Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Francis Chadwick, a prisoner at HMP Altcourse, on 10 August 2021

A report by the Prisons and Probation Ombudsman

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Francis Chadwick died on 10 August 2021 after being found hanged in his cell at HMP Altcourse. Mr Chadwick was 45 years old. I offer my condolences to Mr Chadwick's family and friends.

Although we have some concerns about some aspects of the ACCT procedures, we are satisfied that Mr Chadwick did not disclose his suicidal thoughts to staff in the days before his death.

Our investigation also found that Mr Chadwick's mental health needs were not consistently acted upon or followed up and multi-agency working, particularly with mental healthcare, could have been improved.

The clinical reviewer concluded that the mental health care Mr Chadwick received at Altcourse was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community.

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 **April 2022**

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Summary

Events

1. On 14 July 2021, Mr Francis Chadwick was remanded to HMP Altcourse. Court staff completed a Suicide and Self Harm (SASH) warning form as Mr Chadwick had attempted to take his own life in the community. Prison staff started suicide and self-harm prevention procedures (known as ACCT) and Mr Chadwick was placed on observations due to his presentation and concerns around self-harm.

2. On 5 August, Mr Chadwick's ACCT procedures were ended. He had received input from the mental health team and had attended several counselling sessions. It was agreed that the prison should have one meaningful conversation each day with Mr Chadwick during the post-closure period, and staff recorded details of these conversations for 6 to 9 August. Mr Chadwick appeared to be in a positive mood and did not disclose any suicidal thoughts.

3. On 10 August, Mr Chadwick was found hanged in his cell by two officers. A medical emergency code was called immediately, and Mr Chadwick was cut down by one of the officers. A prison paramedic who was nearby responded immediately and began first aid. An ambulance was called, and more paramedics arrived. Mr Chadwick was confirmed dead following attempts to resuscitate him.

Findings

4. We found that staff did not properly record a care plan with actions designed to reduce Mr Chadwick's risk of suicide and self-harm. The ACCT should not have been closed until these actions had been completed.

5. We are concerned that mental health staff did not share relevant information about Mr Chadwick's mental health which they received from court staff on 21 July, and which might have affected the assessment of his risk.

6. It was good practice to hold daily conversations with Mr Chadwick during the ACCT post-closure period. We are satisfied that Mr Chadwick chose not to share his distress and suicidal thoughts with staff.

7. The clinical reviewer concluded that the mental health care Mr Chadwick received at Altcourse was not of the required standard and not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Director should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:
    - ACCT Care Plans are completed with actions that are specific and meaningful, identify all of the issues identified during the assessment interview and at case reviews, and that ACCT monitoring does not stop until all care plan actions have been completed.
    - Where relevant, a multidisciplinary approach should be taken to ACCT reviews, particularly in regard to mental health input.

- The Director and Head of Healthcare should ensure that:
    - prisoners identified as at risk of suicide and self-harm are provided with support prior to, and following, attending court; and
    - prisoner's requests for mental health support are followed up.

- The Director and the Head of Healthcare should ensure that:
    - there is a procedure in place to review prisoners when they go to and from court, to aid continuity of care and ensure concerns are actioned.
    - prison general practitioners are aware of the need to consider titration of antidepressant medication that was prescribed in the community if there is no confirmation of compliance prior to coming into prison custody.
    - information forwarded from the community should be reviewed by a clinician to highlight if there are areas that have not been addressed in the reception screening and substance misuse screening.
    - the Head of Healthcare and Mental Health Team Manager review the process of follow up from the mental health team and how this is completed and monitored; and
    - attendance at ACCT case reviews is reviewed for prisoners assessed as requiring input from the mental health team.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact him.

9. At the request of the investigator HMP Altcourse provided relevant paperwork related to Mr Chadwick, as well as CCTV footage and recordings of his phone calls. The investigator interviewed eight members of staff via video link in October 2021.

10. NHS England commissioned a clinical reviewer to review Mr Chadwick's clinical care at the prison. The investigator and clinical reviewer jointly conducted the interviews.

