



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP&YOI
Altcourse in March 2014**

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 hanging in his cell at HMP&YOI Altcourse in March 2014. He was 66 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received in prison was undertaken. Altcourse cooperated fully with the investigation.

The man had served a number of prison sentences, most recently at HMP Hewell in 2009, where he was not considered to be at risk of suicide or self-harm. He cut an isolated figure in his local community in North Wales and a dispute with his neighbours led to charges of harassment. In November 2013, he was referred to community mental health services. The consultant forensic psychiatrist treating him found evidence that he had a paranoid personality structure and prescribed risperidone (an anti-psychotic), but there is no evidence that he had started taking it. The consultant had not arrived at a definitive diagnosis when, on 8 February, he was remanded into custody at HMP Forest Bank.

When the man arrived at Altcourse on 11 February, he said he had a history of depression and was appropriately referred to the Primary Mental Health Team. He was assessed, but not found to have clinical symptoms. He was referred to the mental health in-reach team on 19 February after information was belatedly received about his involvement with community mental health services. The in-reach team nurse said he appeared to be coping well and, at a session two days before he died, was in good spirits and keen to show her letters about his release. According to a prisoner who became good friends with him, he was concerned about a chest infection and a forthcoming court appearance, but was planning for his future and showed no sign he was thinking of ending his life.

While it is unfortunate that Altcourse did not receive information about the man's involvement with community mental health services until eight days after he arrived, the investigation did not find that this had had an adverse effect on his care. However, once it became clear that he had been prescribed anti-depressants in the community, there should have been a proper medication review. Nevertheless, I have not found any evidence that he presented an obvious risk of harming himself and I do not believe that prison staff could have reasonably foreseen or prevented 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.

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SUMMARY

1. The man was 66 years old. He had served a number of prison sentences since the 1970s, most recently at HMP Hewell in 2009. There is no indication that he was considered to be at risk of suicide or self-harm during this sentence. He reported that he had put a ligature around his neck some years previously. He had no other history of attempted suicide, suicidal thoughts or self-harm.
2. The man was first referred to community mental health services in November 2013. When he was sent to Altcourse, he was undergoing assessment by a consultant forensic psychiatrist. The psychiatrist told the man's community GP that there was evidence that he had a paranoid personality structure, but he had not reached a definitive diagnosis. He recommended risperidone (an anti-psychotic drug) and his GP prescribed this for him on 22 January. There is no evidence that he had started taking risperidone.
3. The man was remanded into custody at HMP Forest Bank on 8 February and was transferred to HMP Altcourse on 11 February after receiving a 120 day sentence for harassment. At reception into both prisons, he said that he had not been involved with mental health services. At Altcourse, he said that he had a history of depression and was referred to the Primary Mental Health Team. At his assessment, he again denied having any mental health issues and did not present with clinical symptoms.
4. The community mental health team became aware the man was in Altcourse on 19 February and contacted the prison with details of his assessment and treatment. He was assessed by the mental health in-reach team and taken on to their caseload. He told them that he was not on any medication and was not given risperidone.
5. The man's behaviour in prison did not cause any concern and he seemed to be coping well. A prisoner who got to know him well said he was planning for the future. He appeared cheerful at an appointment with a mental health in-reach nurse only two days before he died.
6. The man was found hanging in his cell at about 1.00pm in March. Officers and nurses tried to resuscitate him and paramedics arrived promptly. He was taken by ambulance to h, but was pronounced dead at 1.45pm.
7. We have found no evidence that the man presented a risk of harming himself and are satisfied that there were no indicators that he intended to kill himself. We do not believe that prison staff could have reasonably foreseen or prevented his death. However, we make a recommendation about the reviewing of medication prescribed in the community.

