

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joshua Collinson a prisoner at HMP Swinfen Hall on 3 September 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**



Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*

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

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

Mr Collinson was found hanged in his cell in at HMP Swinfen Hall on 3 September 2015. He was 18 years old. I offer my condolences to Mr Collinson's family and friends.

Mr Collinson had been sentenced just one day after his eighteenth birthday. He was a very vulnerable young man, yet there were repeated failures to identify and respond to the extent of his vulnerability after he was sentenced. Transition arrangements from a secure training centre to young adult custody were disjointed and poorly managed at Parc and the Youth Offending Service did not communicate relevant information effectively. The evidence indicates systemic as well as local failures and I therefore make a national recommendation about the need for better transition planning.

I am concerned that the mental health team at Parc overlooked key information about the extent of Mr Collinson's mental health problems. I am also concerned that, despite Mr Collinson's youth and vulnerability, his transfer from Parc seems to have been arranged to relieve population pressures, rather than in response to his needs. Finally, I am concerned that no one at Swinfen Hall identified that Mr Collinson might be at risk of suicide when he said that he had tied a ligature the previous day and was unhappy about his transfer. The prison needs to ensure that staff responsible for such assessments are adequately trained to identify risk factors for suicide.

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

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Summary

Events

1. In September 2014, when he was 17 years old, Joshua Collinson was charged with sexual offences against another child. He had a history of self-harm and was known to Social Services. He was initially taken to the young persons unit at Parc, but was transferred to Oakhill, a secure training centre (STC), in October, as he was considered too vulnerable (due to the risk of harm from other prisoners who had become aware of the details of his offence) to stay at Parc.
2. On 24 November, Mr Collinson was convicted and stayed at Oakhill while pre-sentence reports were completed. The Youth Offending Service (YOS) completed a report, but sentencing was postponed for a full psychological assessment. This meant that Mr Collinson was not sentenced until 12 March 2015, the day after his eighteenth birthday. He was sentenced to four years and sent to Parc, where he lived in the adult vulnerable prisoner unit.
3. The Youth Justice Board (YJB) contacted Parc and Oakhill some weeks before Mr Collinson was due to be sentenced, and Oakhill sent information about Mr Collinson to Parc. Little was done with the information. The probation officer (offender manager) who became responsible for Mr Collinson when he reached 18 had little contact with his YOS worker and the YOS worker did not brief anyone personally about Mr Collinson's vulnerabilities. Mr Collinson's personal officer at Parc knew little about him and did not know he had been in Oakhill before he was sentenced.
4. For much of his time at Parc, Mr Collinson was managed under Prison Service suicide and self-harm prevention procedures known as ACCT and he often self-harmed. His behaviour was sometimes difficult to manage and he had complex needs but no one implemented a behaviour management plan. Healthcare staff did not read the comprehensive psychological assessment of February 2015, which detailed his learning difficulties and possible significant mental illness and did not refer him for a psychiatric assessment.
5. On 2 September, because of population pressures, Mr Collinson was transferred to Swinfen Hall. He told a reception nurse that he had tied a ligature the day before, as he did not want to go to Swinfen Hall but she and other reception staff did not identify him as at risk of suicide and self-harm. Mr Collinson had a single cell and no one checked him during the night.
6. At 5.50am on Thursday 3 September, a night patrol officer found Mr Collinson hanged in his cell. It was clear that Mr Collinson had been dead for some time, and staff did not try to resuscitate him.

Findings

7. We are concerned that there was little effective management of Mr Collinson's transition from a secure training centre to a vulnerable prisoner unit in an adult prison. Communication between the Youth Offending Service and the Probation Service was poor, no one at Parc took responsibility for ensuring his

smooth transition and coordinating his care and there was no agreed plan for his future.

8. Staff at Parc appropriately managed Mr Collinson's risk of suicide and self-harm. A learning difficulties nurse drew up a supported living plan to help manage his learning difficulties but this was not communicated to staff responsible for his day to day care. Mr Collinson had behavioural difficulties which led to him losing privileges and being punished under the prison disciplinary procedures. The need for a behavioural management plan was identified but one was never implemented and we are concerned that there was an inadequately coordinated approach to his care and management and no evidence that staff considered enhanced ACCT case management, which might have helped.
9. The psychological report of February 2015, prepared for the court, had identified possible significant mental illness and recommended an urgent psychiatric assessment. Although Mr Collinson eventually had a psychiatric assessment in August, this was at the request of the Court of Appeal and not the healthcare team who had not read the report or used this to inform their assessments, which concluded he did not need ongoing mental health support.
10. Mr Collinson transferred to Swinfen Hall because of population pressures rather than to meet his needs and no one took account of his vulnerabilities. Reception staff at Swinfen Hall did not recognise his risk of suicide and self-harm when he arrived, despite clear indicators of risk.

Recommendations

- The Chief Executive of the National Offender Management Service, the Chief Executive of the Youth Justice Board and the Director of the National Offender Management Service in Wales should ensure that transition arrangements for young people moving to adult custody include a jointly agreed management plan covering at least the first six months after transfer, outlining how their needs will be met, and how their risks and vulnerabilities will be managed.
- The Director of Parc should ensure that ACCT procedures are managed effectively to coordinate care and that staff use enhanced case management procedures for more complex cases with a range of vulnerabilities. Prisoners at risk of suicide or self-harm should not be segregated unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
- The Head of Healthcare at Parc should ensure mental health assessments take into account all relevant information, use standard mental health assessment tools, and that assessment and treatment are in line with NICE guidelines.
- The Director of Parc should ensure that decisions about the routine transfers of prisoners are taken at sentence planning meetings where possible, that transfers meet their identified needs and take into account any vulnerabilities.
- The Governor of Swinfen Hall should ensure that all reception staff who assess newly arrived prisoners are trained to recognise risk factors for suicide and self-

harm, fully record the reasons for decisions, and open an ACCT whenever a prisoner has recently self-harmed or has other significant risk factors. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners.

The Investigation Process

11. The investigator, issued notices to staff and prisoners at Parc and Swinfen Hall, informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
12. The investigator visited Swinfen Hall on 7 September 2015 and obtained copies of relevant extracts from Mr Collinson's prison and medical records. She interviewed two prisoners who had transferred from Parc with Mr Collinson.
13. NHS England commissioned a clinical reviewer to review Mr Collinson's clinical care at Swinfen Hall. Health Inspectorate of Wales (HIW) reviewed Mr Collinson's care at Parc.
14. The investigator interviewed four members of staff at Swinfen Hall on 28 October, and six members of staff and one prisoner at Parc on 10 November. The clinical reviewers were present for some interviews. She also interviewed two probation staff, a social worker from the Youth Offender Service, an operational manager, and two prison officers at Parc, by telephone.
15. We informed HM Coroner for South Staffordshire District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Collinson's mother to explain the investigation. Mr Collinson's mother wanted the investigation to consider why he had been transferred to Swinfen Hall, which was a long way from his home and why he was not checked during his first night at Swinfen Hall. She wanted to know whether there were any similarities with the circumstances of a previous death at Swinfen Hall in March 2014.
17. Mr Collinson's family received a copy of the initial report. The solicitor representing them wrote to us and confirmed they had no comment to make on the factual accuracy of the report.
18. The prisons and Youth Justice Board also received a copy of the report. They pointed out some factual inaccuracies, and the report has been amended accordingly.

