

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gareth McCarroll a prisoner at HMP Altcourse on 1 October 2016

**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 Gareth McCarroll was found hanged in his cell on 1 October 2016 at HMP Altcourse. He was 41 years old. I offer my condolences to Mr McCarroll's family and friends.

Mr McCarroll had a history of substance misuse which contributed to his offending and he had been in prison before. Staff were aware that he suffered with depression and anxiety and that he had previously had suicidal thoughts in 2012. Mr McCarroll also declared a disability caused by back pain. He had been in prison for only two days when he took his own life.

The investigation found that there were missed opportunities to adequately assess and monitor Mr McCarroll's risks in his early days in custody, including his withdrawal from drugs and alcohol, and pain management.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

June 2017

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Summary

Events

1. On 29 September 2016, Mr Gareth McCarroll was sentenced to 16 weeks custody for shoplifting offences. Mr McCarroll had been in prison before for similar offences.
2. Mr McCarroll arrived at HMP Altcourse with a risk assessment form from the court stating that he was taking methadone for heroin addiction and that he was an alcoholic. The form also stated that he suffered from depression and anxiety and that he had previous suicidal thoughts in 2012. The reception officer noted that Mr McCarroll had a historic risk of suicide and self-harm and that he required drug detoxification. The officer also noted that Mr McCarroll declared a disability due to back pain.
3. Mr McCarroll was prescribed 10mls methadone (a heroin substitute) as well as ibuprofen for his back pain by the prison doctor. The doctor requested that he should be monitored closely for signs of withdrawal. Mr McCarroll was then allocated to the first night centre where he was observed by prison staff throughout the night. He was not monitored by healthcare staff.
4. Mr McCarroll was moved to the drug detoxification wing on 30 September. He had a further health screening with a different doctor who increased his dose of methadone to 20mls. There is no evidence that he was assessed for back pain although he was prescribed a further supply of ibuprofen.
5. During the night of 30 September, Mr McCarroll pressed his cell bell complaining of back pain and asking to see a doctor. He also threatened to harm himself. The night officer phoned the night nurse who said that Mr McCarroll was due to see the doctor first thing in the morning and advised that he continue taking the prescribed ibuprofen. The night officer gave Mr McCarroll a supply of paracetamol as he said he had taken all the ibuprofen. He was not assessed by the night nurse or anyone from healthcare.
6. At 8.35am on 1 October, Mr McCarroll was found hanging from the bunk bed in his cell. He had used a ligature made from his bed sheet. An ambulance was called immediately. Prison staff cut the ligature and started chest compressions. Healthcare staff arrived shortly afterwards and continued to attempt resuscitation before ambulance staff arrived. Ambulance staff made further attempts to resuscitate Mr McCarroll but they were unable to do so and he was pronounced dead at approximately 9.16am.

Findings

7. We found that reception staff did not fully consider Mr McCarroll's risk factors for suicide and self-harm when he arrived at Altcourse. Important information about his risk was not shared with everyone who should have seen it.

8. The night officer and the night nurse were both aware that Mr McCarroll had threatened to harm himself. Despite this, we found no evidence that consideration was given to starting suicide and self-harm prevention measures.
9. The prison doctor prescribed methadone and asked that Mr McCarroll's withdrawal symptoms be closely monitored. We found no evidence that he was appropriately monitored by healthcare staff.
10. When Mr McCarroll rang his cell bell complaining of back pain and asking to see the doctor, the nurse gave advice to the night officer over the telephone. Given that Mr McCarroll was undergoing detoxification and had declared a disability in relation to his back pain, we consider that he should have been assessed by healthcare.

