manager.

The man's death was the third apparently self inflicted death at Altcourse in three weeks. I have looked carefully at all three deaths but can find no links to explain why they happened around the same time. I have therefore chosen to write separate investigation reports into each of the deaths.

The man had been in Altcourse for less than 36 hours when he died, having arrived on the evening of 27 July. I raise concerns about Altcourse's approach to heroin detoxification and its contingency plans for a death in custody at night time

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2006**

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Summary

The man was a 30 year old man who had been in and out of prison custody several times, usually for short sentences of a few months. He was addicted to drugs with a long list of previous convictions dating back to when he was 17 years old. The man had been taken to Altcourse on 27 July 2005, after being remanded into custody by Warrington Magistrates' Court for several offences including theft and affray. He was due to appear before the Court again on 1 August by video link.

The man had spent periods in custody at Altcourse on several occasions and staff knew him quite well. He normally began his sentence on a detox programme on Furlong unit. My investigator looked at three back records for the man in order to assess whether his behaviour on 27 to 29 July was any different to how he had previously seemed. The records indicate that he invariably presented in a similar way. He always told reception medical staff that he was a drug addict and said he suffered with asthma, angina and epilepsy. The man said he had never been in contact with any psychiatric services, never taken medication for any mental health problems, had never tried to harm himself and that he did not feel like harming himself now. Once on Furlong unit, the man usually completed his detox programme, but often received warnings during his sentence about not attending education classes or other courses he was allocated. The staff and prisoners to whom my investigator spoke all said that the man would have been "one of the last people they could imagine" deciding to take his own life. His friend who had known him for over 20 years, described the man as being able to do prison "standing on his head".

The man was quite reasonably not assessed as a suicide risk by staff during his reception on 27 July. He was put into a shared cell (cell 46). The pair got on well enough, but both had their own friends on the unit with whom they socialised during the day. The man began a detox for benzodiazepines on the morning of 28 July, after seeing a nurse and doctor. Nothing eventful or unusual happened during the day, and he spent time with his friends on the unit during both the day and evening. He was interviewed during the day by a member of the CARATS team. She had no concerns about his mental state. The man was locked back in his cell with his cell mate about 8.45pm that evening. The man had given no indication to any staff, prisoners or friends that he might be feeling depressed or suicidal. The two men watched *Bad Lads* on television together. At around 10pm, the man complained of chest pains. Two medical staff visited him and he was given some GTN spray, advised to sleep on the bottom bunk or the floor, and told to call staff again if necessary. At about 10.30pm, his cell mate fell asleep.

The man's cell mate woke around 4.30am to use the toilet. On his return, he switched on the television set. At this point, he saw the man hanging from the end of the bunk bed and pressed the cell bell in order to raise the alarm with staff. He said the man was cold to touch. A Prison Custody Officer (PCO)

arrived, opened the cell observation panel and saw the man hanging. He used his radio to alert the comms room (communications and radio centre for the prison), but did not press his personal alarm button. The message was received by comms as a request to ask the night manager to go to Furlong as "there may be a code one". (Code one refers to a medical emergency such as a hanging or cardiac arrest. It indicates to medical staff which equipment to take with them to the scene and alerts other staff to the type of emergency they are running to attend.) The communications room onwardly transmitted the message for staff to attend Furlong unit, but did not use the words "code one". Because no code one message went out, the responding staff did not act with urgency and did not know the true nature of the incident they were about to face. Healthcare staff did not take any medical equipment with them. The arriving staff took around five minutes to get to Furlong, as opposed to about one minute had a "code one" message gone out.

During these five minutes, the (PCO) remained outside the man's cell. Another member of staff, a PCO was also on the unit, but neither man discussed unlocking cell 46 and going in.

The man's cell was unlocked by the night manager when he arrived with the medical team. The arriving staff were shocked to discover that the man was hanging. Two staff had to run back to healthcare and collect the appropriate equipment. The medical staff tried to resuscitate him. He did not respond. The paramedics arrived within 15 minutes of being called and decided to cease resuscitation attempts.

The man was described by the medical staff and his cell mate, as being very cold and stiff. He had probably been dead for some time when the cell mate found him. However, I am concerned about the way in which the alarm was raised by staff and the delay in entering the man's cell. In another situation, minutes could prove vital in saving someone's life. I ask the director to review his local contingency plans for a death in custody at night time and to clarify the guidance to staff about raising the alarm, entering a cell at night and administering resuscitation techniques.

I am also concerned that Altcourse's approach to heroin detoxification is out of line with practice in the Prison Service.

My report makes seven recommendations.

Investigation Process

My colleague first visited HMP Altcourse on 1 August 2005. She was given the initial papers that had been assembled about the man, and was briefed about the circumstances surrounding his death. She also met with four members of the Independent Monitoring Board. A notice to staff and a notice to prisoners were issued by the prison, inviting anyone who might have information relating to his death, to make themselves known. No one came forward from these notices.

My colleague commissioned a clinical review from the Director of Prison Healthcare, North Liverpool Primary Care Trust. My colleague returned to Altcourse during the week commencing 8 August, and then again for one night the following week, in order to talk to staff and prisoners who had known the man. Some of these discussions were taped and transcribed; a summary note was written to record other meetings. My colleague returned on 4 November in order to complete remaining staff interviews.

One of my family liaison officers contacted the man's father and brother. They did not have specific concerns that they wanted the investigation to look at, but did ask to see a copy of the draft report.

HMP Altcourse

HMP Altcourse is a local prison on the outskirts of Liverpool. It was opened in December 1997 and is managed by GSL (Global Solutions Limited) UK. It receives both sentenced and remand prisoners from the courts in Merseyside, Cheshire and North Wales. Altcourse also takes young offenders on remand.

The prison's residential areas consist of six main house blocks, each divided into two units holding up to 83 prisoners in each unit. Separate buildings contain the healthcare centre, rehabilitation unit, college, sports centre and segregation unit. As from February 2005, the healthcare services were provided by Veritas Limited. The healthcare service provides 24 hour cover and there is a 13 bed in-patient unit.

In her report of an announced inspection in February 2005, Her Majesty's Chief Inspector of Prisons declared Altcourse to be a very good local prison. Altcourse was described as a safe prison in the main, even though prisoners were out of their cells for a considerable amount of time with low staffing levels. The quality of staff and prisoner relationships was judged as extremely good.

The certified normal accommodation at Altcourse is 1,010. On 8 August, when my investigator first visited, the prison roll was 967. The typical movements in and out of reception are 20 prisoners on each weekday. The day when my investigator first visited was a busy one and there were 34 new receptions.

