Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Collins, a prisoner at HMP Highpoint, on 25 November 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Martin Collins was found hanged in his cell on 25 November 2023 at HMP Highpoint. He was 66 years old. I offer my condolences to Mr Collins' family and friends.

Mr Collins had been in prison since 2020 and was serving a ten-year sentence. He struggled to adapt to prison life and maintained his innocence throughout his sentence. He was worried that his refusal to accept guilt would prevent him from progressing through his sentence and to release. Mr Collins was subject to suicide and self-harm monitoring on a number of occasions, often due his refusal to eat.

My investigation found that Mr Collins was well supported at Highpoint. Staff reassured him that he could progress through his sentence. He was well supported by the suicide and self-harm monitoring process and staff acted appropriately to address any identified needs.

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

Adrian Usher
Prisons and Probation Ombudsman **July 2024**

Contents

Summary 1

The Investigation Process.....3

Background Information.....4

Key Events.....6

Findings 11

Summary

Events

1. Mr Martin Collins was serving a 10-year sentence for making explosive substances, arson, and assault. He had been in prison since April 2020. In February 2022, he spent a brief period in a low secure mental health unit for assessment under the Mental Health Act. In August, he returned to prison and on 12 June 2023, he transferred to HMP Highpoint.

2. During his prison sentence, staff supported Mr Collins under suicide and self-harm monitoring procedures (known as ACCT) on nine occasions, including twice at Highpoint. Mr Collins maintained his innocence and sometimes refused food in protest against his conviction (although he sometimes told staff that he just did not like prison food). On at least two occasions, Mr Collins deliberately hit his head on a wall out of frustration. Mr Collins was keen to complete offending behaviour courses but thought he would not be able to do so unless he admitted his guilt.

3. Mr Collins had a close relationship with his partner, who was his main source of support. On 24 November 2023, she visited him at Highpoint. During the visit, Mr Collins became angry and asked her to leave. Staff took Mr Collins back to his cell. He was calm and raised no issues.

4. That evening, Mr Collins called his partner 61 times, but she did not take his calls. He left at least two voice messages and he sounded upset.

5. On 25 November, a prison officer went to Mr Collins' cell to complete a morning routine check. He saw that Mr Collins had ligatured from his bed. The officer immediately radioed a medical emergency code and waited outside the cell for staff to arrive. When staff entered the cell, they noted that Mr Collins had been dead for some time. Staff attempted cardiopulmonary resuscitation and continued until the paramedics arrived at 6.20am. At 6.40am, the paramedics confirmed that Mr Collins had died.

Findings

6. Mr Collins had been subject to ACCT monitoring twice at Highpoint. Staff managed the process well; multi-disciplinary reviews were held and actions to address his immediate needs were completed.

7. There is no evidence to suggest Mr Collins should have been on ACCT monitoring at the time of his death. Although he had a history of self-harm in prison, there were no obvious indications that his risk of suicide had increased following his partner's visit on 24 November.

8. The clinical reviewer concluded that the clinical care Mr Collins at received at Highpoint was partially equivalent to what he could have expected to receive in the community. He considered that Mr Collins' mental health needs assessment should have been supported by standardised assessment tools that measured symptoms over time, in line with NICE guidance. He also found that healthcare staff did not conduct reviews of the medication Mr Collins kept in his cell, and Mr Collins' Do Not

Attempt Cardiopulmonary Resuscitation order had not been shared with all staff who came into contact with him.

The Investigation Process

9. HMPPS notified us of Mr Collins' death on 25 November 2023.

10. The investigator issued notices to staff and prisoners at HMP Highpoint informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator visited Highpoint on 5 December. He obtained copies of relevant extracts from Mr Collins' prison and medical records, along with relevant CCTV and Body Worn Video Camera (BWVC) footage.

12. The investigator interviewed two members of staff at Highpoint on 16 February.

13. NHS England commissioned a clinical reviewer to review Mr Collins' clinical care at the prison.

14. We informed HM Coroner for Greater Suffolk of the investigation. The coroner gave us the results of the post-mortem and toxicology examination. We have sent the coroner a copy of this report.

15. The Ombudsman's office contacted Mr Collins' family to explain the investigation and to ask if they had any matters they wanted us to consider. They raised no concerns.

