

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Robinson, a prisoner at HMP Altcourse, on 25 April 2021

A report by the Prisons and Probation Ombudsman



Our vision

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



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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 Stuart Robinson was found hanged in his cell at HMP Altcourse on 25 April 2021. He was 20 years old. I offer my condolences to Mr Robinson's family and friends.

Mr Robinson arrived at Altcourse on 3 March 2021 with a suicide and self-harm warning form. However, staff did not start suicide and self-harm monitoring (known as ACCT). I am concerned that prison and healthcare staff did not fully consider the documentation that arrived with Mr Robinson and failed to assess his risk of suicide and self-harm properly.

Staff started ACCT monitoring on 8 April, after Mr Robinson wrote a letter to a friend saying he intended to kill himself. He was still being monitored under ACCT when he died.

The investigation found that the ACCT procedures were poorly managed. Caremap actions to address Mr Robinson's risks were not always reviewed or completed, observations were not reinstated when Mr Robinson self-harmed two days before he died and apart from the first review, healthcare staff did not attend ACCT reviews.

The investigation also found that when Mr Robinson indicated to staff that he was in debt to other prisoners, staff did not explore this further to establish whether he might be a victim of bullying.

The clinical reviewer was concerned that despite Mr Robinson having a history of self-harm and being monitored under ACCT, the mental health team did not put a care plan in place.

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

Sue McAllister CB
Prisons and Probation Ombudsman

December 2021

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Summary

Events

1. On 3 March 2021, Mr Stuart Robinson was sentenced to 26 weeks in prison for failing to comply with a notification order. He was sent to HMP Altcourse.
2. Mr Robinson arrived at Altcourse with a suicide and self-harm warning form, but reception staff did not start suicide and self-harm prevention procedures (known as ACCT).
3. On 8 April, staff intercepted a letter that Mr Robinson had written to a friend which said he intended to kill himself. Staff started ACCT procedures.
4. Mr Robinson told staff that anniversaries of the deaths of several family members were approaching and asked for counselling. Staff noted that Mr Robinson would need additional support around the anniversary of one of the deaths in mid-May and should be referred to a counselling service in the community before his release on 1 June.
5. At around 5.00am on 25 April, during a routine count of prisoners, an officer found Mr Robinson hanging by a ligature tied to the cupboard in his cell. He called a medical emergency code. Staff arrived and cut down Mr Robinson, but they did not try to resuscitate him as there were clear signs he was dead. Paramedics arrived and at 5.16am, confirmed that Mr Robinson had died.

Findings

6. Mr Robinson's risk of suicide and self-harm was not properly assessed when he arrived at Altcourse. Staff did not fully consider information on the suicide and self-harm warning form that arrived with him.
7. We found that the ACCT procedures, once started, were poorly managed. The immediate action plan was recorded as having been completed before the ACCT was opened, the ACCT assessment was not completed within 24 hours, and the caremap lacked specific detail to support and manage Mr Robinson's risk and was not reviewed as it should have been. Observations were not restarted when Mr Robinson cut his arm on 23 April. ACCT reviews were not multidisciplinary as healthcare staff attended only the first review.
8. The clinical reviewer concluded that the clinical care Mr Robinson received at Altcourse was of a reasonable standard and equivalent to that he could have expected to receive in the community. However, he considered that staff should have put mental health care plans in place. He also considered that the prison counsellor should have seen Mr Robinson about his bereavement issues.
9. In the week before his death, Mr Robinson told an officer during a key work session that he had issues on the wing and indicated during an ACCT review that he may be in debt, yet there is no evidence these comments were explored further to assess whether Mr Robinson might be a victim of bullying.
10. Mr Robinson tried to call his grandmother several times on 23 and 24 April but the calls would not connect. This was because her number was never added to Mr

Robinson's PIN phone, despite several requests. The number he provided was a digit short, but nobody checked with him to correct the error. Altcourse has told us that they are reviewing the PIN number process.

Recommendations

- The Director and Head of Healthcare should ensure that reception staff:
 - consider all information arriving with the prisoner, particularly the PER and SASH form, when assessing their risk of suicide and self-harm to ensure the assessment of a prisoner's risk of suicide and self-harm is based on the prisoner's known risk factors, rather than on their presentation alone; and
 - record the information considered and their reasoning when they decide not to start ACCT procedures.

