

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in December
2012 at hospital, while a prisoner at HMP Altcourse**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found to have strangled himself with a ligature in his cell at HMP Altcourse on the morning of 29 December 2012. He was resuscitated and taken to hospital, but died there a few days later. He was 34 years old. I offer my condolences to his family and friends. I apologise for the delay with this report.

A clinical review was undertaken to assess the care and treatment the man received at HMP Altcourse. The prison cooperated fully with the investigation.

The man suffered from mental health and substance misuse problems. In 1999, he tried to kill himself by jumping off a railway bridge onto a train and suffered a number of injuries, which affected his mobility. During his time at Altcourse, he made several attempts to hang himself and harmed himself on a number of other occasions. He was monitored under suicide and self-harm prevention procedures. On 28 December, he was moved from the healthcare unit to a standard residential unit. He had threatened to harm himself if he was moved and, on 29 December, an officer found him unconscious after he had tied shoelaces around his neck attached to the sink in his cell. He was resuscitated but later died in hospital. His family were with him at the time.

The clinical reviewer found some deficiencies in the standard of healthcare the man received at Altcourse and was concerned about the availability of psychiatrists, although the mental health care he subsequently received was good. Despite some concern about the limited investigation of suggestions that he may have been bullied, I consider that he was appropriately supported under suicide and self-harm prevention procedures while he was at Altcourse. Sadly, this was insufficient to prevent his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2014

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SUMMARY

1. The man was remanded into custody at Altcourse on 25 May 2012 for an offence of aggravated robbery. He was convicted on 31 May and sentenced to eight years imprisonment. When he arrived at Altcourse, he was described as vulnerable and found it difficult to settle. He had been taking a number of prescription medications in the community, but one of these, to treat a duodenal ulcer, was not prescribed until a month after he arrived at the prison. He was monitored under suicide and self-harm prevention procedures (ACCT) for five days from 12 July, after telling a nurse that he felt like he was going to harm himself.
2. On 16 August, after the man cut his arms with a razor, ACCT monitoring began again and continued until his death. He harmed himself on two more occasions and was treated by mental health staff.
3. The man found life on the standard houseblocks difficult and felt better when he was living in the healthcare inpatient facility.
4. The man had been admitted to the inpatient facility on 11 November but, on 28 December, a doctor assessed him as being fit to return to a houseblock. There was a need for inpatient bed spaces as other prisoners were returning from hospital treatment. He had been stable for some time and there was no identified clinical need for him to remain an inpatient. He did not want to move and threatened that he would harm himself if he was moved. He was taken to a single cell on Canal Unit later that day. He was still subject to ACCT monitoring and his observations were increased to five each hour, as he was regarded as a high risk.
5. On 29 December at 8.30am, an officer checked the man and found him kneeling by the sink with shoe laces tied around his neck and attached to the taps. An emergency ambulance was called but not until a nurse arrived at his cell and examined him. He was resuscitated and taken to hospital, but died there a few days later. His family were with him when he died.
6. Overall, we have found that the man was cared for and treated appropriately at Altcourse. However, we are concerned about the issuing of medication, sharing of information for prisoners who are subject to suicide and self-harm monitoring and delays in seeing a psychiatrist. We make three recommendations.

THE INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners at Altcourse inviting anyone with information to contact the investigator. A prisoner at Altcourse contacted the investigator and, with one of her colleagues, interviewed him at HMP Durham on 8 March 2013. On 19 June, she received a statement from another prisoner, who she interviewed at HMP Lowdham Grange, on 25 June.
8. The investigator visited Altcourse on 7 January and met the Deputy Director, the safer custody manager, the prison's family liaison officer and a member of the Independent Monitoring Board. She obtained copies of the man's prison and clinical records.
9. The investigator interviewed staff at Altcourse on 8 and 13 March. After interviewing the prisoner at Lowdham Grange on 25 June, she returned to Altcourse on 6 August to interview staff about new information the prisoner had given her.
10. The clinical reviewer reviewed the clinical care and treatment the man received at Altcourse.
11. The clinical reviewer contacted HM Coroner for Liverpool, who provided a post-mortem report. The Coroner has been sent a copy of this report.
12. One of our family liaison officers contacted the man's parents to explain the investigation process and to allow them to identify relevant issues they wished the investigation to consider. The family asked the investigation to consider the following points:
 - This was the first time their son had been in prison. He had mental health problems and they had supported him when he was at home. His family said he was not likely to ask for things he needed.
 - His parents said they had contacted the prison a number of times about his prescription for omeprazole, which he took for an ulcer. He did not receive this until 26 June.
 - His parents said that when they found out that he had had his shoe laces taken off him because he had previously attempted to use them as a ligature they sent him some training shoes with Velcro fasteners. They wanted to know why he had not been given them. There was also other property that they had left at the prison for him, which was returned unopened after his death. They wanted to know why this had not been given to him.
13. We are sorry for the delay in the issue of this report which was caused by the need to undertake additional interviews at Altcourse after further information was received at a late stage in the investigation.
14. The family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence

HMP ALTCOURSE

15. HMP Altcourse is a category B local prison in Liverpool, receiving prisoners from the Merseyside, Cheshire and North Wales areas. It is managed by G4S custodial services and holds up to 1,324 sentenced and remand adult and young male offenders. Altcourse is made up of seven houseblocks, divided into individual units. These units hold between 60 and 95 prisoners.
16. G4S also runs the healthcare services at the prison. There is a 12 bed in-patient unit that has a care suite and has 24 hour nursing cover.