16. An inquest into Mr Collins' death was concluded on 12 September 2025. The medical cause of death was given as hanging. However, the Coroner issued a Regulation 28 – Report to prevent future deaths. In the report, which was shared with the MOJ, the Coroner stated:

    The available telephone system for prisoners does not presently have the capability, in an automated manner, to recognise high or unusual volumes of calls by prisoners - and then to notify prison staff or healthcare in the event of such a pattern. This is despite the fact that the data on telephone calls made by a particular prisoner is available and is readily capable of being obtained, such that patterns of calls could be monitored manually by staff. The lack of system for monitoring of volumes of prisoners' telephone calls may lead to missed opportunities to identify risk triggers and so missed opportunities to intervene and prevent suicide. Even though the Ministry of Justice or HM Prison Service may not themselves be able directly to make changes to the software or computer system and although the electronic system is provided under contract with the Ministry, it remains for the Ministry to obtain and implement the technology in question. Changes could therefore be sought of a technology provider by the Ministry.

Background Information

HMP Highpoint

17. HMP Highpoint is a Category C prison in Suffolk. Practice Plus Group provides general, mental health and clinical substance misuse services. Healthcare is provided seven days a week, but it is not 24 hours. Phoenix Futures provide a psychosocial substance misuse service and The Forward Trust provide talking therapies.

HM Inspectorate of Prisons

18. The last full inspection of HMP Highpoint was in August 2019. Inspectors reported excellent staff and prisoner relationships and decent living conditions. Inspectors noted self-harm had increased among prisoners, but it was still lower than other category C prisons. Inspectors noted that the quality of mental health care was good for prisoners in crisis.

19. Inspectors also noted that there had been three deaths since their last inspection. They said that Highpoint took the Prisons and Probation Ombudsman's recommendations seriously and the prison had ensured that lessons had been learned.

Independent Monitoring Board

20. 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 published in June 2023, the IMB reported a notable eight percent decrease in self-harm and the number of prisoners supported by suicide and self-harm monitoring (ACCT).

21. The IMB reported positively about the ongoing development of the key worker scheme. They noted all prisoners were allocated a key worker, but time spent with prisoners was subject to the prison's regime and staff availability.

Previous deaths at HMP Highpoint

22. Mr Collins was the seventh prisoner to die at Highpoint since January 2020, and the third self-inflicted death. Up to the end of April 2024, there had been no self-inflicted deaths since Mr Collins' death.

Assessment, Care in Custody and Teamwork

23. 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 the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Staff should complete observations at irregular intervals to prevent the prisoner anticipating when they will occur.

24. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how staff will meet these. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key worker scheme

25. The key worker scheme provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

26. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

27. On 6 April 2020, Mr Martin Collins was remanded to HMP Bristol charged with making an explosive substance, arson and assault. This was not his first time in prison. Mr Collins raised no immediate concerns and denied any thoughts or intentions of self-harm.

28. Mr Collins told nursing staff that he had undergone heart surgery in 2017, but he had not taken any medication 'for months'. Following a review, a GP prescribed aspirin. A health screen identified a history of depression, and the reception nurse referred him to the mental health team for further assessment. The mental health assessment concluded that he was not experiencing any mental health difficulties at that time, and he was not added to the mental health team caseload. However, in May 2020, Mr Collins was prescribed sertraline (antidepressant medication).

29. Between June 2020 and June 2021, staff monitored Mr Collins under suicide and self-harm prevention procedures, known as ACCT, after he said that he was refusing food in protest against his imprisonment. Staff noted that he continued to drink fluids and eat food from the prison shop. Staff recorded that, at times, Mr Collins was non-compliant with his prescribed medication and his behaviour was poor. Mr Collins told staff that this was because he felt he had been wrongfully accused of his offence and should not be in prison.

30. Mr Collins received regular key worker sessions and saw his appointed offender manager regularly.

31. On 7 June 2021, Mr Collins was sentenced to 10 years in prison with a five-year extended licence period. He would be eligible for parole from 5 December 2026. He transferred to HMP Guys Marsh on 27 July.

32. On 31 July, staff started ACCT monitoring after Mr Collins said that he was refusing food and fluids in protest against his conviction. He refused to engage with the ACCT process, but staff continued to monitor him until 10 August when he began eating again.

33. In February 2022, Mr Collins self-harmed by cutting his arms and filled the cuts with faeces. He was transferred to a low security psychiatric hospital under the Mental Health Act for assessment to see if he was suffering from any underlying mental health disorder. Mr Collins' behaviour continued to be poor; he was rude, confrontational, refused to engage with medical staff and was non-complaint with his medication. He remained there until 2 August 2022, when it was concluded that he had no severe or enduring mental illness and he returned to prison and was sent to Wormwood Scrubs.