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular staff should:
 - ensure case reviews are multidisciplinary, with healthcare staff in attendance where appropriate;
 - set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk;
 - ensure all caremap actions are reviewed and completed;
 - review risk and level of observations following an incident of self-harm; and
 - invite family members to contribute to the ACCT, if appropriate.

- The Head of Healthcare should ensure that staff put mental health care plans in place for prisoners who need ongoing support from the mental health team.

- The Director should ensure that staff identify and manage prisoners at risk of bullying, intimidation, or violence in line with the prison's violence reduction policy, in particular all staff should:
 - receive training on CSIP and understand the referral process and expectations of their role;
 - provide effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations; and
 - consider whether apparent victims are at increased risk of suicide and self-harm.

- The Director should ensure that the review of the PIN phone application process considers how PIN phone access for prisoners subject to ACCT monitoring can be prioritised and if numbers are found to be incorrect, they are flagged to the prisoner at the earliest opportunity.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Robinson's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Robinson's clinical care at the prison. The investigator interviewed eleven members of staff and one prisoner. Seven of these interviews were conducted jointly with the clinical reviewer. All the interviews were conducted remotely because of the restrictions imposed in response to COVID-19.
14. We informed HM Coroner for Liverpool and the Wirral of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The PPO's family liaison officer contacted Mr Robinson's mother to explain the investigation and to ask if there were any matters she wanted us to consider. She did not have any questions.
16. Mr Robinson's family received a copy of the initial report. They did not identify any factual inaccuracies.
17. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP Altcourse

18. 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

19. The most recent full inspection of Altcourse was in November 2017. Inspectors reported that Altcourse had an excellent staff culture and that all interactions between staff and prisoners that they saw were positive.
20. 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

21. 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 healthcare provision was highly regarded in the prison and that nurses attended all residential units daily to offer clinics, triage and to give medication.
22. 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 Robinson was the 15th prisoner to die at Altcourse since April 2019. Of the previous deaths, 12 were from natural causes, one was self-inflicted, and in one case the cause of death was unascertained.
24. We have previously made a recommendation about the management of the ACCT process at Altcourse.

Assessment, Care in Custody and Teamwork (ACCT)

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and support the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

26. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Key Events

27. On 3 March 2021, less than two weeks after being released from HMP Preston, Mr Stuart Robinson was sentenced to 26 weeks in prison as he had failed to comply with a notification order. (Those convicted of sexual offences are required to notify certain personal details to the police in their area.) He was sent to HMP Altcourse.
28. On Mr Robinson's Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose) court staff had recorded that Mr Robinson had a history of self-harm ("cut arm 17.02.21"). A police warning form also accompanied the PER which noted that Mr Robinson had said in the past (November 2020) that he intended to hang himself in prison. He was monitored every 30 minutes while in police custody and, when he was taken to court, he was placed in a cell that could be constantly monitored (although he was not on constant watch). Mr Robinson told all those he had contact with that he had no current thoughts of suicide or self-harm.
29. When Mr Robinson arrived at Altcourse, an officer completed the reception screen. He noted on Mr Robinson's prison record that Mr Robinson had arrived with a suicide and self-harm (SASH) form but had said he had no thoughts of harming himself. On the first night assessment and support paperwork, the officer noted that Mr Robinson had expected to be sent to prison, had no issues with drugs or alcohol, but had depression and anxiety. The officer did not record the information from Mr Robinson's PER and noted that the suicide and self-harm markers were 'historic'. There is no evidence that he considered opening an ACCT. Mr Robinson completed a form for his mother, grandmother and two friends to be added to his PIN phone.
30. A nurse completed the initial health screen. She noted in Mr Robinson's medical record that no concerns had been raised about his risk and that he had not tried to harm himself, but later noted that Mr Robinson said he had cut his wrist about a month earlier. Mr Robinson said he was teetotal and did not use drugs. He declined to be referred to the mental health team but said he wanted to discuss his medication with them.
31. On 4 March, a nurse completed Mr Robinson's secondary health screen. His care was discussed at the integrated mental health team meeting (IMHT) and he was referred to the primary care mental health team for assessment. On 6 March, a prison GP prescribed Mr Robinson with an antidepressant (citalopram), which he was allowed to keep in his possession.
32. On 8 March, Mr Robinson submitted a form granting permission for money to be transferred from his account as phone credit and listed his mother, grandmother and two friends on his PIN phone. The form has been marked with a tick against his mother and one friend's name, but 'NA' next to his grandmother and second friend. The next day Mr Robinson submitted another PIN phone request form. The PIN phone records show the number for his grandmother as 'barred' but marked in pen as 'deadline'. (During a key work contact on 6 April and during an ACCT conversation on 18 April, Mr Robinson again requested that his grandmother's telephone number be added to his PIN phone and an officer sent it to be processed, but the number was never added as it was incorrect as one digit was missing.)