11. We informed HM Coroner for Liverpool and Wirral Area of the investigation. The post-mortem report was not available at the time of writing this report. We have sent the Coroner a copy of this report.

12. The Ombudsman's family liaison officer contacted Mr Chadwick's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked for the following matters to be addressed:

    - Why were ACCT procedures ended?
    - On 9 August 2021, Mr Chadwick said he was mocked by the person dispensing medicine at the hatch. They made a gesture of hanging with their tongue out.
    - Mr Chadwick told his family he had not eaten or had anything to drink for five days. Did staff know, and what was done?
    - How did he hang himself?

    We have addressed these questions in our report.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

14. We sent a copy of our initial report to Mr Chadwick's next of Kin. They did not point out any factual inaccuracies.

Background Information

HMP Altcourse

15. 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.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Altcourse was in November 2017. Inspectors noted that there had been three self-inflicted deaths since their previous inspection and the prison had made reasonable progress towards meeting the PPO's recommendations. Levels of self-harm, while still high, were reducing year on year. Inspectors found that ACCT assessments were generally good, but care maps were often inadequate.

17. Altcourse was also one of three local prisons subject to a short scrutiny visit in April 2020, to give a snapshot of how it was responding to the COVID-19 pandemic. Inspectors reported that self-harm had reduced slightly since the start of COVID-19 restrictions.

Independent Monitoring Board

18. 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 2021, the IMB reported that there would inevitably be long-term effects on prisoners' mental health and wellbeing as a result of enforced isolation, limited contact with their families, lack of social interactions and purposeful activity. However, the IMB noted that a positive measure the prison had taken was setting up 0800 phone lines in cells.

19. The IMB report noted that the revised ACCT version had been fully implemented and the new paperwork would take some time to 'bed in' as staff were learning on the job.

Previous deaths at HMP Altcourse

20. Mr Chadwick was the 16th prisoner to die at Altcourse since August 2019. Of the previous deaths, three were self-inflicted, 11 were from natural causes and one was drug-related.

21. In a previous investigation into the death of a prisoner at Altcourse in 2020, we were concerned about the management of suicide and self-harm procedures. We made recommendations, including making care plans more specific and meaningful and making detailed records of ACCT reviews.

22. The prison accepted our recommendation and said that any learning of best practice on ACCTs, including setting quality care map actions, is fed back as part of

monthly Safer Custody meetings and is also disseminated to ensure staff are aware of the importance of specific and meaningful care map actions which are aimed at reducing risk. The prison also said all ACCT case reviews and other documentation were reviewed for compliance and quality.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the case management approach used to support those at risk of suicide or self-harm within HM Prison Service. The purpose of the ACCT is to identify risk, how to monitor and supervise the prisoner, and how to reduce risk. The prisoner is assessed when the ACCT is opened, and the level of checks and supervision are set according to the perceived risk. Regular multidisciplinary review meetings with the prisoner should be held.

Key Events

24. On 27 April 2021, Mr Francis Chadwick was remanded to HMP Altcourse for threatening violence against his ex-wife. This was his first time in prison. Prison staff started ACCT procedures on his arrival at the prison as he had recently self-harmed in the community. He was released from prison on 25 May.

25. On 14 July, Mr Chadwick was again remanded to HMP Altcourse. Mr Chadwick came from court with a Suicide and Self Harm (SASH) warning form which reported that he had attempted suicide the previous day and had said he had taken an overdose. Mr Chadwick also said that he heard voices telling him to self-harm. A Prisoner Custody Officer (PCO) started suicide and self-harm procedures, known as ACCT.

26. At his reception health screen, a nurse noted that he had attempted suicide, had thoughts of self-harm and was low in mood, and had been prescribed citalopram, an antidepressant, in the community. Mr Chadwick was referred to the prison's mental health team.

27. The following day, a PCO carried out Mr Chadwick's ACCT assessment. She recorded that he said that he was hearing voices telling him to self-harm which started after he was first sent to prison. Mr Chadwick said that the breakdown of his marriage had triggered his mental health issues. The PCO noted he had received medication and support in the community for depression and anxiety. Mr Chadwick told her that he had tried to set himself on fire three days before and had texted his ex-wife about his intentions. This breached a restraining order restricting contact between him and his wife and had resulted in him returning to prison.