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at HMP&YOI Altcourse inviting anyone with information to contact her. No one asked to speak to her in response.
9. NHS England (North West Team) commissioned a clinical reviewer to carry out a clinical review. The investigator and clinical reviewer visited Altcourse on 3 April 2014 and met the Director. They interviewed eight members of staff and one prisoner. The investigator spoke to the manager of the man's community mental health team, on the telephone. The manager and a consultant forensic psychiatrist provided written answers to questions about his mental health care. The investigator was provided with a copy of the Serious Incident Review commissioned by NHS Wales. She also spoke to the manager of the Criminal Justice Liaison Team in North Wales. Feedback was provided to the prison via the liaison officer. She also liaised with the Coroner's Officer.
10. One of our family liaison officers informed the man's brother about the investigation. He confirmed that the prison had offered financial assistance with the funeral expenses in line with national guidance and had returned his brother's property. He said he had been offered the opportunity to visit the prison, but had declined. He was sent a copy of the draft version of this report. He said he was satisfied with the conclusions of the investigation.

HMP&YOI ALTCOURSE

11. HMP Altcourse is a local prison in Liverpool which takes prisoners from the courts in Merseyside, Cheshire and North Wales. It is managed by G4S custodial services and holds up to 1,133 sentenced and remanded adult and young adult men. G4S runs the company that provides primary healthcare services at the prison. Secondary mental health services are contracted to Prime Care.
12. Altcourse is made up of seven houseblocks, divided into individual units. These units hold between 60 and 95 prisoners. The man lived first on Melling Brown (the induction unit) and then Melling Blue (for short-term sentenced prisoners).

HM Inspectorate of Prisons

13. Her Majesty's Inspectorate of Prisons (HMIP) conducted an unannounced inspection of Altcourse in June 2014. The report was not available at the time of writing, but initial feedback from inspectors was that suicide and self-harm prevention procedures were very good and emergency response procedures were effective, with defibrillators available on every wing. The previous inspection of Altcourse was a short, follow-up inspection in October 2012. Inspectors found that the quality of staff-prisoner relationships was excellent and it was a safe prison with a relaxed, but appropriately controlled atmosphere. The personal officer scheme had developed, but most prisoners felt confident in approaching most staff. Healthcare was reasonable, but problems with mental health diversion services from the North Wales courts meant that the prison managed some prisoners with serious mental health conditions. Resettlement had improved, but there was no adequate custody planning for short-term convicted and remand prisoners.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year ending June 2013, the IMB noted that the primary mental health team was up to full strength and links with the mental health in-reach team and the safer custody officers had been embedded. A consultant forensic psychologist had been contracted for three hours a week. The IMB said the safer custody team continued to improve an already robust policy to ensure a safer environment. Thirteen full-time and five part-time prisoner carers looked after new prisoners and were available 24 hours a day.

Previous deaths at Altcourse

15. There have been two self-inflicted deaths at Altcourse since December 2012. There are no similar issues with the man's death.

KEY EVENTS

16. The man was originally from the West Midlands, but moved to North Wales in 2012. He served several prison sentences in the 1970s and 1980s. In 2009, he served a 20 week sentence for common assault. There were no recorded incidents of suicidal behaviour or self-harm during that sentence.
17. In September 2013, the man's GP referred him to the Older Person's Mental Health Service for assessment after police in North Wales raised concerns about his erratic behaviour and risk to the public. This appears to have been his first contact with mental health services. A Consultant Old Age Psychiatrist interviewed him on 12 November 2013. At the time, he was on bail for charges of harassment of his neighbours and animal cruelty. The psychiatrist said his house was in a very poor state of repair and, during the interview he shouted, swore and refused to talk about his mental health. The psychiatrist said his speech was loud and he was preoccupied with anger towards his neighbours and the police. He denied feeling low and having any thoughts of suicide or self-harm and refused to work with the Older Person's Mental Health Service. The psychiatrist said he was unable to make a complete mental health diagnosis and recommended that he have a further assessment, including of his risk to others.
18. The psychiatrist referred the man to Adult Mental Health Services. He was taken on to the caseload of the manager of the Hafod community mental health team, and assessed by a consultant forensic psychiatrist, on 18 December 2013. The man told the psychiatrist that he did not have mental health problems. He told him about a land dispute with his neighbours and about his previous convictions which he blamed on miscarriages of justice and police corruption. He told him he had tried to hang himself about ten years previously, but denied any other self-harming. The psychiatrist concluded that his assessment was not complete, but suggested multi-agency working to properly assess his level of risk to others. The psychiatrist noted he was on a number of medications for asthma and diabetes and citalopram (an anti-depressant).
19. The psychiatrist and the manager of the Hafod community mental health team saw the man again on 31 December 2013. In his letter to his GP, the psychiatrist concluded there was a strong suggestion that the man had a paranoid personality structure, although he did not arrive at a definitive diagnosis. He recommended a multi-agency meeting, including the police, and further assessment. The psychiatrist recommended the GP discontinue citalopram and begin him on risperidone (an anti-psychotic). The psychiatrist intended to see him again in a month.
20. The man did not attend an appointment with the psychiatrist on 29 January 2014, but went to see the manager of the Hafod community mental health team unannounced on 3 February. He told her he was unsure whether he had started taking risperidone, but reported feeling less anxious. He told her he was due in court on 11 February. They discussed the possibility of a prison sentence and he appeared relaxed about it. He told her he had some