8 April: ACCT monitoring

33. On 8 April, a staff member intercepted a letter Mr Robinson had written to his friend, which said that he intended to kill himself by taking all his medication. Staff started suicide and self-harm monitoring (known as ACCT) and set observations at five an hour. According to the time on the Concern and Keep Safe form, the ACCT was opened at 9.41am. However, a First Line Manager (FLM) recorded that he had completed the immediate action plan at 9.00am. A nurse collected Mr Robinson's medication, which he was no longer allowed to keep in his possession.
34. On 9 April at 11.00am, an officer completed Mr Robinson's ACCT assessment. Mr Robinson said that he struggled with family bereavements and that the anniversaries of several deaths were approaching. (We understand that his elder brother had died on 14 May 2015, his youngest brother on 17 June 2020 and his stepson on 14 June 2020, but this has not been verified.) Mr Robinson said he had tried to hang himself in December 2020 and had cut his arms in January 2021 while he was at Preston. Mr Robinson said speaking to his mother, grandmother, uncle and girlfriend provided him with support, but he wanted to engage with the mental health team and specialist bereavement counselling.
35. A nurse completed a mental health assessment with Mr Robinson before his first ACCT review. Mr Robinson told her that he had been taking antidepressant medication for four months but did not feel it had helped and asked if he could change to a different medication. She told him that she would ask the prison GP to review his medication.
36. Mr Robinson told the nurse that he had suffered several bereavements which he found difficult, and the approaching anniversaries had led to his low mood. He said he had spoken to someone from safer custody, that he felt better and no longer wanted to end his life. She recorded that Mr Robinson's mother, and his friend, were protective factors and he spoke to them daily. She provided Mr Robinson with a distraction pack and referred him for advice on bereavement counselling for when he was released. (The prison bereavement counsellor said Mr Robinson was too close to release for him to undertake counselling in the prison.)
37. At 2.30pm, a FLM chaired the first ACCT review, which was attended by the nurse and Mr Robinson. (An officer provided a verbal contribution). The FLM recorded that Mr Robinson was looking forward to his release on 1 June and to celebrating his 21st birthday with his family but was affected by the deaths of family members. Mr Robinson said he had spoken to his mother which had helped, and he had no current thoughts of suicide or self-harm. The FLM noted that there was insufficient time for counselling, but that Mr Robinson would be referred to outside agencies for support on release. The FLM recorded that Mr Robinson would continue to receive support from the mental health team and his medication would be reviewed. (There is no record of what support the mental health team would provide and there was no mental health care plan.) The FLM noted that Mr Robinson found the level of observations intrusive, and they were reduced to two an hour.
38. The FLM added three caremap actions: the mental health nurse to refer Mr Robinson for community bereavement counselling prior to his release; for the ACCT case manager to put protective measures in place around the trigger date of 14 May (anniversary of brother's death); and for a review of Mr Robinson's antidepressant medication.