28. The PCO noted that a 'good outcome' would be Mr Chadwick being supported for his mental health issues, as he said without it he feared he would take his life when released back into the community. Medication and engagement with the prison's mental health team were both recorded as factors that would help Mr Chadwick.

29. Later that day, a First Line Manager (FLM) led the first ACCT case review as the ACCT case co-ordinator. A nurse and an officer also attended. During the review they discussed the reasons for Mr Chadwick being back in prison, and his feelings and concerns. The nurse agreed to prepare support for Mr Chadwick in the community in case he was released after his next court appearance in six days. No support actions were agreed while he remained in prison.

30. On 19 July, Mr Chadwick's referral was discussed at the mental health team meeting. He was allocated to a healthcare support worker.

31. On 21 July, Mr Chadwick attended court. An alert was sent to the prison's mental health team from the court which said that Mr Chadwick had been experiencing auditory hallucinations from a 'pig man' telling him to self-harm. A follow up review was scheduled for the mental health team to see Mr Chadwick within 48 hours. Mr Chadwick was not seen until 25 July.

32. Mr Chadwick was on two ACCT observations an hour and two conversations a day from 15 to 22 July. During this time staff consistently recorded conversations they had with him, and in particular how he was feeling. A PCO conducted several observations on Mr Chadwick. She told us he would always engage, some days

more than others, but there was no indication of any self-harm throughout this period.

33. On 22 July, another ACCT case review was conducted. A FLM recorded that Mr Chadwick looked relaxed and engaged well in the review. Mr Chadwick had been remanded until sentencing on 17 August, which he said he had accepted. He did not report any thoughts of self-harm during the review. He said that he was much better and thanked them for the support he had received. The FLM told us she saw a big improvement in Mr Chadwick between reviews, both in what he was saying and how he was presenting. Following this review, contact with Mr Chadwick was reduced to two conversations a day and no observations.

34. On 25 July, a mental health nurse assessed Mr Chadwick. She recorded that Mr Chadwick had attempted suicide but said he had no current thoughts or intention to self-harm. She recorded that he should be added to the mental health team's case load for allocation to review his medication and mood.

35. The next day, Mr Chadwick was discussed at the mental health team meeting. They listed him for access to psychological intervention services.

36. On 29 July, a FLM conducted a further ACCT review with input from a counsellor. Mr Chadwick engaged well with the review and said he was feeling better and that he wanted a job. The counsellor explained that he would stay with her for counselling.

37. The counsellor told us during interview that Mr Chadwick had several counselling sessions. The first, on 29 July, was an introductory session, and the second, on 5 August, related to what he wanted from counselling. She told us they discussed Mr Chadwick's relationship breakdown in the second session. She also told us that Mr Chadwick was less upset in the second session, and he appeared happy in the following session. Mr Chadwick had told her he was coming to terms with his relationship breakdown and was understanding it.

38. On 5 August, a FLM chaired another ACCT case review with the counsellor. Mr Chadwick said that he was feeling much better and had accepted his marriage was over, and that it was time to move on with his life. He was asked about any thoughts of self-harm, and he said he had none. He also said that he had a lot of things to look forward to. During interview the FLM told us Mr Chadwick was chatty, laughing and discussed his new grandson.

39. The FLM ended the ACCT procedures and scheduled a post-closure review for 12 August. She told us Mr Chadwick appeared to accept that his relationship was over and felt positive about other aspects of his life. He also said that his engagement with the counsellor was helping him address things.

40. During interview several members of staff including mental health staff, told us that Mr Chadwick appeared better both in mood and physical appearance. The nurse who attended the first ACCT case review told us he was a totally different person when she met him after the ACCT was closed.

41. On 5 August, Mr Chadwick made an application to see a 'psychiatric nurse'. There is no evidence that this was actioned.

42. Staff recorded one conversation a day from 6 to 9 August as part of the ACCT post closure review process. Each entry indicated that Mr Chadwick was in a positive mood when engaging with staff.