HMP Onley

34. On 26 September 2022, Mr Collins transferred to HMP Onley.

35. In October and March 2023, Mr Collins was subject to ACCT monitoring on two occasions, after he said that he was refusing food due to frustration with his partner. The last ACCT remained open until 20 March.

36. In March, the mental health team discharged Mr Collins from their caseload after they had made numerous attempts to engage him. Mr Collins consistently declined any support and the mental health team considered he had the capacity to make this decision.

37. On 24 March, a multidisciplinary team (MDT) meeting was held. The meeting noted that Mr Collins struggled to engage with support services and took a long time to trust professionals. Staff had witnessed him intentionally banging his head against a wall, but Mr Collins refused to engage with the ACCT process. The meeting identified that a trigger for his self-harm was his relationship with his partner. The chaplaincy team had raised concerns about the number of telephone calls he was making to his partner. They felt that if he had a negative telephone call then he was more likely to harm himself.

38. On 20 April, staff re-started ACCT monitoring after Mr Collins said that he was refusing food, but following an assessment, staff stopped ACCT procedures. Mr Collins told staff that he felt that he was not progressing at Onley and submitted transfer requests to move to another prison.

39. On 25 May, a psychiatrist saw Mr Collins. He recorded that Mr Collins showed no signs of depression and did not present as psychotic, although his mood was 'up and down.' Mr Collins denied any thoughts of self-harm and had no physical health concerns. He said that he wanted to move prisons so his partner could visit him, and he still did not want to eat prison food. Mr Collins said that he was prescribed promethazine (antipsychotic medication) although he did not feel any benefit, but he did not want to change it. The psychiatrist tried to discuss this with Mr Collins, but he said that it was his 'final decision'.

HMP Highpoint

40. On 12 June 2023, Mr Collins transferred to Highpoint.

41. Staff completed the reception procedures and recorded that Mr Collins had alerts on his record for arson, domestic violence and was an armed forces veteran. A nurse completed a transfer health screen. Mr Collins raised no concerns and denied any thoughts or intent to self-harm. She recorded that he did not need support of the ACCT process but noted that he had been subject to ACCT procedures previously and had been under the care of the mental health team at Onley. She referred him to the mental health team at Highpoint. Mr Collins was taken to the induction unit.

42. On 13 June, Mr Collins completed the induction and he engaged positively. He said that he had no issues with being at Highpoint and felt safe. He was polite and patient during the induction and presented himself well. He said that he had frequent contact with his partner through telephone calls and visits and these were important to him.

43. On 14 June, an officer spoke to Mr Collins and introduced himself as his temporary key worker. Mr Collins told him that he was 'fighting' with depression. The officer asked him whether he wanted to see the mental health team and Mr Collins said that he had already spoken to healthcare during his reception screen.

44. On 15 June, a nurse from the mental health team went to see Mr Collins, but he did not wish to speak with her.

45. Mr Collins remained on the induction unit until 28 June, when he moved to unit 10, a standard residential unit.

46. On 16 July, a prisoner told an officer that Mr Collins had not been eating the meals that he had collected for him from the servery. When the officer spoke to Mr Collins, he said that he had never eaten prison food, only toast now and again. He said he had done it previously in other prisons because of his sentence. Mr Collins said that 'he can't do jail' and that his partner was experiencing financial pressure for his legal bills. The officer opened an ACCT document, started a food refusal log and informed the healthcare team. Observations were set at two per hour. Mr Collins was unhappy that she had opened an ACCT.

47. Later that day, a Custodial Manager (CM) reviewed the immediate action plan and reduced the observations to one during the morning, afternoon, and evening. Mr Collins said that he had no thoughts of self-harm and would not do anything to harm himself. He said he was refusing food in protest at his wrongful conviction, but that he was expecting a visit from his partner, and he may eat something she bought from the visit hall cafe. The CM recorded that Mr Collins seemed in a jovial mood.

48. On 24 July, Mr Collins told staff that he had decided to end his food refusal. He said that he did not understand why staff had opened an ACCT as he had not eaten prison food for a long time, and he had no desire or plans to change this. He said he had no thoughts of self-harm and that he 'certainly didn't want to kill himself'. Staff decided to close the ACCT with a post-closure review scheduled for 1 August.