39. On 12 April, a nurse assessed Mr Robinson after he passed out in his cell. Mr Robinson's cellmate alerted staff and had placed him in the recovery position. She noted that all of Mr Robinson's clinical observations were within normal range and advised him to maintain his fluid intake as he was probably dehydrated.
40. On 14 April, a FLM, the ACCT case manager, chaired a review attended by an officer and Mr Robinson. The FLM recorded that Mr Robinson wanted to attend the chapel to light a candle and he added this to the caremap (the other caremap actions were not reviewed). He assessed that Mr Robinson's risk of suicide or self-harm had reduced to low. He stopped observations but set two meaningful conversations a day, one each morning and afternoon. He scheduled the next review for 26 April.
41. A prison GP responded to the referral from the nurse to review Mr Robinson's antidepressant medication and scheduled an appointment with him for 22 April.
42. On the evening of 18 April, a nurse assessed Mr Robinson after he made a cut to his right forearm. She noted that the wound was superficial, and she cleaned and dressed it. She recorded that ACCT observations had been increased to hourly and she referred Mr Robinson to the mental health crisis team.
43. On 19 April, a FLM held an ACCT review with an officer and Mr Robinson. He noted that Mr Robinson had cut his arm as he was stressed because he had run out of vapes but 'is able to sort them to pay back on canteen day'. There is no evidence that staff considered if Mr Robinson was being bullied for a debt and no evidence that violence reduction measures (known as CSIP) were considered. Mr Robinson said he had attended the chapel which he had found helpful.
44. The FLM assessed that Mr Robinson's risk was low. He stopped hourly observations and replaced them with one conversation each morning and afternoon. He reviewed the caremap and noted that two actions had been completed. Mr Robinson had spoken to the chaplain and lit a candle. The action for the case manager to put protective measures in place around the trigger date was recorded as completed, but there is no record of what measures had been put in place or what support was being provided to Mr Robinson. He scheduled the next review for 25 April.
45. On the morning of 20 April, a nurse recorded in Mr Robinson's medical record that she had seen him for 'crisis intervention' and completed a mental health assessment. She noted Mr Robinson did not seem down or low in mood, and that he said he had no intention of harming himself and had cut himself for many years to cope with stress. Mr Robinson told her that he had found the chaplaincy helpful, had support from his mother and girlfriend and had a GP appointment booked about his medication. He also said that he was looking forward to being released and seeing his family again. She noted that she was going to refer Mr Robinson to the IMHT to follow up on her assessment and his medication.
46. Mr Robinson maintained contact with his family and friends throughout his time at Altcourse. All prisoners' telephone calls, except those that are legally privileged, are recorded and prison staff listen to a random sample. The investigator listened to the calls Mr Robinson made in the days before his death.

47. At 4.53pm on 20 April, Mr Robinson spoke to his girlfriend for around eight minutes. During the call Mr Robinson said he 'will get pissed off and cut his arms' and she replied if he loved her then he would not harm himself. Mr Robinson said he was looking forward to his cellmate being released, that he had 40 days left of his sentence and they ended the call by each saying they loved the other. At 6.12pm, Mr Robinson spoke to his mother for around eight minutes. They discussed her sending money to his cellmate, about arguments between his partner and another girl and he questioned if he was being lied to.
48. On 21 April, an officer met Mr Robinson for a key work session and recorded in the prison record that Mr Robinson had told him he was having issues on the wing but did not say what they were. He noted that he told Mr Robinson that if it carried on, staff would need to know so they could deal with it. There is no corresponding entry in Mr Robinson's ongoing ACCT record that he had issues on the wing.
49. Mr Robinson made several phone calls to his girlfriend and to his mother. When he contacted his mother at 4.43pm, Mr Robinson's grandmother answered and he told her that he had 'cut his arm the other day', but the call ended abruptly. When he called back, both said they did not know why the call ended and went on to discuss other things and did not return to the subject of Mr Robinson's self-harm. During calls to his girlfriend, they discussed ongoing arguments between people they knew, but then agreed to get married when Mr Robinson was released.
50. On the morning of 22 April, a prison GP spoke to Mr Robinson on his in-cell telephone (due to COVID-19 restrictions). He noted that Mr Robinson said his antidepressant was not working and he wanted to change medication. He also said that the anniversary of his brother's death was approaching but he had no thoughts of suicide or self-harm. He told Mr Robinson that he would change his antidepressant to fluoxetine, signposted him to bereavement counselling and explained the importance of exercise and participating in education or work.
51. That afternoon, Mr Robinson spoke to his mother for just over six minutes. During this call she told him that she could not send money to his cellmate and asked for his bank details again (she later said the bank had declined the transfer). Mr Robinson also told her that his girlfriend's telephone number was on his friend's PIN number and spoke of arguments she was having with another girl. Mr Robinson told his mother to avoid the arguments and said that the situation was 'doing his head in'.
52. Around lunchtime on 23 April, Mr Robinson spoke to his mother for just over eight minutes. He told her that he was pleased to be in the cell on his own as his cellmate had been released. He said that he had not been able to call his grandmother as there had been an issue with getting her number placed on his PIN phone. Mr Robinson then said he was 'stressed out' by arguments between his girlfriend and another woman. Mr Robinson's mother told him to call her again on Monday [26 April].
53. Later that afternoon, an officer recorded in Mr Robinson's prison record that he had made a superficial cut to his arm as he was stressed after a telephone call with his girlfriend. The officer noted in Mr Robinson's ACCT that he would 'remain on conversations'. There is no evidence this decision was discussed with a manager or that re-introducing ACCT observations was considered. A nurse examined Mr