good memories of prison and had made friends on previous sentences. She said he did not have any thoughts of suicide or self-harm. On 4 February, she telephoned his GP who confirmed that he had been issued with a prescription for a four week supply of risperidone on 22 January.

21. On 7 February 2014, the man was arrested and charged with two counts of harassment against his neighbours. The police medical officer noted that he had a variety of medical conditions, including asthma and type two diabetes, but was fit to be detained.
22. On 8 February, the man was remanded into custody at Magistrates' Court and taken to HMP Forest Bank. His Person Escort Record (PER, a form that accompanies a person between police, court and prison and lists risk factors) recorded previous convictions for threats to kill, common assault and sexual assault and that he suffered from asthma. There was no record that he was at risk of suicide or self-harm. At his reception health screen, he said he was prescribed a variety of medication for physical health problems, but denied having any mental health issues. He gave permission for the prison to contact his GP and telephone contact was made on 11 February. A fax was sent to the GP the same day, but there is no indication from the SystemOne record that any information was received in response.
23. The man completed his induction at Forest Bank. He was asked whether he wanted to be treated as a vulnerable prisoner because of his previous conviction for a sexual assault, but he declined. On 11 February, he was sentenced to 120 days imprisonment and taken to HMP Altcourse. (He told his offender manager (probation officer) that he would not comply with the terms of any community based punishment or curfew, making a custodial sentence inevitable.) He was not eligible for early release on Home Detention Curfew and was due to be released on 7 April 2014. His PER showed no risk indicators and the medical section simply said that the writer had been unable to find his medical history on SystemOne (the electronic medical record).
24. The man was asked in reception if he wanted to be treated as a vulnerable prisoner, but declined. A nurse completed a reception health screen. He noted the man appeared settled. The nurse referred him to the GP because he was on medication for asthma and diabetes. He told the nurse he had been in hospital for depression in the 1970s and on anti-depressants for a long while, although he could not remember the name. The nurse recorded that he firmly denied having any current thoughts of suicide and self-harm, but referred him for assessment by the Primary Mental Health Team (PMHT) in line with the prison's policy because he had given a history of depression.
25. The man saw a doctor in reception. The doctor remembered him as slightly unkempt, but calm and polite. He showed no sign of agitation. The doctor said they discussed his transfer from Forest Bank and the fact he had a short sentence. They discussed his medication for asthma and diabetes and the doctor prescribed for him during the session. The doctor said he was not concerned about his mental health and did not think that he was at risk of

suicide or self-harm. The doctor put him on the list for routine blood tests to check his diabetes.