Background Information

HMP & YOI SWINFEN HALL

19. HMP & YOI Swinfen Hall holds up to 654 young adult men aged 18 to 25, who are serving sentences of over four years. It has nine wings and all cells are single. Staffordshire & Stoke-on-Trent Partnership NHS trust is the lead healthcare provider. Nurses are on duty everyday, but there is no healthcare cover at night.

HM Inspectorate of Prisons

20. The most recent inspection of Swinfen Hall was in July 2014. Inspectors reported that prisoners received effective care and support when they arrived. First night induction was good but the accommodation was substandard and there were no dedicated first night cells. Fewer prisoners surveyed than in comparator prisons said that they felt safe on their first night and none of the new arrivals inspectors spoke to had seen a peer supporter on their first night. Staff told inspectors they made additional checks on new arrivals during their first night. Only a third of staff were trained in suicide and self-harm prevention.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2015, the IMB was concerned about the arrangement for transferring prisoners and said that there were too many last-minute cancellations and delays, which could be distressing for prisoners. The IMB noted that the standard of accommodation on the induction wing was poor.

Previous deaths at HMP & YOI Swinfen Hall

22. We have investigated two self-inflicted deaths at Swinfen Hall since the Ombudsman's office began investigating deaths in prisons in 2004, the most recent in March 2014. There were no significant similarities with the circumstances of Mr Collinson's death.

HMP & YOI PARC

23. HMP & YOI Parc is run by G4S and has an operational capacity of 1,723 for convicted men and young adults on remand or convicted. It includes a dedicated unit of 64 beds for young people under 18. Integrated Services, a branch of G4S, provides 24-hour primary general and mental healthcare services at Parc and St John's Medical Practice provides 24-hour GP cover.

HM Inspectorate of Prisons

24. The reports of the most recent inspections of HMP Parc and the young persons unit at Parc have not yet been published. At the previous inspection of the main prison in July 2013. Inspectors reported the prison was safe and, overall, the standard of health services was good. Those most at risk received excellent care in the safer custody unit with high levels of healthcare input. However, the

prison had not given enough thought to managing the behaviour and progress of younger less mature prisoners. Inspectors found that quality of individual assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm was very good but considered that the use of the basic regime to help manage some prisoners assessed as at risk of suicide and self-harm was inappropriate. Young adults were more likely to report emotional and mental health problems and had more negative views about many aspects of their prison experience. Inspectors considered that young adult prisoners were integrated appropriately but their specific needs were not always considered and the prison needed to do more to support them.

25. Working relationships between prison and mental health staff were found to be very effective. Mental health nurses completed all reception screening and attended all ACCT reviews to identify mental health problems quickly. All new referrals had an initial brief assessment and were either signposted to appropriate services or allocated a named nurse. There were good services for prisoners with learning disabilities.
26. The most recent inspection of Parc's young persons unit, for boys under 18, in August 2014, was generally positive. Inspectors found that unit was safe with close staff supervision and prompt support for those at risk of intimidation. There was good support for those at risk of harming themselves and inspectors considered that health services were very good.

Independent Monitoring Board

27. In its latest annual report, for the year to February 2015, the IMB reported that Parc was well managed, the safety of the prisoners was of paramount importance, and the purposeful activity provided was generally very good.

Youth Offender Service

28. Youth Offending Services (YOS – in some areas also known as Youth Offending Teams/YOTs) are multi-agency partnerships that deliver youth justice services locally. The YJB sets standards in youth justice services and monitors YOTs' performance. YOTs are funded by their statutory partners and receive an annual grant from central government administered and overseen by the YJB. YOS workers work with young people under the age of 18 to try to help them desist from crime and are supported by other agencies. YOS workers supervise young people who have been ordered by the courts to serve sentences in the community and in secure accommodation, including secure children's homes, secure training centres (STC) and Young Offender Institutions (YOIs). They are able to make recommendations to the Youth Justice Board about the best place to hold a young person in the secure estate.

Youth Justice Board Placements Team

29. The Youth Justice Board (YJB) works to prevent children and young people under 18 from offending or re-offending, to protect the public and promote the welfare of children and young people in the criminal justice system. The YJB sets standard for youth justice services and monitors performance against this. The YJB also has responsibility for commissioning custody provision for under

18s and placing young people aged 17 and under to appropriate secure accommodation when they are remanded or sentenced to custody.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
31. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
32. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Incentives and Earned Privileges Scheme (IEP)

33. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

Initial reception at Parc

34. Mr Joshua Collinson was 17 years old when, on 10 September 2014, he was charged with sexual offences against a younger child. He was remanded in custody and the Youth Justice Board (YJB) placement service arranged for him to go to the Juvenile Unit at Parc, for boys under 18. Mr Collinson had not been to prison before.
35. At an initial health screen, Mr Collinson told a nurse that he had tried to hang himself twice, in recent years. He said he heard voices that made him angry and that he harmed himself as a result. She considered that Mr Collinson was at risk of suicide and self-harm and began Prison Service suicide prevention measures, known as ACCT. She referred him to the prison GP.
36. On 11 September, a mental health nurse assessed Mr Collinson and noted he had a history of learning difficulties and had been hearing voices since the age of 13. She referred Mr Collinson to the learning disabilities team for an assessment.
37. On 14 September, the mental health nurse attended an ACCT case review, where it was agreed that ACCT monitoring should continue. On 16 September, Mr Collinson punched the wall after other boys had threatened him, apparently because he had told them about his charges. A nurse attended an ACCT case review that day and afterwards, assessed his mental health. She recorded that Mr Collinson told her he had attention deficit hyperactivity disorder (ADHD).
38. On 18 September, a nurse referred Mr Collinson to be assessed by the Children and Adolescent Mental Health Services (CAMHS, specialist NHS services that work with children and young people who have difficulties with their emotional or behavioural wellbeing). Staff continued to monitor Mr Collinson over the next two weeks and told him not discuss the details of his charges with other prisoners.
39. On 29 September, a CAMHS clinical nurse specialist assessed Mr Collinson and did not consider he had psychosis (a mental health problem with main symptoms of hallucinations and delusional thoughts). The nurse considered he should see a doctor and she would review him four weeks later.
40. On 3 October, Mr Collinson moved to Parc's intensive support unit (segregation unit) because other prisoners were threatening him. Parc contacted the YJB placement service because they considered he was increasingly vulnerable and they were concerned about his safety. A multidisciplinary meeting the same day, with representatives from Mr Collinson's Youth Offending Service (YOS) and input from the YJB, decided that Mr Collinson should be moved for his own protection. The YJB agreed that Mr Collinson should move to Oakhill Secure Training Centre (STC). He transferred on 10 October.