A First Night Centre recently opened above the healthcare centre. This unit was not open at the time of the man's death. The First Night Centre can accommodate 24 prisoners and takes new prisoners arriving in Altcourse for one night only. There are two members of staff on duty until 10pm and they ensure that prisoners receive an evening meal, a phone call and are settled for the night. All new prisoners are observed every 30 minutes by staff for the first 24 hours. If they have already been put onto a self harm or suicide watch, they are observed six times an hour. The following morning, prisoners have breakfast, see the doctor, and have a gym and chapel induction followed by individual interviews. At around 2pm, they are moved onto a residential unit. Those prisoners undergoing detox move onto the unit called Furlong red.

The Man

The man was born on 22 August 1974 in Lancashire. His father and brother still live in the area. His mother and one of his brothers pre-deceased him.

He had taken drugs for a number of years. His family thought he had begun by taking sleeping tablets but had progressed onto harder drugs. The man told the CARATS team at the prison that he spent in the region of £750 a week on drugs. He had a long history of offending dating back to 1991. His offences were mainly theft and breaching community punishments including Drug Treatment and Testing Orders.

A friend who had known the man for about 24 years, both in and out of prison, described the man as the kind of person who could do jail “standing on his head” and said he had done lots of short sentences. This friend said the man was quiet but knew how to have a laugh as well. He thought that, if anything was upsetting the man, he would have been one of the few people whom his friend would have turned to. He said the man had never talked about or threatened to ‘slash up’ and that he had never self harmed in the past to his knowledge.

The man had been living in Lancashire prior to his arrest on 26 July.

The man's previous periods in custody

The man had served several short prison sentences, often in Altcourse. The sentences were usually for a few weeks or months. My investigator looked briefly at three recent periods the man spent in Altcourse in order to assess whether his behaviour or demeanour on these sentences was any different to how he presented to staff on 27 July 2005.

The man was sentenced to three months in custody by Warrington Magistrates in March 2004 for theft and failing to surrender to custody. He arrived at Altcourse and went onto Furlong unit and the detox programme. By 9 March, he had been given a final warning about his behaviour on the unit and told that any further problems would result in him being removed from the detox programme and the wing. The man finished his detox on 11 March, and was moved to Melling blue unit the next day. He was put on the list for education classes but refused to attend on 15 and 18 March. There was a note in his history sheet on 24 March by the member of staff responsible for the "Out to Stay" programme indicating that the man had decided not to bother completing the course. The author noted that the man turned up "in body, but not mind". He continued to be reluctant to attend education for the rest of this sentence. He was released on 16 April 2004. There are no entries about the man feeling depressed or suicidal at any time during this sentence.

He was also in Altcourse from August 2004 to October 2004 for six offences, primarily shoplifting. His reception health screen indicates that he took heroin, benzodiazepines and cocaine. It also stated that the man had never had any psychiatric problems, never received medication for mental health issues and had never tried to harm himself. The man completed his induction on Furlong Unit and returned to court on 31 August to be sentenced. He was put on the list for education classes, but entries in his history sheet indicate that he tried not to attend or left early on several occasions. On 23 September, he was removed from his education class for refusing to listen to the teacher and doing insufficient work. He was given a warning by the unit manager on 2 October, and then placed on adjudication for being threatening towards a female officer on 3 October. There are no entries about the man feeling depressed or suicidal at any time during this sentence.

The man's most recent sentence prior to him entering custody on 27 July was from 23 May 2005 until 2 June 2005. This very brief sentence was for theft. He had tested positive for benzodiazepines, cocaine and morphine on 24 May and was put onto the detox programme on Furlong red. The reception health screen identified the same issues as the August to October sentence. On 25 May, at 4am, the man was admitted to healthcare after complaining of chest pain. He had no shortness of breath and his blood pressure was normal. He was discharged back to the unit the following morning. A doctor removed the man from the detox programme on 26 May, and gave the reason as his very poor attitude. The man had apparently refused to go to his gym induction session which was part of the detox programme. There were no entries in his

history sheet to indicate he felt down or suicidal at any time during this sentence.

Events prior to the man's death

The man's time in police custody

The man was arrested by the police in July, and kept in police custody at Widnes Police Station overnight. He told the police he was a heroin addict and had last taken the drug the previous day. The police surgeon saw him. He noted that the man had a shoulder injury from falling off a push bike three days earlier. He assessed him as fit for interview and to remain in custody. A nurse gave him two paracetamol and two ibrufen tablets. The police said the man was lucid, calm and co-operative throughout his period in police custody. He was taken to the Warrington Magistrates' Court the next day, arriving at 9.40am.

The man's admission into Altcourse

The man appeared before Warrington Magistrates in connection with several offences, including theft and affray. The hearing was adjourned until August. That hearing was to be conducted by video link. A solicitor spoke with the man in the court cells at 12.10pm. He said the man had seemed alright and that he was displaying no particular signs of depression. He thought the man had told him his father was ill and that he had lost a brother, although he did not know how long ago this had been.

The man left with GSL escorting staff at 1.55pm, arriving at Altcourse an hour and fifteen minutes later. His Prisoner Escort Record form (PER) ticked as his "risk categories" violent, conceals weapons and drug / alcohol issues.

A Prison Custody Officer (PCO) carried out the reception interview with the man and completed form F2050 (the core prison record). Personal details such as his date of birth, nationality, height, weight, identifying scars or tattoos were all recorded. The man gave the name and address of his brother as his next of kin, but gave the name and telephone number of a friend as the person to contact "in an emergency".

The PCO also completed the Admissions Checklist form. This form is used to identify whether the prisoner requires further specialist assessments or paperwork to be triggered. It identifies potential category A prisoners, those to whom Child Protection Procedures apply, those who may be at risk of suicide or self harm and those prisoners who request vulnerable prisoner status. All categories were marked "not applicable" for the man.

The PCO completed sections one and two of the Prison Service form "Cell Sharing Risk Assessment". This form is intended to identify those prisoners who may be a risk to other prisoners if they were to share a cell together. The type of prisoner it seeks to highlight to staff are those who may be racist, homophobic or particularly aggressive or prone to violence. The man was assessed as a low risk. The officer indicated on the form that he had not been convicted or remanded for a violent offence and that the man did not have a

history of unexplained violence, bullying, assault, hate motivated behaviour or damaging property. The PCO indicated on the form that the man was dependent on drugs, that he was not on an open self harm or suicide monitoring form and that he had no concerns about him sharing a cell.