Previous deaths at Altcourse

17. From 2011 and up to the man's death in 2012, there has been only one other self-inflicted death. There are no similarities in this case. Another prisoner died several days after him, but we are satisfied that there are no common factors in their deaths.

Her Majesty's Inspectorate of Prisons

18. HM Inspectorate of Prisons conducted an unannounced short follow-up inspection of Altcourse in October 2012. Inspectors found that there were excellent staff-prisoner relationships and that Altcourse was fundamentally a safe prison in which prisoners at risk of self-harm received good support. They noted that there were several prisoners with challenging mental health issues, who would have been better off in a secure mental health setting. Inspectors also noted that the demands of the inpatient unit meant that there was a waiting list for prisoners in the main prison to be referred to the primary mental health team.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its annual report for 2011-2012, the IMB considered that the general healthcare provided in the prison met the standards which prisoners could reasonably expect in the community. The IMB was concerned that an influx of prisoners with severe mental health problems was disturbing for other prisoners in the inpatient unit who were unwell, particularly those who were there for palliative care. The IMB was also concerned about the demands placed on prison staff with regard to mental health services and believed urgent action was needed.

ACCT (Assessment, Care in Custody and Teamwork)

20. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which

staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

21. On 25 May 2012, the man was remanded to Altcourse after being charged with aggravated robbery. This was his first time in prison. A nurse carried out a routine reception health screen and noted that he had tried to harm himself in 1999, when he had jumped off a railway bridge onto a train resulting in long-term injuries to his ankle and back. She also noted that he had been receiving medication for mental health problems and she referred him to the prison doctor and the mental health team.
22. At 9.17pm, a doctor examined the man, who told him that he had once injected himself with amphetamine 12 months previously. He said that he had an abscess on his back and suffered from depression. The doctor prescribed him amisulpride, (an antipsychotic used to treat schizophrenia) and citalopram (an antidepressant).
23. The suicide prevention officer told the investigator that she saw the man while he was in reception. She was just passing through, but noticed him because he seemed vulnerable and lost. She spoke to him and explained what would happen next and gave him some encouragement. He was considered fit to live on a standard houseblock. He was allocated a cell in Canal Unit which he shared a cell with another prisoner.
24. On 28 May, the clinical record indicates that a doctor prescribed the following medication for the man:
 - amitriptyline, an antidepressant
 - amisulpride, an antipsychotic
 - amiodarone, for irregular heart beats
 - clonidine, for high blood pressure
 - citalopram, an antidepressant
 - bisoprolol, for high blood pressure
25. On 31 May, the man's mother contacted the prison to say that her son had a duodenal ulcer for which he needed to be prescribed omeprazole. Later that day, he attended court and was sentenced to eight years imprisonment. A nurse assessed him when he returned from court and suggested that he stay in the healthcare unit overnight. It is not clear from the notes why she suggested this. He initially declined but after speaking to the nurse he agreed. She referred him to the mental health team, but did not record the reason in his medical record.
26. On 1 June, the man told healthcare staff that he felt ill and should be prescribed losec (another name for omeprazole). He asked healthcare staff about his prescription for omeprazole again on 8 June. On 9 June, his sister rang the prison to say that he should be prescribed omeprazole. A nurse noted that he was on the waiting list to see a doctor but relisted him as a high priority and gave him an appointment for 12 June. He did not attend that appointment and no reasons were recorded. He was eventually prescribed omeprazole on 26 June, by a locum GP.

27. On 12 July, the man told a mental health nurse that he was feeling low in mood and when he had been like this in the past he had had suicidal thoughts. She completed a concern and keep safe form and started Prison Service suicide and self-harm prevention procedures, known as Assessment, Care in Custody and Teamwork (ACCT). An immediate action plan was completed at 7.30pm. The actions were for him to remain in a shared cell, for five observations an hour and one conversation per shift, to see someone from the mental health team, to contact his family, (he was given £2 telephone credit to allow him to do so) and to talk to a Carer. (A Carer at Altcourse is a prisoner who has been trained by the Samaritans to offer support to other prisoners.)
28. On 13 July, a nurse assessed the man's mental health. He said that he had tried to take his own life 14 years previously, when he had jumped from a railway bridge onto a train. He told her that he had never been diagnosed with anything specific but that he took medication for schizophrenia (amisulpride). He said that he felt horrible sometimes and tended to lose his head. At the assessment, he said that he did not have any thoughts of suicide or self-harm and said that, if he did, he knew that this would upset his family. She suggested that he make an appointment to see the doctor for a medication review and that he should see the prison psychiatrist. He agreed. He was reminded of the support available to him and encouraged to talk to prison staff or a Carer if he felt worse.
29. The man saw a doctor around this time (the date is not clear in the medical record) who suggested that they wait to review his medication until after he had been assessed by a psychiatrist. The doctor told the investigator that there were long waits to see a psychiatrist, a problem the prison had experienced for some time.
30. At 12.20 pm on 13 July, the man attended an ACCT assessment interview with an officer. He said that he was very upset about his sentence, that he was nervous and paranoid and did not think he could cope. He said that he felt that hanging himself would be an end to his problems. He then said that he did not have thoughts of harming himself at that time as he did not want to upset his family, including his daughter. He said that he did not want to speak to a counsellor and that he did not need to be observed any further. He was given a job in the magnets workshop and was given additional telephone credit to help him to stay in contact with his family.
31. At 2.05pm, a first ACCT case review was held. A senior officer (SO), a mental health nurse and an officer attended, along with the man. The SO recorded that he was very nervous and anxious during the review. A caremap was agreed to help address the issues noted during his assessment. It was also noted that he had a disability, an ankle problem for which he wore a built-up shoe. He told staff that he wanted to stay in the cell that he was currently in and could manage the steps. It was agreed that staff should continue to observe him five times an hour, with one conversation each shift.