26. The man was allocated a cell on Melling Brown unit, the first night and induction unit. (He moved to Melling Blue unit, for prisoners serving short sentences, after he completed his induction.) All new prisoners at Altcourse are checked hourly on their first night. His first night record shows that he watched TV until about 10.00pm and then went to sleep. He began his induction the next day and said at his induction interview that he had no issues in prison, but requested a radio because he was registered blind. He also had an interview with a prison carer (a prisoner trained to support prisoners with mobility issues or other disabilities). He said he had not used his prison phone call, no one knew he was in prison and he would not be receiving visits. He said he felt able to cope in custody and was not worried about bullying. He did not feel anxious or depressed and said he had never self-harmed or tried to commit suicide. He was given information about how to contact the prison safer custody team and various prison support groups including the chaplaincy, the Samaritans, the mental health team and the carers.
27. Also on 12 February, the man had an assessment with an officer from the prison diversity team, because he was registered blind. The officer completed a personal emergency evacuation plan and gave him a disability self-assessment care plan to complete. The officer described him as a very bright, polite gentleman who said he did not want to cause any problems. He asked for a magnifying glass to help him read. He said he couldn't see the TV, but liked to have it on as background noise. The officer said he told him that there was a radio channel on the TV and offered to tune it in for him, but he did not want him to. He said he found it harder to see as it got dark. He said he did not need a cane as he only left the wing in daylight.
28. On Friday 14 February, the manager of the community mental health team became aware that the man had been sent to prison after seeing an article in the local press. She agreed with the psychiatrist that they would find out which prison he was in and share information with them. She contacted the Criminal Justice Liaison Team (a community mental health team employed to visit courts and complete mental health assessments) the same day. The Criminal Justice Liaison Team covers all of North Wales, but only has three practitioners and none of them were in court when he was sentenced. They agreed to find out which prison he was in.
29. On 17 February, the man saw a nurse for his mental health assessment. He said that he did not have any mental health issues or suffer from depression. She said he appeared to be quite dismissive and in denial. Eventually, he said that he felt depressed when he was constipated. His general demeanour was relaxed and quite jovial. He mentioned an issue with his neighbours, but did not appear fixated about it. There was no intensity to his speech. She asked him whether he had any thoughts of suicide or self-harm and he said he did not. She said she did not put him on the list for a follow up

appointment because he did not appear to have any clinical symptoms of mental illness.

30. The same day, the man completed his disability self-assessment questionnaire. He said he had learning difficulties, visual impairment, diabetes and asthma. He said he used a magnifying glass for reading outside prison and would like one to be provided for him. He said he could wash, dress, clean his cell and collect his meals without assistance, but needed help when moving off the wing and found it difficult to hear the call for medication. The officer from the diversity team spoke to him briefly when he collected his questionnaire. He said the man appeared cheerful and did not raise any other issues with him. He was provided with a magnifying glass.
31. On 18 February, the man was interviewed by an officer from the Offender Management Unit (OMU) for a public protection risk assessment. The officer said that he was cooperative, but did not want to speak about the offence for which he was in prison. The man said that he did not have any history of suicidal intent or current thoughts of suicide. The officer noted the terms of his harassment order and that he was fully aware of the restrictions imposed on him.
32. On 19 February, the Criminal Justice Liaison Team told the manager of the community mental health team that the man was at Altcourse. She rang the prison and spoke to a nurse. She gave his history of contact with mental health services and faxed the relevant notes to the prison. He was referred back to the nurse for further assessment.
33. A doctor saw the man again on 21 February when he requested a repeat prescription for his inhalers. He seemed well. The blood tests requested by the doctor on 11 February had showed that his diabetic medication was appropriate. The doctor examined his chest and found it to be clear.
34. A nurse saw the man for a second assessment on 24 February. She said at first he said that he had not seen anyone from mental health in the community. She said the more she pressed him about the issue the more paranoid he became about why the information had come into the prison and the more apparent it became that he had mental health issues. He talked about his neighbours with increasing anger. He told her that the psychiatrist was talking rubbish. She asked him whether he had been prescribed risperidone because the manager of the community mental health team had mentioned it when she called the prison. He said he was not on any medication.
35. The nurse explained that if a prisoner says they are on prescribed medication for mental health issues and this is confirmed with the community mental health team, then the prison will prescribe the medication. If the medication has only been suggested as a course of action in the community then the prison will refer the prisoner to the psychiatrist to explore whether they should be on medication. She said she would normally have referred the man to the primary mental health team psychiatrist, but did not do so because she

referred him to the mental health in-reach team instead. (The mental health in-reach team works with prisoners with severe and enduring mental illness and those under the care of community mental health teams.) The mental health in-reach team has its own psychiatrist.