Oakhill STC

41. Staff at Oakhill STC supported Mr Collinson using vulnerability management and suicide and self-harm procedures (known as SASH – the equivalent of ACCT in prisons). The resettlement manager at Oakhill said that Mr Collinson found it difficult to cope at the secure training centre and self-harmed four times while he was there, once by tying a ligature around his neck.
42. On 24 November, Mr Collinson was convicted at Crown Court. He remained at Oakhill STC waiting for a psychology assessment and pre-sentence reports. In a pre-sentence report, a YOS worker noted that Mr Collinson was particularly vulnerable, had complex welfare needs and was at high risk of suicide. Mr Collinson had been due to be sentenced on 19 January, but sentencing was adjourned because the psychology report had not been completed.
43. A psychologist interviewed Mr Collinson at Oakhill on 9 January and 6 February 2015. In his report of 9 February, the psychologist concluded that Mr Collinson had a significant mental health disorder, possibly major depression with psychosis, schizophrenia or bipolar disorder, and had weak problem-solving skills. The psychologist recommended that Mr Collinson should be referred immediately for a psychiatric assessment.
44. Mr Collinson was due to be sentenced on 12 March, the day after his 18th birthday. After he was 18, and as it was expected that Mr Collinson would receive a long term sentence, he would not continue to be supervised by the YOS. On 5 March, his YOS worker contacted a senior probation officer and discussed Mr Collinson's continuing supervision. She told the YOS worker that Mr Collinson would not be suitable for the community sex offender treatment programme (SOTP), because of the difficulties identified in the psychological assessment.
45. In an addendum to his pre-sentence report, dated 11 March, the YOS worker wrote that Mr Collinson would not be suitable for group work programmes, specifically the sex offender treatment programme (SOTP), because of his immaturity, learning difficulties and the potential mental health issues outlined in the court psychology report.

Transition to a the young adult estate

46. As Mr Collinson's 18th birthday was the day before his sentencing, it was planned he would go to Parc after his court appearance on 12 March. On 15 December 2014, a worker from the Youth Justice Board (YJB) placement team contacted Oakhill to ask them to send Parc Mr Collinson's records as part of the transition arrangements from the children and young person's estate to a young adult young offender institution or prison. During February, the YJB contacted Parc, who confirmed that they had received Mr Collinson's records and said they could provide a safe and supportive regime for Mr Collinson in the adult vulnerable prisoner unit. (Young adults between 18 and 21 are integrated with older adult prisoners at Parc.)
47. The YOS worker, resettlement manager (Oakhill), the Head of the Young Persons Unit, Parc and a worker from the YJB agreed on 10 March that Mr

Collinson would go to Parc from Crown Court. The same day, a worker from Parc's safer custody team forwarded an email from the YJB, which outlined Mr Collinson's details to others in the safer custody team, the prison's offender management unit, the complex case manager, and managers of the vulnerable prisoner unit (X Block). She did not send the email to healthcare staff. Despite information about Mr Collinson's vulnerability in her email, there was no coordinated plan for Mr Collinson's transition.

48. On 10 March, the YJB sent a "transitions form" to Parc, which named a manager in Parc's offender management unit as Mr Collinson's caseworker. He told the investigator he had never been a caseworker and had no recollection of any contact with the YJB. The 'transition checklist' provided by the YJB Placement Service records that he had been spoken to on 10 March by the Head of OMU; there are no other records of this telephone call.
49. On 12 March, Mr Collinson was sentenced to four years in prison and went to Parc, as agreed. After Mr Collinson was sentenced, the YJB had no further involvement in Mr Collinson's care.
50. The operational manager for X Block (the vulnerable prisoners unit) said that she knew that Mr Collinson had come from a secure training centre, but did not know that she was expected to liaise with the Oakhill about his care. Parc's own transition policy is limited to young people who move from the young persons unit at Parc. It requires the unit manager to liaise with staff from the young persons unit at Parc and involve them in the transfer arrangements. However, she was also unaware of that. Under this policy she, as the vulnerable prisoner unit's operational manager, would have been responsible for ensuring that all the departments involved in Mr Collinson's care shared relevant information to assist his transition.

Mr Collinson's move to X Block at Parc

51. At an initial health screen when Mr Collinson arrived at Parc on 12 March, he told a mental health nurse that he had been diagnosed with bipolar disorder, schizophrenia, ADHD and learning difficulties. Mr Collinson said he had previously self-harmed in the past. She identified Mr Collinson as high risk of suicide and self-harm and began ACCT suicide and self-harm prevention procedures.
52. His ACCT case manager recorded issues of boredom, anxiety and lack of family contact on Mr Collinson's caremap. She noted that staff should allocate Mr Collinson to an activity, refer him for a mental health assessment and set up his telephone PIN number so he could contact his family. (Every prisoner has an individual number associated with their personal telephone account, which they need to use the telephone.)
53. On 16 March, a nurse assessed Mr Collinson's learning difficulties. She recorded that Mr Collinson appeared agitated, inconsistent and vague. Mr Collinson told the nurse he had difficulty reading and writing. She referred Mr Collinson to the GP and prison mental health services and asked staff to gather information about Mr Collinson's behaviour to help draw up a supported living plan. (A supported living plan is designed to provide additional help for

everyday living and to ensure prison staff are aware of prisoner's specific healthcare, disability or diversity needs.)

54. On 18 March, the caseworker completed an initial categorisation and allocation form (for prisoners under 25 years) a standard form completed at all local prisons for all newly sentenced prisoners to assign a security category and recommend subsequent suitable prisons to best meet the prisoner's needs. This should be based on all relevant documents about the prisoner's offence. He recorded that because of his age and his offence, the only suitable places for Mr Collinson were HMYOI Aylesbury and HMP Swinfen Hall. He recorded on the form that he had looked at Mr Collinson's pre-sentence reports. However, he told the investigator that this was a mistake and he had looked only at his previous convictions and his most recent prison record. He said he did not know that Mr Collinson had come to Parc from Oakhill Secure Training Centre. He did not record that Mr Collinson was at risk of suicide or self-harm or any other information about his risk factors.
55. On 20 March, Parc received Mr Collinson's psychology report, dated 9 February 2015, and it was scanned into his medical records that day. The report had recommended an urgent psychiatric assessment as the psychologist had concluded that Mr Collinson had a serious mental illness. However, there is no record that anyone in the healthcare team read the report when it arrived. No one referred Mr Collinson for a psychiatric assessment.
56. On 22 March, the lead mental health nurse recorded that Mr Collinson said he was depressed and had been diagnosed with ADHD, bipolar disorder and depression, but was not currently taking any medication. She recorded 'no abnormalities detected'. She did not read the recently received psychology report and did not note any plans for ongoing mental health treatment.
57. Mr Collinson continued to be monitored under ACCT procedures. Between 12 March and 21 April, the operations manager chaired four of the five ACCT case reviews.
58. On 1 April, Mr Collinson's offender supervisor and his offender manager met him to discuss his sentence plan. The offender supervisor noted the psychology report, and wrote that she would follow this up with healthcare staff, but there is no record that she contacted healthcare staff about it afterwards. She recorded that Mr Collinson had clear learning difficulties that might prohibit him from completing group work and assessments. They set targets for Mr Collinson, including ongoing engagement with the mental health team and an assessment for the Thinking Skills Programme. There was no reference to the information from Oakhill STC or the YJB. There is no evidence she discussed Mr Collinson with anyone involved in his care on X Block.
59. On 2 April, Mr Collinson poured boiling water over his right forearm. A nurse dressed the wound with a large dressing. Staff did not review Mr Collinson's risk of suicide or self-harm until an ACCT case review, two days later. At the review, the operations manager recorded that Mr Collinson still did not have a PIN phone number and had not spoken to his mother since he had arrived at Parc over three weeks earlier. His PIN phone account was set up that day and this action was marked as completed on his caremap. The mental health nurse