Recommendations

- The Director should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.
- The Director and Head of Healthcare should ensure that:
 - staff begin ACCT procedures in accordance with PSI 64/2011 when there is a risk or threat of suicide or self-harm;
 - observations, particularly those involving a risk of suicide or self-harm, are *accurately* recorded in the wing observation book.
- The Head of Healthcare should ensure there is clear guidance outlining how often healthcare staff should check prisoners withdrawing from drugs or alcohol when they arrive at the prison and that checks continue until their condition has stabilised.
- The Director and Head of Healthcare should ensure that suitably qualified personnel are available 24 hours per day to monitor withdrawal in patients with substance misuse issues.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. NHS England commissioned a clinical reviewer to review Mr McCarroll's clinical care at the prison.
13. The investigator visited Altcourse on 7 October 2016. She obtained copies of relevant extracts from Mr McCarroll's prison and medical records.
14. The investigator interviewed four prisoners and four members of staff at Altcourse in November. The investigator also interviewed four members of staff by telephone. The clinical reviewer interviewed one member of healthcare staff separately by telephone.
15. We informed HM Coroner for Liverpool and Wirral of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr McCarroll's brother and the family's solicitor to explain the investigation and to invite them to raise any questions. No questions were raised by the family at that time.
17. A copy of our initial report was sent to Mr McCarroll's family. They raised a factual inaccuracy which has been amended in the foreword of this final report. They also raised other queries which do not alter the factual accuracy of our report and have therefore been addressed in separate correspondence.

Background Information

HMP Altcourse

18. HMP Altcourse is a Category B 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 1,324 sentenced and remanded adult and young adult men. G4S runs the company that provides primary healthcare services at the prison. Prime Care provides secondary mental health services.
19. Altcourse is made up of seven houseblocks, divided into individual units. These units hold between 60 and 95 prisoners. Mr McCarroll lived on Furlong Red, a designated Drug Recovery Unit (DRU) where prisoners with drug and/or alcohol dependency are initially located for a period of assessment. On this specialised unit, prisoners have access to substance misuse workers and Integrated Drug Treatment System (IDTS) nurses that are aware of the significant link between drug withdrawal and suicide.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Altcourse took place in June 2014. Despite prisoners saying they felt safe and having a positive early days experience, inspectors reported that levels of self-harm were higher than at similar prisons. They also criticised the standard of cells and shortages of basic equipment for prisoners. The inspectors reported strong positive relationships between prisoners and staff, including good support for those at risk of suicide or self-harm, and a good standard of healthcare. The inspectors said that the substance misuse psychosocial services were among the best they had seen, with an impressive array of therapeutic opportunities and some commendable practice.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to June 2016, the IMB reported that there had been a rise in the number of incidents of self-harm, and a subsequent rise in the number of prisoners subject to suicide and self-harm monitoring procedures. They found that the safer custody team made continuing efforts to ensure Altcourse was a safe prison, although staff shortages had had a significant impact throughout the prison.

Previous deaths at HMP Altcourse

22. Since 2014, we have investigated 16 deaths at Altcourse, four of which were self-inflicted. Our investigation into the most recent self-inflicted death at the prison in July 2016, found that reception staff did not fully consider and record all of the prisoner's risk factors for suicide and self-harm