A nurse was on duty in reception that day. Her role was to interview and assess all new receptions. She completed the Prison Service / Department of Health Form "First Reception Health Screen" about the man. The First Reception Health Screen form is an eight page document. It asks a wide range of questions about physical health including any diagnosed illnesses, alcohol and drug use and mental health history, including any previous attempts of self harm and how the person is feeling about being in custody now.

The nurse knew the man from previous sentences and had completed the First Reception Health Screen forms about him before. The form on 27 July was completed as he presented on that day. The form is heavily reliant on the answers that the prisoner gives. The nurse said she considers both verbal and non-verbal communication from the person she is assessing. The man said he had not seen a doctor in the past few months, was not taking any prescribed medication and had no outstanding hospital or doctor appointments. He said that he had not received any physical injuries in the past few days, although the man did in fact have a shoulder injury.

The nurse took the man's blood pressure. The reading was high so she asked another nurse, a registered general nurse, to come to admissions and assess him. The man also complained of feeling dizzy. The second nurse went to admissions. She recorded in his medical record that he was eating a meal when she went to see him and that he did not want to talk very much. The second nurse said that he looked well, had no cyanosis and was not pale or sweaty. The reception nurse then took a second blood pressure and pulse check which gave a reading within normal limits.

The reception nurse continued with the questions on the form. The man answered 'yes' to asthma, epilepsy or fits and chest pain (angina). The man did not have an asthma inhaler with him and so the nurse did not give him one. She said that it would have been inappropriate for her to issue an inhaler or other medication solely on the strength of what the man said. He would be seen by the doctor the next day and he would assess the man's medication requirements. The nurse said that the "yes" to epilepsy or fits might have been linked to drug withdrawal. She described the man as withdrawing from drugs, but said that he did not have any severe symptoms of drug withdrawal.

In the substance misuse section of the form, the man said that he drank about five cans of lager a day, and that he used heroin, benzodiazepines and crack on a daily basis. He took drugs intravenously. No detox medication was given to the man on 27 July. This is normal practice in the prison. Drug detoxification is prescribed by the doctor after an assessment of the patient the following morning. A urine drug test ("a dip test") is carried out by Furlong Unit staff prior to the person's appointment with the doctor.

The section of the form entitled “Mental Health” asked whether the prisoner had ever received treatment from a psychiatrist, stayed in a psychiatric hospital, whether they have a CPN or care worker in the community, whether they have ever received medication for any mental health problems, if they have ever tried to harm themselves and whether he feels like harming himself because of coming into prison. The man answered no to all the questions.

There is then a space on the form for the nurse to record their impression of the prisoner’s behaviour and mental state. The nurse did not complete this section but during interview said, “He appeared lethargic, tired and knackered and that because he was rattling [coming off drugs], a bit worse for wear.” She assessed both his verbal and non-verbal responses and said that she had no concerns about his mental health or risk of suicide or self harm.

The last page of the form asks the nurse to tick if further assessments or referrals need to be made. There were no ticks on the form. During her discussion with my colleague the nurse said that the form should have been ticked for completeness but that she had not done so for two reasons. First, that it was automatic that the man would see the doctor the following day and secondly, the other boxes about whether a mental health assessment was needed, a suicide monitoring form opened or a detox programme commencing are recorded in a separate “Admissions Book”, kept in reception. This book lists all prisoners who are received into Altcourse each day and uses a tick list to indicate what follow up action is required. I agree with the nurse in that the follow up action is recorded and clearly done in the man’s case, but for completeness and continuity of care the First Reception Health Screen Form should indicate the planned action on the last page. I draw this housekeeping point to the attention of the prison’s Director.

The nurse then completed a separate form called “Risk Assessment, New Admissions”. This form was designed by Veritas and GSL and is a local form. I notice that the form does not have a section for the name or signature of the person completing the form. I make a second housekeeping point about this. The form asks a series of questions about risk to self, risk to others, risk of neglect and risk of vulnerability. Many of the questions are a repeat of parts of the First Reception Health Screen. The nurse said that she asked all the questions again. She said that quite often prisoners give different answers from earlier ones as they may feel more relaxed or at ease, or they cannot remember what response they gave earlier. The man answered “no” to every question about risk. Accordingly, the nurse did not open a suicide or self harm monitoring book on him. I think her assessment and judgement in the circumstances were entirely appropriate.

The nurse’s final task was to complete section three of the Cell Sharing Risk Assessment form. She agreed with the admissions officer that the man presented a low risk of harm to others.

Form F2052A (a prisoner’s history sheet) was opened and stamped with a record of the same initial reception checks. It is hard to read, as the stamp is very faint. An officer has written below that the man had been in Altcourse before and had no

issues. He stated that the man said he had no thoughts or history of suicide or self harm. He was then moved to Furlong red unit.

The man's first night on Furlong Unit

The man signed a "Contract for the Detoxification Unit". This contract stated that he wished to be admitted to the detox unit and that he was fully aware of the contract and rules of the wing. These rules included a commitment to not use any illicit drugs or those not prescribed to him, not to use violent or threatening behaviour to staff or other prisoners, to agree to closed visits, to provide urine samples when asked to do so, and to attend all programmes and activities on the unit.

A "Prisoners Initial Custody Pack" was also started for him. This pack records the prisoner's progress through the induction programme as it is completed. It asks a member of staff to sign off each element of the induction programme. The programme covers several subjects including a gym induction, education assessment and timetabling, suicide and anti-bullying awareness, race relations, health and safety, library and an induction interview. The "initial paperwork" section was signed as complete for the man on 27 July. The initial paperwork includes a first interview with an officer. This was done by an officer and records some pertinent details such as the man's next of kin, the fact that he lived alone, and that he had no dependants or pets that arrangements needed to be made for. It also recorded he had been in custody before. The man signed a form about having a television in his cell and agreed to pay 50 pence per week from his wages for the rental of this.

The man was put into cell 1-46 on Furlong Unit. His cell mate had arrived at Altcourse on the same day as the man (27 July 2005). They had never met before. The man's cell mate was already in the cell when the man was brought in. The man's cell mate was also undergoing a detox. The cell mate remembered that on that first evening they watched television, and had a chat until about 9.30pm, and then he said he fell asleep. He was on the bottom bunk and the man on the top bunk. He said the man did not talk that much but recalled the man telling him that he "had had problems with his wife and that he did not get to see his kid anymore". The man's "First Night Watch" form was completed by a PCO. This form records half hourly observations of the man from 9pm until 10am the next morning. Its purpose is to assess how the prisoner is coping with being in custody, and to see whether they are showing signs of anxiety or distress that might indicate the need to open an F2052SH (suicide and self harm watch form). From the entries on the form, the man continued watching television until 11.30pm and then slept until unlock the next morning at 7.30am. The man had his breakfast at 8am, saw the doctor around 8.30am, the nurse at 9am and then returned to his cell. The form was then signed off by the residential manager. This meant that the half hourly observations could cease. No concerns had been raised about the man by any member of staff.