who attended the case review, referred Mr Collinson to the mental health team for another assessment.

60. On 10 April, a mental health nurse assessed Mr Collinson. She recorded that she had found no evidence of a serious mental health illness and no further action was necessary. In making her assessment, she had not reviewed Mr Collinson's previous medical notes and had not read the psychology report of 9 February.
61. A nurse saw Mr Collinson for a learning disabilities assessment later that day. He did not consider that Mr Collinson had ADHD and noted that he would be reviewed in three months. The mental health and learning disabilities team provided a summary of their assessments for each of Mr Collinson's ACCT case reviews, but he and another nurse did not attend any of them.
62. On 12 April, Mr Collinson was appointed a personal officer. The role of personal officers is to get to know the prisoners they are responsible for, act as a first point of contact for any problems, support them with sentence planning and resettlement issues and make regular entries in their record. She did not know that Mr Collinson had been at a secure training centre before he came to Parc. She did not attend any of his ACCT case reviews.
63. On 13 April, Mr Collinson made a ligature from a sheet. The unit manager increased his observations from hourly to half hourly. The complex case manager from the safer custody team attended an ACCT case review the next day. There is no specific record of whether the review considered managing Mr Collinson under enhanced case management measures. The operations manager who chaired the case review told the investigator that the review had agreed Mr Collinson did not need enhanced case management, as he was already receiving support from the mental health team, learning difficulties team and from officers. There is no evidence on the record of the case review that enhanced case review procedures had been considered. The review referred Mr Collinson for a GP appointment to discuss treatment for his low moods. Although he had been found with a ligature the day before, the review assessed Mr Collinson's risk of suicide and self-harm as low. Staff were required to check him at least once every half hour.
64. On 16 April, Mr Collinson started education classes and spoke to a prisoner mentor. A prison GP saw Mr Collinson and prescribed sertraline (an antidepressant) for anxiety and depression, and asked the mental health team to monitor him. She had not seen the psychology report of 9 February, recommending an urgent psychiatric assessment.
65. On 21 April, at an ACCT case review, the operations manager updated Mr Collinson's caremap and indicated that all actions had been completed. The case review decided that Mr Collinson was no longer at risk of suicide or self-harm and ended ACCT monitoring. On 28 April, at an ACCT post-closure review, she recorded that Mr Collinson had told her he was enjoying education, he mixed well on X Block and had been in contact with his family.
66. On 22 April, the offender manager discussed Mr Collinson's completed OASys report (the assessment of an offender's risks and needs) with the offender

supervisor. Although Mr Collinson's YOS worker had indicated he was unsuitable for group work, the offender manager suggested that Mr Collinson should complete the Thinking Skills Programme as part of his sentence plan. She did not recommend a programme for sex offenders. The risk of harm section of the OASys did not record Mr Collinson's risk of suicide and self-harm, or list any circumstances which might increase his risk in prison.

67. On 8 May, the YOS worker and social services staff visited Mr Collinson at Parc. He did not tell anyone at Parc that he was visiting that day, or speak to any staff responsible for Mr Collinson's management, while he was at the prison. He introduced Mr Collinson to his new social worker and explained that he would no longer be supervised by the YOS. He told the investigator he did not know that Mr Collinson's offender manager had changed and had assumed that he did not have to attend a transition meeting because he had not heard anything from the Probation Service.
68. On 9 May, an officer began ACCT monitoring procedures when Mr Collinson self-harmed by scratching his arm. Mr Collinson said he had flushed his antidepressant medication down the toilet. He said he was depressed because his mother was ill but did not want to die. The operations manager held an ACCT review the next day and recorded one caremap action for a nurse to arrange a doctor's appointment to review Mr Collinson's medication. Observations were set at hourly.
69. An officer in Mr Collinson's prison record that he had disobeyed a number of orders and, by 10 May, he had received two written warnings for poor behaviour. Mr Collinson told the officer that being locked in his cell "[did] his head in".
70. On 13 May, a prison GP prescribed Mr Collinson sertraline again. He specified that Mr Collinson should take the medication under staff supervision and not keep it in his possession.
71. On 18 May, Mr Collinson tied the cable of his television aerial around his neck, which cause bruising and also self-harmed by scratching his arm. A supervising officer increased his observations from hourly to half hourly. The operations manager chaired an ACCT case review the next day, which the complex case manager also attended. Although this was not recorded, the operations manager told the investigator that they had discussed enhanced case management but decided it was not necessary. They did not add any new actions to the caremap.
72. On 22 May, the operations manager recorded that Mr Collinson had been reduced to the basic level of the Incentives and Earned Privileges (IEP) Scheme, because he had accumulated a number of warnings for threatening staff, abusive language and not obeying orders. Parc's IEP policy states there should be a review after seven days and afterwards at 14 or 21 day intervals depending on the prisoner's behaviour. Mr Collinson remained on the basic regime for 32 days, but there is no record this as the local policy requires. Because Mr Collinson had been assessed as at risk of suicide and self-harm, he was allowed to keep his television but other restrictions, including spending more time locked in his cell, applied.