43. On 7 August, Mr Chadwick called his sister via the in-cell telephone. He discussed considering suicide and said the only help which was available to him was talking which did not help. Mr Chadwick called his sister again later that day. He told her that he was struggling and didn't know what to do. His sister asked whether he was speaking to anyone about how he was feeling, and he said that it did not help. Prison staff were not aware of these calls. (All prisoners telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed.)

44. On 9 August, Mr Chadwick called his sister and said that someone at the medication hatch had made gestures mimicking suicide at him and had made derogatory comments. He said he had told an officer, but they walked away, and no one had been to see him. Mr Chadwick also said that he was struggling with the impact of spending 23 hours a day in his cell. A nurse was dispensing medications that day. She told us that she asked Mr Chadwick whether he had tried to overdose in the past, as she was issuing medication for him to hold in his possession. She told us that he told her to "shove it" and left straight away. She said she never meant to mock him, it was just a check which is done for prisoners keeping their own medication, and she was not aware he was under ACCT procedures at that time.

45. Later that day, the counsellor saw Mr Chadwick. She noted that he engaged with the session throughout and had open body language. She recorded that Mr Chadwick became upset at times when discussing his family situation and they discussed ways to reduce his stress. She recorded that he had left the session happy.

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46. At 8.56am, Mr Chadwick made a call to his sister from his cell. He wanted his ex-partner to respond to messages he had passed on via his sister and indicated he was getting closer to "doing it". He made a further call to his sister at 9.19am, and the same issues were discussed.

47. At 9.37am, Mr Chadwick made a further phone call to his sister. He said that he believed his ex-partner had been cheating on him and he had been taken out of the picture so she could see someone new. Mr Chadwick said, "Tell her she's killed me … I'm so fucking sorry for doing this".

48. At 10.45am, two PCOs delivered purchases from the prison shop (known as 'canteen') to Mr Chadwick's cell. Mr Chadwick's cellmate was at work at this time. When they opened the cell door, they noticed Mr Chadwick's feet coming from the bathroom which was directly to the right of the door. They found that Mr Chadwick had hanged himself from a ligature made from a bedsheet, which was tied to the sink in the bathroom.

49. PCO A called a 'code blue' medical emergency (indicating that a prisoner is unconscious or is having breathing difficulties). PCO B cut the ligature from Mr

Chadwick's neck. He said he was joined within a minute by a prison paramedic who had been on the wing that morning. PCO C told us he was on the landing below when the code blue was called and immediately went to assist.

50. Staff began cardiopulmonary resuscitation (CPR) under the instruction of the paramedic for around five minutes in the cell and then moved Mr Chadwick to the landing outside the cell and continued to provide medical assistance. Several nurses and other prison staff assisted with CPR.

51. At 10.47am, the control room operator called for an ambulance. At 11.05am, an ambulance arrived, and emergency response staff took over Mr Chadwick's medical care. But, at 11.29am, they confirmed that Mr Chadwick had died.

Contact with Mr Chadwick's family

52. The Deputy Director and a prison chaplain visited Mr Chadwick's mother on 10 August and informed her of Mr Chadwick's death.

53. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

54. After Mr Chadwick's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

55. The prison posted notices informing other prisoners of Mr Chadwick's death, and offering support.

Post-mortem report

56. The post-mortem report was not made available to the PPO at the time of writing this report.

Findings

Management of Mr Chadwick's risk of suicide and self-harm

57. Prison Service Instruction (PSI) 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns.

58. Prison staff appropriately started ACCT procedures on 14 July, when Mr Chadwick arrived at HMP Altcourse with a suicide and self-harm warning form and a tearful and distressed presentation. While some aspects of his risk were well-managed, we are concerned that some aspects of the ACCT procedures were not managed in line with Prison Service policy.

Care Plan

59. PSI 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It says that support actions must be set at the first case review, to mitigate and lower risk, for all prisoners subject to ACCT monitoring. These should be completed as part of a Care Plan in the ACCT document, identifying action points required to reduce risk, who is responsible for completing these action points and when they should be completed.