28 July 2005

The prison GP completed an assessment of the man at around 8.30am on 28 July. He noted the man had an old injury to his shoulder, for which he advised the man to wear a collar and cuff support under his clothes and prescribed him Diclofenac. The GP felt that the man had no current signs of opiate withdrawal and therefore did not prescribe an opiate detox programme of DF118 for him. The man's opiate withdrawal score chart (a three day system of assessing a person's withdrawal from opiates) was four. A score of zero to ten is classed as "no evidence of opiate withdrawal". The score range is from zero to 27. The GP did prescribe a benzodiazepine detox programme for the man. This was Diazepam, on a 14 day reducing programme, starting at 20mg morning and afternoon, reducing gradually to zero. He also prescribed the man Quinnine sulphate (a drug that provides symptomatic relief for leg cramps "shakes") and Metochloropromide (a drug for symptomatic relief for vomiting).

The man and his cell mate were then unlocked for most of the day. The two men did their own thing and did not associate together.

A CARATS worker spoke to the man for about 20 minutes during the afternoon of 28 July, in order to carry out an initial CARAT [drugs treatment] assessment. She recalled that the man looked tired and that he was obviously withdrawing from drugs. He told her that he was happy with his detox programme and that he was okay, but just felt a bit rough. The man reported spending about £500 to £1,000 a week on drugs (about £350 each on heroin, cocaine and crack). He said that he took the drugs with friends and that he always injected. Then man told her he would like to get clean and stay drug free.

The CARATS worker remembered asking the man if he was okay now and he replied, "yes, just tired". She asked him if he had any thoughts of self harm or suicide to which he replied "no". The man did tell her that he suffered with slight depression and said this was because he had lost his brother when he was much younger. However, the man also told her that the depression was not bad enough for him to take anything for it. The CARATS worker was not concerned at all about the man when he left the appointment. She said he did not appear out of the ordinary, just someone who was going through detox.

Another CARAT worker, also spoke to the man on 28 July on Furlong Unit and said that he seemed fine. The next steps in the CARAT process would have been to assign the man a named CARAT worker for his particular home area, as they know exactly what services are available in that locality. A full care plan assessment, and the form "Comprehensive Substance Misuse Assessment" would have been completed. That appointment was scheduled for 8 August 2005. This assessment is a detailed look at a person's past, parenting, accommodation issues, medication, education, leisure interests and offending history.

A long standing friend of the man, said they and a few others were in a cell chatting and having a laugh during the daytime on 28 July. He thought the

man had looked a bit rough and that he was “rattling” a bit because of coming off drugs, but that nothing was out of the ordinary. The long term friend said that if he had had concerns about the man’s state of mind he would have told the officers, but that nothing was unusual or seemed out of place. He said they were reminiscing about past sentences they had done together. The long term friend described the man as “the last person to have done anything”, and that he had no history of suicide or self harm.

At around 5pm, the detoxification wing was locked up for a roll check and the evening medication was brought round to the cells. At 6pm, the wing was unlocked again and there were a few more hours association time. Again, the man and his cell mate did not associate together – the man went off to associate with his mates and the cell mate with his.

The long term friend said that lock up would have been about 8.40pm. He thought the man who died was the last to lock up on the wing because of collecting his detox medication. He remembered the man asking for a pillow. The long term friend gave him one of his and said the man went behind his door “fine”. He said the man was very used to prison and that it was part of his way of life. He had appeared “just as normal as ever” at lock up time, and the long term friend said neither officers nor prisoners could have had any idea that he would do something.

The evening and early hours of 29 July

After lock up, the cell mate said that the man was quiet, but he thought that he might normally be like that or that he was simply quiet because he was going through detox. There were two night staff on duty covering Furlong red and green. One Prison Custody Officer (PCO) was doing the first night observations and therefore was the officer carrying the cut down knife (fish knife). The cell key, in a sealed pouch, was carried by the other PCO. The cell mate remembered that they were watching *Bad Lads* on ITV and that, just before it finished at 10pm, the man who died complained of a pain in his chest. The cell mate pressed the cell bell for him. PCO doing the observations arrived at the cell and decided to call out the healthcare staff, a nurse and a health care assistant.

The nurse and health care assistant went to Furlong Unit with the Orderly Officer. The nurse asked the man to put out his cigarette and to open a window. She then stood on a chair so that she could reach the man on the top bunk and took his blood pressure and pulse. Neither were outside the normal range. The man told the nurse that he had been diagnosed with angina from his GP and that he had a GTN spray. The nurse said that the man looked well enough, was not breathless and his colour was good. She decided to give him two GTN sprays and then advised the man to call her out again if he carried on feeling unwell.

The nurse said that she would not have admitted him to healthcare at that stage as the man looked okay and was relaxed. She did not offer Healthcare as an option and the man seemed okay with this. The cell mate thought he remembered the man asking to go to healthcare, but that the nurse told him it

was too late in the evening to move. The nurse suggested that he swap bunks so that the man would be on the lower level but the man said he was okay where he was. She left the cell after about ten minutes and returned to Healthcare. The nurse thought the man's mood was no different to any other time she had seen him on previous sentences, although she was not specifically looking at or assessing his mood during the visit.

The cell mate said the man was calm after the staff had left but may have said something like "no one cares in here". The cell mate fell asleep shortly afterwards - he estimated around 10.30pm.

No other significant or memorable events took place on Furlong Unit or the rest of the prison between 10.30pm and 4.30am.

The man said he woke around 4.30am as he needed the toilet. The cell was dark. He went to the toilet, came back and put the television on. He then saw the man at the end of the bed. He initially assumed that he was sleeping on the floor as the nurse had told him too, but upon looking again saw that he had something around his neck and that he was hanging by his shoelaces. The man was hanging from the upper bar of the bunk bed. The cell mate felt for a pulse but there was none – he said the man's hand was freezing cold. The cell mate pressed the cell bell and shouted out words like "he's choking himself".