73. On 28 May, the operations manager chaired an ACCT case review, which assessed that Mr Collinson was no longer at risk and ended ACCT monitoring. There was no reference in the record of the case review to his reduction in privileges or his deteriorating behaviour. The only caremap action, for Mr Collinson to restart his medication, had been completed.
74. On 5 June, Mr Collinson's probation supervision transferred to a new offender manager. She contacted the offender supervisor to say that she was his new offender manager and gave her the information needed from his probation records to refer Mr Collinson for offender behaviour programmes.
75. On 10 June, an officer started ACCT procedures when Mr Collinson self-harmed again by scratching his arm. Mr Collinson told her he was upset, did not like being locked in his cell and harmed himself to help cope with this. At an ACCT case review the next day, the operations manager decided that officers should give Mr Collinson jobs to do on the unit to relieve his boredom, keep him occupied and out of his cell. This was the only action recorded on the caremap.
76. On 16 June, there was some confusion about Mr Collinson's antidepressant medication and he did not receive it for two days. On 18 June, a prison GP restarted the sertraline prescription. Mr Collinson told the doctor he had some fleeting thoughts of self-harm. The GP recorded this in Mr Collinson's medical record, but not in the ACCT record.
77. The last entry in Mr Collinson's IEP plan was on 7 June, when an officer recorded that he had refused an order and so he had not been allowed to remain out of his cell during an association period (when prisoners are able to socialise with each other.) On 19 June, the officer recorded in Mr Collinson's prison record that he was no longer on the basic regime, but was still subject to ACCT monitoring. She described Mr Collinson as 'a very poor copier'.
78. On 30 June, at a learning disability review, Mr Collinson told a nurse that he found being at Parc boring compared to Oakhill. She noted that unit officers had said that he was vulnerable because of his age and his learning difficulties, and that he had difficulty processing lots of information.
79. The operations manager recorded in the ACCT document, and a nurse recorded in his medical record, that they would draw up a behavioural management plan for him. The nurse recalled starting Mr Collinson's behaviour management plan with aims to improve his communication with staff but this does not appear to have been completed. The prison could not provide a copy of the plan and no other member of staff remembered seeing or using it.
80. On 2 July, the offender supervisor added Mr Collinson to the waiting list for the Thinking Skills Programme, a group programme. There is no record that anyone considered the concerns identified in his pre-sentence reports that he would not be able to manage group work. She noted that he had some mental health problems and issues with self-harm, but they were manageable. Despite his identified difficulties with reading and writing, she recorded that he had no problems with literacy, language and dyslexia.

81. On 2 July, at an ACCT review, chaired by the operations manager, Mr Collinson said he had no thoughts of suicide or self-harm and enjoyed being busy on the wing and working with his mentor. The review decided that Mr Collinson was no longer at risk and ended ACCT monitoring.
82. On 5 July, a nurse examined Mr Collinson after he made further scratches to his arm. He told her that he had not been swallowing his medication when he was given it under supervision. She encouraged him to take his medication. No one began ACCT procedures because of his self-harm. The next day, 6 July, an officer began ACCT procedures after Mr Collinson said that he had been told all of his life that he was 'mental' and he had serious thoughts of self-harm.
83. On 7 July, officers contacted healthcare staff, including the lead mental health nurse, after Mr Collinson told them he had psychotic dreams about hurting staff. The operations manager chaired an ACCT case review that day, but no one from the mental health team was present. She recorded two caremap actions, for Mr Collinson to have a mental health assessment and that officers should monitor his behaviour and discuss this with a nurse. The learning disability nurse, who was at the ACCT review, said that he would ask a mental health nurse to assess Mr Collinson later that day.
84. That afternoon, a nurse assessed Mr Collinson and recorded that he did not have any symptoms of mental illness, but she would offer support for his anxiety and behavioural issues. There was no record of any further mental health support after the assessment. As with other healthcare staff, she told the investigator that she said she had not seen the psychology report completed for Mr Collinson's court appearance.
85. Later that day, officers found Mr Collinson with a plastic bag over his head. A nurse examined him as he said that officers had hurt his arm when they removed the plastic bag but found no injury. The unit manager confirmed his observations remained half hourly, but there was no immediate case review to reassess his level of risk.
86. At a disciplinary hearing on 8 July, Mr Collinson received a punishment of five days cellular confinement for threatening staff. He stayed in his cell on X Block and had a radio and some puzzles in his cell to help occupy his time. A nurse assessed him as fit for segregation. Although it was recorded that Mr Collinson was subject to ACCT monitoring, there was no evidence that the manager who gave the punishment recognised that prisoners assessed as at risk of suicide and self-harm should be segregated only in exceptional circumstances.
87. The operations manager chaired an ACCT case review and recorded that Mr Collinson said he felt guilty for harming himself and for threatening staff, but said he had been bored. The review assessed Mr Collinson's as at raised risk of suicide or self-harm. He continued to be check at least once every half hour. There was no note in the ACCT record to justify exceptional reasons for segregating Mr Collinson.
88. On 10 July, the Court of Appeal notified Parc that Mr Collinson had been granted an appeal against his sentence and they needed a full psychiatric

assessment. The healthcare manager received the request from the prison's legal services team.

89. On 14 July, Mr Collinson cut his chest. A nurse recorded that she had dressed the wound with a large dressing and that Mr Collinson told her he no longer had thoughts of suicide or self-harm. The operations manager held an ACCT case review but did not review the caremap. Although he had self-harmed that day, the case review assessed his risk of suicide or self-harm as low. ACCT monitoring ended on 21 July, when a Supervising Officer (SO) noted that a behaviour management plan would be more appropriate than management under ACCT procedures. No one initiated a behaviour management plan.
90. On 4 August, a nurse reviewed Mr Collinson's mental health and recorded that he had told her he was coping well with his anxiety and watched television as a distraction. He said he did not want any more support from the mental health team. She recorded that another nurse was working on anxiety and anger management issues, but there is no evidence of this in the medical record. She discharged Mr Collinson from the mental health team caseload, noting that he was receiving support from a nurse in the learning disability team and had a behaviour management plan, although there is no evidence of this plan.
91. On 5 August, a nurse reviewed Mr Collinson because of his learning disabilities. He noted that Mr Collinson was stable but bored and planned to review him in three months.
92. On 12 August, a psychiatrist saw Mr Collinson at the prison, for the assessment required by the Court of Appeal. The psychiatrist reviewed Mr Collinson's GP and prison medical records, but noted that Parc had not provided him with the psychology report of 9 February prepared for his trial. The psychiatrist considered that Mr Collinson's main difficulty was coping with stress and he possibly had a conduct disorder. He assessed him as at high risk of suicide or self-harm, as he had very limited coping skills. There is no record that the psychiatrist discussed this assessment with anyone from the healthcare team at the time and the prison did not receive a copy of the psychiatric report until after Mr Collinson had died.
93. Towards the end of August, a senior prison manager contacted the national population management unit because he was concerned that Parc was reaching its operational capacity. The population management unit indicated that there were five places at Swinfen Hall. He said that there were five places for long-term young adult sex offenders at Swinfen Hall and only a few young adults fitted the criteria, so Mr Collinson's name was added to the transfer list.
94. On 31 August, Parc's offender management unit emailed all relevant departments with the names of five prisoners who had been selected to transfer to Swinfen Hall the next day, 1 September. (The email did not ask anyone to consider the suitability for transfer of those on the list.) On 1 September, a further email said the transfers had been rescheduled to 2 September.
95. The operations manager spoke to Mr Collinson about the decision to move him to Swinfen Hall. She told the investigator that he had been upset at first, but he settled when he realised that four other prisoners he knew from X Block would

be moving at the same time. She told Mr Collinson that once he had completed his offending behaviour programmes, he would be able to return to Parc.