Robinson and recorded that he had used a razor blade to cut his arm; she cleaned and dressed the wound.

54. That afternoon and evening, Mr Robinson tried to telephone his grandmother on three occasions, but the call would not connect as her number was not on his approved list of numbers. Mr Robinson also tried to call his girlfriend four times, but there was no answer. He also tried to call the other girl involved in the dispute with his girlfriend on four occasions, but the call would not connect as it was also not on his approved list of numbers.
55. On 24 April, a FLM completed an ACCT review, in response to Mr Robinson's recent self-harm, with another FLM and Mr Robinson. He recorded that Mr Robinson said he had cut his arm after an argument with his girlfriend. He recorded 'this was just a flash reaction out of frustration'. Mr Robinson said he had resolved the argument with his girlfriend, and they were engaged to be married. The FLM assessed Mr Robinson's risk as low and kept him on one conversation each morning and afternoon. He did not review the caremap. He scheduled the next ACCT review for 27 April.
56. Mr Robinson tried to make 21 calls that day, including two to his grandmother (number barred) and 13 calls to his girlfriend. None of the calls were answered.

25 April

57. Closed circuit television (CCTV) shows that at around 5.00am on 25 April, while conducting a roll check (count of prisoners), an officer arrived at Mr Robinson's cell and looked through the observation panel. He saw Mr Robinson hanging and radioed a code blue (a medical emergency code used when a prisoner is unconscious). Another officer responded to the call and unlocked the cell. He found Mr Robinson with a ligature around his neck tied to his cupboard by a torn bedsheet. He cut the ligature and lowered Mr Robinson to the floor. Other prison and healthcare staff also responded to the medical emergency. They did not start cardiopulmonary resuscitation (CPR) as it was clear that Mr Robinson was dead: he was cold, his lips were blue and rigor mortis (stiffening of the body after death) was present.
58. When the code blue was radioed, the Control Room immediately contacted North West Ambulance Service and requested an ambulance. Ambulance Service records show an ambulance was requested at 5.01am. Paramedics arrived at Mr Robinson's cell at 5.13am. They assessed him and at 5.16am confirmed he had died.

Information after Mr Robinson's death

59. A friend of Mr Robinson's, who lived on the same wing, told staff that on 24 April, Mr Robinson had told him that a prisoner had punched him in the face. He said this was because his cellmate, who had been released, had left a debt and the prisoners he owed told Mr Robinson he had inherited the debt as he was in the same cell. (This is common practice among prisoners.) He said Mr Robinson did not show any emotion when he told him this but that he thought he was likely to have been scared.

60. The friend said the last time he saw Mr Robinson was at the medication hatch that night and they said hello. He said that Mr Robinson was a bit down because of what had happened during the day, but that Mr Robinson did not say anything that caused him concern. He said after Mr Robinson's death he was told by other prisoners that Mr Robinson had been trying to sell his clothing and belongings during the day on 24 April. There is no evidence that wing staff were aware of these events.

Contact with Mr Robinson's family

61. Altcourse appointed chaplain manager as the family liaison officer (FLO). The FLO and the Director of Altcourse told Mr Robinson's next of kin of his death in person. They offered their condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Robinson's funeral, which was held on 12 May 2021.