36. A nurse from the mental health in-reach team saw the man on 3 March. She read the information about his appointments with the psychiatrist. She said she remembered that the psychiatrist thought he might have a paranoid personality disorder and that he was considered a risk to others but not to himself. She said he was very pleasant. He told her about his neighbours and why he was in prison and that he was selling his house. He told her he had no contact with his family. She said he appeared quite well, quite bright and seemed to be coping well on Melling Blue unit. She said her only concern at their first meeting was that he was close to release. She therefore referred him to the care programme approach (CPA) coordinator, so that she could assess his needs for when he was released and begin the discharge process.
37. The nurse obtained the man's consent to access his community medical records. She explained to the investigator that this was a routine request and not because she thought she needed to see any further information. She said that at first he said that he had not seen anyone from his community mental health team. When she said she had seen letters from them he seemed happy to talk to her about his mental health. She said she thought he enjoyed talking to people. She said she discussed risk of suicide and self-harm with him and he said that, some time ago, he had put a ligature around his neck and then decided he did not want to kill himself. He had been in custody at the time. He told her that he could not be bothered to do anything like that now. She said he had shown no indication of being at risk or having a history of risk to himself. When she was told about his death her first reaction was to assume he had had a heart attack. She was very shocked and surprised to hear he had killed himself.
38. The CPA co-ordinator saw the man on 5 March. Her role is to assess the needs of prisoners on the MHIRT caseload who are due for release. Her assessment involves questions about housing, social services, medication, and family and mental health support. She contacts various agencies in the community to ensure continuity of care on the prisoner's release. Although her title is CPA co-ordinator, not every prisoner she works with is managed under CPA, which is no longer used in Wales. He was being managed under their equivalent process. She usually becomes involved three months before the prisoner's release date. For those on shorter sentences, she gets involved immediately. In his case, she was asked to assess him as soon as he was taken on to the MHIRT caseload because his release date was only weeks away.
39. The man told her that he owned his own house, but was selling it. He showed the CPA co-ordinator a letter from the conveyancing solicitor and said he did not have any housing needs on release. She said she noticed he had bad eyesight and asked him if he needed any help from social services. He told

her he had been offered help, but was able to cope on his own. He said he did not need her to contact a community mental health team. She said he was cheery, bright and helpful. He had no apparent concerns about his release. She planned to see him again before his release, but he died before they met.

40. On 10 March, the man saw a prison GP after he asked for an appointment. The doctor said he had multiple issues rather than one overriding issue. He was fairly animated and direct. He repeated himself quite a lot and talked around his issues. The doctor thought this was part of his personality rather than a learning difficulty. He found it hard to get a history from him, who complained of having a chest infection but when asked for symptoms just said, "I know I've got one". The doctor examined him and decided he did not need antibiotics, but told him to come back if it got worse. He then told him he was constipated and needed some lactulose. After the doctor prescribed this, the man told him he needed a walking stick. He said he had one in the community and wanted one in prison. The doctor said he did not appear to have any problem walking about the prison. He advised him to talk to the disability liaison officer.
41. The man told the doctor he would not be going home on release because "he could not afford to". (Other people we have spoken to thought that he thought he could not return home because of the problems with his neighbours.) The doctor asked him where he was going and he said he did not know. They discussed groups who might be able to offer help. The doctor said he thought he wanted his problems solved then and there and when he could not do that, he left in a bit of a huff. The doctor said he did not seem low in mood. There was nothing in his demeanour to suggest that he had any mental health issues. He did not seem anxious, depressed, agitated or thought disordered.
42. A nurse had a second appointment with the man on 11 March. They spoke while he was in the exercise yard. She said he was in good spirits and seemed to be enjoying himself. She said he seemed a bit preoccupied with his neighbours, which fitted with his possible diagnosis of a paranoid personality disorder. He took her to his cell and showed her letters that another prisoner had helped write for him. She said his mood did not fluctuate, his behaviour was appropriate and he gave her no cause for concern. She said he seemed so settled that she made the next appointment for three weeks time when she thought he might be close to release.
43. The nurse said she did not refer the man to the MHIRT psychiatrist even though he had seen a psychiatrist in the community who had suggested that this should continue. She said the MHIRT psychiatrist is only contracted for three hours a week and he was not in prison for very long and she did not think he was an urgent case or needed to be seen as a priority. She said she would have referred him if he had been on a longer sentence.
44. A prisoner said he met the man on Melling unit not long after he arrived at Altcourse and was friends with him until his death. The prisoner said the man had a number of different problems. He was partially sighted and appeared