49. On 25 July, an officer spoke to Mr Collins and introduced herself as his key worker. Mr Collins told her that he was keen to complete the victim awareness course, but he believed he would be unable to as he refused to admit any guilt for his crime, and he was innocent. He felt that by maintaining his innocence the Parole Board would not release him when he became eligible for parole. He said that he would not be blackmailed into saying he did something that he did not do. She noted that she was unable to provide him with the answers that he wanted to hear.

50. On 27 July, Mr Collins' prison offender manager (POM) spoke to him because he continued to worry about his progress if he did not admit guilt. She reassured him and asked him if he wanted support from the mental health team. Mr Collins declined.

51. On 3 August, staff completed the ACCT post-closure interview. Mr Collins said, 'I am still here, so I must be OK.' He had no thoughts of self-harm but was frustrated about his sentence and completion of offending behaviour courses. He said that his relationship with his partner was 'very much up and down', and he still refused to eat food from the servery. All actions on the caremap had been completed and it was decided that the ACCT would remain closed.

52. Mr Collins submitted several prison transfer requests, but they were refused because it was considered he was already at a prison that could meet his needs.

53. On 25 August, Mr Collins submitted a non-urgent application to speak with someone from the mental health team.

54. On 5 September, a nurse went to triage Mr Collins. Mr Collins said that he could not cope with being in prison, he could not progress and do the courses he was expected to do as he was not guilty of his crime. He said that while his partner visited him regularly, they had little to speak about and this was also causing him frustration. She recorded that it was difficult to understand what Mr Collins wanted in terms of help from mental health team, but she felt that he did not need their support at that time.

Events of 24 and 25 November

55. On the morning of 24 November, an officer spoke to Mr Collins at his request. She said that she could see that Mr Collins wanted 'to get things off his chest'. The conversation was based around his assertion that he should not be in prison and his concerns that his partner was not always able to answer the telephone when he rang her. She had no concerns about his wellbeing.

56. During a visit with his partner, at around 3.15pm, Mr Collins asked a SO to tell his partner that she could leave at any time. The SO noted that Mr Collins appeared calm.

57. At around 4.00pm, Mr Collins appeared frustrated and became a little irate. He asked a SO to tell his partner that she should leave, and he did not wish to speak to her. To calm the situation, the SO told Mr Collins' partner that it was best for her to leave the visits room to prevent the situation escalating. As he escorted Mr Collins' partner from the visits room, the SO asked her what could have caused the frustration. Mr Collins' partner said that it was a regular occurrence when she visited.

58. Mr Collins' partner told the investigator that their previous visit had gone well, but when she arrived in the visits room on 24 November, Mr Collins did not greet her as usual and was hostile toward her. She said that initially, Mr Collins would not look at her, insisted that she had not booked another visit and accused her of trying to end their relationship. Mr Collins' partner said that she had seen this type of behaviour from him before and could usually calm him down, but during that visit, he was relentlessly critical and insulting towards her. Mr Collins did calm down and ate some food that she had bought him, but he accused her of trying to pacify him. She said she tried to respond calmly but firmly but felt overwhelmed and struggled to maintain the conversation.

59. Mr Collins remained in the visits room until the session ended at 4.15pm. The SO asked Mr Collins if he was all right, and Mr Collins reassured him that he was. Mr Collins said that he was only concerned that he had upset his partner. The SO noted that Mr Collins appeared calm and settled, and he had no concerns about his wellbeing. Staff escorted Mr Collins to his unit, and they had no concerns about him. Staff had no reason to check Mr Collins during the night.

60. Between 5.05pm and 11.18pm, Mr Collins attempted to telephone his partner 61 times. Mr Collins' partner said that during her journey home, Mr Collins left a long voice mail message. He sounded calm and rational and apologised for his

behaviour. He said that he had checked with staff and knew that she had a visit booked for the following week and asked that she visit him as planned. Mr Collins' partner said that he later left a voice message in which he sounded upset and asked her to answer the telephone. Mr Collins' partner said that she was unable to answer the calls as she was either driving or not at home.

61. Just after 6.00am on 25 November, an Operational Support Grade (OSG) began completing the morning routine check. When he reached Mr Collins' cell, he looked through the observation panel and saw Mr Collins sitting, fully clothed on his bed. He immediately thought this was unusual and on looking closer, he saw a ligature around Mr Collins' neck. He turned on the cell night light and noted that Mr Collins looked deceased. He radioed an emergency medical code blue (indicating that a prisoner is unconscious or is having breathing difficulties) and said that a prisoner had ligatured.