Support for prisoners and staff

62. After Mr Robinson's death, two duty Directors debriefed the prison and healthcare staff involved in the emergency response to ensure that they had the opportunity to discuss any immediate issues and to offer support. The staff support team and the TRiM (trauma risk management) manager also contacted prison staff.
63. The prison posted notices informing prisoners of Mr Robinson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Robinson's death.

Post-mortem report

64. The post-mortem report concludes that Mr Robinson's death was due to hanging. We have not been provided with the results of the toxicology tests, so we do not know whether Mr Robinson had any illicit substances in his system at the time of his death.

Findings

Assessment of Mr Robinson's risk of suicide and self-harm

Reception

65. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that staff must follow when they identify that a prisoner is at risk of suicide and self-harm. The PSI states that, after speaking to a prisoner, staff should use their judgement in combination with all available evidence to inform their decision as to whether a prisoner poses a risk to himself. It lists risk factors and potential triggers for suicide and self-harm.
66. Mr Robinson arrived at Altcourse with a number of these risk factors: he had a history of self-harm, suicidal thoughts and anxiety and depression. However, although he arrived with a suicide and self-harm warning form, neither the reception officer nor the reception nurse started ACCT procedures. They recorded that Mr Robinson said he had no thoughts of suicide or self-harm. We are concerned that they did not properly consider his risk factors or record why they did not start ACCT procedures. We recommend:

The Director and Head of Healthcare should ensure that reception staff:

- **consider all information arriving with the prisoner, particularly the PER and SASH form, when assessing their risk of suicide and self-harm to ensure the assessment of a prisoner's risk of suicide and self-harm is based on the prisoner's known risk factors, rather than on their presentation alone; and**
- **record the information considered and their reasoning when they decide not to start ACCT procedures.**

ACCT procedures

67. PSI 64/2011 says that ACCT case reviews should be multidisciplinary where possible, that a caremap should be completed at the first review, and that caremap actions must be tailored to meet the individual needs of the prisoner, be aimed at reducing the prisoner's risk to themselves and be time-bound.
68. Staff started ACCT procedures for Mr Robinson on 8 April, which remained in place until his death. We identified a number of issues with the management of the ACCT: the time recorded for the immediate action plan is 41 minutes before the ACCT was opened; the ACCT assessment was not completed within 24 hours of the ACCT being opened; caremap actions were either not reviewed or were marked as completed when there was no evidence they had been; and the interventions of healthcare staff when Mr Robinson either self-harmed or was assessed by the mental health team were recorded on his medical record, but not on the ACCT document. In addition, while a member of the mental health team attended the first ACCT review, no one from healthcare attended any of the subsequent reviews.

69. We consider that the caremap was inadequate in terms of addressing Mr Robinson's risk. Although it is documented in the first review that Mr Robinson would continue to receive support from the mental health team, there is no evidence of what support was to be provided and it was not added as a caremap action. The caremap action for the case manager to put protective measures in place around the trigger date of 14 May was marked completed on 19 April, but there is no record of what measures, if any, had been put in place or how staff intended to provide additional support. When Mr Robinson self-harmed on 23 April, observations were not reintroduced when they should have been.
70. During the last ACCT review on 24 April, the day before Mr Robinson died, which was held after Mr Robinson had self-harmed for the second time, the case manager assessed Mr Robinson's risk as low and decided that observations were not necessary; he remained on one conversation each morning and afternoon. The caremap was not reviewed.
71. We consider that Mr Robinson's risk of suicide and self-harm should have been managed better. We recommend:

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

- **ensure case reviews are multidisciplinary, with healthcare staff in attendance where appropriate;**
- **set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk;**
- **ensure all caremap actions are reviewed and completed;**
- **review risk and level of observations following an incident of self-harm;**
and
- **invite family members to contribute to the ACCT, if appropriate.**

Mental health

72. Mr Robinson had no mental health diagnosis but had a history of anxiety and depression. On both occasions when he self-harmed in April 2021, a mental health assessment was requested and completed, but there is no evidence a care plan was in place for his mental health needs that would have informed mental health support and the ACCT process. A care plan would have described what monitoring was required and a more proactive approach could have been adopted. We recommend:

The Head of Healthcare should ensure that staff put mental health care plans in place for prisoners who need ongoing support from the mental health team.