The prison's response to finding the man

The PCO carrying out the first night observations was in the central office in the middle of Furlong Unit and said he responded to the emergency cell bell immediately. The cell mate thought the officer arrived after about two minutes. The PCO said he went up the stairs and opened the view panel on the door. He saw the man hanging from the top bunk. He said the cell mate was pointing to the man. The PCO then used his radio. The PCO said he told the communications room there was a code one and that he was on Furlong Unit. The member of staff working in the communications room, said that the message on the radio from the PCO was "Could you get Oscar one, we *may* have a code one". He said the PCO had not pressed his personal alarm button on the radio, but had transmitted the message as a normal radio transmission. The PCO did not clarify the message further. The communications room man did not therefore know anything about the nature of the incident, nor which cell or prisoner was involved. He did not take the message to mean that there was a code one.

Oscar one, the orderly officer, was in the control room sitting next to the communications man. He said he could not remember the exact words of the PCO's message, but thought it was "looks like a code one". The communications man did not record the message on his Assignment Log as it had not been called in as a code one emergency. He was not sure of the time, but thinks it would have been around 4.35am.

The orderly officer said he ran to healthcare to pick up the nursing staff and told the communications man to get the other staff to Furlong. The communications man then put out a message to the officers with radio call signs November and Oscar two to go to Furlong Unit. He did not use the term "code one" in the message. One of them radioed back to ask who was picking up the healthcare staff, who do not carry keys and who cannot therefore leave the healthcare unit unless 'collected' by a person with keys. The communications man then radioed the orderly officer to check that he was picking up the healthcare staff, which he confirmed.

Meanwhile, the PCO who had gone to the cell went down the stairs after making his radio call and told the other PCO (who had the cell key) that the man was hanging. Both men went up to cell 46. The PCO with the cell key said that the cell mate was trying to get the man onto a chair so that his weight was released from the ligature. The cell mate remembered some wind came out of the man as he tried to do so but that his body was very cold. The cell mate tried to remove the shoe laces from around his neck but could not. Two officers were now outside the cell. The PCO with the cell key said he did not go into the cell because the man might have been "feigning it". Neither officer discussed going into the cell with the other. The PCO with the cell key said he knew the other PCO would not go in and neither would he. He said that the cell mate was calm, but that he would still not consider entering the cell. The PCO with the cell key said he would not enter a cell without four members of staff being present. The PCO who had first responded to the cell bell said that entering a cell at night was a "grey area" and that he thought even a single cell should have three members of staff present before

unlocking. He said he personally did not feel safe enough to go into the cell. The first response PCO did not have a cell key, but had the cut down knife. The other PCO then left the area and went back downstairs to the office to wait for the duty manager and healthcare team.

A Health Care Assistant (HCA) was sitting in the office on the in-patient side of healthcare with a Senior Nurse. They both remember the control room putting out a message for radio call signs Oscar 2 and November to attend Furlong Unit. The HCA said the message was "Oscar two, can you make your way to Furlong". He said there was no mention of a code one or possible code one. The HCA assumed it was a call out because of a general illness or something of that nature. The PCO with the call sign November thought the communications room message was "Can you make your way asap to Furlong Unit". He said no code one was called. The PCO walked to Furlong Unit from the segregation unit. He thought it took him about three minutes to get to Furlong. There was then a further radio message for staff to pick up the healthcare staff en route to Furlong Unit. It was not clear what had happened on Furlong Unit. No emergency radio message had gone out.

The Senior Nurse telephoned Furlong Unit in order to find out what was going on. A PCO answered the phone and said, "Oh, its [the prisoner], he's got a rope around his neck". The nurse said that the PCO spoke in a casual manner and so she interpreted this as meaning the man was sitting with a rope around his neck "threatening" to do something. The nurse did not pick up any emergency equipment such as the "grab bag", defibrillator or oxygen. She said there was no urgency in the PCO's tone of voice. The PCO said during interview that he did not remember speaking to anyone from healthcare, although the HCA confirms a conversation took place.

The healthcare staff went to the entrance of healthcare and were let out of the gates by an officer. All three started to make their way to Furlong Unit. They walked. The officer did not indicate to the nurse that there was an emergency of any sort. The officer thought it took three or four minutes to arrive at Furlong Unit after the initial message from the PCO.

The PCO with the November radio call sign, arrived at Furlong Unit first. He entered the unit and went into the office and saw the PCO who had raised the alarm. The PCO thought he would have told the PCO with the call sign November where the incident was and that he went upstairs. The PCO with the call sign November said that upon his arrival, the PCO who raised the alarm said, "the lad you had seen earlier has just tried to hang himself". The PCO took this to mean that the man had not actually hung himself and so decided to wait in the office for the arrival of the healthcare team and duty manager. He estimated that another minute or minute and a half passed before they arrived. There were now three officers present on the unit. There was still no discussion about unlocking the man's cell. The PCO who raised the alarm said, "It is down to the manager to unlock, not me."

Oscar two is the only member of staff with the "doubles" key. The entrance to every residential unit should be locked at night and then "double locked". Only the Oscar two should have been able to let the other arriving staff, Oscar

one, November and the healthcare staff, into Furlong Unit. Oscar two said he saw Oscar one and the healthcare staff making their way to Furlong as he was coming out of Valentine Unit. He walked briskly and caught them up so that they all arrived outside Furlong Unit at the same time. Oscar two said he removed the doubles and they all went inside. The fact that the PCO with the call sign November was already in the unit at this time leads me to question whether the doubles were in fact on at that time.

According to the nurse, when they arrived on Furlong Unit the PCO who raised the alarm was sitting in the central office, seemingly doing paperwork. Both the Nurse, the PCO who raised the alarm and the HCA thought that about five minutes had now elapsed from the time of the radio message to Oscar one asking him to pick up the healthcare staff and their arrival on Furlong. Oscar two said that the PCO who raised the alarm directed them to cell 46. The PCO remained downstairs in the office in case the control room rang the unit and to carry on with the other watches that needed doing.

One of the other PCOs had remained outside the man's cell during this time. The man's cell mate could not remember whether the officer was giving him instructions about what to do or not. The PCO said he was asking the cellmate questions like how long the man had been there, if he had heard a noise, how he had found him. The cell mate said he had just woken up.

The staff went up the stairs and found the PCO at the door of the man's cell. The HCA looked through the door view panel and saw the man perched on a chair at the end of the bunk beds. He had a ligature from his neck to the top of the bunk, which now looked slack. Oscar one opened the cell. Oscar two thought that the arriving staff only realised at this point how serious the incident was. The cell mate was taken out of the cell and put into a separate room. The nurse, the HCA and the PCO went straight to the man. The nurse tried to cut the ligature with a knife that had been passed to her. She said that the ligature had dug deep into the man's neck and was very tight. The HCA assisted in cutting the ligature (a shoelace). The man's neck was cold and rigid. The nurse shouted, "Why wasn't a code one called?" She then asked Oscar one to call the paramedics. They put the man on the landing so that they would have enough space to administer first aid.