32. Over the next few days, the man told staff on a number of occasions that he did not have any thoughts of suicide or self-harm. On 17 July, a SO chaired an ACCT review which an officer, a nurse and the man attended. It was noted that he seemed more settled and was coming to terms with the length of his sentence. The objectives in his caremap had been addressed and it was agreed that the ACCT should be closed. A post-closure ACCT review took place on 20 July at which he said that he felt good, was enjoying working and wanted to remain on Canal unit.
33. On 23 July, the man was discussed at a meeting to review those on the waiting list to see a psychiatrist and it was agreed that he should remain on the list. That day, a nurse was called to Canal Unit to examine him, who had told staff that his “head had gone” and he felt stressed. He said that he did not have any thoughts of harming himself. He was subsequently encouraged to speak to carers or talk to staff if he needed support.
34. On 31 July, the man told his supervisor in the magnets workshop that he no longer wanted to work there. This was regarded as negative behaviour and he was told that he would not be allowed out of his cell during work times for the next two weeks if he was not attending work and that he would be moved to another unit when a space became available. He said that he was not bothered about this.
35. A nurse examined the man on 8 August when staff on Canal Unit became concerned that he seemed paranoid, was behaving strangely and did not come out of his cell during association periods. She recorded that he was lying on his bed and appeared distressed and agitated. He told her that “everybody was out to get him” including her. She was unable to reassure him. He said he had not taken any illicit substances but his medication was not working. He told her he was not thinking about harming himself. She noted that he was still waiting to see the psychiatrist and that appointments took time. She then spoke to a doctor and they agreed that he should be admitted to the healthcare unit for a period of observation.
36. A doctor saw the man on 9 August. He told her that his “head had gone” and he was seeing images of past experiences. He again said that he was not using any illicit substances and agreed to take a voluntary drug test, which did not indicate any illicit drug use. The doctor arranged for him to stay in the healthcare unit over the weekend for staff to monitor him and noted that he should be seen by the psychiatrist sooner rather than later.
37. The man remained as an inpatient in the healthcare unit and seemed settled, although he spent a lot of time in his cell. On 14 August, the psychiatrist received his case notes and information about his symptoms and behaviour. He noted in the clinical record that there was a possible relapse of a psychotic illness. (He was prescribed medication for schizophrenia although it is unclear if he had ever been formally diagnosed.) He asked for a number of blood tests and an electrocardiogram (ECG), which were completed on 15 August.

38. The doctor issued a repeat prescription for the man's current medication on 15 August, and noted that the blood test and ECG results were appropriate. That evening, he showed signs of agitation and was given a lorazepam tablet to ease his anxiety. Staff recorded that he slept well overnight.
39. At 2.30pm on 16 August, the man cut his wrist with a razor. An ACCT was opened and an immediate action plan was completed. The immediate actions were for him to remain in the healthcare unit, for staff to observe him five times an hour and for staff to have a conversation with him in the morning and evening each day. He was reminded of how he could access support. His wrist was treated but the injuries were not serious.
40. Later that evening at 6.45pm, a PCO completed an ACCT assessment. The man told her that about a week previously his "head went" and he had felt suicidal. He said that the feelings had been building up over the previous few days and he was still coming to terms with his sentence. He said that the prison had decreased his amisulpride medication for schizophrenia and that it was now not effective.
41. The man refused to see a counsellor or a Carer and said he was aware of the Samaritans phone. (A cordless phone which prisoners can use in their cells to speak to the Samaritans.) He said that cutting himself had not helped him and that he would not do it again. He was glad that he was not dead and thought that, if his medication was sorted out, he would be fine. He told the PCO that he had had to cut his last family visit short because he had felt paranoid in the visits room. He agreed that his mother could be contacted and informed of his self-harm, and this was done.
42. A caremap was completed with a number of objectives. These were for him to see the mental health in reach team, to promote healing to his wrist and for the doctor to review his medication. The man told a prison doctor that he was seeing pictures and getting paranoid thoughts. The doctor noted that he was showing evidence of psychotic thoughts and also diagnosed a delusional disorder. The doctor increased his amisulpride to 200mg twice a day and arranged a prescription from 17 August. (He had been prescribed 200mg once a day since he had arrived at the prison. As his community prescriptions were not checked when he arrived we do not know whether this was less than he had previously been prescribed, as he had suggested, and whether the increase to twice a day returned him to his previous dose.) Two further reviews took place, one on 17 August and one on 21 August.
43. On 27 August, another ACCT review was held. The man was noted to be more relaxed and settled and said that he did not want to be on the ACCT as he no longer had thoughts of harming himself. He had been in contact with his family and had arranged a visit. It was agreed that his risk of self-harm had reduced and the observations were reduced to three an hour, with conversations in the morning and evening. Another review was held the next day when he said that he still felt low on occasions and he was not feeling the full effect of his medication. It was explained that this took time. The

observations were reduced again to two an hour with one conversation each shift.