73. Mr Robinson repeatedly told staff that he was finding issues around his bereavements difficult. Due to the significance of the anniversaries that were imminent, the clinical reviewer concluded that the prison bereavement counsellor should have seen Mr Robinson to ascertain if she could have provided any support to him prior to his release.

Violence Reduction

74. A Prisons and Probation Ombudsman (PPO) publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013-2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated, and responded to robustly.
75. Altcourse has a Violence Reduction strategy dated June 2021, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence, using the challenge, support and intervention plan (CSIP) model.
76. There is evidence to suggest that Mr Robinson was being bullied. During an ACCT review on 19 April, a day after Mr Robinson cut his arm, he told the ACCT case manager that he had run out of vapes but could 'pay them back on canteen day'. This comment suggests that Mr Robinson was in debt to other prisoners, yet there is no evidence this was explored further. During a key work session on 21 April, Mr Robinson told an officer that he was having issues on the wing but did not provide any detail. During his interview, Mr Robinson's friend said that the day before Mr Robinson died, he told him he had been punched and had inherited a debt from his cellmate who had been released.
77. We cannot verify this information and there is no other supporting intelligence that Mr Robinson was either in debt or being bullied. However, as Mr Robinson was being managed under ACCT at the time and had recently cut his arm, we consider that staff made inadequate attempts to investigate or further explore Mr Robinson's comments and did not follow the prison's violence reduction and safer custody strategies. We make the following recommendation:

The Director should ensure that staff identify and manage prisoners at risk of bullying, intimidation, or violence in line with the prison's violence reduction policy. In particular all staff should:

- receive training on CSIP and understand the referral process and expectations of their role;
- provide effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations; and
- consider whether apparent victims are at increased risk of suicide and self-harm.

Access to PIN phone

78. PSI 49/2011, *Prisoner Communication Services*, sets out the requirements for all prisoner communication, including telephone use. The PSI says, '*The checking of social numbers must be proportionate to risk and checked as necessary in accordance with the NSF [National Security Framework] and as set out in the local security strategy*'. Altcourse have a local Prisoner Communications Policy, dated November 2019, which states that they use the 'call-enabling' system whereby prisoners have to have their numbers verified and activated before calls can be made and prisoners can only dial approved numbers.

79. Mr Robinson's records are clear that contact with his family, including his grandmother, was a protective factor. However, he was unable to make any telephone calls to his grandmother while at Altcourse as her telephone number was not added to his approved PIN numbers. He submitted his grandmother's number on at least four occasions, including while subject to ACCT measures, but it was incorrect (there was a digit missing). PIN telephone records show that he tried to contact his grandmother 15 times in the week before he died, twice on the day before he took his life.
80. The PIN phone administrator said if a number was incorrect, she would not check the system to see if the number had been recorded previously or contact the prisoner directly, but would note the problem on the application form, which was sent back to the wing. She said she would only be aware if a prisoner was subject to ACCT measures if a member of staff spoke to her directly with a request.
81. In interview, a FLM was critical of how the PIN phone applications were processed. He said if a phone number had not been added within the first week of a reception, a prisoner had to wait another month. He said even when a prisoner was subject to ACCT measures, it was often difficult to get phone numbers added.
82. Altcourse's local policy does not set out a target time for responding to applications to have telephone numbers added to the PIN phone. The PIN administrator said that applications were processed on a wing-by-wing basis every 30 days, but since Mr Robinson's death they are now being completed in date order of submission. The Head of Safety told the investigator that there is only one PIN administrator and it was not possible for her to chase up all prisoner applications when there was an issue. He said that the PIN number process was being reviewed. While we are pleased that a review of the PIN process has started, we consider that there needs to be more flexibility on how phone numbers are approved, particularly when a prisoner is subject to ACCT measures. We therefore make the following recommendation:

The Director should ensure that the review of the PIN phone application process considers how PIN phone access for prisoners subject to ACCT monitoring can be prioritised and if numbers are found to be incorrect, they are flagged to the prisoner at the earliest opportunity.

**Prisons &
Probation**

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