Oscar one told another officer in the communications room what had happened and that it was a code one emergency. The officer recorded this on his Assignment Log at 4.40am. He also asked the communications room to call for an ambulance. The officer recorded doing this on his log at 4.43am. The officer did not video record any of the incident, which would have been normal practice, because he was the only person in the communications room that night and usually there would have been two staff on duty.

The nurse told the HCA to go back to healthcare and collect the emergency equipment (emergency grab bag, defibrillator machine, drug bag and oxygen). The HCA and the PCO with the call sign November went together. They ran there and back and were gone for around one or two minutes. Meanwhile, the nurse commenced CPR at a rate of 15 chest compressions to two breaths, using a face mask carried on her belt. The PCO who had waited outside the

cell was present at this time. He did not assist the nurse in resuscitation but held the man's head. The man did not respond to CPR. When the emergency equipment arrived, the man was given oxygen. The HCA took over doing the CPR whilst the nurse set up the defibrillator machine. The defibrillator indicated that the man was "not shockable". This instruction was automatically reviewed every minute by the machine. No shocks were administered to the man. The nurse and the HCA continued with CPR until the paramedics arrived.

The ambulance arrived at 4.50am, seven minutes after being called. The officer in the communications room had used his automatic override to open both gates (inner and outer) in order to speed up the passage of the ambulance. Oscar two escorted the ambulance to Furlong Unit, via the back of the prison and through three gates. The paramedics arrived at cell 46 at 4.55am. The paramedics asked the Nurse how long she had been giving CPR and she replied about 15 minutes. They all agreed that further efforts were very unlikely to be fruitful and so the nurse left to go and ring the doctor so that he could attend and certify the man's death. The paramedics did an ECG reading which was a flatline. The man's body was moved into cell 45 and both cells were sealed, pending the arrival of the police and Coroner.

The prison's response following the man's death

The man's cell mate had been taken to the activity room on the wing and left there whilst the staff worked to resuscitate the man. After the man had died, the HCA went to the room and sat with the cell mate and told him what had been happening. He told the cell mate that the man had died. The HCA thought that the cell mate was very calm about what had happened and said this surprised him. Some staff commented during interview that the cell mate was fully dressed with his trainers on and that, in hindsight, this seemed odd. Whilst the man's clothing and reaction might have been a little unusual, I do not conclude that anything was more seriously amiss about events that night. The police have not suggested that the man's death was other than self-inflicted.

The HCA said he reassured the cell mate and told him that lots of people would see him during the day time and that help was there if he needed it. The cell mate went to healthcare for the rest of the night. The HCA gave him a cup of tea and then kept an eye on him. He said that the cell mate seemed to go back to sleep quite quickly. The cell mate has since been seen by a Carer, chaplain, counsellor and the doctor.

The duty director arrived at 5.15am. He held a short staff debrief later that morning. The doctor attended the prison and pronounced the man dead at 6.25am.

The Chaplain was asked by the Director upon her arrival at the prison at 7.45am to break the news of the man's death to his family. She left the prison with the designated family liaison officer at 9.15am and travelled to the address they had been given for the man's brother. Upon arrival, they were told that he no longer lived there and that he was living with, and caring for, his elderly father. They therefore travelled to the father's address, arriving at 9.50am.

The news of the man's death was broken to his brother and father by the chaplain and family liaison officer. In her note of the meeting, the chaplain said his family told her they had worried for some time that the man might have overdosed on drugs. His brother said he knew what prison was like and that "you can't watch them all the time". The chaplain asked about possible funeral arrangements and offered financial support from the prison. She also asked whether his father or brother wished to visit Altcourse and see Furlong Unit. The family declined this offer.

A notice to staff and prisoners informing them of the man's death was written and displayed. Staff who had been directly involved were approached by the Care Team and offered support if they needed it.

Issues considered during the investigation

- ***Admissions process***

My investigator observed a first reception discussion between a PCO and a newly arrived prisoner. The PCO used this period to check the prisoner knew why he was in custody, to complete form F2050 (a prisoner's core record) and the first section of the Cell Sharing Risk Assessment form (a form used to identify those prisoners who might not be suitable to share a cell due to a known history of violence, homophobia or racism). F2050 records details such as the prisoner's name, prison number, date of birth, nationality and identifying information such as height, weight, eye colour, tattoos, scars. The prisoner was asked for their last address and also the name, address and telephone number of their next of kin / person to contact in an emergency. The officer used this time to ask the prisoner how he was feeling, if he had any worries about being in prison, if he had been in before etc. The officer kept returning to these issues every now and again. He specifically asked the prisoner if he was feeling depressed, suicidal or like hurting himself. He also asked whether the prisoner had ever tried to self harm in the past. After the discussion, the officer explained to my investigator that he was also looking out for non-verbal indications that something might be wrong such as lack of eye contact, looking nervous or worried, unusual mannerisms. My investigator was impressed with the conduct of this officer and the quality of his reception screen.

Prisoners are offered a two minute telephone call in Admissions. Once they arrive on the wing, they are able to write down the numbers they want to have on their PIN phone system and are given a £2 advance so that they can make telephone calls as quickly as possible.

There is always at least one Carer in Admissions. 'Carers' are the equivalent to "Listeners" in public sector prisons. A Carer is a prisoner trained in listening and communication skills. They also receive some training in mental health awareness and first aid. Their role is to offer help and support to other prisoners, particularly those who may be feeling depressed or suicidal. The Carers have a chat with each person and try to find out if a prisoner in Admissions has any problems or if it is their first time in custody. They list all the names of the prisoners they speak to on a sheet on paper, and also identify those they feel should have a follow up visit once they are on the wing. If a Carer has a real worry about someone, they would speak to a member of staff straightaway and alert them to their concerns.

My only observation about the Carers process in Admissions is that my investigator felt it was difficult for the Carers to have any privacy with the person they were speaking to. There was no separate screened off area or room. This might mean that some new prisoners feel too inhibited or 'on show' to open up to a Carer and say how they are really feeling. I ask the

Director to explore whether a more private interview area could be provided for the Carers.

Local Recommendation 1: *The Director should explore whether a more private interview area could be provided for the Carers in Admissions.*

The Samaritans phone number is advertised on wings and in reception and prisoners are able to call the Samaritans from any pin phone.