Early Days in Custody and Substance Misuse

23. A PPO Learning Lessons bulletin, published in February 2016, identified that the most common theme among deaths in early days and weeks of custody was a failure to act on information about known risk factors. Prison Service Instruction (PSI) 07/2015 requires staff to be alert to the increased risk of suicide and self-harm among new prisoners. They are required to interview new prisoners to assess the risk of suicide and self-harm and act appropriately to address any concerns, including starting suicide and self-harm prevention measures if necessary. All staff that come into contact with prisoners are expected to be aware of these risks. The NHS document 'Clinical Management of Drug Dependence in the Adult Prison Setting' highlights the heightened suicidal risk prisoners dependent on drugs. The risk is particularly high in the first seven days in prison but remains raised throughout the first 28 days. This risk is also identified in PSI 45/2010.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. On 29 September 2016, Mr Gareth McCarroll was sentenced to 16 weeks imprisonment for various shoplifting and bail offences. He arrived at HMP Altcourse with a Person Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) stating that he was prescribed methadone for heroin addiction and that he was an alcoholic. The form also stated that he suffered from depression and anxiety and that he had reported suicidal thoughts in 2012.
26. The reception officer noted that Mr McCarroll had a previous history of self-harm but that he had no current thoughts of self-harm or suicide. The officer also noted that Mr McCarroll declared a disability due to back pain.
27. The cell sharing risk assessment (CSRA) was carried out by Officer A. She noted that Mr McCarroll had no thoughts of suicide or self-harm but made no mention of his previous suicidal thoughts even though this was noted on the PER. The officer considered that Mr McCarroll could share a cell.
28. Mr McCarroll was allocated to the first night centre where Officer B started the induction process with him. The officer noted that Mr McCarroll had a previous history of suicide and self-harm, that he required detoxification and that he had a disability caused by back pain. She said that she knew Mr McCarroll would be seeing the nurse and he could discuss his back pain with her.
29. Nurse A carried out the initial healthcare screening. Mr McCarroll told the nurse that he had a slipped disc in his back and asked to see a doctor for pain relief and for detoxification. He also told the nurse that he was previously prescribed medication for anxiety and depression but he said the medication was not working. The nurse noted that Mr McCarroll appeared settled in mood and engaged well during the assessment and said he had no thoughts of suicide or self-harm. She referred him to the doctor for further assessment and placed him on a waiting list to see the mental health team. The nurse endorsed the CSRA document to confirm that he was a standard cell sharing risk and that he required detoxification. She did not see any information relating to his previous thoughts of suicide in 2012.
30. Dr A assessed Mr McCarroll later that evening and observed that he was showing signs of drug withdrawal. Mr McCarroll said that he was prescribed methadone (a heroin substitute) in the community but he was also using illicit drugs and drinking alcohol. Mr McCarroll's urine tested positive for cocaine, opiates, benzodiazepines and methadone. The doctor phoned the community substance misuse service to establish Mr McCarroll's prescribed dose of methadone which was 25ml. He prescribed a starting dose of 10ml to stabilise Mr McCarroll for his first night. The doctor did not prescribe anything for alcohol withdrawal but noted in his medical records that Mr McCarroll should be monitored closely for signs of withdrawal.
31. Mr McCarroll told Dr A that his community GP had prescribed pregabalin and gabapentin to relieve his back pain. The doctor did not think it was appropriate or safe to prescribe this medication without confirmation from Mr McCarroll's GP, so he prescribed ibuprofen and explained to Mr McCarroll that a doctor would

review his pain relief medication once he was stabilised. He wrote on Mr McCarroll's notes "*please do not prescribe gabapentin*". The doctor did not examine Mr McCarroll's back but said that Mr McCarroll walked, sat and stood normally, and did not appear to be in any obvious pain.

32. Mr McCarroll was placed in a shared cell and prison staff checked him every 30 minutes during the night. Staff did not record any concerns. He was not observed or assessed by healthcare staff during this time although healthcare staff were available if needed.
33. On 30 September, Mr McCarroll was moved to a shared cell on the drug detoxification wing (Furlong Red). That afternoon, Dr B increased his dose of methadone to 20ml and planned to increase it again to 30ml the following day. Mr McCarroll agreed with this plan. There is no evidence that the doctor examined Mr McCarroll's back, but he prescribed a further supply of ibuprofen.
34. Also that afternoon, Mr McCarroll spoke to the prison chaplain as part of the reception process and told her that he had no fixed address, had no contact with his parents or his children, and that he would not receive any visits. The prison chaplain recorded this information on his prison record.
35. A basic custody screening (BCS) assessment was also completed by an offender manager on 30 September. She noted that Mr McCarroll needed help to find accommodation on release from prison. The offender manager's assessment made no reference to Mr McCarroll's risk of self-harm or suicide, although it did mention that he was previously on medication for depression and anxiety and he had previous contact with mental health services. The offender manager said that she had not seen the PER or any other paperwork and she had no knowledge of Mr McCarroll's previous suicidal thoughts in 2012. She said that her assessment of his risk of self-harm or suicide was based on what he told her and how he presented to her at the time.
36. At 3.45pm, Mr McCarroll phoned a friend and told him that he was in prison and on the drug detoxification wing, which he said was the best place for him. He said he was doing all right, but was worried that he did not have very much to come out to. He said he would call his friend again the following day.
37. Later that evening, Mr McCarroll spent some time in the cell of a prisoner who he knew from the community. The prisoner said that Mr McCarroll was upset and tearful when he talked about his father, who had been unwell. However, the prisoner said that Mr McCarroll did not mention thoughts of suicide and the prisoner had no particular concerns about him. The prisoner's cell mate was also in the cell and saw that Mr McCarroll was in physical pain. The prisoner's cell mate thought this was because Mr McCarroll was withdrawing from heroin. At about 5.00pm, all of the prisoners were returned to their cells for the night. The prisoner and his cell mate said that other prisoners helped Mr McCarroll back to his cell because he was having difficulty walking.
38. Mr McCarroll's cell mate said that Mr McCarroll was in excruciating pain during the night of 30 September. He said he had to help Mr McCarroll with everything, including helping him to the toilet and making a warm compress to put around his