44. Further ACCT reviews were held on 5 September and 9 September, when the man appeared calm and more settled. He said that he wanted to go back to his unit except that when he had been to the gym on 30 August, he had felt paranoid so was not yet ready to do so. On 5 September, ACCT monitoring was reduced to one conversation each shift and no observations. On 9 September, he said that he was ready to go back to a residential unit. As there was no space on Canal Unit, he agreed to go to Reynoldstown Brown Unit.
45. When the man was taken to Reynoldstown Brown Unit later that day he became very agitated and anxious and said he could not stay there. Officers tried to encourage him to stay but he would not agree so he returned to the healthcare unit, where he settled. Another ACCT review took place on 13 September. He apologised to staff and agreed to go back to Canal Unit when there was a space. He said that he did not have any thoughts of self-harm. The level of monitoring remained the same and caremap objectives of encouraging him to keep in contact with his family, to attend the gym and to use the support of Carers and staff remained ongoing.
46. On 17 September, a prisoner told staff in the healthcare unit that the man had made a noose from his shoe laces and shoe laces were found tied to the sink in his cell. He told staff that he was struggling to cope and wanted to end it all. Staff took the laces from him, reviewed the ACCT and increased his observations to five each hour. He said that his actions had nothing to do with his pending move back from the healthcare unit.
47. At an ACCT review on 18 September, the man said that he was worried about moving from the healthcare unit but that he no longer had thoughts of harming himself. A nurse noted that, in her opinion, he was harming himself so that he could stay in the healthcare unit, where he felt safe. He was still required to be observed five times an hour. She noted in his clinical record that he should not be moved from the healthcare unit until he had been assessed by the psychiatrist. The psychiatrist agreed that his prescription for amisulpride should be increased again. He settled on the healthcare unit for the next few days.
48. It was agreed that the man would move to Canal Unit on 20 September, and an ACCT review took place that day before the move. A doctor had assessed him as fit to return to the unit. At the review, he said that he was happy to move although he was slightly apprehensive. He maintained that he had no thoughts of harming himself. His ACCT observations remained at five an hour with one conversation each shift. During evening medication a Healthcare Assistant (HCA) noticed that he was clammy, pale and anxious. She asked him how he felt and he said his "head had gone". She reassured him and advised him to talk to staff if he felt like harming himself. He moved back to Canal unit that evening.

49. Intelligence from another prisoner was received on 20 September, alleging that a prisoner was selling drugs in the healthcare unit and that the man had bought some. A further ACCT review took place on 21 September. He told staff that his head was “falling off” and that he wanted to go back to the healthcare unit. He said that he had no thoughts of harming himself but that he wanted to die. He was encouraged to speak to staff for support and told that he could not go back to the healthcare unit and that he needed to give Canal unit a try because it was better for him to be in an ordinary location. His observations remained as before.
50. On 21 September, a Canal Unit prisoner told staff that the man had taken a “donkey” (a mixture of strong painkillers.) It was also reported that he had been taking subutex (a synthetic opiate) which he had obtained after selling his tobacco. A mandatory drug test indicated that he had subutex in his system but the level was below the cut off point for staff to charge him with a disciplinary offence under Prison Rules.
51. On the morning of 26 September, at an ACCT review, the man said that he was feeling much better but was still feeling anxious. A nurse suggested some coping techniques and gave him some self-help material. He had started working in the magnets workshop again and had settled onto the unit. He said that he was not thinking of harming himself. His observations were reduced to one each hour.
52. Later that morning, the man did not attend an appointment with a doctor, who instead went to see him on Canal Unit in the afternoon. He said that he was having panic attacks, thoughts of self-harm and that he feared for his life when he was standing in the medication and meal queues. He was still waiting for a psychiatric assessment and the doctor arranged for him to see the psychiatrist but noted that the earliest this could happen would be 2 October. He said that he could not manage until then and the doctor prescribed him lorazepam to reduce his anxiety. (He did not see the psychiatrist until 9 October.) The doctor asked for his observations to be increased to five an hour and arranged for him to return to the healthcare unit for observation when a bed became available. However, he refused to return to the healthcare unit.
53. At his next ACCT review on Canal Unit, on 28 September, the man smiled and made good eye contact. He said that he was settled and had no thoughts of harming himself. Observations were reduced to one an hour and conversations continued at one each shift.
54. That evening, a nurse noted that the man had concealed his medication in his mouth after he received it. His lorazepam was stopped that night. There is a note in his clinical record, on 2 October, that Canal Unit staff were concerned about his lorazepam being stopped and contacted healthcare staff. They said that while he was taking lorazepam he was settled on the wing and they had not had any problems while he was taking it.