The man underwent the full reception process upon his arrival at Altcourse on 27 July. The relevant core record paperwork was completed accurately by the reception officer, and the reception nurse carried out an appropriate reception health screen. Neither member of staff identified any concerns about the man's mental health and neither viewed him as at risk of suicide or self harm. The Carers did not raise any concerns about the man when he came through Admissions. I think the assessments and judgements made by staff in reception regarding the man were reasonable.

- ***Clinical review***

The clinical review concluded that the health issues raised by the man during the first reception health screen were addressed appropriately. It also concluded that, as no psychiatric history, history of self harm or any concerns were raised by or about the man, there was nothing to suggest opening an F2052SH form would have been appropriate. No recommendations for improvement were suggested by North Liverpool PCT.

- ***Detox programme***

A qualified nurse (RMN or RGN) sees a prisoner in reception and assesses whether they are showing signs of drug and/or alcohol withdrawal. Once located on a residential unit, one of the officers does a urine dip test and notes the result. The following morning, about 8.30am, one of the doctors sees all the detoxing receptions from the previous night. The doctor is given the results of the dip test (which provides a partial picture) and then goes on to assess how addicted or dependent a person is. A full history is taken in order to assess this level of dependency. Pulse and blood pressure are also taken and the prisoner is asked what symptoms they are experiencing.

DF118 is given for heroin detox over a 14 day, high to low dose programme.

Diazepam is given for benzodiazepine detox and this also helps people to sleep.

Librium is given for alcohol detox.

It is not normal practice to admit people into the healthcare centre when they are undergoing a heroin detox. Prisoners who are severely withdrawing from alcohol may be admitted to the healthcare centre for a couple of days for an increased level of observations.

A compact is signed before the detox commences. If the compact is broken, for example by the prisoner hoarding his medication or giving it to someone else, the doctor will decide whether to remove him from the rest of his detox. If this happens the prisoner may be asked to move to the other side of Furlong Unit (Furlong green). Once a detox programme has been started, a specialist detox nurse assesses all of the patients every day for three days, using an opioid scoring system. This helps to indicate the level of severity of their withdrawal. The detox nurse can also advise the doctor if she feels the prisoner's medication may need adjusting.

Medication is dispensed by a nurse on Furlong red unit. The nurse watches each prisoner take their medication. The CARAT team normally carry out an initial assessment within 72 hours of a person's arrival. The detox regime looks thorough, carefully managed and controlled, although the use of DF118 for heroin detoxification is no longer in line with practice in most prisons. My investigator thought the opiate scoring system looked particularly good and I have identified this as an area of good practice.

Good practice – *The daily assessment of all prisoners undergoing detox by a qualified nurse using an opiate scoring system is an example of good practice.*

Nationally, the Prison Service encourages the prescribing of methadone, iofexidine or subutex over DF118 as an opioid detoxification drug. DF118 is not licensed for detox but may be used for symptomatic relief. Although the man was not prescribed a detox programme for his heroin misuse during this last period of custody, I urge the Director – in conjunction with Veritas Ltd - to review the detoxification medication used and the new Prison Service policy for withdrawal management.

Local recommendation 2 – *The Director, in conjunction with Veritas, should review the detoxification medication used for prisoners undergoing detox for opioid misuse.*

- ***The staff response upon finding the man***

Altcourse has a code system that is used to alert all staff, and medical staff in particular, to the type of situation they are being called to respond to. A code one indicates that the emergency is a hanging, cardiac arrest or unconscious collapse. Code two indicates that someone is bleeding or having trouble breathing and a code three indicates a fit or convulsion. This system of codes ensures that the right medical equipment is taken to the scene of an incident.

The officer in the communications room said normal radio procedure for a code one emergency is for the member of staff to press the personal alarm button on their radio. This comes up on the screen, along with a bleeping noise. The member of staff relays what the incident is and also its location. By pressing the personal alarm button, everyone carrying a radio in the prison is automatically aware that there is an emergency and everyone is prepared to respond to it. The communications room then puts the net on "talk through" (so that every person with a radio hears the message) and would say "all

stations first response" and state the location. Healthcare staff are then immediately aware of the nature of the incident and are able to take the appropriate medical equipment with them.

Oscar two confirmed that this is normal radio procedure when a code one is called. Oscar one subsequently re-iterated to all his night staff that, if there is a code one situation, then staff should press the personal radio alarm button so that the bleeps go out to everyone. This method of alerting the communications room ensures everyone with a radio knows there is a code one and can respond accordingly.

The message from the PCO at the cell was not transmitted in this way. The PCO said he did not use the personal alarm button on his radio as that would have meant the control room had to get back in touch with him in order to find out what the emergency was. However, my judgement is that the PCO did not use the most appropriate means of alerting staff to the situation on Furlong Unit.

The PCO stated during interview that he did know what sort of emergency a code one referred to. He went on to say that he told the communications room there was a code one on Furlong Unit in his radio message. The interviews with other staff indicate that the PCO's message upon finding the man was more likely to have been "we may have a code one" or "looks like a code one", not that there actually was one. The two staff who heard the message directly from the PCO, the officer in the control room and Oscar one, both agree that the PCO did not say it was a code one emergency. These two staff went on to react as though it was not a code one emergency either – the officer in the communications room did not use the term "code one" in any of his following radio transmissions and, although Oscar one says he ran to healthcare, he stated that he walked from there to Furlong and did not communicate any urgency to the healthcare staff he collected en route.

The senior nurse telephoned Furlong Unit in order to find out what was going on as she was uncertain of the nature of the incident they were about to go to. She said that, although the PCO she spoke to indicated the man had a rope around his neck, he said it in such a casual, non-urgent way, that she assumed he meant the man was threatening to do something and that this was why healthcare had been asked to go over to Furlong Unit. The PCO apparently did not recall having this conversation with the nurse at all, although the HCA confirms it definitely took place.

The upshot of both the way in which the PCO transmitted his message, the actual message itself, and the telephone conversation with the senior nurse, is twofold. First, that there was a time lapse of around five minutes between the first radio message and the healthcare team's arrival on Furlong Unit. The healthcare centre is not far from Furlong Unit and a response would have been possible within about a minute or slightly over. Secondly, no emergency medical equipment was initially taken to the man's cell. The HCA and PCO with the call sign November had to run back to healthcare to collect the equipment upon discovering the true nature of what they had responded to. Whilst it is probably fair to say that neither the time delay nor lack of medical

equipment had an impact on the likelihood of the medical staff being able to resuscitate the man, they are both relevant in terms of learning from what happened. In a future situation, lost minutes or lack of medical equipment might be of vital importance and might be the difference between saving or losing someone's life.