generally infirm. The prisoner thought he was fixated on the issues with his neighbours which had resulted in his sentence and said it was very difficult to get him off the subject. He felt that no one was interested in his account of events, that the police were against him and society had wronged him. The prisoner said he tried to distract him, but he took every opportunity to return to the subject. He was paranoid about returning to his house because he thought he would end up arguing with the neighbours and be returned to prison. The prisoner said the man was volatile and liable to become very worked up about the situation with his neighbours. He tried to calm him down and told him to be careful about raising his blood pressure.

45. The prisoner said the issues that really seemed to bother the man were his cough, the fact that his cell was cold and a court appearance on 1 April. He was anxious he would not be taken to court and would be found guilty in his absence. He did not feel that his cough was being properly investigated. The prisoner felt that staff treated the man like a bit of a moaner. They did move him to another cell on the day of his death because of his complaints that he was cold. He said he thought his main issues were outside prison and that the court appearance was a bigger issue than the sale of his house.
46. The prisoner said there were three or four prisoners on Melling Blue unit who were kind to the man and he thought that he probably had more company in prison than at home. Some prisoners used to make fun of the fact he did not always hear the call for medication. They would shout 'meds' at the wrong time and then laugh when he went to the hatch. The prisoner described this as "schoolboy humour". He said the man had shown no signs that he felt suicidal. In the week of his death, he had looked slightly dishevelled and had not shaved, but he put this down to him feeling unwell. He had not seen any indication that he was at risk of harming himself. He said he helped him write a number of letters about matters relevant to his life after release. He thought the man was planning for the future. They had planned to go to the library together on the afternoon that he died.

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47. A nurse remembered giving the man his medication at about 7.30am. She said he was his usual chatty self and he appeared to be getting on well on Melling Blue unit whenever she saw him. An officer was absent from work during the investigation and was not available for interview. In a statement to the police, she said that, at about 8.00am, he told her that he was cold at night and there was a problem with the window in his cell. She said the problem with the window had already been reported so she and another officer decided to move him to a different cell on the same unit. He moved to cell number 10 during the morning. She said he appeared to be his usual self and did not appear agitated.
48. The usual wing routine at Altcourse is that prisoners who do not go to work or education are locked in their cells at about 9.00am and unlocked at about 11.30am when those at work or education return to the wing. All prisoners are locked in their cells again at noon for a roll count. Staff look through the

cell observation panels to check everyone is present, but are not required to get a verbal response from prisoners. Usually prisoners are unlocked again at 12.30pm for lunch and at 1.00pm either go to work, education or back in their cells.

49. The investigator was provided with CCTV coverage of Melling Blue unit between 11.45am and 2.30pm on the day of the incident. The time on the CCTV camera, the timings on the communications officer's log and timing from North West Ambulance Service are different. CCTV shows the man going in and out of his cell three times between 11.46am and 11.49am. He collects a hot drink, walks up and down and talks briefly to other prisoners. He does not appear agitated. At 12.00pm, he stands in his cell doorway before being locked inside at 12.01pm by an officer. At 12.06pm, the officer looked through his observation flap for roll count. The officer told the police that he seemed well and appeared to be his normal self.
50. Officer A came on duty at 12.15pm. She was also absent from work during the investigation and was not available for interview. In a statement to the police, she said there was a problem with the roll count which delayed the prisoners being unlocked. CCTV shows her unlocking the man's cell at 12.59pm. This was the first time anyone had gone to his cell since 12.06pm. She said she looked through his observation flap and saw him hanging from the bunk bed. He had used the cable from his radio as a ligature and was slumped forward in a sitting position.
51. Officer A shouted for assistance from Officer B and pressed the emergency button on her radio to request "first response" (this broadcasts a specific alarm to all radios to indicate a non-medical emergency and requires all available officers to attend). She said they entered the cell with some difficulty as the man's legs were obstructing the door. She then used her radio to call a Code 1 emergency. Officer B supported his weight while she cut the ligature from the bed and they laid him on the floor. CCTV shows her enter the cell immediately, followed by Officer B. The communications room log records the radio first response at 1.01pm and the Code 1 message at 1.02pm. The communications room log records an ambulance being called at 1.05pm. North West Ambulance Service's incident call report records the 999 call at 1.00pm and the ambulance being mobile at 1.05pm.
52. Officer C said he was in the unit office when he heard the sound for first response on his radio. He ran immediately to Melling Blue unit and saw a number of prisoners outside the man's cell. He went in and saw Officer A standing at the back of the cell in tears and very distressed. Officer B was standing by the toilet. CCTV shows Officer C and two other male officers go into the cell 20 seconds after Officer A, at 1.00pm.
53. Officer C said the man was lying on his back on the floor with his legs folded underneath him. The power cable from the radio was tied around his neck. He removed the cable and another officer helped him lay him flat. He checked for signs that the man was breathing and then started cardio pulmonary resuscitation (CPR). He said he received annual refresher training