55. On 2 October, the man asked for his lorazepam when he went to get his medication. The nurse explained that it had been stopped because he had been seen concealing it. At first, he denied concealing it but then said it had been an accident. The nurse told him she could not give it to him that night because there was no prescription for it and he needed to discuss it with the doctor. He then said that he was going to harm himself. His ACCT observations were increased to five an hour.
56. During an ACCT review on 3 October, a SO challenged the man about concealing his medication. He seemed happy on Canal unit and said he no longer had any thoughts of harming himself. It was agreed to reduce monitoring to one observation a day and a conversation each shift. That afternoon, he asked a doctor for lorazepam. The doctor told him that he could not prescribe any more and that he was not changing his medication until the psychiatrist had examined him.
57. On 5 October, the man's mother contacted the safer custody team and spoke to an officer because she was concerned about her son. The officer told her that her son was being monitored under ACCT procedures and being observed regularly. At 11.33am, officers called the healthcare unit because he had made superficial cuts to his left arm and wrist. He gave no reason. His arm was treated and his observations were increased to five an hour. He later told a nurse that he had self-harmed because his lorazepam had been stopped. The nurse explained that this was not the right way to deal with it and that the psychiatrist would decide about his medication.
58. On 8 October, the man attended a counselling session and said that he had no thoughts of harming himself.
59. On 9 October, a psychiatrist examined the man for the first time since he had been referred in July. He noted that his mental state was fairly unstable and, while he was asking for lorazepam - the medication that he had been accused of concealing - it should not be assumed that he was not unwell. The psychiatrist arranged a transfer to the healthcare unit and increased his prescription for amisulpride by another 50mg, to be increased in three days if he tolerated it. He did not prescribe lorazepam.
60. On 11 October, the man asked a doctor for lorazepam again. The doctor declined but offered an increase in amisulpride. He refused this. At 3.20pm, a multi-disciplinary meeting was held to plan a way forward for him. He seemed confident and said that he had recently had a visit from his family, which went well. He said that he did not intend to harm himself and that he felt good. Observations were reduced to three an hour. He refused to attend a planned counselling session on 12 October.
61. On 23 October, a psychiatrist saw the man, who had written down his thoughts and his problems. He said that he heard voices which told him his head was "messed up" and that he wanted to feel normal. He said that he spent most of his days sitting on his bed with his head in his hands. He asked the psychiatrist for lorazepam and the doctor explained to him that this was

not the right treatment for him. According to the notes, he accepted this explanation.

62. On 31 October, a doctor examined the man and noted that he had been losing weight and had some sores around his mouth and on his arms. He said he did not have any pain. The doctor noted that he was taking a large dose of antipsychotic medication (amisulpride) which would need to be reviewed by the psychiatrist. He also asked for a weekly weight check on him and some blood tests to be completed. There is no record that these were done.
63. Further ACCT reviews took place on 16 October and 1 November. The man was reported to be settled at each review but staff noted that he spent long periods of time alone in his cell and was still asking for lorazepam. He told staff that he felt okay one day but not the next. At an ACCT review on 5 November, he said that he would accept counselling again and asked for lorazepam. He said that he was more settled and less anxious than he had been before and had no thoughts of harming himself. He agreed to go to Melling Blue Unit and started to pack his belongings. However, while he was packing his belongings he started to become more anxious and told staff that he felt suicidal and that he was anxious about returning to a residential unit. After encouragement he agreed to go to Melling Blue and he was told of the support available to him. His observations were increased to five an hour until he settled.
64. At an ACCT review on 7 November, the man was reported as appearing settled and well. A nurse told him how well he looked. He said that he was getting on well with his cell mate and had no thoughts of harming himself. He said he would never attempt that again. He had some friends on the unit and was attending education. It was agreed that his observations should be reduced to two an hour at night, with conversations in the morning and evening.
65. The man attended a counselling session on 8 November and engaged well. Further sessions were planned. On 9 November, he asked to see the doctor as he was having panic attacks. He refused to see a nurse from the mental health team so an appointment was made for him to see a doctor. There are two entries on his clinical record indicating that he saw the doctor but there is no other information about what was agreed or if any treatment was given. (This doctor has left the prison and has not been interviewed as part of this investigation.)
66. On 10 November at 1.47pm, the man's cell mate returned to their cell and found him suspended from the wardrobe door by a ligature made from shoe laces. Two officers responded to the prisoners call for help and cut the ligature. He was still breathing and was able to talk but with raspy, short breaths. He had a large indentation on his neck. Healthcare staff gave him oxygen. He eventually regained full consciousness and was admitted to the healthcare inpatient unit.

67. At an ACCT review later that afternoon, the man told a doctor that he had wanted to die and had planned to take his life while his cell mate was out of the cell. He said that he had been thinking about it for a week and had planned it just before lunch and waited until his cell mate had left. He told the doctor that he had lied to staff about being okay but he now regretted his actions and did not want to die. He did not feel his medication was working. He told the doctor that he was in debt on the unit. The doctor arranged for him to stay in the healthcare unit for observations on his neck injury. ACCT observations were to be five an hour. He spent a settled night in healthcare and slept well. He agreed that his family should be informed and that his mother could be involved in his ACCT reviews. Arrangements were made for his mother to visit him in a private room, so that he did not become anxious in the main visiting area.
68. On 11 November, the man told a nurse that he was in debt to other prisoners on the unit and could not pay it back. He said that he felt stupid about what he had done and did not want to die because he had a family to think about. He agreed to continue with his counselling sessions and asked for a doctor to review his antidepressant medication because it was not working. On 12 November, a doctor increased amitriptyline to 75mg and asked for a psychiatrist review to be arranged.
69. A psychiatrist reviewed the man on 13 November. He said that he needed very close observations so that staff could try and predict how he would behave. A specialist in forensic psychiatry also examined him. He told the specialist that he had visions and a voice in his head. He said that he felt like he had "mental missions" where he could see places that he had been in the past. The voice did not tell him to harm himself but told him his "head had gone". The specialist summarised that he had described psychotic symptoms but he did not think they were connected to his attempt to hang himself.
70. A doctor reviewed the man on 14 November and changed his anti-depressant medication. She noted that he was on a non-therapeutic dose of amitriptyline and was also taking citalopram (an antidepressant). She discussed this with him and he told her that he previously taken venlafaxine (an antidepressant) which had been effective. She prescribed him 75mg venlafaxine, to be taken twice a day.
71. On 19 November, a prisoner informed staff that the man had tried to hang himself in the shower with his pyjama drawstring. At an ACCT review that day, he presented as in a low mood and would not engage with staff. He could not explain why he had tried to hang himself but said that he was having hallucinations and hearing voices. His neck was red and the doctor examined him. Staff suggested if he was finding it difficult to talk to them he could write down his thoughts, which he agreed to do. Staff continued to observe him five times an hour.
72. At an ACCT review on 26 November, the man seemed more settled. He agreed that having some work to do would help take his mind off things. His

observations remained at five an hour and an action was added to his caremap that he should obtain work.