62. An officer responded. He looked through the observation panel and saw Mr Collins with a string around his neck. They entered the cell. The officer said that Mr Collins' appearance indicated that he had been in that position for some time. Other staff arrived, they removed the ligature and lifted Mr Collins onto the floor. Mr Collins' body was rigid. Staff started cardiopulmonary resuscitation and continued until the paramedics arrived. Paramedics arrived at 6.20am and at 6.40am, they confirmed that Mr Collins had died.

Contact with Mr Collins' family

63. The prison appointed a family liaison officer. Initially, she attempted to get a FLO at HMP Pentonville, which was closer to Mr Collins' partner's home address, to visit and break the news in person. However, she was unable to do so, as no one was available, and in order to inform his partner as quickly as possible, she telephoned. She informed Mr Collins' partner of his death and explained the information known at that stage and the process that would follow.

64. The prison contributed towards funeral expenses in line with national policy.

Support for prisoners and staff

65. After Mr Collins' death, duty 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 and local Samaritans were notified for additional support as part of the HMPPS postvention process following a death in custody.

66. The prison posted notices informing other prisoners of Mr Collins' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the death.

Post-mortem report

67. The post-mortem report gave Mr Collins' cause of death as hanging. Toxicology indicated no non-therapeutic drugs in Mr Collins' system at the time of his death.

Findings

Assessment of risk

68. Mr Collins had a number of risk factors that increased his risk of suicide and self-harm. He was often low in mood, had a history of relationship instability and maintained his innocence and refused to accept his sentence.

69. He was subject to ACCT monitoring on nine occasions, mainly because he refused to eat food. We found that that the ACCT process in general and most notably the more recent ACCT monitoring at Highpoint was managed well, with timely, multidisciplinary reviews completed and actions to address Mr Collins' immediate needs were added to a care plan and actioned.

70. During a multidisciplinary meeting in March 2023, while at HMP Onley, members of the chaplaincy team raised concerns about the number of telephone calls Mr Collins was making to his partner and felt, at that time, that if he had a negative telephone call, he was more likely to harm himself. Mr Collins placed significant importance on the support from his partner.

71. On 24 November, Mr Collins became angry during his partner's visit and eventually asked staff to tell her to leave. Mr Collins' partner said that this was not unusual. Mr Collins did not tell staff that he was upset by the visit. Staff were not aware that he subsequently tried to call his partner 61 times that evening. That he was unable to speak to her is likely to have been a cause of distress. However, we found no evidence that staff should have identified Mr Collins as at imminent risk of suicide, or that they should have considered beginning ACCT monitoring that evening.

Clinical care

72. The clinical reviewer concluded that the physical and mental health care Mr Collins received at Highpoint was partially equivalent to what he could have expected to receive in the community.

73. Mr Collins had a Do Not Attempt Cardiopulmonary Resuscitation order in place following his heart surgery. The clinical reviewer found that this information had not been shared with relevant staff. The clinical reviewer has made a recommendation about this which the Head of Healthcare will wish to address.

74. Healthcare staff did not review the medication Mr Collins was able to keep in his cell after his arrival at Highpoint. The clinical reviewer considered that this should have been done given his risk factors.

75. The clinical reviewer noted that Mr Collins had been treated for depression with antidepressant medication on and off since 1998. This, coupled with his recent psychiatric history and social circumstances, indicated that Mr Collins had complex needs. The clinical reviewer considered that Mr Collins' mental health needs assessment would have benefited from a systematic approach which should have been supported by standardised assessment tools that measured symptoms over time, in line with NICE guidance.

76. The clinical reviewer made some recommendations about record keeping and medication assessments which we do not repeat here but which the Head of Healthcare will wish to address.

Governor and Head of Healthcare to note

Resuscitation

77. Resuscitation Council (UK) guidelines state that staff should consider whether CPR efforts would be successful and, in the patient's best interests. The guidelines state that, 'resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile'. The guidelines define examples of futility as including the presence of rigor mortis. Rigor mortis normally sets in between two and six hours after death. When staff found Mr Collins, his body indicated the presence of rigor mortis and that he had been dead for some time.

78. We understand the wish to continue resuscitation until death has been formally recognised and that staff relied on the training they had received. We note that Highpoint's local safer custody policy did not reflect the above guidance. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The Governor will wish to consider this.

Good practice

79. During his time at Highpoint, Mr Collins received regular keywork and benefited from consistency with his assigned keyworker, and clear, meaningful records were maintained of those contacts. Staff knew Mr Collins well and there was evidence that they had developed a respectful relationship with him.

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