in first aid and started breaths and compressions at a rate of 30 compressions to two breaths. He had a breathing mask on his belt but did not use it. He said the man's face was swollen and his eyes were bloodshot and rolled back into his head. His hands were blue.

54. The emergency response nurse responded to the Code 1. CCTV shows her enter the cell at 1.02pm. Other nurses arrive with her. She asked the officers to move the man on to the landing so there was more room to work on him. She said he had no pulse and was unresponsive. She took over CPR from Officer C while a nurse gave oxygen via an airway and ambu-bag. A defibrillator was attached but found no shockable heart rhythm and signalled that CPR should continue.
55. A prison doctor said he arrived when the man had been brought out of the cell and CPR was underway. He said he showed no signs of life and that he was unable to gain access to his veins in order to insert a cannula. His limbs were cold, but he could not recall whether his body was warm. He said the emergency equipment was all in working order and nothing was missing. CCTV shows paramedics arrive and begin treating him at 1.12pm. The communications room log records the ambulance arriving at 1.17pm. North West Ambulance Service's incident call report records the ambulance on scene at 1.08pm.
56. At 1.35pm, the man was taken by ambulance to hospital with an escort of two officers. No restraints were applied and paramedics continued to perform CPR. They arrived at hospital at 1.37pm and he was taken to the emergency department. He was pronounced dead at 1.45pm. A hot debrief was held for all staff involved in the incident. Members of the staff care team were present. All staff interviewed reported that they felt appropriately supported by the prison. Prisoners on open ACCT documents were reviewed. The prisoner said that he had received support from a nurse as he was a patient of hers.

Family liaison

57. A prison family liaison officer was appointed. Due to the distance between Altcourse and the man's brother's address, the prison decided to ask a family liaison officer from HMP Oakwood to break the news of his death. The man's brother was informed at about 4.00pm that afternoon. The family liaison officer contacted him the next day and remained in contact with him and his wife. She visited the family and returned his brother's property. The family were invited to a memorial service at the prison, but declined. She attended the funeral.

Post-Mortem

58. The post-mortem report gave the cause of death as "1a, external compression of the neck and 1b, hanging". Toxicology showed the man was not under the influence of alcohol or drugs when he died.

ISSUES

Assessing the risk of suicide and self-harm

59. The man told both the psychiatrist and a nurse that he had once put a ligature around his neck some ten or 12 years previously. Apart from that he appeared to have no history of suicide or self-harm. He consistently said that he did not have any thoughts of suicide or self-harm during his reception health screen and during his four mental health assessments at Altcourse. In the community, he was regarded as a risk to others but not to himself. A prisoner who knew him well in Altcourse said that he had never shown any sign of being at risk of suicide and was planning for his future outside prison. CCTV coverage shows him getting a hot drink and walking around the unit showing no signs of distress or agitation less than an hour before he was discovered hanging. We have seen no evidence that he presented a risk of harming himself and are satisfied that there were no indicators that he intended to kill himself. We do not believe that prison staff could have reasonably foreseen or prevented his death.