73. The specialist in forensic psychiatry reviewed the man on 27 November. He told the doctor that he had felt better since he had started taking venlafaxine. He said that he no longer wanted to kill himself. The specialist noted that he appeared brighter in his mood than he had last time he spoke to him and that he had promised his mother he would not try to hang himself again. He asked the doctor for lorazepam and zopiclone (for insomnia) and whether he could change his prescription for amisulpride. The specialist told him that his medication could not be changed because he had only recently started to take venlafaxine and this needed time to take effect.
74. Apart from a few low moments, the man seemed settled on the healthcare unit. An ACCT review meeting had been arranged for 12 December, but was stopped because of an incident on the healthcare unit. However, as he had been settled for some time, his ACCT case manager and a nurse agreed that he could have his shoe laces back. The ACCT review was re-arranged to take place the next day. The case manager told the investigator that it was not usual to take a prisoner's shoe laces off them because it degraded them and alerted other prisoners to their vulnerability. She also said that prisoners could use many other things to make a ligature but she had made sure that his shoe laces were a lot shorter than previously. According to the ACCT record, he was pleased to have his shoe laces back. At his ACCT review on 13 December, he was relaxed and in a good mood. He told staff that he had good contact with his family and was looking forward to a visit from his sisters and was about to start work in his cell for the magnets workshop. Staff were still required to observe him five times an hour.
75. The man's father telephoned the prison on 18 December, asking about some property that his family had sent in for him. He told the investigator that among other things, they had sent in a pair of training shoes with velcro fasteners when he was not allowed shoe laces. The case manager told the investigator that she did not know about this property and that if he had asked her she could have gone to pick it up from admissions but he never mentioned it. The Head of Residence explained that prisoners have to put in an application to ask to have property which has been sent in for them, but this can only be done only once every three months. His property record indicates that his family sent in a pair of Reebok medically-adapted training shoes on 23 August, which were given to him on 20 September. The property record also shows that his family sent in some other items of clothing on 4 September. These were subject to the three month rule and he never received them.
76. At an ACCT review on 20 December, the man was said to engage well and was relaxed and more positive. As he had been settled for a while it was agreed that his observations should be reduced to three an hour during the day and five an hour at night. He also agreed to be referred for counselling again. His next review was planned for 3 January 2013.

77. On 24 December, the man told staff that he was struggling because he was hearing voices in his head but did not have any thoughts of harming himself. Staff spent some time talking to him and he said that if things changed he would alert them about how he was feeling. His observations were increased to five an hour and it was agreed that his ACCT review should be brought forward. A doctor saw him on 24 and 25 December and noted that he said he did not have any thoughts of harming himself.
78. On 28 December, a doctor assessed that the man was fit to return to a residential unit. The doctor told the investigator that the healthcare unit was full and they needed beds for other prisoners who were returning from hospital. An ACCT review took place on 28 December and plans were made for him to move to Canal Unit because of the shortage of beds in the healthcare unit. Healthcare staff carried out a mental health assessment and found him to be settled, in a good mood, confident and relaxed. He said that he was bored on the healthcare unit.
79. A nurse said that the man had been settled for weeks and would still have had the support of the mental health team when he moved. However, when he was told about the move, he refused to go. He said he would harm himself in order to get back to the healthcare unit as it was quieter there. He was told that he needed to go to Canal Unit because he had had three and a half years of his sentence to serve and could not expect to spend all the time in the healthcare unit. He was advised not to get into debt, as he had done in the past. He moved to Canal Unit later that day, but made it clear he was unhappy with the move.
80. The man's ACCT remained open and he was assessed as high risk of self-harm because of his reaction to the move. His observations were increased to five an hour with three conversations each day. The mental health team were asked to see him daily. Because he had lived in a single cell in the healthcare unit, he was given a single cell on Canal Unit, as staff thought it would be better for him to live on his own at first because he preferred to be quiet. It does not appear that this was discussed and agreed at an ACCT case review.
81. According to the ACCT document, the man was checked at irregular intervals throughout the night, five times an hour. CCTV footage showed that checks were completed at 7.56am, 8.08am, and then at 8.20am, when an officer noted that he was lying in bed with his knees up. When interviewed, she was adamant that he was alive at this check. She said that she could see clearly as the nightlight was very bright in his cell, and because nearly every time she checked him he lifted his hand up to shield his eyes from the light. She handed responsibility for ACCT observations to another officer after this check.
82. At 8.30am on 29 December, an officer checked the man and saw him kneeling with a shoe lace around his neck, which was attached to the sink. She immediately radioed a code 1 emergency, to indicate a life threatening situation. She then went into the cell, used her anti-ligature knife to cut the

shoe laces around his neck. She put him into the recovery position and a nurse arrived at the cell. Another officer also responded to the emergency call. As the nurse had started cardiopulmonary resuscitation (CPR) and other healthcare staff were arriving, the officer began to lock other prisoners in their cells.