Transfer to HMP & YOI Swinfen Hall

96. At 3.38am on 1 September, a nurse at Parc recorded in Mr Collinson's medical record that he was fit to be transferred. She had not seen Mr Collinson and had not reviewed his medical records in making this assessment.
97. On 1 September, Mr Collinson had been taken to the reception area with four other prisoners when they learnt that the transfer had been postponed until the next day. A friend of Mr Collinson said that Mr Collinson had told him in reception that morning that he was worried he would be stabbed at Swinfen Hall and that he was going to "string up" (hang himself). He said that he made Mr Collinson promise that he would not do this. He told the investigator that he did not think Mr Collinson would go ahead with his threat. He did not tell anyone about this conversation at the time and Mr Collinson did not report his fears to staff. When the transfer was cancelled, Mr Collinson and the other prisoners returned to X Block. The operations manager went to see Mr Collinson later that morning and she said he had said he understood the need to progress in his sentence and was not worried about going to Swinfen Hall.
98. When Mr Collinson and his friend were being transferred to Swinfen Hall the next day, his friend said they talked about the implications of prisoners who had committed sexual offences being mixed with other prisoners. (In most prisons, such prisoners are regarded as vulnerable to threats and attacks from other prisoners and are therefore kept separate and live on different wings. However, at Swinfen Hall, all prisoners are integrated, regardless of their offences.) He said that he and Mr Collinson were both worried about how other prisoners would treat them.
99. Mr Collinson arrived at Swinfen Hall at around 1.30pm on 2 September. An officer had checked the prison records of transferring prisoners before they arrived and had noted that Mr Collinson had previously been managed under ACCT procedures, as at risk of suicide or self-harm, but was no longer considered at risk. The officer noted on a 'First Night Interview and Checklist' that he did not consider Mr Collinson was at increased risk of suicide or self-harm. He told the investigator that Mr Collinson had seemed jovial when he spoke to him and had not mentioned any concerns about his transfer. Mr Collinson told the officer that he had transferred with a friend.
100. Mr Collinson called his mother from reception at 4.18pm and told her that he had been transferred to Swinfen Hall. He did not sound upset during the telephone call.
101. At an initial health screen at Swinfen Hall, a nurse noted that Mr Collinson was prescribed sertraline and had been on a recent ACCT. She noted that he had said that he tied a ligature the day before as he did not want to transfer. She told the investigator she did not review any of Mr Collinson's prison documents, such as his personal record and escort record and was not required to do this. She said Mr Collinson had told her his mother was ill and he was disappointed he would miss a visit from her, but she did not record this in his medical record.

102. A nurse went on to assess Mr Collinson's mental state, using a structured assessment. This indicated he had 'definite indicators of risk of deliberate self-harm or suicide attempt'. Mr Collinson told her that he had not wanted to transfer to Swinfen Hall as it was too far from home. She recorded "... he had thoughts of making a ligature and has a history of self-harm, appears vulnerable", and again noted that he had said that he had tied a ligature the day before because he did not want to transfer. Although Mr Collinson had told her he had tied a ligature the day before as he was unhappy about the transfer and the assessment indicated he was at risk, she did not begin ACCT procedures.
103. The lead mental health nurse told the investigator that she had considered Mr Collinson would be vulnerable to bullying, not that he was at risk of suicide or self-harm. She said that she had considered Mr Collinson's history of depression, previous self-harm and the fact that he said that he had tied a ligature the previous day. However, she did not think he was at risk of suicide because he was chatty and thinking about the future. She did not discuss Mr Collinson's level of risk with anyone else or record that he had tied a ligature the day before, other than in his medical record.
104. A first night induction officer interviewed Mr Collinson and recorded that he said he had no thoughts of suicide or self-harm and had told her that he was happy to be at Swinfen Hall. Mr Collinson was given a cell at the end of a short spur on the induction wing. The cell next door and the one opposite were empty, as they were damaged.

Thursday 3 September

105. As Mr Collinson was not assessed as at risk of suicide or self-harm, staff did not check him during the night. The night patrol officer, an operational support grade (OSG), said it would be against prisoners' human rights to check them through the night. She started a routine check of prisoners at 5.45am. When she got to Mr Collinson's cell and looked through the door observation panel, she saw him hanging by a sheet attached to the bars of his window.
106. At 5.50am, the night patrol officer radioed a code blue medical emergency indicating a life threatening situation. The control room called an ambulance immediately. (West Midlands Ambulance Service confirmed they received a request for an emergency ambulance at 5.51am.) She said she had been extremely shocked and did not go into the cell. The operational manager in charge of the prison responded to the code blue with an officer. They went into Mr Collinson's cell less than a minute after the code blue had been called.
107. The operational manager cut the sheet and he and the officer lowered Mr Collinson to the floor. He checked for signs of life but found none. He told the investigator that Mr Collinson's body was cold and there were signs of rigor mortis. As it was clear that Mr Collinson had died they did not try to resuscitate him. He placed a pillow under Mr Collinson's head and covered him with a blanket.
108. Paramedics arrived at Swinfen Hall at 6.29am and at 6.38am, recorded that Mr Collinson was dead. They noted in the ambulance record that it was apparent that Mr Collinson had been dead for many hours.

109. Mr Collinson had written a letter which he left in his cell, saying that Swinfen Hall was different and he wanted to go back to Parc.

Contact with Mr Collinson's family

110. The Governor of Swinfen Hall and a prison chaplain left the prison that morning to break the news of Mr Collinson's death to his parents in Wales and offer condolences. Swinfen Hall contributed towards the costs of Mr Collinson's funeral in line with national instructions.

Support for prisoners and staff

111. After Mr Collinson's death, the deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
112. The prison posted notices informing other prisoners of Mr Collinson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Collinson's death.

Post-mortem report

113. A pathologist concluded that Mr Collinson had died from hanging. A toxicology report found he had taken prescribed sertraline, but he was not under the influence of any other substances at the time of his death.