Mental health care

60. The man said he had a history of depression during his reception health screen and was appropriately referred to the Primary Mental Health Team for assessment. He was assessed within the target time. He denied any involvement with community mental health services and did not present with any clinical symptoms. When the manager of the community mental health team contacted the prison and sent them his community mental health records, he was appropriately referred to the mental health in-reach team. He was again assessed within time targets and was taken on to their caseload.
61. The man told the manager on 3 February that he was due in court on 11 February and they discussed the possibility of him going to prison. In the event he was arrested on new charges on 8 February and remanded into custody. She only became aware that he was in prison on 14 February when she saw an article in the local press. She received confirmation that he was in Altcourse on 19 February and immediately contacted the prison with details of his involvement with mental health services. The Criminal Justice Liaison Team for North Wales has three practitioners who are unable to cover every court every day and none of them were on duty when he was sent to prison. Although it is unfortunate that Altcourse were unaware of his involvement with community mental health services for some eight days after his arrival, we do not consider that this had an adverse impact on his treatment and assessment. He had already been identified and assessed by the primary mental health team before she contacted the prison.
62. The Serious Incident Review by NHS Wales noted that, when interviewed on several occasions by health care professionals in the community and in Altcourse, the man denied having any problems with his mental health and said he believed mental health services could not do anything to assist him. The review found that assessment of him in the community had been made

difficult by his inconsistent attendance at appointments. They concluded that he appeared to have difficulty engaging with healthcare teams and did not have well-developed relationships with care givers and this might have led to him not disclosing symptoms to healthcare professionals in prison.

63. The man consistently told staff at Altcourse that he was not on any medication for his mental health. He was not prescribed risperidone at Altcourse and was not referred to a psychiatrist. In response to questions put by the investigator, the psychiatrist said he believed it would have been beneficial for him to continue to take risperidone, but that he did not particularly need to have been under the care of a psychiatrist in prison. The man did not ask for his risperidone to be continued.
64. The manager of the community mental health team mentioned the prescription of risperidone when she rang the prison on 19 February. As a result, a nurse asked him about it when she saw him on 24 February. He said that he was not on any medication for his mental health. The nurse does not seem to have asked him and, as he was not referred to the psychiatrist, his medication was not reviewed again. It is unclear whether he would have taken risperidone had it been prescribed to him in prison (he seemed unaware he had been prescribed it in the community), but the prison were aware of the prescription and the psychiatrist believes that it might have helped him. We do not consider that this issue was addressed properly and we make the following recommendation:

The Head of Healthcare should ensure that prisoners are referred for a medication review when it is confirmed that they have been prescribed medication in the community.

Emergency response

65. When she discovered the man hanging, Officer A pressed the emergency button on her radio to summon an immediate response from colleagues. She entered his cell immediately and then used her radio to call a Code 1. Although she did not immediately call a Code 1, the delay was a matter of seconds and staff responded very quickly to the first response call. Officer C began CPR within seconds of him being discovered. Nurses arrived a minute after the Code 1 call with the emergency bag and within three minutes of him being discovered.
66. There is a discrepancy between the timings on CCTV, the time recorded by the communications room log keeper and the time on North West Ambulance Service's call log. The log keeper records a gap of three minutes between the Code 1 being called and the ambulance being called and 12 minutes between the ambulance being called and its arrival, a total of 15 minutes. CCTV shows that paramedics were with the man only 13 minutes after he was discovered. The North West Ambulance Service call log records eight minutes between the 999 call and paramedics arriving which also suggests an ambulance was called immediately in response to the Code 1. Although the timings differ, we are satisfied there was no delay in the response to finding

him hanging. CPR was given promptly and in accordance with resuscitation council guidelines and all the emergency equipment was available and functioning.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners are referred for a medication review when it is confirmed that they have been prescribed medication in the community.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners are referred for a medication review when it is confirmed that they have been prescribed medication in the community.	Accepted	<p>Once the establishment has confirmation of the prescribed medication from the community GP, a referral is made to the establishment GP.</p> <p>The establishment GP will conduct a medication review to determine the appropriateness of medication, taking into account safety and prescribing guidelines.</p> <p>The prisoner will be informed of the outcome, either directly by the GP if deemed necessary or a member of Healthcare team.</p>	Completed June 2014	