back. He believed that staff were aware of the amount of pain Mr McCarroll was in. He said that Mr McCarroll had been led to believe that a doctor was coming to see him that evening but that did not happen once he was returned to his cell.

39. At around 12.30am on 1 October, Mr McCarroll pressed his cell bell and the night officer, Officer C, responded. Mr McCarroll complained of back pain and asked to see a nurse. Mr McCarroll threatened to cut himself if he did not get some help for the pain. There are no nurses on the drug recovery unit after 8pm so the officer spoke to the duty manager who advised her to phone the night nurse, Nurse B.
40. Nurse B told Officer C that Mr McCarroll was due to see the doctor first thing in the morning. The nurse told the clinical reviewer that Officer C said Mr McCarroll had threatened to harm himself and had asked to see a doctor and to be prescribed stronger pain relief. The nurse checked his medical record and found that he had been given ibuprofen so she advised the officer that she could give him paracetamol if he needed it. The nurse said that she told Officer C to keep an eye on him and get back to her if there were any further problems.
41. Officer C said that she relayed Nurse B's message to Mr McCarroll and gave him some paracetamol. She said that he was grateful to her for speaking to the nurse and she said he remained polite and courteous. She had no concerns about him and, although he did press his cell bell at other times during her shift, he remained polite and, she said, was simply checking on the time and asking her basic questions about the regime. She did not consider that he was in severe pain and had no concerns about the risk of suicide or self-harm. Mr McCarroll's cell mate's view of this differed from the officer. He said that Mr McCarroll was crawling around in tears and he made numerous comments to the officer that he was going to cut himself if she could not get anyone to help him. Mr McCarroll's cell mate said that the officer kept saying that she was unable to do anything for him until the morning.
42. Mr McCarroll's cell mate said he tried to stay awake with Mr McCarroll because he was worried about him, although he was not concerned that he would do anything to harm himself. He said he eventually fell asleep around 4.30am. Mr McCarroll pressed the cell bell at 5.50am and Officer C came to the cell. She said that he wanted to know what time the prisoners would be unlocked. She saw that Mr McCarroll's cell mate was asleep on the top bunk bed at this time. The officer had no further contact with Mr McCarroll after this time. She completed the morning roll check at 6.00am and she went off shift at around 7:15am.
43. At around 8.30am, Officer D began unlocking the prisoners on the unit. When she reached the cell of Mr McCarroll and his cell mate, she saw Mr McCarroll hanging from the bunk bed with a sheet tied around his neck. The officer ran to the nearby main office to alert her managers, Manager A and Manager B, and both managers followed her back to the cell. Manager A immediately radioed a code blue emergency which indicates that a prisoner is unconscious, not breathing or is having breathing difficulties. Staff in the control room called for an ambulance straightaway. On arrival at the cell, Manager B cut the ligature from Mr McCarroll's neck, laid him on the floor of the cell, and began chest

compressions. Nurse C arrived shortly after, followed by other healthcare staff, and they took over the resuscitation attempt. Paramedics arrived at 8.39am and continued resuscitation attempts before pronouncing Mr McCarroll dead at 9.16am.

Contact with Mr McCarroll's family

44. Mr McCarroll had not provided any next of kin information when he arrived at Altcourse, but the prison was able to trace his father. At about 12.30pm on 1 October, the prison Director and the appointed family liaison officer, visited Mr McCarroll's father at home and informed him of his son's death. The prison contributed to the cost of Mr McCarroll's funeral, in line with Prison Service instructions.