Recommendation 3 – *The Director should remind all staff of the code one, two and three emergency coding system and what incidents each number refers to.*

Recommendation 4 – *The Director should remind all night staff of the correct radio procedure when calling in a code one emergency.*

PSO 2710, "Follow up to deaths in custody", states at para 2.2, "The first person on scene must summon help and request local emergency clinical assistance. If establishments use codes to alert clinical staff to the type of emergency and type of first aid equipment that will be needed, local contingency plans must explain clearly the code definitions..."

PSO 2710 states at para 2.3, "If the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible, following the local strategy for safely doing so. Local protocols must contain clear instructions covering cell entry, especially for night patrols ... carry out emergency first aid procedures described in PSO 2700 (annex C), until clinical staff arrive." Annex C states that a person found hanging should be cut down, placed on their back on a flat, solid surface, and a check made for any signs of life. It goes on to say that, unless rigor mortis has clearly set in, resuscitation (using a face mask with a non-return valve) should be attempted.

The night state death in custody contingency plan for Altcourse does not mention the code system for alerting healthcare to the type of emergency. Bullet point two states that the "first on scene" during night state must not automatically assume death. Bullet point three says first aid should be rendered, using other staff to assist. The next bullet point states, "do not unlock a cell unless you are absolutely satisfied that there is a genuine need. Await assistance from the night manager if in doubt." During night state it would not be possible to render first aid without unlocking the cell. If death should never be assumed, then there would always be a genuine need to unlock a cell in an emergency situation. The contingency plans do not make reference to staff safety in deciding whether to unlock a cell, nor how many staff are appropriate to unlock a cell. Altcourse's plans do not conform to the guidance given in PSO 2710.

Neither the PCO who raised the alarm nor the PCO who spoke to the nurse said they knew the contents of the local contingency plan for a death in custody, nor what it said about the actions of someone who was first on the scene. They were both first aid trained and had been refreshed in the last three years. The PCO who spoke to the nurse carried a medi-pack on his belt; the PCO who raised the alarm did not.

The PCO who raised the alarm said he personally would not feel safe entering a cell at night on his own – not particularly because the cell mate was in cell 46, but just generally. The PCO who raised the alarm said he did consider it at the time, but decided not to go in. He said he would not generally go in. He thought three members of staff should be present before unlocking. The PCO who spoke to the nurse said he would only go into a double cell with four officers. My investigator asked him if this was still the case when one of the prisoners was hanging. He replied, "supposedly" hanging. My investigator put it to him that it was almost unheard of for someone to "fake" a hanging in this way. The PCO replied that he had seen people hanging who had "pretended to be hanging". The PCO also said, "It is down to the manager to unlock, not me". I am disappointed by the responses of the PCO, and his clear unwillingness to enter a cell in an emergency situation such as this.

For a minute or two before the healthcare team and Oscar one arrived, there were three officers on the unit. There was still no discussion about, and no consideration given, to entering the man's cell.

Recommendation 5 – *The Director should revise the local contingency plan for first on the scene when a death in custody is suspected. The revised instructions should make reference to the code system of alerting others to the emergency. They should also make clear the expectations placed on staff in relation to how to raise the alarm, when to enter the cell (and what safety considerations to take into account before doing so) and when and how to administer first aid.*

Recommendation 6 – *The Director should ensure PCOs are familiar with the contents of the local contingency plans for a death in custody. Night staff could be issued with a copy of key instructions when they come on duty and collect their night equipment.*

Recommendation 7 – *The Director should consider issuing an instruction to staff clarifying the policy about wearing a small medi pack as part of their standard issue equipment.*

List of Recommendations

Local recommendation 1- The Director should explore whether a more private interview area could be provided for the Carers in Admissions.

The prison responded by accepting this recommendation and said, "this has been in place for some time, however, the lack of an alternative location has meant that the carers location has remained".

Local recommendation 2 – The director, in conjunction with Veritas, should review the detoxification medication used for prisoners undergoing detox for opioid misuse.

The prison responded by accepting this recommendation and said, "A review will be carried out – Office for Contracted Prisons have yet to accept the Prison Service Policy for withdrawal management. The policy at Altcourse does allow for Lofexidine when prisoners are moderately to severely withdrawing and for Methadone in certain defined circumstances. It is also worth pointing out that the 'Orange Book' which is supposed to shape policy includes a rider at the bottom of the Methadone section which says 'in the case of Methadone allergy use Dihydrocodeine'".

Local recommendation 3 – The Director should remind all staff of the code one, two and three emergency coding system and what incidents each number refers to.

The prison responded by accepting this recommendation and said, "All staff will be reminded in writing of the emergency coding system and what incidents each code refers to".

Local recommendation 4 – The Director should remind all night staff of the correct radio procedure when calling in a code one emergency.

The prison responded by accepting this recommendation and said, "All night staff will be refreshed in Emergency Radio Procedures via one to one training".

Local recommendation 5 – The Director should revise the local contingency plan for first on the scene when a death in custody is suspected. The revised instructions should make reference to the code system of alerting others to the emergency. They should also make clear the expectations placed on staff in relation to how to raise the alarm, when to enter the cell (and what safety considerations to take into account before doing so) and when and how to administer first aid.

The prison responded by accepting this recommendation and said, "Contingency Plans have been updated to include reference to the code system of alerting others to the emergency. The update also makes clear the expectations placed on staff in relation to how to raise the alarm, when to enter the cell, what safety considerations to take into account before entering a cell and when and how to administer first aid".

Local recommendation 6 – The Director should ensure PCOs are familiar with the contents of the local contingency plans for a death in custody. Night staff could be issued with a copy of key instructions when they come on duty and collect their night equipment.

The prison responded by accepting this recommendation and said, "All staff have access to local contingency plans including those for a death in custody. Night staff will be issued with a set of key instructions".

Local recommendation 7 –The Director should consider issuing an instruction to staff clarifying the policy about wearing a small medi pack as part of their standard issue equipment.

The prison responded by accepting this recommendation and said, "Medi packs have been ordered and will be issued to all staff. Instructions regarding their use and their inclusion as standard issue equipment will also be issued".

Housekeeping a – Form 'HMP Altcourse Risk Assessment – New Admissions' should include a space for the name and signature of the person completing the form.

Housekeeping b – Form 'First Reception Health Screen' should be fully completed, including the last page about planned follow up action.

Good Practice

The daily assessment of all prisoners undergoing detox by a qualified nurse using an opiate scoring system is an example of good practice.