83. A nurse was about to begin issuing medication on Canal unit, when she heard the code 1 call and went immediately to the man's cell. She said it took her less than a minute to get there. As soon as she arrived she shouted for staff to radio the control room to call for an emergency ambulance and for someone to bring the defibrillator. (A defibrillator administers a shock to restore the rhythm of the heart in a cardiac arrest.) He was lying on the floor and he had a deep ligature mark around his neck. He had no pulse and was not breathing and his pupils were fixed and dilated, so she immediately started CPR, assisted by an officer. Oxygen was used. The defibrillator did not advise a shock. Other healthcare staff arrived to support but the nurse was in control, so continued CPR until paramedics arrived.
84. Paramedics arrived at 8.36am and took over the resuscitation attempt. They attached their own defibrillator to the man. It indicated that they should stop doing CPR and that he had a pulse measurement. They took him to hospital. No restraints were used. Prison staff contacted his family, who arrived at the hospital at 11.55am and were informed of his condition by the prison's family liaison officer.
85. The man was transferred to the intensive care unit and his family stayed by his side and were allowed to visit at any time. He remained sedated. A few days later his blood pressure dropped and he died. His family were with him at the time.
86. The staff involved in finding and resuscitating the man were invited to a debrief and offered support which they said was helpful. An officer who was at the hospital with him when he died was also offered the support of the care team. Prisoners were informed of the death. Prisoners who were being monitored as a risk of suicide and self-harm had their cases reviewed in case they had been affected by the man's actions and subsequent death. A memorial service was arranged for prisoners to attend.
87. The prison family liaison officer remained in touch with the man's family and a financial contribution towards the funeral was offered in line with national guidance.
88. A note was found in the man's cell after he had been taken to hospital. It is not clear when it was written. In the note, he referred to his mental health problems which he said could never be fixed. He said he wanted to get away from the paranoia.

ISSUES

Clinical care

89. The clinical reviewer commented on the issuing of medication to the man and the standard of record keeping. He said that the reason why he was prescribed some medication – amiodarone, clonidine and bisoprolol - was not clearly recorded. The clinical reviewer was also concerned that a prescription for omeprazole was not written up till 26 June, even though there had been several reminders from the man's family. He said that it was fortunate that he came to no harm, as not having omeprazole could have had serious consequences for him. We make the following recommendation:

The Head of Healthcare should ensure that medication is issued appropriately and that community GP records are checked for current prescriptions.

90. The clinical reviewer also commented that the mental health team assessed the man appropriately and provided him with continuous care. However, he also noted that having spoken to both a GP and a psychiatrist, one session a week from a visiting psychiatrist was not enough to meet the needs of prisoners at Altcourse. We note that despite his acknowledged mental health problems, it took over three months for him to see a psychiatrist, but he was seen reasonably frequently after that. Both the IMB and the Inspectorate commented about the pressures on mental health services in their latest reports which did not appear to meet needs. We make the following recommendation:

The Head of Healthcare should ensure that psychiatric services are adequate to meet the needs of prisoners at Altcourse.

91. The clinical reviewer concluded that, overall, the care and treatment for mental health the man received at Altcourse was comparable to that he would have had in the community. He notes some deficiencies in relation to physical health checks which the Head of Healthcare will wish to consider. As these were not related to his death they are not covered in this report. As noted above, we have included a recommendation about the failure to prescribe omeprazole, as this could have had very serious consequences.

Assessment of Care and Teamwork (ACCT)

92. We are surprised that an ACCT was not opened when the man first arrived at Altcourse. This was his first time in prison; he had a known mental health problem and had previously tried to kill himself. All of these are risk factors for suicide. However, his vulnerability was recognised subsequently.
93. During his time at Altcourse, the man was monitored under ACCT procedures for two separate periods. The first was for a short period from 12 July to 17 July. The ACCT documentation is comprehensive and there was a good assessment of his level of risk. The actions in the caremap were completed

before the ACCT was closed and a post-closure review was carried out on 20 July. At this review, he told staff that he had felt well supported.

94. The second ACCT was opened on 16 August, when the man cut his arms. This period of ACCT monitoring continued until he died. He was monitored and reviewed appropriately during this time and the level of observations were increased and decreased according to his assessed level of risk. He was offered support throughout the period and the caremap actions were reviewed as required. All reviews were multi-disciplinary and included a member of the healthcare team. We consider that in general the ACCT arrangements were managed to a satisfactory standard.

Decision to move the man on 28 December

95. The man lived in the healthcare unit between 11 November and 28 December. Staff decided move him to the Canal Unit on 28 December because the healthcare unit was full and they had three prisoners returning to the prison who needed clinical care. A doctor assessed him as fit to move and a careplan was put into place ensuring that he was supported by the ACCT, observed five times an hour and seen daily by a member of the mental health team. Canal Unit was chosen because this was a quiet wing which housed mainly prisoners on the highest level of the incentives and earned privileges (IEP) scheme. He had lived there previously and had friends on the wing. Staff advised him not to get into debt on the unit and reminded him of the support systems available for him.
96. The man did not want to move from the healthcare unit and told staff that he would harm himself in order to return there if he was moved to Canal Unit. Because of his initial refusal to move, staff decided to arrange a planned move, which meant that he would be escorted by four officers but in the event he complied with the move and no force was used. He went to a single cell on Canal Unit. Staff said that he was given a single cell because he had lived on his own in the healthcare unit and preferred things to be quiet. It would have been preferable for staff to have fully discussed this decision at an ACCT review but we accept that it was a considered decision and seems to have been reasonable in the circumstances.
97. While ultimately there were tragic results, we are satisfied that the reasons for moving the man were appropriate and that due consideration was given to his new location. The move itself was handled professionally and a careplan put in place to ensure that he remained supported on Canal Unit. Sadly, staff did not anticipate that he would carry out his threat.