Findings

Transition from youth offender services

114. Mr Collinson had been convicted of an offence when he was a child but was sentenced on 12 March 2015, the day after his 18th birthday. He had been at Oakhill Secure Training Centre since 10 October 2014 because he was too vulnerable to remain in the young persons unit at Parc on remand. Moving a 17 year old to a secure training centre in such circumstances is highly unusual and suggests that Mr Collinson must have been regarded as exceptionally vulnerable, yet few staff at Parc seemed to be aware of his history when he returned as a young adult offender on 12 March 2015.
115. The Youth Justice Board (YJB), Oakhill, Parc and the Youth Offender Service (YOS) had agreed that the adult vulnerable prisoner unit at Parc would be a suitable allocation for Mr Collinson after he was sentenced. However, we do not consider his transition from services for children to the young adult estate was managed effectively.
116. The YJB arranged for Oakhill to send Mr Collinson's records to Parc. A worker from the safer custody team emailed key information from his records about Mr Collinson's risks and personal circumstances to relevant prison departments, including the vulnerable prisoner unit and offender management unit, but no one used this information to create a care plan to support him through his transition and plan his initial months in the adult estate. Had such a care plan been in place, Mr Collinson's particular vulnerability would have been identified and we consider it would have been unlikely that he would have transferred to Swinfen Hall.
117. A document from the YJB recorded an individual as Mr Collinson's caseworker and that he was the prison's Head of the Offender Management Unit, both roles he had never held. He said he did not remember speaking to the YJB, he did not know Mr Collinson and he did not think it was his responsibility to ensure his safe transition from the young people's estate. We are concerned that no one appeared to accept this responsibility at Parc.
118. Parc's transitions policy requires that the receiving unit's manager should manage a young person's transition to the adult prison from Parc's young persons unit. The policy does not explicitly cover a situation when a young person moves to Parc from elsewhere in the children and young persons' estate. The manager of the vulnerable prisoner unit did not know about the transitions policy and no one took responsibility for managing Mr Collinson's adjustment to an adult prison from a secure training centre. Mr Collinson's personal officer did not even know that Mr Collinson had come from a secure training centre directly to an adult vulnerable prisoner unit and was not involved in any discussions to help him adjust to an adult prison.
119. Mr Collinson's YOS worker outlined Mr Collinson's particular vulnerability in his pre-sentence report before he went back to Parc. He described Mr Collinson's learning difficulties, family background, involvement with social services, possible mental health problems, previous self-harm and that he had not been able to cope in the young persons unit at Parc. He spoke to Mr Collinson's

offender manager, but did not meet her in person to discuss Mr Collinson's specific needs or risks. He said that he thought he did not need to because Mr Collinson's offender manager had not contacted him.

120. Mr Collinson's offender manager told us that she had tried to speak to the YOS worker but he was not available when she called, and she did not try again. The YOS worker did not take the opportunity to meet staff at the prison when he visited Mr Collinson at Parc in early May, although he knew Mr Collinson was assessed as at risk of suicide or self-harm at that time and was well placed to brief prison staff about his particular vulnerabilities.
121. In a publication issued by the Youth Justice Board in February 2014, (Deaths of Children in Custody: Action Taken, Lessons Learnt) the YJB recognised it had a role and responsibility to ensure effective transition between youth and adult justice services in order to help promote the safety of young people. It said it was working with NOMS to improve transitions and referred to a protocol that NOMS had published in September 2012, for transitions from youth to adult custody with guidance about how the process should work. The introduction to the NOMS guidance recognised that transfers of young people from the under 18 estate to the young adult estate was a particularly vulnerable time and it was therefore essential that the transition should be completed as smoothly as possible with particular consideration given to issues of safety and security.
122. The specific objectives of the protocol were listed as to:
 - provide a clear and structured process for transition which is understood by young people and staff alike;
 - provide guidance on roles and responsibilities for those involved in the transition process;
 - provide guidance on identifying needs and sharing information during the transition process and;
 - help build relationships between Youth Offending Teams/Services and young adult YOIs to support continuation of care.
123. We identified problems with transition of children to the young adult prison estate in our Learning Lessons Bulletin about the self-inflicted deaths of young adult prisoners, published in July 2014 and it is concerning to see that this is still a problem. To a large extent, Mr Collinson was treated as a new adult reception when he returned to Parc from court in March 2015. The protocol suggests that NOMS, the YOS and the Probation Service should work together to agree a suitable placement and plan their transition before a child turns 18. However, there is no requirement for such joint working after the young person's move into the adult justice system has been completed.
124. Parc's local transition policy for remanded and sentenced young people to the adult estate is limited to young people who move between the young persons unit at Parc and the adult part of the prison. Mr Collinson's transition from a secure training centre to Parc was not typical, but was a reflection of his particular vulnerability.

125. The decision that Mr Collinson should go to the adult vulnerable prisoner unit at Parc had been discussed and agreed in principle several weeks before it took place. The YJB sent Parc appropriate information to help manage his risk when he moved but no one at Parc took responsibility for acting on it and coordinating his care and neither did his offender manager or his YOS worker.
126. There were a number of deficiencies in managing Mr Collinson's transfer to Parc from Oakhill, many of them failures of local procedures at Parc and by the Probation Service. However, we consider the responsibility of the STC and the YOS who had been responsible for Mr Collinson's care in the previous months since his remand into custody should have consisted of more than merely handing over written information to Parc; that cannot be regarded as effective joint care planning. Transition suggests an ongoing process or a period of change from one state or condition to another. While legal responsibility changes at the age of 18, we consider there is still a responsibility for youth offending services to continue their involvement at least until there is a clear plan, jointly agreed, outlining the young person's needs, risks and vulnerabilities and how they will be met for at least six months after a child becomes 18 (when the sentence extends that far). Ideally, this should be agreed before the child reaches 18, but this should not prevent it happening after that.
127. We recognise that a number of the deficiencies in the transition process were the result of local failures at the prison, by the Probation Service and by the local Youth Offending Service. However, we are concerned, from this and other cases, that these problems also represent systemic failures in transition arrangements for young people, which still need to be addressed. It is axiomatic that any child transferring from a secure training centre to an adult prison will be vulnerable and transition arrangements need to recognise this. We make the following recommendation:

The Chief Executive of the National Offender Management Service, the Chief Executive of the Youth Justice Board and the Director of the National Offender Management Service in Wales should ensure that transition arrangements for young people moving to adult custody include a jointly agreed management plan covering at least the first six months after transfer, outlining how their needs will be met, and how their risks and vulnerabilities will be managed.

Management of Mr Collinson's risks

128. Mr Collinson was appropriately identified as at risk of suicide and self-harm when he arrived at Parc, and was managed under ACCT procedures for much of his time at the prison. The learning disability team assessed the extent of his learning difficulties and regularly reviewed him, using a supported living plan but few officers were aware of this. The learning disability nurse also agreed to start a behaviour management plan, but again that was never used by officers, and the prison has not been able to give us a copy of the plan. The mental health team assessed Mr Collinson several times, but he did not have ongoing mental health support, despite his treatment for depression. Staff used the IEP scheme and cellular confinement to manage Mr Collinson's increasingly challenging behaviour on the wing.