Support for prisoners and staff

45. After Mr McCarroll's death, the duty Director debriefed staff involved in the emergency response to offer support and ensure they had the opportunity to discuss any issues arising. The staff care team also offered support.
46. The Director posted a notice for prisoners informing them of Mr McCarroll'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 McCarroll's death. Mr McCarroll's cell mate felt that he had not been adequately supported by the prison since Mr McCarroll's death, particularly in respect of his mental health medication.

Post-mortem report

47. The post-mortem report concluded that Mr McCarroll's death was due to hanging. The toxicological report showed that there were various prescription and non-prescription drugs present in Mr McCarroll's body but none contributed to his death.

Findings

Identification and management of risk of suicide and self-harm

48. Mr McCarroll arrived at Altcourse with a history of drug and alcohol dependence, depression, anxiety and previous suicidal thoughts and chronic back pain, all of which are recognised risk factors in predicting suicide in prisoners. PSI 07/2015, about early days in custody, includes a mandatory action that reception staff must examine all available documentation, including the Person Escort Record (PER), to identify any immediate needs or recorded risks for newly arrived prisoners. Nurse A said she did not see the PER and no information about his previous suicidal thoughts was shared with her.
49. In February 2016, the PPO published a Learning Lessons Bulletin about early days in custody. We found that, from the information and documents available to them, staff need to identify, record and act on all known risk factors during reception and first night. Mr McCarroll spoke to several different members of staff and one prisoner mentor on his first night, but we are concerned that the information gathered by these individuals was not appropriately recorded or shared to ensure an adequate risk assessment. There is no record that any member of staff identified or took into account Mr McCarroll's risk factors when assessing his risk of suicide and self-harm. We are also concerned that not all reception staff see and review key documents. For example, we know that the reception nurse did not see the PER and was therefore unaware of Mr McCarroll's previous suicidal thoughts.
50. During the night of 30 September, Mr McCarroll complained of severe back pain and told the night patrol officer that he would harm himself if she could not get anyone to help him or give him any stronger pain relief. Nurse B said that Officer C told her on the phone that Mr McCarroll had threatened to harm himself. Despite this, there is no evidence that consideration was given to starting suicide and self-harm procedures (ACCT). Furthermore, the officer incorrectly recorded this information against another prisoner's name in the wing observation book and the nurse did not record the information in Mr McCarroll's medical record. We make the following recommendations:

The Director should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known factors of a newly arrived prisoner when determining the risk of suicide and self-harm.

The Director and Head of Healthcare should ensure that:

- **staff begin ACCT procedures in accordance with PSI 64/2011 when there is a risk or threat of suicide or self-harm;**
- **observations, particularly those involving a risk of suicide or self-harm, are accurately recorded in the wing observation book and other relevant records, including medical records.**

Substance misuse provision

51. Prison Service Order (PSO) 3550 – clinical service for substance misusers and the national clinical guidelines for substance misuse prescribing and drug treatment require that prisons have a protocol for the management of prisoners' substance misuse needs on their first night in prison. The protocol should be clear about how often staff should check prisoners withdrawing from drugs or alcohol on their first night and who is responsible for the checks. We do not consider that the prison's protocol is clear on these points.
52. Dr A prescribed methadone but did not prescribe anything to alleviate the symptoms of alcohol withdrawal. The doctor asked that Mr McCarroll's withdrawal symptoms be closely monitored. Although he was observed at 30-minute intervals by prison staff during his first night in custody, there is no evidence that he was monitored by healthcare staff for signs of withdrawal.
53. When Mr McCarroll rang his cell bell asking to see the nurse, the night officer was given advice over the telephone by a nurse with no substance misuse training. Given that Mr McCarroll was undergoing detoxification and was threatening self-harm, we consider that he should have been assessed by a suitably qualified substance misuse professional at that time. We therefore make the following recommendation:

The Head of Healthcare should ensure there is clear guidance outlining how often healthcare staff should check prisoners withdrawing from drugs or alcohol when they arrive at the prison and that checks continue until their condition has stabilised.

The Director and Head of Healthcare should ensure that suitably qualified personnel are available 24 hours a day to monitor withdrawal in prisoners with substance misuse issues.

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