60. The prison provided us with Mr Chadwick's full Care Plan after we issued our initial report. Section 1.4 of the Care Plan, which contains support actions for a prisoner, has several sections blank and lists engagement with mental health as the only support action. Further to this, 'quality of life' support considerations were blank and marked as to be reviewed in ACCT assessment one. This appears to be an oversight, and lacks meaningful detail

61. With the exception of the first ACCT review, no mental health nurses attended the ACCT case reviews with Mr Chadwick despite risks about his mental health being highlighted. As a result, the ACCT review on 22 July, which reduced the number of observations Mr Chadwick was having, was not aware of the information from the court about his reported hallucinations telling him to kill himself. This was available on SystmOne (an electronic medical record which can only be read by healthcare staff) but was not passed on to inform the ACCT review or Care Plan.

62. Although there was an immediate action plan and risk factors were identified in Mr Chadwick's ACCT, it is concerning that the Care Plan was so brief. We have previously made recommendations to Altcourse about the importance of including detailed Care Plans as part of the ACCT documentation and it is disappointing that we are having to repeat this recommendation again. We recommend:

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

- **ACCT Care Plans are completed with actions that are specific and meaningful, identify all of the issues identified during the assessment interview and at case reviews, and that ACCT monitoring does not stop until all care plan actions have been completed.**

- **Where relevant, a multidisciplinary approach should be taken to ACCT reviews, particularly in regard to mental health input.**

Identifying the risk of suicide and self-harm

63. PSI 64/2011 instructs that a post-closure review must take place within seven days of closure. Mr Chadwick's ACCT procedures were ended on 5 August, with the post-closure review scheduled for 12 August. It was agreed that staff should have one meaningful conversation a day with Mr Chadwick during this period. This was good practice.

64. Staff recorded that Mr Chadwick appeared to be in a positive mood during these conversations and gave no indication of suicide or self-harm.

65. However, Mr Chadwick's telephone calls to his sister on 7 and 10 August reveal that he was having thoughts of suicide, and evidence from phone calls suggests he was withholding this from prison staff. We are satisfied that there is no indication Mr Chadwick made prison staff aware of how he was feeling in the days leading up to his death.

66. We make no recommendation.

Mental health care

67. The clinical reviewer concluded that the mental health care Mr Chadwick received at Altcourse was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community.

68. Concerns were raised over Mr Chadwick's mental health throughout his time in custody, but there were limited follow ups from the mental health team. Mr Chadwick received his first follow up with the prison's mental health team ten days after his initial assessment, but no further monitoring had been planned. Also, when Mr Chadwick requested to see a mental health worker on 5 August, there is no evidence that this was acknowledged or followed up.

69. We are also very concerned that on 21 July, when information about Mr Chadwick's mental health was reported from the court to the mental health team, there is no record that this was fed into the ACCT case review on 22 July.

70. The clinical reviewer concluded that it is difficult to assess whether further input from the mental health team would have impacted Mr Chadwick's decision to end his own life. We recommend:

The Director and Head of Healthcare should ensure that:

- **prisoners identified as at risk of suicide and self-harm are provided with support prior to, and following, attending court; and**
- **prisoners' requests for mental health support are followed up.**

71. The clinical reviewer has made a number of recommendations about the procedures when a prisoner goes to and from court, about medication and about

how information is communicated and used from community mental health teams, which the Head of Healthcare will need to address. We recommend:

The Director and the Head of Healthcare should ensure that:

- **there is a procedure in place to review prisoners when they go to and from court, to aid continuity of care and ensure concerns are actioned.**
- **Prison general practitioners are aware of the need to consider titration of antidepressant medication that was prescribed in the community if there is not confirmation of compliance prior to coming into custody.**
- **information forwarded from the community should be reviewed by a clinician to highlight if there are areas that have not been addressed in the reception screening and substance misuse screening.**
- **the Head of Healthcare and Mental Health Team Manager should review the process of follow up from the mental health team and how this is completed and monitored; and**
- **attendance at ACCT case reviews is reviewed for prisoners assessed as requiring input from the mental health team.**

Inquest

72. The inquest, held on 12 July 2023, concluded that Mr Chadwick died from suicide.

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