Bullying

98. Two of the man's cellmates told the investigator that he had been bullied for his medication and tobacco and that staff did not do anything about it. Intelligence records indicated that, on 30 May, a prisoner was seen intimidating him in his cell on Melling Unit. On 13 June, intelligence records indicate that another prisoner had tried to give drugs to him and his cellmate.

There were several other security information reports which indicated that he was involved in trading medication or was pressured by other prisoners. On 25 July, intelligence records indicate that another prisoner was intimidating him on Canal Unit. On 20, 21, and 22 September intelligence records indicate that he was buying drugs and swapping tobacco and medication with prisoners, so that he could obtain stronger medication. On 10 December, a number of prisoners, including him, were noted to have bought bags of sugar. The same day, most prisoners ordered fruit instead of donuts for their evening meal, which prison staff thought was to brew hooch (illegal alcohol). The last entry into his security file was on 26 December when a prisoner allegedly entered his cell in the healthcare unit while he was sleeping in order to steal his tobacco.

99. Following these allegations, the investigator spoke to the Suicide Prevention Officer. She said that each wing has a safer custody telephone line on which prisoners could make confidential calls if they had concerns about the well-being of another prisoner. She checked all the calls, which are recorded, but could not find any calls relating to the man.
100. It has not been possible to establish whether the man actually was being bullied for his medication. The Head of Safer Custody said that subsequently one prisoner was moved and put on report. We are concerned that this information was not referred to in ACCT reviews or raised directly with the man. This might have been one of the underlying causes of his problems at Altcourse and should have been explored with him to see if there were any issues that could have been resolved. We make the following recommendation:

The Director should ensure that all information indicating potential bullying is fully investigated and that staff consider security information about bullying as part of the ACCT process and discuss with the prisoner at risk to ensure he is appropriately protected and supported.

Information received from prisoners after the man's death

101. In June 2013, Prisoner A, now at HMP Lowdham Grange, but who had shared a cell for some time previously on Canal Unit with the man, sent a letter and statement to the investigator. He outlined concerns that he had about his care and treatment at Altcourse. The investigator spoke to the prisoner on 25 June. He said that staff did not care for him appropriately and did not check on him according to the level of ACCT observations. He said that he had been with him in the morning of 29 December, and staff only checked him twice in a 40 minute period. (CCTV from the wing shows that checks were made at 7.56am, 8.08am and 8.20am.) He also alleged that on a previous occasion a member of staff incited the man to harm himself and told him to get out of bed and clean his cell.
102. The investigator returned to Altcourse to interview four members of staff and put to them the allegations that the prisoner had made. They all denied what he had said. There is insufficient evidence to substantiate the allegations and

in particular, contrary to what he said, we are fully satisfied that ACCT checks were conducted on the morning of 29 December as recorded in the ACCT document, and that these checks were in line with the requirement in place at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that medication is issued appropriately and that community GP records are checked for current prescriptions.
2. The Head of Healthcare should ensure that psychiatric services are adequate to meet the needs of prisoners at Altcourse.
3. The Director should ensure that all information indicating potential bullying is fully investigated and that staff consider security information about bullying as part of the ACCT process and discuss with the prisoner at risk to ensure he is appropriately protected and supported.

ACTION PLAN: The Man, HMP Altcourse - December 2012

No	Recommendation	Accepted/ Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that medication is issued appropriately and that community GP records are checked for current prescriptions.	Accepted	All staff have been advised of the requirement to complete and issue medications appropriately by notification. Senior nurses will randomly audit the dispensation of medication on a weekly basis and advice and training is given when appropriate. The clinical performance manager also audits a random sample of prescription charts and again advice and training are given if appropriate. In order to prescribe medications clarification is sought in all instances from GPs. Only upon receipt will the prison GP review the individual's medication and prescribe it, if appropriate. Should the GP feel that an individual requires medication before the confirmation is returned he can consider prescribing.	Completed	
2	The Head of Healthcare should ensure that psychiatric services are adequate to meet the needs of prisoners at Altcourse.	Accepted	In order to ensure that the psychiatric needs of the offenders at HMP Altcourse are being met a review of the psychiatric services needs to be undertaken, This request has been forwarded to the Clinical Director so a review of the current Service Level Agreement with the psychiatrist can be completed. The current case loads and practice will form part of the review.	On-going	

3	<p>The Director should ensure that all information indicating potential bullying is fully investigated and that staff consider security information about bullying as part of the ACCT process and discuss with the prisoner at risk to ensure he is appropriately protected and supported.</p>	Accepted	<p>In January 2013 a new Anti Social Behaviour (ASB) procedure was introduced, which ensured all incidents of a ASB (including bullying) nature were investigated and appropriate management introduced, monitored and reviewed. All victims of bullying are now offered support by the Safer Custody Team which consists of both Violence Reduction and Suicide Prevention. Any Intelligence Reports regarding bullying are sent to the Safer Custody Team to investigate and action.</p> <p>ACCT Assessors will consult security prior to undertaking the ACCT assessment to ascertain whether there is any intelligence to suggest bullying either as a perpetrator or victim so this can be incorporated into the ACCT plan / caremap. This new procedure will be incorporated into the ACCT awareness training and will be communicated to all ACCT assessors. The security department have already been advised that this information is required.</p>	<p>Completed</p> <p>Completed</p>	
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