129. In our Learning Lessons Bulletin about the self-inflicted deaths of young adult prisoners, issued in July 2014, we identified that the potential for conflict between care plans for support under ACCT and systems for managing poor behaviour had particular relevance to younger age groups. We noted that managing risk of suicide and self-harm, treating mental health and managing behaviour needed to be better integrated to ensure a balanced, holistic and consistent approach.
130. Although Mr Collinson was identified as at risk of suicide and self-harm for most of his time at Parc, the ACCT procedures did not operate effectively to coordinate his care. Different departments managed Mr Collinson using different procedures including disciplinary action and the incentives and earned privileges scheme, without any reference to his vulnerability. Had ACCT procedures been used correctly, all of Mr Collinson's risks should have been discussed and managed through one multidisciplinary process.
131. In our Learning Lessons Bulletin about young adult prisoners, we also identified that challenging behaviour can mask vulnerability and that the transition between the juvenile and young adult estates was a particularly vulnerable time. We noted that one way to achieve an appropriate balance between managing challenging behaviour and vulnerability was through greater use of enhanced case reviews. These are designed to help manage more complex cases through a coordinated, multidisciplinary and holistic approach to ACCT reviews, overseen by senior staff. The operations manager told the investigator that she had considered using the enhanced case management system twice, but there is no record of this in the relevant case reviews.
132. We are also concerned that no account seems to have been taken of the effect of segregation on Mr Collinson's risk of suicide and self-harm when he was punished by five days cellular confinement in July. In a Learning Lessons Bulletin we issued in June 2015, we noted that segregation reduces protective factors against suicide and should be used only in exceptional circumstances for those at risk. PSI 64/2011 recognises this and requires that, when a prisoner at risk is held in segregation the exceptional reasons must be documented in the ACCT document and include other options that have been considered but discounted. There is no evidence that anyone considered this when agreeing Mr Collinson's segregation.
133. More effective management of the ACCT procedures would have resulted in a more coordinated approach to managing Mr Collinson's self-harm, mental health, learning difficulties and disruptive behaviour. We make the following recommendation:

The Director of Parc should ensure that ACCT procedures are managed effectively to coordinate care and that staff use enhanced case management procedures for more complex cases with a range of vulnerabilities. Prisoners at risk of suicide or self-harm should not be segregated unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.

Mental health

134. A psychology report, prepared for the court when Mr Collinson was sentenced in March 2015 concluded that Mr Collinson had a significant mental health disorder. The psychologist considered Mr Collinson might be suffering from a serious mental illness and recommended that he should have an urgent psychiatric assessment. No one appears to have taken account of this report.
135. Parc received and scanned the report into their records on 20 March, but no one from the healthcare team reviewed or acted on it. Mr Collinson's mental health was assessed four times between March and August, yet none of the mental health nurses looked at the psychology report to inform their assessment. In the absence of this key information, each mental health assessment concluded that Mr Collinson did not need ongoing mental health support. The clinical reviewer considered that the healthcare team missed opportunities to provide additional support to Mr Collinson. It was not until August that a psychiatrist assessed Mr Collinson and then only because the Court of Appeal had asked for an assessment, rather than because mental health staff at the prison had identified a need. The prison did not provide the psychiatrist with a copy of the report.
136. A prison GP prescribed Mr Collinson an antidepressant and asked the mental health team to monitor him. Contrary to NICE (National Institute for Care and Health Excellence) guidelines, Mr Collinson was not offered any psychological therapies to support him with his depression. No one used a standard assessment tool to assess the extent of Mr Collinson's depression. The clinical reviewer concluded that, in this respect, Mr Collinson's care was not adequate. We make the following recommendation:

The Head of Healthcare at Parc should ensure mental health assessments take into account all relevant information, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.

Transfer to Swinfen Hall

137. Because of population pressures, Mr Collinson was identified as one of a small number of prisoners to be transferred to Swinfen Hall, because of the nature of his offence, his age and the availability of offending behaviour programmes. However, Mr Collinson did not have a sentence plan target to complete the sex offender treatment programme and his YOS worker and offender manager had noted that he was unsuitable for group work.
138. No one in the offender management unit spoke to either Mr Collinson's offender manager or his offender supervisor about his transfer to Swinfen Hall. Nor is there any evidence that anyone considered the impact on his relationship with his family, who he relied on for support. His transfer appears to have been the result of population pressures at the prison, rather than in response to meeting any of Mr Collinson's identified needs.
139. Just a few months before his transfer to Swinfen Hall's fully integrated regime, Mr Collinson had been assessed as too vulnerable to remain at the young

persons unit at Parc. A properly co-ordinated transition care plan when he returned to Parc would have identified the extent of his vulnerability and made it unlikely that he would have been considered suitable for a transfer to the fully integrated regime at Swinfen Hall, at least at that stage of his sentence.

140. In our Learning Lessons Bulletin about the self-inflicted deaths of young adults we identified that the impact of significant disruption on the wellbeing and safety of already vulnerable prisoners should be fully considered in transfer decisions. There is no evidence that this was considered. We make the following recommendation:

The Director of Parc should ensure that decisions about the routine transfers of prisoners are taken at sentence planning meetings where possible, that transfers meet their identified needs and take into account any vulnerabilities.

Assessment of risk at Swinfen Hall

141. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action.
142. PSI 64/2011 and PSI 7/2015 - Early Days in Custody - both list a number of risk factors and potential triggers for suicide and self harm. These include impulsiveness, previous self-harm, young age, history of mental health problems and a terminally ill family member. Transfer between prisons is also listed as possible trigger. All of these factors applied to Mr Collinson, yet there is no evidence that staff considered them.
143. A general nurse, who assessed Mr Collinson when he arrived at Swinfen Hall, told the investigator that she had not had any specific training in either mental health issues or ACCT procedures other than a brief introduction to suicide prevention during her induction. She did not begin ACCT procedures because she said that Mr Collinson was chatty and seemed to be thinking about his future. However, he had told her that he had tied a ligature the day before because he did not want to move to Swinfen Hall. We consider that she attached too much weight to his presentation and not enough to his risk factors, including the information he gave her about his recent self-harm.
144. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. We are concerned that none of the staff who saw Mr Collinson when he first arrived at Swinfen Hall seemed to consider his vulnerability and risk factors or understood that that they were likely to be heightened because of his transfer. It is particularly concerning that staff are expected to assess the risk of newly arrived prisoners without adequate training.
145. At the inspection of Swinfen Hall in July 2014, staff told inspectors that they made additional checks on newly arrived prisoners during their first night at the

prison. Mr Collinson was not checked on his first night and the night patrol officer appeared to consider that this was not allowed. Such a check would have provided an additional safeguard.

146. All prison staff, but particularly those in reception and responsible for first night procedures need to have a good awareness of risk factors for suicide and the need to balance those risks against the prisoner's presentation when assessing their risk. We make the following recommendation:

The Governor of Swinfen Hall should ensure that all reception staff who assess newly arrived prisoners are trained to recognise risk factors for suicide and self-harm, fully record the reasons for decisions, and open an ACCT whenever a prisoner has recently self-harmed or has other significant risk factors. First night procedures should recognise the additional vulnerabilities of newly arrived prisoners.

**Prisons &
Probation**

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Independent Investigations